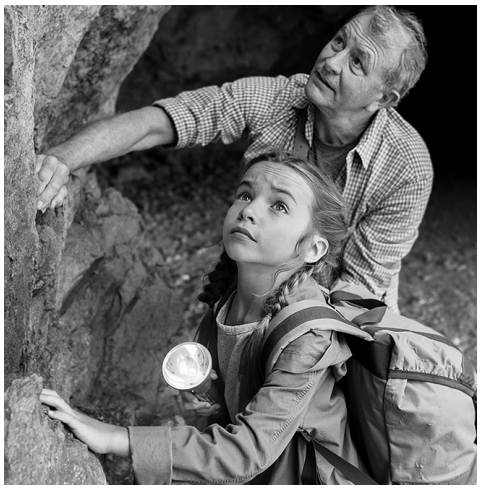
Administered by:

BlueCross BlueShield of New Mexico



YOUR HEALTH CARE BENEFITS PROGRAM

BlueEdge℠

A Preferred Provider Option (PPO) Plan

To be used in conjunction with the BlueEdge HCA Plan

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

A message from your group

Welcome to Blue Cross and Blue Shield of New Mexico's health care benefit **plan** for eligible employees and 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 **claim administrator** for this health care benefit **plan**.

Under your PPO Blue Preferred **plan**, you are not restricted to using certain network Providers exclusively but may also choose to receive most benefits services outside the network at a reduced benefit level..

The BlueEdge HCA is a health coverage **plan** that includes an HCA (Health Care Account) to help cover medical expenses. It offers a broad statewide network, that allows **members** the freedom to choose their providers without needing referrals. BlueEdge HCA allow **members** to effectively manage their healthcare spending.

Please take some time to get to know your health care benefit **plan** coverage, including its benefit limits and exclusions, by reviewing this important document and any enclosures. Learning how this **plan** works can help make the best use of your **health care benefits**.

If you have any questions once you have read this **benefit booklet**, talk to your benefits administrator or call us at the number listed on the back of your **ID card**, or as listed in the **CUSTOMER SERVICE** section above. It is important to all of us that you understand the protection this coverage gives you.

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

Note: This **plan**'s benefit administrator and your group may change the benefits described in this **benefit booklet**. If that happens, BCBSNM or your group will notify you of those mutually agreed upon changes.

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QUICK REFERENCE

Where to Find the Answer	
Provider Directory	www.bcbsnm.com
Prescription Drug List	www.bcbsnm.com/prescription-drugs/managing-prescriptions/drug-lists
Prior Authorization List	www.bcbsnm.com
Preventive Care	www.bcbsnm.com//provider/clinical/clinical-resources/preventive-care-guidelines
• Customer Service • Prior Authorization • Inpatient **Admissions** • Appeals • **Claim** Forms • Prescription Drug • Mail-Order Services • Pharmacy Locator	See **CUSTOMER SERVICE** section in this **benefit booklet** for contact information such as phone numbers, websites and mailing addresses where available
Definitions	See **GLOSSARY** section. Defined terms are in bold in your booklet
Your cost share information for **covered services**	Contact your employer for a copy of the **SUMMARY OF BENEFITS and COVERAGE (SBC)**

CUSTOMER SERVICE

Medical Benefits	Call	Website
Customer Service Helpline	See telephone number on the back of your **identification card**	www.bcbsnm.com BCBSNM Provider Directory Prior Authorization Wellness Other Online Services and Information
Prior Authorization Non-**Behavioral Health** and **Behavioral Health**	See telephone number on the back of your **identification card**	
Inpatient admissions Non-**Behavioral Health** and **Behavioral Health**	See telephone number on the back of your **identification card**	

Self-Service Member Portal Blue Access For Members (BAM)	**Website**
Provider Directory	www.bcbsnm.com
Identification card	www.bcbsnm.com

For Medical Appeals Send via fax or mail to	**Fax**	**Mailing Address:**
Non-**Behavioral Health**	(505) 816-3837	Blue Cross Blue Shield of New Mexico P.O. Box 660058 Dallas, TX 75266
Behavioral Health/Mental Health/Substance Use Disorder Treatment	(505) 816-3837	

BLUECARD® NATIONWIDE/WORLDWIDE COVERAGE PROGRAM

BLUE CROSS BLUE SHIELD GLOBAL CORE

1-800-810-BLUE (2583) – www.bcbsnm.com/provider

MDLIVE® 1-888-684-4233

Where to Mail Completed Claim Forms

For Medical Claims	Prescription Drug Claims
Blue Cross Blue Shield of New Mexico P.O. Box 660058 Dallas, TX 75266	Prime Therapeutics LLC PO Box 25136 Lehigh Valley, PA 18002-5136

INTRODUCTION

This is your **health care benefits booklet**. It describes your **covered services**, what they are and how you obtain them.

The defined terms throughout this booklet are in bold font and are defined in the **GLOSSARY** or defined within the applicable section.

The terms "you," "your", and "**member**" are used in this **benefit booklet** in reference to the **employee** or **subscriber**. The terms "us, " and "we" are used in this **benefit booklet** in reference to 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 **claim administrator** for this self-funded health care benefit **plan**.

Your Identification Card

We will mail you your **identification card**. Show your **identification card** each time you receive services from a **provider**. If you haven't received it before you need **covered services**, or if you lose it, you can print a temporary card on the member website at www.bcbsnm.com//member. Only members on your **plan** can use your **identification card**.

Provider Network Directory

The **provider** network directory is available through the BCBSNM website at www.bcbsnm.com. It lists all **providers** 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.

About Your Summary of Benefits and Coverage (SBC)

Your **Summary of Benefits and Coverage (SBC)** shows the out-of-pocket costs you are responsible for when you receive **covered services.** It may also show benefit limitations or other useful information that apply to your **plan**.

Out-of-pocket costs include things like **deductibles**, **copayments,** and **coinsurance**. Limitations include things like maximum age, visits, days, hours, and **admissions**.

Your **Summary of Benefits and Coverage (SBC)** will also show any total maximum out-of-pocket limit(s) that may apply.

You are responsible for paying your part of the cost sharing. You are also responsible for costs not covered by us.

See **HOW THE PLAN WORKS** below and your **Summary of Benefits and Coverage (SBC)** for more information.

What Medical Necessity/Medically Necessary Means

You will see the terms **medical necessity** or **medically necessary** in your **benefit booklet**. The **GLOSSARY** defines it but resources like Customer Service or Blue Access for Members℠ (BAM) can help you with questions on if specific services meet the requirements to be considered **medically necessary** or meet **medical necessity**.

Your **plan** pays for its share of the costs for **covered services** when these requirements are met:

- The service is **medically necessary** and/or meets **medical necessity** requirements.
- For preferred **benefits**, you get the service from a **preferred provider**.
- Your **provider** or you get **prior authorization** on services when required.

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.

WHO GETS BENEFITS

No eligibility rules or variations in premium will be imposed based on your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other **health status related factor**. **Benefits** under this **plan** are provided regardless of your race, color, national origin, disability, age, sex, gender identity, sexual orientation, political affiliation, or expression. Variations in the administration, processes or **benefits** of this **plan** that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

Eligibility Requirements

The **eligibility date** is the date you or your **dependents** qualify to be covered under this **plan**. You are eligible for coverage under this **benefit booklet** when you satisfy the following:

- Meet the definition of an eligible person as specified by your **employer.**
- Have applied for this coverage.
- Have received a Blue Cross and Blue Shield of New Mexico **identification card.**

Dependent Eligibility

If you apply for coverage, you may include your **dependents**. Eligible **dependents** are:

- Your spouse
- Your **domestic partner**
- Your **child** until the end of the month they turn age 26.
- Any other **child** such as a step**child**, an eligible foster **child**, an adopted **child** or **child** placed for adoption (including a **child** for whom you, your spouse or your **domestic partner** is a party in a legal action in which the adoption of the **child** is sought), under 26 years of age.
- An unmarried **child** who is medically certified as **totally disabled** and dependent upon you, your spouse or **domestic partner**, is eligible to continue coverage beyond age 26, provided the disability began before the **child** turned age 26.

Note: domestic partner coverage is available at your **employer's** discretion. Contact your **employer** for information on whether **domestic partner** coverage is available for your group.

Information for Noncustodial Parents

When a **child** is covered by the **plan** under the noncustodial parent:

- Information needed for the **child** to receive **plan benefits** will be shared with the custodial parent.
- The custodial parent or the **provider,** with the custodial parent's approval, can submit claims for **covered services**.
- Payments for approved claims will be made directly to the custodial parent, **provider**, or the state Medicaid agency if applicable.

Applying For Coverage

You and your eligible **dependents** can apply for coverage during the following time periods by contacting your **employer**:

- During the **open enrollment period**
- At special enrollment periods during the year

Some **employers** may only offer coverage to their **employees** and not to their **employee's dependents.**

Open Enrollment Period

Your group will designate an **open enrollment period** during which you may apply for or change coverage for you and, your eligible **dependents**, **domestic partners** and their **eligible children**. If your employer offers employees more than one choice of health **plan**, you and your **eligible family members** may change coverage to one of the other health care **plans** for which the **subscriber** meets eligibility requirements. This is the only period during which a **member** may "voluntarily" change from one health care **plan** to another for which they are eligible.

Special Enrollment Period

You may apply for or change coverage for yourself and your eligible **dependents** during the following qualifying events:

- You or your dependent lose other health insurance coverage or COBRA continuation coverage.
- You lose a dependent.
- You gain a dependent through birth, adoption, or placement for adoption, legal guardianship, or placement of a foster child.
- You gain a dependent through marriage or court ordered coverage.
- You or your dependent lose eligibility for coverage under a Medicaid plan or a state child health plan under Title XXI of the Social Security Act.
- You or your dependent become eligible for assistance under a Medicaid plan or a state child health plan.

Employee Application / Change Form

You must notify the group **within 31** days following any changes that may affect you or a family Member's eligibility. You can obtain an **employee** application / change form from your **employer**, by calling the number on your **identification card** or by accessing your self-service member portal, Blue Access for Members℠ (BAM) for the qualifying events listed above in addition to:

- Updating you and your **dependents'** name
- Updating you and your **dependents'** address
- Cancel all or a portion of your coverage.

An address change may result in benefit changes for you and your **dependents** if you move out of the **service area** of the **network**.

Members covered under federal continuation must submit enrollment/change forms directly to the COBRA administrator.

Late Enrollment

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 **plan** (e.g., a newborn child added to coverage more than 31 days after birth when, for example, family coverage (or Employee/Children coverage, if available) is not already in effect, a **child** added

more than 31 days after legal adoption, or a new spouse or stepchild added more than 31 days after marriage).

- Anyone enrolling on the group's initial BCBSNM enrollment date who was not covered under the group's prior plan (but who was eligible for such coverage).
- Anyone eligible but not enrolled during the group's initial enrollment; and
- Anyone who voluntarily terminates their coverage and applies for reinstatement of such coverage later (except as a Provider under USERRA of 1994).

Application for coverage from **late applicants** will be accepted only during your group's annual **open enrollment** period, except as described under **Special Enrollment Period**.

When Coverage Begins

Coverage begins after you have applied for coverage for yourself and your eligible **dependents**. The **effective date** is the date coverage begins. It may be different from the eligibility date.

This **plan** does not cover any service received before your **effective date of coverage** (which, for **eligible family members**, may be later than the **subscriber's** effective date). Also, if your prior coverage has an extension of benefits provision, this **plan** will not cover those charges incurred after your effective date that are covered under the prior benefit plan.

Dependent Special Enrollment Coverage

Coverage begins on the first day of the month following the date the application for coverage is received if you apply for this change within 31 days of the qualifying event.

However, if a court has ordered you to provide coverage, coverage begins the date the order has been filed as public record with the State or the effective date of family coverage, if available, whichever is later. Your group must receive a copy of the court or administrative order.

Coverage is automatic for the first 31 days for the following qualifying event. For coverage to continue beyond this time, you must apply for this change within the 31-day period:

- You gain a dependent through birth, adoption or placement for adoption, legal guardianship, or placement of a foster child.

Medicaid or Child Health Plan Special Enrollment Coverage

Coverage begins no later than the first of the month if you apply within 60 days of the following qualifying event:

- You or your dependent lose eligibility for coverage under a Medicaid plan or a state child health plan under Title XXI of the Social Security Act.
- You or your dependent become eligible for assistance under such Medicaid plan or state child health plan.

Loss of Other Health Insurance Special Enrollment Coverage

Coverage begins no later than the first of the month if you apply within 31 days of any of the following qualifying events:

- You or your dependent lose other health insurance coverage or COBRA continuation coverage.

The special enrollment period for loss of other health insurance coverage is available to you and your **dependent** who meet the following requirements:

- You and your dependent were covered under other health insurance coverage or COBRA continuation coverage when you were first eligible to enroll for this coverage.

You and your **dependent** lost the other health insurance coverage due to:

- Legal separation
- Divorce or the end of a domestic partnership.
- Death of a spouse or domestic partner
- Termination of employment or reduction of hours
- COBRA continuation coverage is terminated as explained in **COBRA Continuation Coverage section**.
- You and your **dependent** did not lose coverage due to failure to pay premiums or fraud.

If it was required, you stated in writing that you and your dependent were covered by other health insurance or COBRA continuation coverage as reason for declining enrollment in this coverage.

Medicaid/SCHIP Group health Plan Premium Assistance Eligibility

A state may offer premium subsidies through Medicaid or a state child health plan (SCHIP) to low-income children and their families for qualified employer-sponsored coverage. This includes premium assistance for continuation coverage under federal or state law. Therefore, if an eligible employee or an **eligible family member** is not enrolled in the **plan** and later becomes eligible for **group health care plan** premium assistance under Medicaid or under SCHIP, the eligible person may enroll in the **plan** without being considered a **late applicant**. To be eligible for **special enrollment**, the affected person must apply for coverage through the employer no later than 60 days after becoming eligible for premium assistance. For a family member to be eligible for **special enrollment**, the employee must be covered under the employer's health plan. If the employee is not enrolled in the **plan** when the **eligible family member** becomes eligible for assistance, the employee must enroll into the p**lan** at the same time as the **eligible family member**.

Documentation from the state – supporting the fact that the person is eligible for premium assistance from Medicaid or SCHIP – may be submitted later with the employer's approval, but the employee must submit the completed and signed enrollment/change form within 60 days of the affected person's premium assistance eligibility date.

Note: Enrollment changes cannot be processed until all documentation is provided to the employer.

The current employee who is eligible but not enrolled for coverage under the terms of the **group health care plan** (or a dependent of such an employee who is eligible but not enrolled for **group health care plan** coverage under such terms) may enroll in the **group health care plan** upon becoming eligible for a state premium assistance subsidy under Medicaid or SCHIP if **special enrollment** is requested in a timely manner.

Medicare-Eligible Members

Shortly before you turn age 65 or qualify for **Medicare** benefits for other reasons, you are responsible for contacting the local Social Security office to establish **Medicare** eligibility. You should then contact your benefits administrator to discuss coverage options.

If an active employee qualifies under the provisions of federal law for the working aged (TEFRA), then the working employee aged 65 or older and/or their eligible spouse aged 65 or older who is covered by **Medicare** may continue this **plan** coverage as primary over **Medicare** until the eligible employee retires.

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

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

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

In addition to the **GLOSSARY** section of this benefit booklet, the following definitions apply to this section:

Open Enrollment Period means the 31-day period preceding the next **contract date** during which **employees** and **dependents** may enroll for coverage.

HOW THE PLAN WORKS

Your **Summary of Benefits and Coverage (SBC)** lists what you pay for each type of **covered service**. In general, this is how your **benefits** work:

- You pay the **deductible** when it applies. Then we, the **plan** and you, the **participant**, share the expense. Your share is called a **copayment** or a **coinsurance amount**.
- Then we, the **plan**, pay the entire expense after you reach your **out-of-pocket maximum**.
- Expenses in this general rule means the **allowable amount** for services received from a **preferred provider** and **non-preferred provider**.

Allowable Amount

The **allowable amount** is the maximum amount of benefits we will pay for expenses you incur under the **plan**. We have established an **allowable amount** for:

- **Medically necessary** services, supplies, and procedures provided by **preferred providers** that have contracted with us or any other Blue Cross and/or Blue Shield Plan.
- **Medically necessary** services, supplies, and procedures provided by **non-preferred providers** that have not contracted with us or any other Blue Cross and/or Blue Shield Plan.

When you choose to receive **medically necessary** services, supplies, or care from a **provider** that does not contract with us, you will be responsible for any difference between our **allowable amount** and the amount charged by the **non-preferred provider**.

You will also be responsible for the charges incurred for services, supplies, and procedures limited or not covered under the **plan.**

Coinsurance

For some **covered services**, you must pay a percentage of **covered charges** after you have met your annual **deductible**. This amount is your **coinsurance.** After your **coinsurance** has been calculated, this **plan** pays the rest of the **covered charge**, up to maximum benefit limits, if any. You pay a lower **coinsurance** when you visit a **preferred provider**.

Copayments (Copays)

Some of the care and treatment you receive under the **plan** will require that a **copayment** be paid at the time you receive the services. Refer to your **Summary of Benefits and Coverage (SBC)** for your **copayments.**

Copayments do not apply to services received from **non-preferred providers**.

Benefits for the following **covered services** will be provided at the payment levels shown in your **Summary of Benefits and Coverage (SBC).** Services may be subject to **deductible** and/or **coinsurance** (if applicable):

- Any services provided during the office visit or at the time of consultation (i.e. lab and x-ray services).
- Surgery performed in the physician's office.
- Surgery performed in the urgent care center.

- Physical therapy billed separately from an office visit.
- Physical therapy billed separately from an **urgent care** visit.
- Occupational modalities in conjunction with physical therapy.
- Allergy injections billed separately from an office visit.
- Therapeutic injections
- Any services requiring prior authorization.
- Certain diagnostic procedures, if shown on your **Summary of Benefits and Coverage (SBC)**.
- Imaging services, if shown on your **Summary of Benefits and Coverage (SBC)**.
- Services provided by an independent laboratory, imaging center, radiologist, pathologist, and anesthesiologist.
- Outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.

Deductible(s)

Benefits under your **plan** will be available after you meet your **deductible(s)** as shown on your **Summary of Benefits and Coverage (SBC)**.

How individual **deductibles** work**:**

- **Benefits** will be available after your individual deductible amount, shown under your **Summary of Benefits and Coverage (SBC),** have been met.

How family **deductibles** work:

- If a single-family member reaches the individual **deductible** shown under your **Summary of Benefits and Coverage (SBC),** they will be eligible for **benefits** and do not have to wait for other family members to meet their **deductible**. This is known as an embedded family **deductible**.
- A family member may not apply more than the individual **deductible** amount toward the family **deductible** amount.

Should the federal government adjust the **deductible** amount(s) applicable to this type of coverage, the **deductible** amount(s) will be adjusted accordingly.

What is not subject to the **deductible**:

- **Preventive care**
- Primary preferred provider office visit charges
- Charges covered under your **Drug Plan Rider**
- Fixed-dollar **copayments** or services with no charge
- The following services when received from Preferred Providers: preventive care, and other diagnostic tests, (excluding MRIs, PET scans, and CT scans)
- The fitting and dispensing of hearing aids and ear molds for Members under the age of 21; and
- MRI, cardiac CT scans, CAC tests, PET scans.

Admissions Spanning Two Calendar Years

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

How Out-of-Pocket Maximums Work

The **out-of-pocket maximum** is the total amount of **deductibles**, **copayments** and/or **coinsurance** which must be satisfied during your **benefit period** for all **covered services** received from **preferred providers** before the **plan** will begin to cover all charges at 100% for the remainder of the **benefit period**.

How Individual Out-of-Pocket Maximums Work

When you have met the **out-of-pocket maximum** specified in your **Summary of Benefits and Coverage (SBC)**, no additional **deductible**, **copayment** and/or **coinsurance** will be required for **covered services** you receive during the remainder of your **benefit period**.

How Family Out-of-Pocket Maximums Work

If you have family coverage and your family's out-of-pocket payments during the **benefit period** equals the family **out-of- pocket maximum shown** under the **Summary of Benefits and Coverage (SBC)** then for the rest of the **benefit period**, all family members will have **benefits** for **covered services** (except for those charges specifically excluded below) paid by us at 100% of the **allowable amount**.

The **out-of-pocket maximum** will not include:

- Any penalty incurred due to your failure to follow the **plan's** requirements for prior authorization.
- Services, supplies, or charges limited or excluded by the **plan**.
- Charges covered under your **drug plan rider**.

Benefit Limits

There is no general lifetime maximum benefit under this **plan**. However, certain services have separate benefit limits per **admission** or per **benefit period** specified in your **Summary of Benefits and Coverage (SBC)**.

Preferred Provider Option 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 care**.

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 they are 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.

Preferred Providers

To receive preferred **benefits** as shown under your **Summary of Benefits and Coverage (SBC)**, you must choose a **primary preferred provider (PPP) or other preferred provider** within the network (except for emergencies).

We have established a network of **providers** that may offer care and **covered services** to you and your dependents. These include:

- **Physicians**
- **Providers**
- Specialists
- **Hospitals** and
- other health care facilities

When you choose a **preferred provider**, the **provider** will bill us, not you, for services provided.

For help in finding a **primary preferred provider** or other **preferred provider** you can view our **provider** directory by visiting our website at www.bcbsnm.com. A paper copy of the BCBSNM *Preferred Provider Network Directory*, is also available to you upon request. Contact BCBSNM Customer Service and one will be mailed to you free of charge.

- You pay an annual deductible and a lower percentage of **covered charges** (**coinsurance**) after the **deductible** is met for exception, see last item, below).
- You have a lower annual **out-of-pocket** limit.
- The **provider** will not bill you for amounts above the **covered charge**.
- **Preferred providers** that contract directly with BCBSNM will obtain necessary **prior authorizations** for you.
- Primary **preferred provider** (**PPP**) office visit charges are not subject to **deductible**. You pay only a fixed-dollar **copay** (see "Cost-Sharing Features" for details). Other services of a **PPP** and services of a non-**PPP preferred provider** are subject to **deductible** and **coinsurance** (see "Cost-Sharing Features" for details).

Non-Preferred Providers

If you choose a **non-preferred provider**, only **non-preferred benefits** will be available. If you go to a **provider** outside of the network, then **benefits** will be paid at the **non-preferred** benefit level. You may have to pay in full and then submit a claim to us for reimbursement.

- You pay a higher annual **deductible** and a higher **coinsurance** percentage percentage of **covered charges** after the **deductible** is met.
- You have a higher annual **out-of-pocket** limit to meet for **nonpreferred provider** benefit levels.
- You may need to file claims.
- You may have to pay amounts above the **covered charge**.
- You are responsible for **admission** review and other **prior authorization**.
- Some benefits are not available unless services are received from a **preferred provider**. See your **Summary of Benefits and Coverage (SBC)** for those services not covered at the **preferred provider** benefit level.
- **nonpreferred provider** services are not eligible for the **PPP** office visit **copayment**, even if required due to an emergency.

Federal Balance Billing and Other Protections

This section is based upon the No Surprises Act, a federal law enacted in 2020 and effective for **plan years** beginning on or after January 1, 2022. Unless otherwise required by federal or New Mexico law, if

there is a conflict between the terms of this Federal Balance Billing and Other Protections section and the terms in the rest of this certificate, the terms of this section will apply.

Continuity of Care

If you are under the care of a **preferred 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:

- You are undergoing a course of treatment for a serious and complex condition.
- You are undergoing institutional or inpatient care.
- You are scheduled to undergo nonelective surgery from the **provider** (including receipt of postoperative care from such **provider** with respect to such surgery).
- You are pregnant or undergoing a course of treatment for your pregnancy.
- You are determined to be terminally ill.

A serious and complex condition is one that:

- 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).
- For a chronic illness or condition:
    - Life-threatening, degenerative, disabling or potentially disabling, or congenital.
    - 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**.

Protections From Unexpected Costs for Medical Services from Non-Preferred Providers

Your **benefit booklet** contains provisions related to protection from surprise balance billing under New Mexico law. The federal laws provide additional financial protections for you when you receive some types of care from **providers** who do not participate in your **network**. If you receive the types of care listed below, your **preferred** cost-sharing levels will apply to any **network deductible** and **out-of-pocket maximums**. Additionally, for services below that are governed by federal law (instead of state law), your cost-share amount may be calculated on an amount that generally represents the median payment rate that New Mexico has negotiated with **preferred providers** for similar services in the area:

- **Emergency care** from facilities or **providers** who do not participate in your **network.**
- Care furnished by **non-preferred providers** during your visit to a **preferred** facility.
- Air **ambulance** services from **non-preferred providers** if the services would be covered by **preferred providers.**

Non-preferred or non-participating providers may not bill you for more than your **deductible**, **coinsurance amount** or **copayments** for the service types referenced above. There are limited instances when a **non-preferred network** or **non-participating provider** may send you a bill (for the care services referenced above) for up to the amount of that **provider**'s billed charges.

The requirements of federal law that impact your costs for care from **non-participating provider**s may not apply in all cases. Sometimes, New Mexico law provisions relating to balance billing prohibitions may apply. You may contact us at the number on the back of your **identification card** with questions about claims or bills you have received from **providers**.

To the extent state and federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this section, the regulations and any additional guidance will control over conflicting language in this section.

Note: You are only responsible for payment of the **non-participating provider**'s billed charges if, in advance of receiving services, you signed a written notice form that complies with applicable state and/or federal law.

Transition of Care

This provision applies to both **Continuity of Care** and **Transition of Care** sections of this **benefit booklet**. 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 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:

- 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.
- 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.
- The second or third trimester of pregnancy, through the postpartum period.
- Ongoing course of treatment for a health condition for which a treating Physician or health care **provider** attests that discontinuing care by that Physician or health care **provider** would worsen the condition or interfere with anticipated outcomes.

The period will be sufficient to permit coordinated transition planning consistent with your condition and needs. Special provisions may apply if the required transitional period exceeds 30 days. Call the BCBSNM Customer Service department for details.

If **medically necessary covered services** are not available through network Professional **providers**, BCBSNM and the network **professional** will refer you to an out-of-network **professional**. However, the payment for the out-of-network **provider** will not exceed the payment that would have been made in the absence of any referral.

Note: You have the right to **appeal** any decision made for a request for Benefits under this provision, as explained in Claims Filing and Appeals Procedures.

Members who extend coverage under an extension of benefits due to disability after the group contract is terminated 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.

Note: These are the only instances in which the services of a non-preferred provider will be covered.

COVERED SERVICES

This section describes **covered services** for which your **plan** pays **benefits** for you and your eligible **dependents. Covered services** must also meet the criteria for **medically necessary**. Some services may require **prior authorization.** It is your responsibility to ensure that **prior authorization** is obtained, or those services may carry a cost share penalty or a denial of payment. Refer to the **UTILIZATION MANAGEMENT** section or contact Customer Service by calling the number on the back of your **identification card** or visiting the Blue Access for Members℠ (BAM) website for additional information including which services may require **prior authorization**.

Some services may be **covered services** but are not listed in your booklet. For assistance determining if a service will be covered you may call the number on the back of your insurance **identification card**.

Covered services appear alphabetically.

Acupuncture

Covered services include:

- Standard manual **acupuncture**

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

Ambulances Services

Covered services include:

- Emergency ground transportation by means of a specifically designed and medically equipped vehicle used for transporting the sick and injured.

Non-emergency ground **ambulance** transportation to or from a **hospital** or medical facility, outside of the acute care **hospital** setting, may be considered **medically necessary** if your condition is such that trained **ambulance** attendants are required to monitor your clinical status (e.g., vital signs and oxygenation), or provide treatment such as oxygen, intravenous fluids or drugs, in order to safely transport you, or you are confined to bed and cannot be safely transported by any other means.

Air **ambulance** emergency transportation is covered when:

- Terrain and/or distance require the use of air **ambulance** services rather than ground **ambulance**.
- Your physical condition or other medical circumstance is critical and requires rapid transportation from one hospital/facility to another.
- High-risk maternity and newborn transport to **tertiary care facilities**.

Non-emergency air **ambulance** services require **prior authorization**. 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.

Outside the Service Area

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

The following are **not covered services**:

- 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 Disorder

Covered services include:

- Psychiatric care, including diagnostic services
- Psychological assessments and treatments
- Habilitative or rehabilitative treatments
- Therapeutic care, including behavioral speech, occupational and physical therapies that provide treatment in the following areas:
    - Self-care and feeding
    - Pragmatic, receptive, and expressive language
    - Cognitive functioning
    - **Applied Behavior Analysis (ABA)** intervention and modification
    - Motor planning
    - Sensory processing

The following are **not covered services**:

- Any Experimental, long-term, or maintenance treatments unless listed above.
- Any services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children 3 to 22 years old who have **autism spectrum disorder**.
- Services in accordance with a treatment plan that has not obtained prior authorization from BCBSNM.
- Respite services or care.
- Sensory Integration Therapy (SIT) or Auditory Integration Therapy (AIT).
- Music therapy, vision therapy, or touch or massage therapy.
- Floor time.
- Facilitated communication.
- Elimination diets; nutritional supplements; intravenous immune globulin infusion; secretin infusion.
- Chelation, Hippotherapy, animal therapy, or art therapy.

Applied Behavioral Analysis (ABA) means 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.

The following **Applied Behavior Analysis** (**ABA**) **are not covered services:**

- Services with a primary diagnosis that is not **autism spectrum disorder.**
- Services by a provider that is not properly credentialed.
- Activities primarily of an educational nature
- Respite, shadow, or companion services.

Autism spectrum disorder means a **neurobiological disorder** that includes autism, Asperger's syndrome, or pervasive developmental disorder not otherwise specified.

A **neurobiological disorder** means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

Behavioral Health

Behavioral Health Treatment

Covered services include:

- The treatment of **behavioral health** conditions provided by:
  - A hospital
  - **Psychiatric hospital**
  - **Residential treatment center**
- Office visits with a physician, **behavioral health provider**, psychiatrist, psychologist, social worker, or licensed professional counselor
- Partial hospitalization treatment
- **Intensive outpatient program** Electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)

Intensive Outpatient Program (IOP) mean distinct levels or phases of treatment that are provided by a certified/licensed substance use disorder or **behavioral health** program. IOPs provide a combination of individual, family, and/or group therapy in a day, totaling nine or more hours in a week.

Psychiatric Hospital means 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.

Residential Treatment Center means facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a level of security, supervision, and structure medically necessary to meet the needs of patients served or to be served by such facility. **Residential Treatment Centers** must be licensed by the appropriate state and local authority as a Residential Treatment Facility or its equivalent under the laws or regulations of such locality and/or must be accredited by a national accrediting body as a **Residential Treatment Center** or its equivalent. Accepted accrediting bodies are The Joint Commission, Commission on Accreditation of

Rehabilitation Facilities (CARF), Accreditation Association for Ambulatory Healthcare (AAAHC), Council on Accreditation of Services for Families and Children Inc. (COA), or National Integrated Accreditation of Healthcare Organizations (NIAHOSM). This includes any specialized licensing that may be applicable given the services to be provided or population to be served. As they do not provide the level of care, security, or supervision appropriate of a **Residential Treatment Center**, the following shall not be included in the definition of **Residential Treatment Center**: half-way houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive/custodial environment and/or primarily address long term social needs, even if counseling is provided in such facilities. To qualify as a **Residential Treatment Center**, patients must be medically monitored with 24-hour medical professional availability and on-site nursing care and supervision for at least one shift a day with on call availability for the other shifts.

The following are **not covered services**:

Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses, or group homes.

Behavioral Health and Substance Use Disorder Services

Covered services include:

- Treatment of **behavioral health** and/or substance use disorders.
- Inpatient benefits will also be provided for the diagnosis and/or treatment of **behavioral health** and/or substance use disorder in a residential treatment center.
- **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.

Medical detoxification means treatment in an acute care facility for withdrawal from the physiological effects of alcohol or **drug abuse**.

No Cost Sharing for In-Network Behavioral Health Services

Cost sharing is eliminated for all professional and ancillary services for the treatment, rehabilitation, prevention and identification of behavioral health, substance use disorders and trauma spectrum disorders. This includes cost sharing for inpatient, detoxification, residential treatment and partial hospitalization, intensive outpatient therapy, outpatient, and all medications, including brand-name pharmacy drugs when generics are unavailable.

Biomarker Testing

Covered services include **biomarker testing** for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of a disease or condition.

Biomarker testing means analysis of tissue, blood, or other biospecimen for the presence of a biomarker, including single-analyte tests, multi-plex panel tests, protein expression and whole exome, whole genome, and whole transcriptome sequencing.

Chiropractic Services

Covered services include:

- Standard chiropractic services

Benefits for Chiropractic Services will not be subject to a **copayment** or **coinsurance** that exceeds the **copayment** or **coinsurance** for primary care services.

Clinical Trials

Covered services include:

- **Routine patient costs** and related services you have from a provider in connection with participation in an approved **clinical trial**.

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.
- Services that are usually provided following the non-covered service, such as follow up care or therapy after surgery.
- Approved **clinical trial** means a Phase I, Phase II, Phase III, or Phase IV **clinical trial** that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.

The following are **not covered services**:

- The investigational item, device, or service itself.
- Items or services that are provided solely for data collection or analysis.
- A service that is inconsistent with established standards of care for a given diagnosis.

Routine patient costs mean the cost for all covered items and services provided in this **benefit booklet** that are normally covered for you if you are not enrolled in a **clinical trial**.

Cardiovascular Disease Early Detection Tests

Covered services include early detection test for cardiovascular disease. Computed tomography (CT) scanning measuring coronary artery calcifications (CAC) tests are available to:

- **Members** who are between the ages of 45 and 65 years of age
- **Members** at five-year intervals who have previously received a CT scan measuring CAC with a score of zero.

Cosmetic, Reconstructive, or Plastic Surgery

Covered services may include only those that are **medically necessary** for any of the following circumstances:

- Correction of defects caused by an **accidental injury**.
- Reconstructive surgery following cancer surgery or a mastectomy.
- Correction of a congenital defect, development deformity, functional impairment or craniofacial disfigurement and abnormalities.
- Breast implant removal resulting from sickness or injury.

The following are **not covered services**:

- Any services, surgery, procedures or supplies solely for cosmetic enhancement reasons.
- Breast implant solely for cosmetic reasons, breast implant removal of breast implants that were solely for cosmetic reasons.
- Any services or supplies provided for reduction mammoplasty.

Dental Services and Oral Surgery

Covered services include:

- Anesthesia and facility costs for dental care
- Oral surgery
- Services for treatment or correction of a congenital defect
- The correction of damage caused by **accidental injury**.

For **medically necessary** dental services to be covered in a **hospita**l or surgery center, your **provider** must certify that the dental care you receive could not be performed in the dentist's office due to a physical, mental, or medical condition.

To be covered, *initial* treatment for the **accidental injury** should be sought as soon as possible after an accident to minimize any adverse effects that may occur due to lack of appropriate medical attention. Any services required after the initial treatment must be associated with the initial accident to be covered. Dental injury caused by chewing, biting, or malocclusion is not considered an **accidental injury**.

This **plan** covers inpatient or outpatient **hospital** expenses for dental-related services only if the patient is under age six or has a non-dental, hazardous physical condition (e.g., heart disease or hemophilia) that makes **hospitalization medically necessary**. All **hospital** services for dental-related and oral surgery services must obtain **Prior Authorization from** BCBSNM.

The following are **not covered services**:

- Routine dental care
- Standard dental treatments
- Dental appliances

Diabetic Equipment, Supplies and Self-Management

Covered services include any of the following for the treatment of type I, type II or gestational diabetes (prescribed by a physician or **other provider**):

- Diabetes self-management training in an inpatient or outpatient setting which enables you to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications.
- Visits for re-education and refresher training.
- Telephonic visits with a certified diabetes educator.
- Medical nutrition therapy relating to diet, caloric intake, and diabetes management.
- Medically necessary podiatric DME for the treatment of active diabetic foot ulcers, including topical oxygen therapy.

Equipment:

- Blood glucose monitors
- Insulin pumps
- Lancet devices

Supplies:

- Test strips for glucose monitors
- Insulin syringes
- Lancets
- Visual reading strips and urine test strips
- Tablets which test for glucose, ketones, and protein
- Biohazard disposable containers
- Glucagon emergency kit

This **plan** covers supplies and equipment for diabetic **members** with elevated glucose levels. Supplies are not to exceed a 30-day supply purchased during any 30-day period.

Your **drug plan rider** provides additional diabetic supply coverage for insulin, insulin needles and syringes, visual reading urine and ketone strips; lancets and lancet devices; prescriptive oral agents for controlling blood sugar levels; test strips for glucose monitors, and glucagon **emergency** kits.

Absent a change in diagnosis, management, or treatment of diabetes or its complications, only one **prior authorization** will be required for each covered diabetic supply or covered diabetic drug, per **plan year**, if prescribed as **medically necessary** by a **health care provider**.

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:

- Maintain an adequate formulary to provide these resources to individuals with diabetes.
- 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**.
- Reimbursement will be provided within 30 days after receiving a written notice of claim in accordance with the claim procedures specified in Claim Filing and Appeals Procedures, or interest will be paid at the rate of eighteen percent (18%) per year.

Diagnostic and Supplemental Breast Examinations

Covered services include:

- Diagnostic and supplemental breast examinations without cost sharing when obtained from a **participating provider**.

Diagnostic Services

Covered services include:

- Tests, scans, and procedures specifically designed to detect and monitor a condition or disease.

The following are covered diagnostic and diagnostic imaging service examples:

- Radiology and x-ray
- Ultrasounds
- Nuclear medicine
- Laboratory and pathology
- ECG, EEG, PET, CT, MRI, and other electronic medical procedures
- Bone Scan
- Cardiac Stress Test
- Myelogram
- Sleep Studies

Diagnostic Services mean 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.

Durable Medical Equipment

Durable Medical Equipment and Appliances

Coverage includes:

- The rental and/or purchase of durable medical equipment with a written prescription for your therapeutic use. Rental equipment is not to exceed the total cost of the equipment. If you purchase your durable medical equipment the equipment will only be covered if you need it for long-term use.

The following are **covered** equipment examples:

- Wheelchair, cane, crutches, walker, ventilator, oxygen tank
- Mandibular reconstruction devices
- Internal cardiac valves, internal pacemakers
- External heart monitors (cardiac event detection monitoring device)

The following are examples of **non-covered** equipment:

- Modifications to home or vehicle such as: vehicle lifts or star lifts
- Biofeedback equipment.
- Computer assisted communication devices.
- Replacement of lost or stolen durable medical equipment.
- Personal comfort, hygiene or convenience items such as support garments and air purifiers.
- Physical fitness equipment.

Durable medical equipment (**DME**) means equipment or supplies ordered by a health care provider that help you complete your daily activities, serves a medical purpose and the equipment can withstand repeated daily or extended use.

Breast Pumps

Coverage includes:

- Rental of hospital grade breast pumps (not to 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.

Electric breast pumps 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**.

Medical Supplies

Coverage includes:

- 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 (limited to twelve per **calendar year**).

Medical Supplies mean 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**.

Orthotics and Prosthetic Devices

Coverage includes:

- Surgically implanted **prosthetics** or devices, including, but not limited to, penile implants required because of illness or **accidental injury.**
- Externally attached prostheses to replace a limb or other body part lost after **accidental injury** or surgical removal, fitting, adjustment, and repairs.
- Replacement of **prosthetics** only when required because of wear (and the item cannot be repaired) or because of a change in your condition.
- Breast **prosthetics** when required as the result of a mastectomy and mastectomy bras, which are limited to four bras per **calendar year**.
- Functional orthotics only for patients having a locomotive problem or gait difficulty resulting from mechanical problems of the foot, ankle, or leg. A functional orthotic is used to control the function of the joints and prescribed by a **physician** or podiatrist.
- Orthotics (e.g., collars, braces, molds) prescribed by an eligible **provider** to protect, restore, or improve impaired body function.

The following are examples of **non-covered** equipment:

- Air conditioners, biofeedback equipment, humidifiers, purifiers, self-help devices, or whirlpools.
- Items that are primarily nonmedical in nature such as jacuzzi units, hot tubs, exercise equipment, heating pads, hot water bottles, or diapers.
- Nonstandard or deluxe equipment, such as chairlifts, or beds.
- Repairs to items that you do not own.
- Comfort items such as bed boards, beds or mattresses of any kind, bathtub lifts, overbed tables, or telephone arms.
- Repair or rental costs that exceeds the purchase price of a new unit.
- 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.
- Equipment or supplies not ordered by a **health care provider**, including items used for comfort, convenience, or personal hygiene.
- Duplicate items; repairs to duplicate items; or the replacement of items because of loss, theft, or destruction.
- Stethoscopes or blood pressure monitors.
- Voice synthesizers or other communication devices.
- Items that can be purchased over the counter, including but not limited to dressings for wounds (i.e., bed sores) and burns, gauze, and bandages.
- Items not listed as covered.

Medical Benefit Therapeutic Alternatives

Certain prescription drugs administered by a health care professional have therapeutic equivalents or therapeutic alternatives that are used to treat the same condition. Benefits may be limited to only certain therapeutic equivalents or therapeutic alternatives. However, benefits may be provided for the therapeutic equivalents or therapeutic alternatives that are not otherwise covered under your benefit, if an exception is granted.

You may contact Customer Service at the toll-free telephone number on the back of your i**dentification card**, or visit www.bcbsnm.com/find-care/medical-rx for more information about covered therapeutic equivalents or therapeutic alternatives. To request an exception, you, your prescribing health care **provider**, or your authorized representative, can call the toll-free telephone number on the back of your **identification card**.

Therapeutic equivalents or therapeutic alternatives may be covered through your prescription drug benefit, depending on your benefit **plan**.

Medical Necessity and Nondiscrimination Standards for Coverage of Prosthetics and Orthotics

This **plan** provides coverage for initial and secondary prosthetic devices and custom orthotics in a non-discriminatory manner and without restriction based on predetermined utilization limits, at the same level and cost sharing as the coverage provided for medical and surgical benefits. Prosthetic and custom orthotic devices are considered habilitative and rehabilitative essential health benefits and are not subject to separate financial requirements or utilization restrictions.

Coverage includes:

- Clinical care
- All supplies, materials, and devices determined by the physician to be medically necessary and most appropriate to maximize upper and lower limb function, maintain activities of daily living or essential job-related activities, and meet the medical needs for physical activities such but not limited to running, biking, swimming, strength training.
- All services, including design, fabrication, and repair.
- Replacement of a device, any part of such devices, without regard to useful lifetime restrictions. If an ordering health care provider determines that a replacement device or a replacement part is necessary because of any of the following:
    - Change in your physiological condition.
    - Irreparable change in the condition of the device or in a part of the device.
    - The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than sixty percent of the cost of a replacement device or of the part being replaced.
- Access to prosthetic and custom orthotic devices from at least two (2) distinct device providers in your network.

Utilization management decisions related to coverage for prosthetic or custom orthotic devices will be applied in a non-discriminatory manner using the most recent version of evidence-based treatment and fit criteria as recognized by relevant clinical specialists or their organizations. Prosthetic and custom orthotic benefits will not be denied for an individual with limb loss or absence that would otherwise be covered for a non-disabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same daily functions and physical activity. However, coverage for prosthetic devices and custom orthotics will not be provided when required solely for comfort or convenience.

Emergency Services

Covered services include:

- **Emergency medical care** when you receive **covered services** that meet the definition of **emergency care** (see **GLOSSARY**), and services are received from a **participating provider** or a **non-participating provider** in a **hospital** emergency department.

If you visit a **non-preferred 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, follow-up care from a **non-preferred provider** is paid at the **non-preferred provider** benefit level. Non-emergency services provided in an emergency room for treatment of **behavioral disorders or substance use disorders** will be paid the same as **emergency care** services.

For follow-up care (which is no longer considered **emergency care**) and for all other **nonemergency care**, you will receive the **non-preferred provider** benefit for the services of a **non-preferred provider**, even if a **Preferred Provider** is not available to perform the service, except as specified below.

Emergency Admission Notification

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

You do not need BCBSNM authorization before seeking **emergency room** services or being **hospitalized** as an inpatient from the emergency room for **emergency care**. However, you should call BCBSNM for **prior authorization** of non-participating facility services or in order to notify BCBSNM of any emergency **inpatient admission** as soon as reasonably possible. Such services, when received without **prior authorization**, may be reviewed for **medical necessity**/appropriateness and you may be responsible for all charges.

Family Planning

Covered services include:

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

Your **coinsurance, deductible, copayment**, or any benefit maximum amounts will not apply when the following covered family planning services, are received from a **provider** in the **preferred** or participating **provider** network. When these services are received from an out-of-network **provider**, if your **plan** has out-of-network benefits for non-emergency services, the usual out-of-network **deductible, coinsurance**, and **out-of-pocket** will apply:

- Over-the-counter contraceptives.
- Contraceptives posted on the BCBSNM website (www.bcbsnm.com/) or available by contacting Customer Service at the toll-free number on your **identification 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.
- Contraception methods that are prescribed for the prevention of STIs, which means chlamydia, syphilis, gonorrhea, HIV, and relevant types of hepatitis, as well as any other sexually transmitted infections, regardless of mode of transportation.

When obtaining the items noted above you may be required to pay the full cost and then submit a claim form with itemized receipts to BCBSNM for reimbursement. Please refer to **Claim Filing and Appeals Procedures** of this **benefit booklet** for information regarding submitting claims.

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

Follow-Up Care

For all follow-up care (which is no longer considered **emergency care**) and for all other **nonemergency care**, you will receive the **non-preferred provider** benefit for the **covered services** of a **non-preferred provider**, even if a **preferred provider** is **not** available to perform the service.

Once you are discharged from the emergency room or **inpatient** setting, **prior authorization** for follow-up care from a nonparticipating **provider** must be obtained by BCBSNM in order to be covered. You should notify your PCP and/or BCBSNM as soon as possible after receiving the emergency room care or of being admitted as an **inpatient** in order to arrange for follow-up care.

Exclusions

This **plan** does not cover:

- The follow-up care received outside the Service Area as a result of an emergency or an urgent condition, if you could have returned to the Service Area to receive care without medically harmful results.
- Services received outside the Service Area if you could have foreseen the need for this care before leaving the Service Area.
- **Urgent Care** or follow-up care received from a nonparticipating Provider if it is not authorized in advance by BCBSNM.

Hearing Aids and Audiological Services

Covered services include:

- A hearing examination for the evaluation of hearing impairment, hard of hearing or hearing loss for **members** up to 21 years old.
- A hearing examination for the diagnosis and/or treatment of an **accidental injury** or an illness.

Hearing exam must be performed by a hearing specialist such as an audiologist.

Hearing Aids

Covered services include:

- Prescribed electronic hearing aids installed in accordance with a prescription written during a covered hearing exam.
- Any related services necessary to access, select, and adjust or fit a hearing aid.

The following are not **covered services**:

- Replacement of a hearing aid that is lost, stolen or broken.
- Replacement parts or repairs for a hearing aid
- Batteries or cords

Hearing aids means any wearable, non-disposable instrument or device designed to make up for impaired hearing including the parts, attachments, or accessories.

Benefits are limited to two hearing aid every 36 months for **members** up to 21 years old.

Hearing Implants

Covered services include:

- Internal placement of cochlear implants, an external speech processor and controller.
- Treatment related to the maintenance of your cochlear implants.

Implant components may be replaced as **medically necessary**.

Home Health Care

Covered services include:

- **Home health care** visits with a **hospital** program for **home health care** or an independent licensed home health care agency. A visit is one period of home health service of up to four hours.

Visits may include:

- Professional services of an RN, LPN or LVN
- Medical social service consultations
- Health aide services while you are receiving covered nursing or therapy services.
- Services of a licensed registered dietitian or licensed certified nutritionist, when authorized by your supervising physician and when medically necessary, including diabetes self-management training.
- Medical and surgical supplies
- Prescribed drugs
- Oxygen and its administration
- Physical, occupational, speech, and respiratory therapy services by licensed therapists

The following are **not covered services**:

- Food or home delivered meals
- Maintenance therapy
- Homemaker services
- Services provided primarily for custodial care
- Transportation services

Home health agency means a business that provides home health care and is licensed, approved, or certified by the appropriate agency of the state in which it is located or is certified by **Medicare** as a supplier of home health care.

Home health care means the health care services which are provided during a visit by a home health agency to patients confined at home due to a sickness or injury requiring skilled health services on an intermittent, part-time basis.

Prior Authorization Required

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

Hospice Care

Covered services include:

- Inpatient, outpatient, or hospice facility agency services
- In-home services which are part of a plan of care

Hospice care may be covered when:

- You have a terminal illness with a life expectancy of one year or less, as certified by your attending physician.
- You no longer benefit from standard medical care or have chosen to receive hospice care rather than other standard care.

The following are **not covered services**:

- Home delivered meals
- Homemaker services
- Transportation services
- Custodial care

Hospice Care means an integrated set of services designed to provide palliative and supportive care for terminally ill patients.

Infertility Treatment

Covered services include:

- Surgical treatments such as opening an obstructed fallopian tube, epididymis, or vas deferens when the obstruction is not the result of a surgical sterilization.
- Replacement of deficient, naturally occurring hormones if there is documented evidence of a deficiency of the hormone being replaced.

The above services are the only infertility-related treatments that will be considered for benefit payment.

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

Exclusions

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

- Sterilization reversal
- 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 birthing parent'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.

Infusion Therapy

Covered services include:

- Infusion and injectable therapy

Infusion therapy is prescribed when a patient's condition is so severe that it cannot be treated effectively by oral medications. **Infusion therapy** may also refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes into the membranes surrounding the spinal cord. **Infusion therapy,** in most cases, requires health care professional services for the safe and effective administration of the medication.

Infusion therapy means the administration of medication through a needle or catheter.

Inpatient Hospital Admission

Covered services include:

- Inpatient care received in a **hospital** setting, this includes:
    - Bed, board, and general nursing care when you are in a semi-private room, an intensive care unit or a private room.
- Ancillary services such as:
    - Anesthesia supplies and services rendered by an employee of the **hospital** or **other professional provider**.
    - Lab work
    - Medical and surgical dressings, supplies, casts, and splints
    - Operating, delivery and treatment rooms
    - Whole blood, blood processing and administration

Jaw Joint Disorder Treatment

Covered services include:

The diagnosis, services, supplies and surgical treatment of jaw joint disorder by a provider for:

- Temporomandibular joint dysfunction (TMJ)
- Myofascial pain dysfunction (MPD)
- Related jaw disorders

The following are **not covered services** for the treatment of TMJ and all adjacent muscles:

- Non-surgical therapies such as dental restorations, orthodontics, or physical therapy.
- Non-diagnostic services or supplies such as oral appliances, oral splints, oral orthotics, devices or prosthetics.

Pharmacist Services

Pursuant to a board -approved protocol approved by the New Mexico Medical Board, an in-network pharmacist may order, test, screen, treat, and provide **preventive care** for Flu, Strep Throat, SARS, UTIs, HIV for prep only, and an illness subject to an active Public Health Emergency.

Maternity Care

Covered services include:

Inpatient care for the birthing parent and newborn **child** in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery.
- 96 hours following an uncomplicated delivery by caesarean section.

BCBSNM must be notified if the birthing parent's stay is greater than 48 hours for a routine delivery or greater than 96 hours for a C-section delivery as soon as possible. If not notified, benefits for covered facility services may be reduced or denied.

Maternity care must be received from a participating women's health care **provider**. Therefore, once your pregnancy is confirmed, you may choose a participating women's health care **provider** to provide maternity care and receive benefits for **covered services**. If you are pregnant, you or your Physician should call BCBSNM for **admission** notification before your maternity due date or soon after your pregnancy is confirmed. The **provider** is then responsible for notifying BCBSNM of any **admissions**.

Note: If you are out-of-area and need emergency services, notify BCBSNM and your participating Provider within 48 hours or as soon as possible.

If there is no participating **provider** in your area able to provide maternity services, you or your provider may request authorization from BCBSNM to recommend you to a nonparticipating women's health care **provider**.

If you are pregnant on the date, you enroll and you are already seeing a **provider**, please call Customer Service so that BCBSNM can approve your visits to the **provider** if they are outside the participating **provider** network. If you are in your first or second trimester, in most cases you will be allowed to continue your care with that doctor for at least 30 days. If you are six or more months pregnant, you can continue seeing your doctor for the rest of your pregnancy.

Note: Home births are not covered unless the **provider** has a **preferred provider** contract with their local BCBS **plan** and is credentialed to provide the service.

A covered individual also has coverage for Pregnancy-Related Services. However, if the parent of the newborn *is* a covered dependent 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.

Routine Newborn Care means care of a child immediately following their 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

Covered Services

Covered Pregnancy-Related Services include:

- Prenatal and postnatal medical care of an obstetrician, Certified Nurse-Midwife or Licensed Midwife for routine or complicated delivery.
- Pregnancy-related diagnostic tests, including genetic testing or counseling 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.
- 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.

Coverage for:

- Transportation, including air transport, for the medically high-risk pregnant individual with an impending delivery of a potentially viable infant to the nearest available **tertiary care facility** for newly born infants.
- Services of a Physician who actively assists the operating surgeon in performing a covered surgical procedure when the procedure requires an assistant.
- Spontaneous, or therapeutic termination of pregnancy prior to full term.

This **plan** does **not** cover care for normal deliveries or planned C-sections outside the BCBSNM Service Area, unless you made a reasonable effort to be in the **service area** during the six weeks preceding your anticipated delivery date or your PCP arranges out-of-area care for you by obtaining **prior authorization** from BCBSNM which will direct you to a **contracted provider** in the area you will be visiting.

Newborn Care

Covered services 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.
- Coverage of injury or sickness, including services related to the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

If both the birthing parent's charges and the baby's charges are eligible for coverage under this **plan**, no additional **deductible** for the newborn is required for the facility's initial routine nursery care if the covered newborn is discharged on the same day as the birthing parent.

A newborn who is enrolled for coverage within the time limits specified in ***Who Gets Benefits*** section is also covered if the newborn stays in the **hospital** longer than the birthing parent. The baby's services will be subject to a separate **deductible, coinsurance,** and **out-of-pocket** limit.

If you are in a **non-preferred** facility, you must ensure that BCBSNM is called **before** the birthing parent is discharged from the **hospital**. If you do not, benefits for the newborn's covered facility services will be paid at the **non-preferred provider** benefit level. The baby's services will be subject to a separate **deductible, coinsurance,** and **out-of-pocket** limit.

Physician Visits

Covered services include:

Office Visits and Consultations based on the type of service received while in the office such as:

- Allergy care including, direct skin (percutaneous and intradermal) and patch allergy tests, Radioallergosorbent testing (RAST), allergy serum, and FDA-approved allergy injections.
- Genetic Inborn Errors of Metabolism including:
- Medical assessment
- Clinical services
- Biochemical analysis
- Medical supplies
- Prescription drugs (see your **drug plan rider**)
- Corrective lenses for conditions related to the genetic inborn error of metabolism.
- Nutritional management and special medical foods that have obtained prior authorization as defined and described in your **drug plan rider.**

Services cannot be excluded under any other provision of this **Benefit Booklet** and are paid according to the provisions of the **plan** that apply to that specific service (e.g., Special Medical Foods are covered under your **drug plan rider**, medical assessments under “Physician Visits/Medical Care” and corrective lenses under “Supplies, Equipment and Prosthetics”).

- 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.

Genetic Inborn Error of Metabolism means 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**.

- Breastfeeding Support and Services rendered by a lactation consultant such as a certified nurse practitioner, certified nurse-midwife, or midwife. **Covered services** are not subject to **coinsurance**, **deductible**, **copayment**, or benefit maximums when received from a provider in the preferred or participating provider network.
- Injections and injectable drugs, FDA-approved, therapeutic injections administered in a Provider's office. This **plan** covers some injectable drugs only when prior authorization is received from BCBSNM. Your BCBSNM-contracted provider has a list of those injectable drugs that require prior authorization. If you need a copy of the list, call a BCBSNM Customer Service Advocate. When you request prior authorization, you may be directed to purchase the self-injectable medication through your drug **plan**.

Note: The claims administrator and the **plan** reserves the right to exclude any injectable drug currently being used by a Member. Proposed new uses for injectable drugs previously approved by the FDA will be evaluated on a medication-by-medication basis. Call a BCBSNM Customer Service Advocate if you have any questions about the benefits described in this booklet.

Inpatient Medical Visits when received on a covered **inpatient hospital** day:

- Visits for a condition requiring only medical care, unless related to hospice care.
- Consultations (including second opinions) and, if surgery is performed, inpatient visits by a Provider who is not the surgeon and who provides medical care not related to the surgery.
- Medical care requiring two or more Physicians at the same time because of multiple illnesses.
- Initial routine newborn care for a newborn added to coverage within the time limits.

Covered services do not include:

- Any self-administered drugs dispensed by a Physician.

Transplants when receive **Transplant**

Covered services include:

- Transplant surgery, services and treatment related to organ or tissue transplant provided by a physician and/or hospital for you, your dependents, and the donor.

The following criteria apply:

- Prior authorization for the transplant procedure has been obtained as required under your **plan**.
- You meet the criteria established by us in pertinent written medical policies.
- You meet the protocols established by the hospital in which the transplant is performed.

Covered services do not include:

- Transplants when received from a **non-preferred provider**.

Outpatient Services

Covered services include:

Services performed at a medical facility without an overnight stay and are not referenced elsewhere in the **COVERED SERVICES** section of this **benefit booklet**. Examples of outpatient services:

- Chemotherapy
- Dialysis treatment

- Cardiac and pulmonary rehabilitation
- Electroconvulsive therapy
- Radiation therapy treatments
- Respiratory therapy
- Surgery
- **Urgent care**

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

Skilled Nursing Facility Services

Skilled nursing facility care includes:

- Bed, board and general nursing care
- Ancillary services (such as drugs and surgical dressings or supplies).
- Physical, occupational, speech, and respiratory therapy services by licensed therapists.

The following are **not covered services**:

- Continued skilled nursing visits, if you are no longer improving from treatment.
- Care in the home is not available or the home is unsuitable for such care.
- For custodial care, or care for someone's convenience.

Skilled Nursing Facility means a facility or part of a facility that:

- Is licensed in accordance with state or local law.
- Is a **Medicare**-participating facility.
- Is primarily engaged in providing skilled nursing care to Inpatients under the supervision of a duly licensed physician.
- Provides continuous 24-hour nursing service by or under the supervision of a **Registered Nurse**.
- 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.

Speech-Language

Covered services include:

- Those of a physician or licensed speech therapist to diagnose, treat, prevent or restore speech, language, voice and swallowing disorders from birth through old age.

Urgent Care

Covered services include:

- Services and supplies to treat an urgent condition at an **urgent care** center.

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

Virtual Visits

Covered services include:

- The diagnosis and treatment of certain non-emergency medical and **behavioral health** conditions or illnesses when a virtual provider determines that your diagnosis and treatment can be done without an in-person office visit for:
    - Primary care
    - Convenient care
    - Emergency room care
    - **Behavioral health** care
    - Urgent care

Not all medical or **behavioral health** conditions can be treated by virtual visit. Your virtual **provider** will identify any condition for which treatment should be performed by an in-person **provider**.

Virtual provider means a licensed **provider** that has entered into a contractual agreement with us to provide diagnosis and treatment of injuries and illnesses through either:

- Interactive audio communication (via telephone or other similar technology), or
- Interactive audio/video examination and communication (via online portal, mobile application, or similar technology).

Virtual Visit means a consultation with a licensed **provider** through interactive video and/or store-and-forward technology via online portal or mobile application.

PREVENTIVE CARE

Preventive **covered services** are intended to help keep you healthy, supporting you in achieving your best health through early detection. Preventive **covered services** will be considered **medically necessary covered services** and will not be subject to any **deductible**, **coinsurance**, **copayment** and/or **benefit** maximum when such services are received from an **in-network provider** or **participating pharmacy.** Preventive care services from **out-of-network providers** may be subject to **deductible**, **copayment** and/or **coinsurance**, except for certain state or federally mandated **benefits** (example: childhood immunizations).

The following agencies set the preventive care guidelines:

- United States Preventive Services Task Force ("USPSTF")
- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC")
- Health Resources and Services Administration ("HRSA")
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

The above agencies' recommendations and guidelines may be updated periodically. When updated, they will apply to your **plan.**

To see a listing of the preventive health services available to you at no cost through an **in-network provider** visit https://www.healthcare.gov/coverage/preventive-care-benefits/ or call the number on the back of your insurance **identification card.**

For frequencies and any limits that may apply, contact your physician, or visit https://www.bcbsnm.com/provider/clinical/clinical-resources/preventive-care-guidelines.

HIGH DEDUCTIBLE HEALTH PLAN – HEALTH SAVINGS ACCOUNT (HDHP-HSA) PREVENTIVE DRUG PROGRAM

In addition to the preventive care services listed above, your **benefits** include coverage for certain outpatient prescription drugs, that are covered under the HDHP-HSA preventive drug program, when prescribed by a Physician.

Benefits for outpatient prescription drugs covered under the HDHP-HSA preventive drug program **will not be subject** to any deductible, coinsurance, and/or copayment when obtained from a **preferred participating** or **participating pharmacy**, when prescribed for preventive purposes.

Benefits for outpatient prescription drugs covered under the HDHP-HSA preventive drug program **will be subject** to any deductible, coinsurance, and/or copayment when obtained from an **out-of-network pharmacy**. Please refer to your **Summary of Benefits and Coverage (SBC)** for additional information regarding your payment obligations.

The HDHP-HSA preventive drug program includes outpatient prescription drugs in the following drug categories:

- Anti-Coagulants/Anti-Platelets
- Diabetic Medications and Supplies
- High Blood Pressure (Antihypertensives
- High Cholesterol Orals (Lipid Lowering)
- Depression – Selective Serotonin Reuptake Inhibitors (SSRIs)
- Osteoporosis
- Respiratory (Asthma/COPD)

These drugs could also at times be prescribed for treatment purposes. If your physician has prescribed a listed drug for treatment purposes (and not preventive purposes) then it will be subject to any applicable deductible, coinsurance, and/or copayment, as shown on the **Summary of Benefits and Coverage (SBC**).

Virtual Visit means a consultation with a licensed **provider** through interactive video and/or store-and-forward technology via online portal or mobile application.

MEDICAL LIMITATIONS AND EXCLUSIONS

The following are not **covered services or supplies** under your **plan**. Refer to the **COVERED SERVICES** section of your **benefit booklet** for exclusions associated with specific services or supplies.

- Any services or supplies that are not **medically necessary.**
- Any services or supplies determined to be experimental/investigational or unproven. You may contact Customer Service at the toll-free telephone number on the back of your **identification card** for more information about what **experimental/investigational** services or supplies may be excluded.
- Clinical technology, services, procedures, and service paradigms designated by a temporary (CPT® Category III) code are not covered, except for certain services otherwise specified by state or federal law, or federal coverage or billing guidelines.
- Any services or supplies provided by a person who is related by blood or marriage.
- Any services or supplies provided in connection with an occupational sickness, or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
- Any services or supplies provided for Viscosupplementation (intra-articular hyaluronic acid injection), except for individuals currently receiving maintenance therapy.
- Any services or supplies provided for custodial care.
- Any services or supplies provided for injuries sustained either:
    - As a result of war, declared or undeclared, or any act of war.
- While on active or reserve duty in the armed forces of any country or international authority.
- Any services or supplies that do not meet accepted standards of medical and/or dental care.
- Any service or supplies by more than one provider on the same day(s) for the same covered service.
- Any charges:
    - Resulting from the failure to keep a scheduled visit with a **physician** or **other provider.**
    - For completion of any insurance forms.
    - For acquisition of medical records.
    - Resulting from failure to pay your cost share(s).
    - Incurred while not covered under this **plan.**
- Any services or supplies for the following except as listed as covered in the **COVERED SERVICES** section of your **benefit booklet**:
    - Dietary and nutritional services.
    - Long term or custodial care.
    - Private duty nursing services
    - Any services related to a non-covered service.
- Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
- Any services or supplies provided for, in preparation for, or in conjunction with any of the following:
    - Sterilization reversal

- Sexual dysfunctions
- In vitro fertilization
- Assisted reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.

- Any procedures, equipment, services, supplies, or charges for abortions except for a pregnancy which, as certified by a **physician**, places you in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.
- Treatment of decreased blood flow to the legs with pneumatic compression device high pressure rapid inflation deflation cycle.
- Treatment of tissue damage or disease in any location with platelet-rich plasma.
- Obesity treatment
- Any services or supplies provided for the following treatment modalities:
  - Massage therapy
  - Intersegmental traction
  - All types of home traction devices and equipment
  - Vertebral axial decompression sessions
  - Surface Electromyography EMGs
  - Spinal manipulation under anesthesia
  - Muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
  - Balance testing through computerized dynamic posturography sensory organization test.
- Testing of:
  - Blood for measurement of levels of: Lipoprotein a; small dense low-density lipoprotein; lipoprotein subclass high resolution; lipoprotein subclass particle numbers; lipoprotein associated phospholipase A2, which are fat/protein substances in the blood that might be ordered in people with suspected deposits in the walls of blood vessels.
  - Urine for measurement of collagen cross links, which is a substance that might be ordered in people with suspected high bone turnover.
  - Cervicovaginal fluid for amniotic fluid protein during pregnancy, which might be ordered in people suspected to have fluid leaking from around the baby (premature ruptured membranes).
- Any services, supplies or drugs provided to a **participant** incurred outside the United States, except for **emergency care**.
- Cannabis**.** Cannabis means all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinal (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the pant, its seeds or its resin. Cannabis with THC as an active ingredient may be called marijuana.

UTILIZATION MANAGEMENT

Utilization management may be called a **medical necessity** review, which is used for a procedure, service, inpatient **admission**, and/or length of stay and is based on our medical policy and nationally recognized criteria.

Medical Necessity reviews may occur:

- Prior to care
- During care
- After care has been completed

Please refer to **medical necessity** or **medically necessary** in the **GLOSSARY** section of this **benefit booklet** for additional information regarding any limitations and/or special conditions pertaining to your **benefits**.

Prior Authorization

You need pre-approval from us for some **covered services**. Pre-approval is also called **prior authorization**. This ensures that certain **covered services** will not be denied based on **medical necessity** or **experimental/investigational**.

Prior authorization does not guarantee payment of **benefits**. For additional information and a current list of health care services that require **prior authorization**, please visit our website at www.bcbsnm.com/find-care/where-you-go-matters/utilization-management.

Prior Authorization Responsibility

BCBSNM Preferred (In-Network, Participating) Provider

When required, your **preferred provider** is responsible for obtaining **prior authorization**. If your **preferred provider** does not obtain **prior authorization** and the services are denied as not **medically necessary**, the **participating provider** will be held responsible.

The **participating provider** will not be able to bill you for the services you have received. We recommend you confirm with your **provider** if **prior authorization** has been obtained. For additional information about **prior authorization** for services outside of our **service area**, please refer to the **BlueCard®** Program section.

Note: **Providers** that **contract** with other Blue Cross and Blue Shield plans are not familiar with the **prior authorization** requirements of BCBSNM. Unless a **provider contracts** directly with BCBSNM as a participating **provider**, the **provider** is not responsible for being aware of this plan's **prior authorization** requirements, except as described in the section "The **BlueCard®** Program" in the **General Provisions**.

Non-Preferred (Out-of-Network) or Providers Outside New Mexico

If a **non-preferred provider** recommends an **admission** or service that requires **prior authorization**, you are responsible for obtaining **prior authorization.**

If the service is determined to be **medically necessary**, **out-of-network benefits** will apply. However, if **prior authorization** is not obtained before services are received and determined to be not **medically necessary**, you may be responsible for the charges.

Non-participating Providers Or Providers Outside New Mexico

Except in emergencies, a visit to a **non-participating provider** requires **prior authorization** by BCBSNM. If **prior authorization** is not obtained, benefits will not be available for the services.

Under very special medical circumstances, BCBSNM may approve a visit to a **non-participating provider**. If that **provider** recommends an **admission** or a service that requires **prior authorization**, the **provider** is not obligated to obtain **prior authorization** for you. In such cases, it is **your** responsibility to ensure that **prior authorization** is obtained. If **prior authorization** is not obtained, you will be entirely responsible for the charges.

Recommended Clinical Review Option

A r**ecommended clinical review** is:

- An optional voluntary medical necessity review for a covered service that does not require a prior authorization.
- Occurs before, during, or after services are completed.
- Limits situations where you must pay for a non-approved service.

To determine if a **recommended clinical review** is available for a specific service, please visit our website at www.bcbsnm.com/find-care/where-you-go-matters/utilization-management for the **recommended clinical review** list.

Contacting Medical and Behavioral Health

You may contact us for a **prior authorization** or **recommended clinical review** by calling the toll-free telephone number on the back of your **identification card** and following the prompts to the Medical or **Behavioral Health** Unit or via the member portal.

Post-Service Medical Necessity Review

A **post-service medical necessity review** is sometimes referred to as a retrospective review or post-service claims request and determines:

- Your eligibility
- Availability of benefits at the time of service
- Medical necessity

Failure to Obtain Prior Authorization

If **prior authorization** is not obtained:

- You may be responsible for a penalty for certain **covered services**, if indicated on your **Summary of Benefits and Coverage (SBC)**.
- If we determine the treatment or service is not **medically necessary** or is **experimental/investigational**, benefits will be reduced or denied.
- We will review the **medical necessity** of your treatment or service prior to the final benefit determination.

Note: No provision found in this section guarantees payment of **benefits**. Actual availability of **benefits** is subject to eligibility and the other terms, conditions, limitations, and exclusions under your **plan.**

CLAIM FILING AND APPEALS PROCEDURES

Filing of Claims Required

When you receive care and **covered services** from an **in-network provider,** the provider will usually submit your claim directly to us, but it is your responsibility to make sure we receive your claim.
When you receive care and **covered services** from an **out-of-network provider**, you may be required to file your own claim.

The instructions for filing your own claim are in the chart below.

Filing a Medical Claim	Requirement	Deadline
Notice of claim	• You must give us written notice within 365 days or as soon as reasonably possible after receiving services for **benefits** under this **plan**. • Once we receive your notice, we will provide you with the claim forms for filing a **proof of loss** claim within 15 days.	• If you do not give us written notice within 365 days but can as soon as possible, it will not reduce your claim. • If the claim forms are not provided within 15 days, we will accept a written description that must detail the nature and extent of loss within 365 days of your loss.
Proof of Loss (claim)	• A completed claim form and any additional information required. • File each claimant**'s** expenses separately. **Deductibles** and **benefits** are applied to each claimant separately. Include itemized bills from the **provider**, labs, etc., on their letterhead showing the services given, dates of service, charges, and claimant's name.	• No later than 365 days after you have incurred expenses for **covered benefits.** • We won't void or reduce your claim if you can't send us notice and **proof of loss** within the required time. But you must send us notice and proof as soon as reasonably possible. • **Proof of loss** may not be given later than 365 days after the time proof is otherwise required, except if you are legally unable to notify us.
Benefit Payment	• Written proof must be provided for all **benefits**. • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid after the receipt of **proof of loss**.	• **Benefits** will be paid as soon as the necessary proof to support the claim is received.

Our Receipt of Claims

A claim will be considered received by us for processing upon actual delivery to our Administrative Office in the proper manner and form and with the required information. If the claim is not complete, it may be denied, or we may contact either you or the **provider** for additional information.

Filing a Prescription Drug Claim	Requirement	Deadline
Mail-Order Program	• A completed mail service prescription drug claim form	• Within 90 days. • **Proof of loss** may not be given later than 365 days after the time proof is otherwise required, except if you are legally unable to notify us.
Prescription Drug Claims	• A completed Prescription Reimbursement Claim Form • Include itemized bills from the **pharmacy** showing the name, address, and telephone number of the **pharmacy**, claimants prescription drugs received, including the name and quantity of the drug, prescription number and date of purchase	• Within 90 days. • Proof of loss may not be given later than 365 days after the time proof is otherwise required, except if you are legally unable to notify us.

For additional information and claim forms, please visit www.bcbsnm.com/.

Please mail completed claim forms to:

Medical Claims	Prescription Drug Claims
Blue Cross Blue Shield of New Mexico P.O. Box 660058 Dallas, TX 75266	Prime Therapeutics LLC P. O. Box 25136 Lehigh Valley, PA 18002-5136

Who Receives Payment

Benefit payments are made directly to contracting **providers** when they bill us. If unpaid at your death, any **benefits** payable to you will be paid to your beneficiary or to your estate.
Except as provided in the **Assignment and Payment of Benefits** section**,** rights and **benefits** under the **plan** are not assignable before or after services and supplies are provided.

Benefit Payments To a Managing Conservator

Benefits for services provided to your minor **dependent child** may be paid to a third party if the third party is named in a court order as managing or possessory conservator of the **child**, and we have not already paid any portion of the claim.

For **benefits** to be payable to a managing or possessory conservator of a **child**, the managing or possessory conservator must submit:

- A claim form.
- Proof of payment of the expenses.

- A certified copy of the court order naming that person the managing or possessory conservator.

Any amounts we are owed may be deducted from our benefit payment. Payment to you or your **provider**, or deduction of amounts owed to us, will be considered in satisfaction of its obligations to you.

An explanation of benefits summary is sent to you so you will know what has been paid.

REVIEW OF CLAIM DETERMINATIONS

Claim Determinations

When we receive a properly submitted claim, we have authority and discretion under the **plan** to interpret and determine **benefits** in accordance with the **plan's** provisions. You have the right to a review by us of any determination of a claim, a request for **prior authorization**, or any other determination made by us concerning your **benefits** under the **plan**.

Timing of Required Notices and Extensions

There are four types of claims as defined below:

- **Urgent care clinical claim** means any pre-service claim that requires **prior authorization**, as described in this **benefit booklet**, for medical care or treatment and your **physician** determines that a delay in getting medical care or treatment could put your life or health at risk; or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain that cannot be adequately managed without the care or treatment.
- **Pre-Service Claim** means any non-urgent request for **benefits** that involves services you have not yet received and requires **prior authorization**.
- **Post-Service Claim** means notification in a form acceptable to us that a service has been rendered or furnished to you.

This notification must include full details of the service received, including:

- Your name, age, and gender
- Identification number
- Name and address of the provider
- An itemized statement of the service rendered or furnished.
- Date of service
- Diagnosis
- Claim charge
- Any other information which we may request in connection with services rendered to you.
- **Concurrent Care Claim** means a claim occurs when you need us to approve more services than we already have approved. Examples are extending a **hospital** stay or adding visits to a **provider**.

Urgent Care Clinical Claim	
Type of Notice (Claim) or Extension	**Time Period**

If your claim is incomplete, we must notify you within:	24 hours
If you are notified that your claim is incomplete, you must provide information to complete your claim to us within:	48 hours after receiving notice
We must notify you of the claim determination (whether adverse or not):	
If the initial claim is complete (taking into consideration medical needs), within:	72 hours. If you are an inpatient at a healthcare facility when services are recommended, we will issue a determination within 24 hours after we receive the request.
After receiving the completed claim (if the initial claim is incomplete), within:	48 hours
Pre-Service Claims	
Type of Notice (Claim) or Extension	**Time Period**
If your claim is filed improperly, the claims administrator must notify you within:	5 days
If your claim is incomplete, we must notify you within:	15 days
If you are notified that your claim is incomplete, you must provide information to complete your claim to we 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
After receiving the completed claim (if the initial claim was incomplete) within:	30 days
If your claim involves post-stabilization treatment after emergency treatment or a life-threatening condition, within:	The time appropriate to the circumstance, not to exceed one hour from the receipt of the request.
Post-Service Claims (Retrospective Review)	
Type of Notice (Claim) or Extension	**Time Period**
If your claim is incomplete, you will be notified 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 consideration medical needs), but no later than:	30 days
After receiving the completed claim (if the initial claim is incomplete), within:	45 days
Concurrent Care Claim	
We will notify you of our determination for such a request within:	24 hours after receipt of your claim for benefits

We may extend the initial 30-day period one time for up to 15 days, only if we determine that an extension is necessary. We will notify you in writing, prior to the expiration of the initial 30−day period of the reasons why an extension of time is necessary and the date we expect to decide. If the initial 30-day period is extended because we require additional information from you or your **provider**, the period for us to decide is paused from the date we send a notice of extension to you until we receive the additional information or when the additional information was to be submitted, whichever date is earlier.

If a Claim Is Denied or Not Paid in Full

If a claim is denied in whole or in part, you will receive a written notice from **us** with the following information, if applicable:

- Reasons for the determination.
- A reference to the health **plan** provisions or the contractual, administrative, or protocol basis for the determination.
- A description of additional information necessary and an explanation of why it is necessary.
- Subject to privacy laws and other restrictions if any:
    - Identification of the **claim**
    - Date of service
    - Health care **provider**
    - Claim amount (if applicable)
    - Statement describing denial codes with their meanings and standards used.
    - Diagnosis/treatment codes with their meanings and the standards used (upon receipt).
- An explanation of our internal review/appeals and external review processes (and how to initiate a review/**appeal** or external review).
- A statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/**appeal**.

- 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 us (in certain situations).
- Copies of all documents, records, and other information relevant to the **claim** (provided free of charge on request).
- Copy of rule, guideline, protocol, or other similar criterion (provided free of charge on request)
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances.
- **Experimental/investigational** treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request (if the denial was based on **medical necessity**).
- **Urgent care clinical claims**:
    - Description of the expedited review procedure applicable
    - Decision may be provided orally, so long as a written notice is given to the client within 3 days of verbal notification
    - Contact information for applicable office of health insurance consumer assistance or ombudsman (as appropriate).

Claims Payment Provisions

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

After a **claim** has been processed, the **subscriber** will receive an *Explanation of Benefits* (EOB). The EOB indicates what charges were covered and what charges, if any, were not.

Note: If a Qualified Child Medical Support Order (QCMSO) is in effect, the QCMSO provisions will be followed. For example, when the **member** is an **eligible child** of divorced parents, and the **subscriber** under this **plan** is the noncustodial parent, the custodial parent may receive the payment and the EOB.

If A Claim or Prior Authorization Is Denied

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

Inquiries/Complaints and Internal/External Appeals For Self-Funded Plans

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.

Initial Internal Review of Claims/Prior Authorization Requests

When you or your treating health care **professional** requests a **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 means 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 us 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 we may request in connection with services rendered to you.
- Pre-service claim - A request for **prior authorization**, which is any non-urgent request for a benefit or for a benefit determination for which the **plan** conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. A voluntary request for advance determination of benefits is not a pre-service request for purposes of this provision.

URGENT CARE CLINICAL CLAIMS	
Type of Notice or Extension	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	**24 hours**

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

You do not need to submit appeals of **urgent care clinical claims** in writing. You should call the us 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 us for up to 15 days, provided we both:

- Determine that such an extension is necessary due to matters beyond the control of the **plan**.
- 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 we expect 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:

- The date on which your response is received by BCBSNM.
- 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 us for up to 15 days, provided that we both:

- Determine such an extension is necessary due to matters beyond the control of the **plan**.
- 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 we expect 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:
- The date on which your response is received by BCBSNM.
- 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, we may deny all or part of your claim. There are several reasons why this may happen. We suggest that you first read the Explanation of Benefits summary prepared by us, 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 us 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 us.
- 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.

NOTE: For Adverse Benefit Determinations that are related to any **claim** or **prior authorization** denial, reduction, termination, or failure to provide or make payment that is based on a determination of eligibility to participate in the **plan**, including contributions for coverage, you must contact your Employee Benefits Department.

INTERNAL APPEAL PROCEDURES

The following definitions apply to the Claims Administrator's internal **appeal** procedures for issues not related to eligibility determinations.

Adverse Benefit Determination means 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.

Appeal means an oral or written request for review of an **adverse benefit determination** or an adverse action by us ("BCBSNM"), its employees, or a participating **provider**.

Final Internal Adverse Benefit Determination means an **adverse benefit determination** that has been upheld by BCBSNM, at the completion of its internal **appeal** process or with respect to which the internal appeals process has been deemed exhausted.

If an ongoing course of treatment had been approved by us or your employer and we 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 **plan**, BCBSNM will refer to both an **adverse determination** and an **adverse benefit determination** as an **adverse benefit determination**, unless indicated otherwise.

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, we 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**, we 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. We 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 us.

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 us 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 their 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 us at the number on the back of your **ID card**.

If you believe we incorrectly denied all or part of your benefits, you may have your claim reviewed. We 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 us to request a claim review. We will need to know the reasons why you do not agree with the **adverse benefit determination**. You may contact us at:

  BCBSNM Appeals Unit
  Blue Cross Blue Shield of New Mexico
  P.O. Box 660058 Dallas, TX 75266
  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.

We 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, we 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 us 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 us 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

Blue Cross Blue Shield of New Mexico
P.O. Box 660058
Dallas, TX 75266
Telephone (toll-free): (800) 205-9926
FAX: (505) 816-3837

Timeframe for Completion of Internal Appeal

Upon receipt of a non-urgent pre-service **appeal**, we 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 us. Upon receipt of a post-service **appeal**, we 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 us.

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 timeframes 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 us.
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

If the Claims Administrator's 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. Rescissions are also eligible for external review.

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.

Preliminary review

- Within five business days following the date of receipt of the external review request, BCBSNM must complete a preliminary review of the request to determine whether:
- You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided.
- The **adverse benefit determination** or **final internal adverse benefit determination** does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination).
- You have exhausted BCBSNM's internal **appeal** process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the Exhaustion section below for additional information about the exhaustion of the internal **appeal** process.
- 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 averse 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 provision of the **mental** health parity.

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 **plan** and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

- Utilization of legal experts where appropriate to make coverage determinations under the **plan**.
- Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
- Within five business days after the date of assignment of the IRO, BCBSNM must provide to the assigned IRO the documents and any information considered in making the **adverse benefit determination** or **final internal adverse benefit determination**. Failure by BCBSNM to timely provide the documents and information must not delay the conduct of the external review. If BCBSNM fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the **adverse benefit determination** or **final internal adverse benefit determination**. Within one business day after making the decision, the IRO must notify BCBSNM and you or your authorized representative.
- Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to BCBSNM. Upon receipt of any such information, BCBSNM may reconsider its **adverse benefit determination** or **final internal adverse benefit determination** that is the subject of the external review. Reconsideration by BCBSNM must not delay the external review. The external review may be terminated as a result of the reconsideration only if BCBSNM decides, upon completion of its reconsideration, to reverse its **adverse benefit determination** or **final internal adverse benefit determination** and provide coverage or payment. Within one business day after making such a decision, BCBSNM must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from BCBSNM.
- Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during BCBSNM's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available, and the IRO considers them appropriate, will consider the following in reaching a decision:
    - Your medical records.
    - The attending health care **professional's** recommendation.
    - Reports from appropriate health care **professionals** and other documents submitted by BCBSNM, you, or your treating **provider**.
    - The terms of your **plan** to ensure that the IRO's decision is not contrary to the terms of the **plan**, unless the terms are inconsistent with applicable law.

- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or **professional** medical societies, boards, and associations.
- Any applicable clinical review criteria developed and used by BCBSNM, unless the criteria are inconsistent with the terms of the Plan or with applicable law.
- 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.
  - 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 us, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

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

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.
- A **final internal adverse benefit determination**, if the claimant has a medical condition where the timeframe 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.

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.

Referral To Independent Review Organization

Upon a determination that a request is eligible for external review following the preliminary review, BCBSNM will assign an IRO pursuant to the requirements set forth in the **Standard External Review** section above. BCBSNM must provide or transmit all necessary documents and information considered in making the **adverse benefit determination** or **final internal adverse benefit determination** to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available, and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during BCBSNM's internal claims and appeals process.

Notice of final external review decision

The IRO must provide notice of the final external review decision, in accordance with the requirements set forth in the **Standard External Review** section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to BCBSNM and you or your authorized representative.

Exhaustion

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the **final internal adverse benefit determination**. For expedited internal review, you have the right to request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if BCBSNM waives the internal review process or has failed to comply with the internal claims and appeals process. If you have been deemed to have exhausted the internal review process due to BCBSNM's failure to comply with the internal claims and appeals process, you may also have the right to pursue any available remedies 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 we demonstrate that the violation occurred in the context of an ongoing, good faith exchange of information between you and us.

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 we have 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 us.

Arbitration for Non-ERISA Plans — The "Arbitration for Non-ERISA Plans" provision applies to all Governmental plans, Church Plans, and plans maintained outside the United States primarily for the benefit of persons substantially all of whom are non-resident aliens. If a dispute about coverage, benefits, or handling of claims or appeals continues after you have followed and **exhausted** the appeals and grievance process set forth above, including having completed the external review process, the issue or claim may be submitted to arbitration. The rules for arbitration shall be the "Commercial Arbitration Rules" developed by the American Arbitration Association. You may obtain a copy of these rules from a Customer Service Advocate. The rules are also available from the American Arbitration Association's Web site (www.adr.org).

Additional Resources — If you need additional assistance, you may call the U.S. Department of Labor's Employee Benefits Security Administration (EBSA):

Call toll-free at (866) 444-EBSA (3272) or visit the EBSA Website 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**.

GENERAL PROVISIONS

Availability of Provider Services

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

Access Plan

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

Assignment and Payment of Benefits

If you or your dependents give a provider a written agreement (assignment of benefits) to receive payment and that agreement is submitted to us along with the claim for benefits, we will pay the provider directly. Once we pay the provider, we have met our obligation to you and your dependents for any benefits that are available through the plan.

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 is 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/.

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**.

Whenever you receive out-of-area **covered services** outside of the BCBSNM **service area** and the **claim** is processed through the **BlueCard Program**, the amount you pay for **covered services**, if not a flat dollar **copayment**, is based on the lower of:

- The billed charges for your **covered services**.
- The negotiated price or **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. 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**, **copayment** 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 healthcare **provider**. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare **provider** or **provider** group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare **providers** after taking into account the same types of transactions as with an estimated price.

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

Members may be responsible for the difference between the amount that the **non-contracted provider** bills and the payment that BCBSNM will make for **covered services** as set forth in this paragraph.

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

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

Out-of-area covered services for EPO Plans refers to **emergency care** obtained outside the geographic area of the BCBSNM Service Area. Any other services will not be covered when processing through any Inter-Plan Arrangements, unless authorized by your primary care physician ("PCP").

If services are provided by a **non-contracted provider**, the **provider** may, but is not required to, submit **claims** on your behalf. 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**.

Member Liability Calculation

In General

Under Inter-Plan Arrangements, when services are received outside the state of New Mexico BSBSNM 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 and will be passed on to BCBSNM. BCBSNM will use the **Host Blue**'s **covered charge** as its **covered charge** so that your **claim** can be processed timely. BCBSNM's **covered charge** will be an amount up to but not in excess of the **covered charge** the **Host Blue** has passed on to BCBSNM. 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 **noncontracted** healthcare **providers**, such as:

- Billed charges for **covered services**
- The payment we would make if the health care services had been obtained within our **service area.**
- A special negotiated payment
- **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.
- **Hospital** or **facility providers** make a payment based on publicly available data reflecting the approximate costs that **hospitals** or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the **hospital** or facility to determine the amount BCBSNM will pay for services rendered by **non-contracted** health care **providers**. 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 **covered services** as set forth in this paragraph.

Emergency Care Services:

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

Providers Outside New Mexico

Out-of-state providers that contract with their local Blue Cross and/or Blue Shield Plan and international **providers** that contract with the Blue Cross and Blue Shield Association as **preferred providers** are also eligible for the **preferred provider** level of benefits for **covered services**, including fixed-dollar **copayment** amounts listed on the **SUMMARY OF BENEFITS and COVERAGE**. 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.

You have a number of ways to locate a **preferred provider** in the United States or around the world:

- BCBSNM Website
- Blue Cross Blue Shield Association

BCBSNM Website

If you have an internet connection, go to the BCBSNM website at www.bcbsnm.com/ click on "Find a Doctor" and then select the line entitled "Search for Doctors as a Guest." Follow the instructions. You will then be linked to the Blue Cross Blue Shield Association's **BlueCard** Doctor and Hospital Finder.

National Website

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

Blue Cross and Blue Shield Association website: www.bcbsnm.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 **BlueCard** Worldwide 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 **identification card**. 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

Exceptions for Non-Preferred Providers

The following are instances in which the services of a **non-preferred provider** may be eligible for coverage:

Emergency Care

If you visit a **Non-Preferred provider** for **emergency care** services, you will receive benefits for the initial treatment, which includes emergency room services and, if you are **hospitalized** within 48 hours of an emergency, the related **inpatient hospitalization**.

For follow-up care and for all other **nonemergency care**, you will receive no benefit for the services of a **non-preferred provider**, except as specified below.

Ancillary Providers

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 **non-preferred** radiologist, anesthesiologist or pathologist assistant surgeon, **emergency** room **physician** and/or other **hospital-based physician** will be paid at the **preferred provider** level and you will not be responsible for any amounts over the **covered charge**.

If a **non-preferred** surgeon provides your care or you are admitted to a **non-preferred hospital** or other treatment facility, you will be responsible for any services received from other **non-preferred providers** during the **admission** or procedure.

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 Program when accessing **covered services**. The Blue Cross Blue Shield Global Core is unlike the **BlueCard Program** available in the **BlueCard** Service Area. 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.

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

Emergency Care Services

This **plan** covers only limited health care services received outside of the United States. As used in this section, **out-of-area covered services** include **emergency** services and **urgent care** obtained outside of the United States. Follow-up care following an **emergency** is also available provided **prior authorization** by BCBSNM is obtained for the services. Any other services will not be eligible for Benefits unless **prior authorization** is 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 nonemergency **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 United States will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for **covered services**.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for **covered services** outside the **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 to initiate **claim** processing. Following the instructions on the **claim** form will help ensure timely processing of your **claim**.

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.

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.

Drug Plan Benefits

BCBSNM has contracted with a separate pharmacy benefit manager to administer your outpatient drug plan benefits. In addition to your **benefit booklet**, you will be sent important information about your drug plan benefits. See your **drug plan rider** for more information about the drug plan.

Execution Of Papers

On behalf of yourself and your **eligible family members** you must, upon request, execute and deliver to BCBSNM any documents and papers necessary to carry out the provisions of this **plan**.

Identity Theft Protection

Identify theft protection services are available to you at no additional cost.

The identity theft protection services include:

- Credit monitoring
- Fraud detection
- Credit/identity repair
- Insurance to help protect your information.

These identity theft protection services are provided by BCBSNM’s chosen outside vendor. Accepting or declining these services is optional for you and your **dependents**.

You may accept identity theft protection services by enrolling in the program online at www.bcbsnm.com/ or by calling 1-800-432-0750.

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.

Medicare

If you are 65 years of age or older, BCBSNM will suspend your **claims** until it receives:

- An Explanation of **Medicare** Benefits (EOMB) for each **claim** if you are entitled to **Medicare**.
- Social Security Administration documentation showing that you are not entitled to **Medicare**.

Member Data Sharing

You may apply for and receive replacement coverage under certain circumstances like from involuntary termination of your health coverage sponsored by the **group**/**employer**.

The replacement coverage will be coverage offered by us. If you do not live in the **service area**, coverage will be offered by the Blue Cross and/or Blue Shield Plan whose **service area** covers the geographic area where you live.

As part of the **benefits** that we offer you, if you do not live in the **service area**, we may assist you in applying for and getting such replacement coverage, subject to applicable eligibility requirements, from the Blue Cross and/or Blue Shield Plan available in the **service area** in which you live.

To do this we may:

- Contact you directly.
- Provide the Blue Cross and/or Blue Shield Plan whose **service area** covers the geographic area where you live, with your personal information and other general information relating to your coverage under this **plan.** Only your necessary information will be provided to prepare the appropriate Blue Cross and/or Blue Shield Plan to offer you uninterrupted coverage through replacement coverage.

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 be treated with courtesy and consideration, and with respect for your dignity and your need for privacy.
- The right to have their privacy respected, including the privacy of medical and financial records maintained by BCBSNM and its health care **providers** as required by law.
- The right to be provided with information concerning BCBSNM's policies and procedures regarding products, services, **providers**, and appeals procedures and other information about the company and the benefits provided.
- The right to receive from your **physician(s)** or **provider**, in terms that you understand, an explanation of your complete medical condition, recommended treatment, risk(s) of treatment, expected results and reasonable medical alternatives, irrespective of BCBSNM's position on treatment options. If you are not capable of understanding the information, the explanation shall be provided to your next of kin, guardian, agent, or surrogate, if able, and documented in your medical record.
- The right to detailed information about coverage, maximum benefits, and exclusions of specific conditions, ailments, or disorders, including restricted prescription benefits, and all requirements that you must follow for **prior authorization** and utilization review.
- The right to 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 the **plan**. You can inspect all records concerning your membership in this **plan** during normal business hours given reasonable advance notice.

Refund of Benefit Payments

Your group's **plan** and we have the right to receive a refund of an **overpayment** from:

- The person to, or for whom, such **benefits** were paid.
- Any insurance company or **plan**
- Any other persons, entities, or organizations, including, but not limited to, in-network providers or out-of-network providers.

If no refund is received, we (in our capacity as insurer or administrator) and/or your group's **benefit plan** have the right to deduct any refund for any **overpayment** due, up to an amount equal to the **overpayment**, from:

- Any future benefit payment made to any person or entity under this **benefit booklet**, even if it is for the same or a different participant.
- Any future benefit payment made to any person or entity under another BCBS administered ASO benefit plan and/or BCBS administered insured benefit plan or policy.
- Any future benefit payment made to any person or entity under another BCBS insured group benefit plan or individual policy.
- Any future benefit payment, or other payment, made to any person or entity.
- Any future payment owed to one or more participating providers or non-participating providers.

Further, we have the right to reduce your **benefit plan's** or policy's payment to a **provider** by the amount necessary to recover another BCBS plan's or policy's overpayment to the same **provider** and to pay the recovered amount to the other plan or policy.

Overpayment means when we or your group's **benefit plan** pay **benefits** for eligible expenses received by you or your **dependents** and it is found that the payment was more than it should have been or was made by mistake.

Religious Employer Exemption and Eligible Organization Accommodation

Your group may certify that its Group health Plan is established or maintained by an organization(s) that is a "religious employer(s)" as defined in 45 C.F.R. 147.130(a), as modified or replaced, and qualifies for a religious employer exemption from the Affordable Care Act requirement to cover certain contraceptive services without cost-sharing under guidelines supported by the Health Resources and Services Administration (*Religious Employer Exemption*). Provided that the Religious Employer Exemption is satisfied for your Group health Plan, then coverage under your Group health Plan will not include coverage for some or all of such contraceptive services. Please call Customer Service at the number on the back of your **ID card** for more information. Questions regarding the Religious Employer Exemption should be directed to your group.

In addition, a certification(s) may have been provided to BCBSNM that your Group health Plan is established or maintained by an organization(s) that is an "eligible organization(s)" as defined in 45 C.F.R. 147.131(b), as modified or replaced, and qualifies for an eligible organization accommodation with respect to the Affordable Care Act requirement to cover certain contraceptive services without cost-sharing under guidelines supported by the Health Resources and Services Administration ("Eligible Organization Accommodation"). Provided that the Eligible Organization Accommodation is satisfied, coverage under your Group health Plan will not include coverage for some or all of such contraceptive services. Please call Customer Service at the number on the back of your **ID card** for more information. If you have questions regarding the certification(s), you may contact your group. For other questions about the Eligible Organization Accommodation, you may contact Customer Service at the number on the back of your **ID card**.

Sending Notices

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

Special Cases: Value-Based Programs

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

Transfer of Benefits

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

COORDINATION OF BENEFITS (COB) AND REIMBURSEMENT

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

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

When this **plan** is secondary, all provisions (such as obtaining **prior authorization**) must be followed, or benefits may be denied.

The following rules determine which coverage pays first:

- No COB Provision — If the **other valid coverage** does not include a COB provision, that coverage pays first.
- **Medicare** — If the **other valid coverage** is **Medicare** and **Medicare** is not secondary according to federal law, **Medicare** pays first.
- **Child/Spouse** — If a covered **child** under this **health care plan** is covered as a spouse under another **health care plan**, the covered **child's** spouse's **health care plan** is primary over this **health care 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 care plan** and as a spouse, **child**, or other family **member** under another, the **health care plan** that designates the **member** as the employee, retiree, or other policy holder (i.e., as the **subscriber**) pays first.
- If you have **other valid coverage** and **Medicare**, contact the other carrier's customer service department to find out if the other coverage is primary to **Medicare**. There are many federal regulations regarding **Medicare** Secondary Payer provisions, and other coverage may not be subject to those provisions.
- **Child** — For a **child** whose parents are not separated or divorced, the coverage of the parent whose birthday falls earlier in the **calendar year** pays first. If the **other valid coverage** does not follow this rule, the father's coverage pays first.
- **Child, Parents Separated or Divorced** — For a **child** of divorced or separated parents, benefits are coordinated in the following order:
    - Court-Decreed Obligations - Regardless of which parent has custody, if a court decree specifies which parent is financially responsible for the **child**'s health care expenses, the coverage of that parent pays first.
    - Custodial/Noncustodial - The plan of the custodial parent pays first. The **plan** of the spouse of the custodial parent pays second. The plan of the noncustodial parent pays last.
    - Joint Custody - If the parents share joint custody, and the court decree does not state which parent is responsible for the health care expenses of the **child**, the plans follow the rules that apply to children whose parents are not separated or divorced.

- Active/Inactive Employee — If a **member** is covered as an active employee under one coverage and as an inactive employee under another, the coverage through active employment pays first. (Even if a **member** is covered as a family **member** under both coverages, the coverage through active employment pays first.) If the other plan does not have this rule and the plans do not agree on the order of benefits, the next rule applies.
- **Longer/Shorter Length of Coverage** — When none of the above applies, the plan in effect for the longest continuous period of time pays first. (The start of a new plan does not include a change in the amount or scope of benefits, a change in the entity that pays, provides, or administers the benefits, or a change from one type of plan to another.)

Responsibility for Timely Notice

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

Facility of Payment

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

Overpayments - Right of Recovery

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

Pricing of Non-Contracted Provider Claims

Except for certain categories of **claims** described below, the BCBSNM **covered charge** for **covered services** received from **non-contracted providers** is the lesser of the 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 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 nonemergency 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 Office of Superintendent of Insurance sets fares).
- Covered **claims** priced by a non-New Mexico BCBS **plan** through BlueCard using local pricing methods.
- The categories of **claims** for **covered services** from **non-contracted providers** discussed in more detail below.

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 an **air ambulance**.

- For PPO health plans, services from **non-contracted providers** that satisfy at least one of the two conditions below and, as a result, are eligible for the **preferred provider** benefit level of coverage.

- **Covered services** from **non-contracted providers** within the United States that are determined by the Member's Host **plan** while outside the Service Area of BCBSNM.

- Transition of care services received from **non-contracted providers** that have obtained **prior authorization**.

Pricing for the following categories of **claims** for **covered services** from **non-contracted providers** will be priced at either the sixtieth percentile of the allowed commercial reimbursement rate for the particular **covered service** based on **claims** paid in 2017, or at 150% of the 2017 **Medicare** allowable for the **covered service**, whichever is greater. Unlike the pricing methods above, you will not be responsible for paying to the **non-contracted provider** the difference between the BCBSNM **covered charge** and the **non-contracted provider's** billed charge for a **covered service**.

- **Covered services** required during an **emergency**, excluding **covered services** received in an **ambulance**.

- Non-emergent **covered services** that have obtained **prior authorization**, if needed, and are rendered at a **contracted facility** where:

    - A **contracted provider** is unavailable.

    - A **non-contracted provider** renders unforeseen **covered services**.

    - A **non-contracted provider** renders **covered services** for which you did not give specific consent to the **non-contracted provider** to render.

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.

Provider Payment Example

The two examples below demonstrate the difference between your liability for services from a **non-preferred provider** (when **prior authorization** has been obtained for such services and the services are not eligible for 100 percent coverage of billed charges) versus a **preferred provider**.

Both examples are for a plan that pays 80 percent of **covered charges** with the remaining 20 percent of **covered charges** paid by the **member**.

Example 1. **Preferred provider claim payment** (plan pays 80 percent; **deductible** is met):

Provider's billed charge	$10,000
Covered charges (maximum amount that can be considered for benefit payment)	$8,000
BCBSNM payment to **provider** (80% of $8,000)	$6,400
Member **coinsurance** (20% of $8,000) applied to the **out-of-pocket** limit	$1,600
Amount over the **covered charges** – the **preferred provider** writes off the difference between billed amount and **covered charge**	$0
Total amount due from **member** (**coinsurance** only)	$1,600

Example 2. **Non-preferred provider claim** payment (plan pays 80 percent; **deductible** is met):

Provider's billed charge	$10,000
Covered charges (maximum amount that can be considered for benefit 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

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:

- Your group has the right to reimbursement for all benefits provided from any and all damages collected from the third party for those same expenses whether or 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 your group has provided **benefits** to you or your covered family **member**s.
- Your group is assigned the right to recover from the third party, or their insurer, to the extent of the benefits your group provided for that sickness or injury.

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

Coverage Termination

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

- The employee terminates employment or otherwise loses eligibility according to the terms of the Administrative Services Agreement. If the group or subscriber fails to notify BCBSNM within 30 days to remove an ineligible person from coverage, BCBSNM may recover any payment made on the ineligible person's behalf.
- When the premium payment or other employee contribution for coverage is not received on time. Coverage will be suspended if premium is not paid when it is due. If premium is not received within 30 days after its due date, the group or affected Member(s) will be terminated at the end of the last-paid billing period. Any claims for Medically Necessary services received during the 30-day grace period will be covered.
- When the member begins a leave of absence or enters the armed forces for more than 30 days or as provided by law. (See "Leave of Absence or Military Service").
- When the member materially fails to abide by the rules, policies, or procedures of this plan or fraudulently provides or materially misrepresents information affecting coverage. If a member knowingly gave false material information in connection with the eligibility or enrollment of the subscriber or any of their eligible family members, the group may terminate the coverage of the subscriber and their eligible family members retroactively to the date of initial enrollment. The subscriber is liable for any benefit payments made as a result of such improper actions.
- When the subscriber dies. Surviving eligible family members remain covered through the last-paid billing period.
- If this plan is primary over **Medicare** due to federal laws and regulations when the **Medicare**-eligible member chooses **Medicare** as their primary coverage. (See "**Medicare**-Eligible Members" for information on coverage options for members who are entitled to **Medicare**).
- When the member acts in a disruptive manner that prevents the orderly business operation of any network provider or dishonestly attempts to gain a financial or material advantage.
- When group coverage is discontinued for the entire group or for the employee's enrollment classification.
- When your group gives BCBSNM or BCBSNM gives your group a minimum 30 days' advance written notice.

Additional Family Member Termination Reasons

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

- At the end of the last-paid billing period for family coverage.
- At the end of the month when a child no longer qualifies as an eligible child under the plan (e.g., a child is removed from placement in the home or reaches the eligible child age limit).
- At the end of the month following the date of a final divorce decree or legal separation for a spouse.
- At the end of the month when the subscriber gives a minimum 30 days' advance notice in writing to end coverage for a covered family member(s), according to the rules of your plan as established by your employer.

- At the end of the month following the dissolution of a domestic partnership.
- If a family member is being removed from coverage because of losing their eligibility under the plan (for reasons other than reaching the eligible child age limit), the enrollment/change form must be received by BCBSNM within 31 days following the effective date of the change. In these cases, the member will be removed from coverage as of the end of the month following the change in their eligibility status and payroll deductions will be properly adjusted, if necessary. BCBSNM and the providers of care may recover benefits erroneously paid on behalf of the removed member.

Voluntary Termination of Coverage

To remove a family **member** from coverage before loss of eligibility or to voluntarily terminate their own coverage, the **subscriber** must submit a completed enrollment/change form to their benefits administrator. If voluntary termination is allowed under your **plan** outside the annual renewal period, coverage will end the first of the month following receipt of the enrollment/change form.

Voluntarily terminated **members** may re-enroll under the **plan**:

- As late applicants (except as provided under "Special Enrollment"). These **members** are **not** eligible for any extension of benefits or federal continuation or conversion coverage. Voluntarily terminated **members** may apply for individual coverage offered by BCBSNM.
- During your group's annual **open enrollment** period

Leave of Absence or Military Service

Coverage will end for a **subscriber** and their **eligible family members** at the end of the month during which the leave began. During a leave of absence covered by the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), coverage will continue as provided by law. Contact your benefits administrator for information.

Continuation Coverage Rights Under Cobra

COBRA continuation coverage may be available to you and to other **members** of your family covered under the health care plan when you would otherwise lose your group health coverage. COBRA continuation coverage, which is a temporary extension of coverage under this **group health care plan** was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), for certain larger group employers. Contact your employer to determine if you or your group are eligible for COBRA continuation coverage.

A summary of COBRA continuation coverage rights is provided in this section. For more information about the rights and obligations under the **plan** and under federal law, contact the plan administrator. The plan administrator of the **plan** is named by the employer or by the group health plan. Either the plan administrator or a third party named by the plan administrator is responsible for administering COBRA continuation coverage. Contact your plan administrator for the name, address, and telephone number of the party responsible for administering your COBRA continuation coverage.

Cobra Continuation Coverage

COBRA continuation coverage is a continuation of health care plan coverage when coverage would otherwise end because of a life event known as a qualifying event. Specific qualifying events are listed below. COBRA continuation coverage must be offered to each person who is a **qualified beneficiary**. Depending on the type of qualifying event, employees, spouses of employees, and **eligible children** of employees may be **qualified beneficiaries**. Under the **plan**, 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 lose your coverage under the **plan** because one of the following qualifying events happens:

- Your hours of employment are reduced.
- 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 lose your coverage under the **plan** because any of the following qualifying events happens:

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

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

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

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

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

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

- The end of employment.
- The reduction of hours of employment.
- The death of the employee.

- With respect to a retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer.
- The enrollment of the employee in **Medicare** (Part A, Part B or both).

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

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

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

- The death of the employee.
- The enrollment of the employee in **Medicare** (Part A, Part B or both).
- Your divorce or legal separation.
- An **eligible child** losing eligibility as an **eligible child**.

When the qualifying event is the end of employment or reduction in hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation can be extended.

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the **plan** is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the plan administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that your plan administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

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

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and **eligible children** in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and **eligible children** if the former employee dies, enrolls in **Medicare** (Part A, Part B or both), or gets divorced or legally separated. The extension is also available to an **eligible child** when that **child** stops being eligible under the **plan** as an **eligible child**.

In all 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/agencies/ebsa.

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.

COBRA Continuation Policy Members

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

How To Continue Coverage

If you lose coverage under this **plan**, you may be able to continue coverage for a limited period of time. There is no **special enrollment** under these provisions. You must enroll timely to qualify for continued coverage.

Continuation Coverage

Your group may be subject to the provisions for continuation of plan coverage under federal law (COBRA or USERRA). If so, employees and their covered family **members** excluding **domestic partners** who lose eligibility under this **group health care plan** may be able to continue as **members**, without a health statement, for a limited period of time by purchasing the continuation coverage described below. You must pay premiums from the date of loss of group coverage.

You are not eligible to enroll for continuation coverage if:

- The employer stops offering this coverage to its employees.
- You do not elect continuation coverage in a timely fashion.

Contact your benefits administrator for details about enrolling in continuation coverage.

Continuation Benefits

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

Federal Continuation (COBRA)

Unless approved in writing by BCBSNM, the following persons may not enroll in this continued coverage option:

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

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

- The first of the month when you become entitled to **Medicare**.
- When the employer discontinues offering this **plan** to employees. If this **plan** is replaced by another **health care plan**, continuation coverage will also be replaced by the new **plan**.
- When you become covered under another **group health care plan**; or
- When the continuation period expires. If this employer's **plan** is still being administered by BCBSNM, you will have the option of changing to the conversion coverage provided by BCBSNM and described under "Conversion to Individual Coverage".

Premium Payments

Subscribers under federal COBRA continuation coverage must pay premiums to the COBRA administrator. Contact your benefits administrator for an application for coverage and details.

USERRA Continuation Coverage

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

For a work-related injury or condition, see the "Work-Related Conditions" exclusion in **Medical Limitations and Exclusions**.

Other valid coverage means all other group and individual (or direct-pay) insurance policies or **health care benefit plans** (including **Medicare**, but excluding Indian Health Service and **Medicaid** coverages), that provide payments for medical services will be considered **other valid coverage** for purposes of coordinating benefits under this **plan**.

Qualified beneficiary means someone who will lose coverage under the health care plan because of a qualifying event.

GLOSSARY

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

Accidental Injury means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a physician or other professional provider.

Admission means the period 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.

Allowable Amount means the maximum amount determined by us to be eligible for consideration of payment for a particular **covered service**, covered supply and **covered drug**. Your **deductible**, **coinsurance** and **copayment** are based on the **allowable amount** and the terms of your **plan**. Your share of **coinsurance** is a percentage of the **allowable amount** after the **deductible** is met.

Ambulance means 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**.

Behavioral health means any condition or disorder involving a mental health condition or substance use disorder listed under any of the diagnostic categories in the mental disorders section of the most recent edition of the International Classification of Disease or in the mental disorders section of the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Behavioral health provider means a **physician** or **other professional provider** who renders services for mental and **behavioral health** conditions or **substance use disorder** and is operating within the scope of such license.

Benefits mean the payment, reimbursement, and indemnification of any kind which you will receive from and through the **plan** under this **contract**.

Benefit Period means the period during which you receive **covered services** for which the **plan** will provide **benefits**.

Benefit Booklet means a document or evidence of coverage issued to you along with your separately issued **SUMMARY OF BENEFITS and COVERAGE**, explains the **benefits**, limitations, exclusions, terms, and conditions of your health coverage.

Blue Access for Members (BAM) means on-line programs and tools that BCBSNM offers its Members to help track claims payments, make health care choices, and reduce health care costs.

BlueCard means a national program that enables **members** of one Blue company to obtain healthcare services while traveling or living in another Blue company's **service area**. The program links participating healthcare **providers** with the independent Blue companies across the country and in more than 200

countries and territories worldwide, through a single electronic network for claims processing and reimbursement.

BlueCard Access mean 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.

Calendar Year means the period commencing on a January 1 and ending on the next succeeding December 31, inclusive.

Chemotherapy means drug therapy administered as treatment for malignant conditions and diseases of certain body systems.

Chiropractic Services means any service or supply administered by a **chiropractor** acting within the scope of their licensure and according to the standards of chiropractic medicine in New Mexico or the state in which services are rendered.

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

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

Coinsurance means the percentage of the allowed amount you pay as your share of the bill. For example, if your **plan** pays 80% of the allowed amount, 20% would be your **coinsurance.**

Contracted Provider means 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 **member's** share (**coinsurance**, **deductibles**, **copayments**, etc.) as payment in full for **covered services**. Also see "Network Provider (In-Network Provider)," in this section.

Copayment (Copay) means the set amount you pay each time you receive a certain service.

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

Covered Charge means the amount that BCBSNM determines is a fair and reasonable allowance for a particular covered service. After your share of a **covered charge** (e.g., **deductible**, **copayment**, **coinsurance**), 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**.**

> **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:

Covered Services mean those services and other items for which **benefits** are available under the terms of the benefit **plan** of an eligible **plan member**.

Deductible means the amount of **covered charges** that you must pay in a **calendar year** before this **plan** begins to pay its share of **covered charges** you incur during that **calendar year**.

Dependent means your spouse or **domestic partner** (provided your **employer** covers **domestic partners**) or any **child** covered under the **plan**.
Child means a:

- Natural **child**
- A step**child**
- A foster **child**
- An adopted **child** including those placed with you for adoption.

A **child** must also be under twenty-six (26) years of age, regardless of:

- Financial dependency
- Residency
- Student status
- Employment status
- Marital status

Diagnostic Breast Examination means a **medically necessary** and appropriate examination of the breast using diagnostic mammography, breast magnetic resonance imaging or breast ultrasound that evaluates an abnormality:

- Seen or suspected from a screening examination for breast cancer.
- Detected by another means of examination.

Domestic Partnership means long-term committed relationship of indefinite duration with a person which meets the following criteria:

- You and your **domestic partner** have lived together for at least 6-18 months.
- Neither you nor your **domestic partner** is married to anyone else or has another **domestic partner.**
- Your **domestic partner** is at least 18 years of age and mentally competent to consent to **contract.**
- Your **domestic partner** resides with you and intends to do so indefinitely.
- You and your **domestic partner** have an exclusive mutual commitment similar to marriage.
- You and your **domestic partner** are jointly responsible for each other's common welfare and share financial obligations.

Drug Abuse means a condition defined by patterns of usage that continue despite occupational, marital, or physical problems related to compulsive use of drugs or other non-alcoholic substance. There may

also be significant risk of severe withdrawal symptoms if the use of drugs is discontinued. Drug Abuse does not include nicotine addiction or alcohol abuse.

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

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

Effective Date means the date the coverage for a **participant** begins.

Eligible Child means 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.**
- Foster child 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 mean family **members** of the **subscriber**, limited to the following:

- The **subscriber's** legal **spouse.**
- The **subscriber's domestic partner.**
- The **subscriber's eligible child** or the **eligible child** of the **subscriber's** spouse or **subscriber's domestic partner** through the end of the month in which the **child** reaches **age 26.**
- The **subscriber's unmarried child** or the unmarried **child** of the **subscriber's** spouse or **subscriber's domestic partner** age 26 or older who was enrolled as the **subscriber's** covered **child** in this **plan** at the time of reaching the age limit, and who is medically certified as **disabled,** chiefly dependent upon the **subscriber** for support and maintenance, and incapable of self-sustaining employment by reason of their disability.

Emergency Care mean medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical, **behavioral health** or substance use disorder 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 their 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
- Poisoning

Employee means an individual employed by a group/**employer**. For purposes of this **plan**, the term **employee** will also include those individuals who are no longer an **employee** of the **employer**, but who are **participants** covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continued under the appropriate provisions of the New Mexico Insurance Code.

If applicable to your **plan**, **employees** who have retired under the large **employer's** established procedures whether by either individual selection by the **employer** or the **employee** to be included in a retiree classification, may continue coverage under this **contract**.

Employer means a **group**, as defined, in which there exists an employment relationship between a **participant** and the **group**.

Enteral Nutritional Products means 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 means any treatment, procedure, facility, equipment, drug, device, or supply (including emerging technologies, services, procedures, and service paradigms) 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.
- The improvement must be attainable outside the Investigational settings.

Facility means a **hospital** or other institution.

FDA —means the United States Food and Drug Administration.

Group means 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 Contract means the administrative services agreement, the **group's** application to the **plan**, this **benefit booklet**, the **SUMMARY OF BENEFITS AND COVERAGE**, and any other applications, riders, enclosures, addenda exhibits, and Amendments, or Endorsements, if any between the **plan** and the **group**, referred to as the **group contract**.

Group Health Care Plan means an employee welfare benefit **plan** as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974 to the extent that the **plan** provides medical care and includes items and services paid for as medical care (directly or through insurance, reimbursement, or otherwise) to employees or their **eligible family members** as defined under the terms of the **plan**.

Habilitative Services mean treatment programs that are necessary to:

- Develop
- Maintain
- Restore to the maximum extent practicable the functioning of an individual.

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 mean **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 mean an institution providing health care services, including a **hospital** or other licensed Inpatient center, an ambulatory surgical or treatment center, a Skilled Nursing Facility, a Residential Treatment Center, a Home Health Care Agency, a diagnostic laboratory or imaging center, and a rehabilitation or other therapeutic health setting.

Health Status Related Factor means:

- Health status
- Medical condition, including both physical and mental health
- **Claims** experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of family violence.
- Disability

Home Health Care Agency means 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.
- 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 mean **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**.

Hospital means 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 means a BCBS Plan outside of New Mexico. When you are outside New Mexico and receive **covered services**, the **provider** will submit claims to the Blue Cross Blue Shield (BCBS) **Plan** in that state. That BCBS **Plan** (the "**Host Blue**" **Plan**) will then price the claim according to local practice and contracting, if applicable, and then forward the claim electronically to BCBSNM - your "Home" **Plan** - for completion of processing (e.g., **benefits** and eligibility determination).

Identification Card (ID card) —means the card BCBSNM issues to the **subscriber** that identifies the cardholder as a **plan member**.

Inpatient Services mean care provided while you are confined as an inpatient in a **hospital** or treatment center for at least 24 hours.

Maternity/Pregnancy-Related means any condition that is related to pregnancy.

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

Medically Necessary or Medical Necessity mean 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. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical, **behavioral health** or substance use disorder, illness, injury, or disease.

Medicare means title 18 of the Social Security Amendments of 1965, "*Health Insurance for Aged and Disabled,"* as then constituted or later amended.

Member means an enrollee, the **subscriber** or any **eligible family member**, who is enrolled for coverage and entitled to receive **benefits** under this **plan** in accordance with the terms of the Administrative Service Agreement. Throughout this **Benefit Booklet**, the terms "you" and "your" refer to each Member.

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

- A body mass index (BMI) equal to or greater than 40 kg/meters^2
- A BMI equal to or greater than 35kg/meters^2 with at least one (1) of the following clinically significant obesity-related diseases or complications that are not controlled by best practice medical management:
    - Hypertension
    - Dyslipidemia
    - Diabetes mellitus
    - Coronary heart disease
    - Sleep Apnea
    - osteoarthritis

Network Provider (Preferred Provider) means a **contracted provider** that has agreed to provide services to **members** in your *specific* type of health **plan** (e.g., PPO EPO, etc.).

Network Service Area means the geographic area designated by BCBSNM, within which the **benefits** of this **plan** are available to **members**.

Non-Contracted Provider means 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-participating Provider means an appropriately licensed health care **provider** that has not contracted directly or indirectly, for the service being provided, with BCBSNM.

Non-Preferred Provider mean **providers** that have not contracted with BCBSNM, either directly or indirectly (for example, through another BCBS **plan**). These **providers** may have "participating-only" or "HMO" **provider** agreements but are **not** considered **preferred providers** and are **not** eligible for **preferred provider** coverage under your health plan unless listed as an exception under benefit level exceptions earlier in the booklet.

Out-of-Pocket Limit means the maximum amount of **deductible**, **coinsurance**, and/or **copayments** that you pay for most **covered services** in a **calendar year**.

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

Participant means an **employee** or **dependent** or a retiree whose coverage has become effective under this **contract**.

Physician means a Doctor of Medicine (M.D.) or osteopathy (D.O.) who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

Plan means Blue Cross and Blue Shield of New Mexico (BCBSNM), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association issued group **benefits** contract.

Preferred Provider — See definition of **provider**, below.

Preventive Care means 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 mean a pre-service determination made by BCBSNM regarding a covered person's eligibility for health care services based on **medical necessity**, health **benefits** coverage and the appropriateness and site of services pursuant to the terms of the health **benefits plan**.

Prosthetics mean an externally attached or surgically implanted artificial substitute for an absent body part, for example, an artificial eye or limb.

Professional Provider means 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.

Provider means licensed health care **professional**, **hospital** or other facility authorized to furnish health care services.

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

- **PPP (Primary Preferred Provider)** means 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** means a **provider** who has contracted with BCBSNM directly or indirectly as a **preferred provider** but does not practice one of the **primary preferred provider** medical specialties.
- **Non-Preferred Provider** mean **providers** that have not contracted with BCBSNM, either directly or indirectly (for example, through another BCBS **Plan**). These **providers** may have "participating-

only" or “HMO” Provider agreements but are **not** considered **preferred providers** and are **not** eligible for **preferred provider** coverage under your health **plan** - unless listed as an exception under **Benefit Level Exceptions** earlier in the booklet.

- **PPO Specialist** means 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”).
- **Preferred (PPO) Provider** mean 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** belong to the **preferred provider network**.
- **Participating Pharmacy** means a retail supplier that has contracted with BCBSNM or its authorized representatives to dispense prescription drugs and medicines, insulin, diabetic supplies, and nutritional products to **members** covered under the drug plan portion of this **plan** and that has contractually accepted the terms and conditions as set forth by BCBSNM and/or its authorized representatives. Some participating pharmacies are contracted with BCBSNM to provide specialty drugs to **members**. These pharmacies are called Specialty Pharmacy Providers and some drugs must be dispensed by these specially contracted pharmacy **providers** in order to be covered.
- **Network Provider** agrees to provide health care services to **members** with an expectation of receiving payment directly or indirectly from BCBSNM or other entity with whom the **provider** has contracted. A **network provider** agrees to bill BCBSNM (or other contracting entity) directly and to accept this plan's payment (provided in accordance with the provisions of the contract) plus the **member's** share (**coinsurance, deductibles, copayments**, etc.) as payment in full for **covered services**. BCBSNM (or other contracting entity) will pay the **network provider** directly. BCBSNM (or other contracting entity) may add, change, or terminate specific **network providers** at its discretion or recommend a specific **provider** for specialized care as **medical necessity** warrants.

Participating Provider means 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 **non-preferred 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**.

Non-participating Provider means a **provider** that does not have either a **preferred** or a **participating provider** contract and is paid at the **non-preferred provider** benefit level.

Recommended Clinical Review means an advance confirmation of **benefits** for a requested covered service. **Recommended clinical review** does not guarantee **benefits** if the actual circumstances of the case differ from those originally described.

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

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

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

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.

Specialty Pharmacy Provider — See definition of “Participating Pharmacy.”

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

Supplemental Breast Examination means a **medically necessary** and clinically appropriate examination of the breast using breast magnetic resonance imaging or breast ultrasound that is used to screen for breast cancer when there is no abnormality seen or suspected and based on personal or family medical history or additional factors that may increase the risk of breast cancer.

Telemedicine means 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 diagnosis or treatment of the patient in real time or through the use of store-and-forward technology.

Tertiary Care Facility means a **hospital** unit that provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication and data analysis systems for the geographic area served.

Totally Disabled means 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 means 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.

DRUG PLAN RIDER

A message from your group

This document describes the prescription drug plan portion of the health **benefits** plan which is provided to you. To assure the professional handling of your prescription drug claims, we have engaged Blue Cross and Blue Shield of New Mexico (BCBSNM) as **claim administrator**. Please read the information in this rider carefully so you will have a full understanding of your prescription drug **benefits**. If you want more information or have any questions about your prescription drug plan **benefits**, please contact the employee **benefits** department.

GLOSSARY

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

Coinsurance — The **percentage** amount of a **covered charge** paid by you after you have met the **deductible** under this plan.

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

Deductible – The maximum amount of **covered charges** you must pay in a **calendar year** before the health **benefits** plan begins to pay its share of **covered charges**, including the covered **pharmacy** prescription charges you incur during the same **calendar year** under this rider. The **deductible** described in the health **benefits** plan may be the same or separate as the **deductible** described in this prescription drug rider. 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 charges** that are subject to the **deductible** that you receive during that **calendar year**, including covered **pharmacy** prescription charges under this rider.

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

Generic Drug — A drug that has the same active ingredient as a **brand-name drug** and is allowed to be produced after the **brand-name drug's** patent has expired. In determining the brand or generic classification for covered drugs, BCBSNM uses the generic/brand status assigned by a nationally recognized **provider** of drug product database information. A list of **preferred generic drugs** is available on the BCBSNM website at www.bcbsnm.com/prescription-drugs/managing-prescriptions/drug-lists. You may also contact a Customer Service Advocate for more information.

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

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

Non-Preferred Brand Name Drug — A covered **non-specialty brand name drug** product or other item that is not identified on the **drug list** as **preferred** and is subject to the **non-preferred brand-name drug** payment level. See "Specialty Drugs," below if the **non-preferred brand-name drug** is listed on the ***Specialty Drug List***.

Non-Preferred Generic Drug — A covered **generic drug** product or other item that is not identified on the **drug list** as **preferred** and is subject to the **generic drug** tier payment level. Tier 1 is for all **generic preferred** and **non-preferred drugs**.

Non-Preferred Specialty Drug — A covered **specialty drug** product that does not appear on the **drug list**. **specialty drugs** that do not appear on the **drug list** are subject to the **non-preferred specialty drug** payment level. The **drug list** is available by accessing the website at www.bcbsnm.com/prescription-drugs/managing-prescriptions/drug-lists.

Participating Pharmacy — A retail supplier that has contracted with BCBSNM or its authorized representative to dispense covered **prescription drugs**, **medicines** and **devices**, insulin, diabetic supplies, and nutritional products to **plan members**, and that has contractually accepted the terms and conditions as set forth by BCBSNM and/or its authorized representative. Some **participating pharmacies** are contracted with BCBSNM to provide **specialty drugs** to **members**; these **pharmacies** are called **"Specialty Pharmacy Providers"** and some drugs must be dispensed by these specially **contracted providers** in order to be covered.

Performance Drug List (hereinafter referenced as "**drug list**") — A list of non-specialty **prescription drugs** and **specialty drugs preferred** for use by BCBSNM for **pharmacy benefits** under a BCBSNM administered health plan. (Specialty Drugs are also listed on the separate Specialty Drug List). The drugs on the **drug list** have been selected to provide coverage for a broad range of diseases. Each drug listed shows to which tiered category it belongs under your 6-Tier drug plan. How your cost for a covered **prescription drug** is determined, in accordance with the applicable tier to which it belongs, is described in the "**Member Copayment and Coinsurance**" section of this rider. **brand-name drugs** may be included on the **drug list** when a **generic drug** is not available to treat a specific medical condition, or the **brand-name drug** offers a significant advantage over available **generic drugs** as determined by BCBSNM. The **drug list** is developed using information from the American Medical Association, Academy of Managed Care **Pharmacies**, and other **pharmacy** and medical related organizations. The **drug list** is subject to periodic review and change by BCBSNM; a copy of it is available on the BCBSNM website at www.bcbsnm.com/. You may also contact a Customer Service Advocate, and BCBSNM **contracted providers** may contact their **network** representative for a copy.

Note: Prescription drugs must be listed on the **drug list** to be covered under this drug plan unless coverage is specifically described elsewhere in this rider and/or is required by applicable law or regulation. However, because a drug is listed on the **drug list** does not mean the drug is covered under your health **benefits** plan. **drugs** prescribed for a condition that is not covered under the medical portion of your health **benefits** plan are not covered under this **drug plan rider**.

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

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

Preferred Brand-Name Drug — A covered **non-specialty brand-name drug** product or other item that is identified on the **drug list** and is subject to the **preferred brand-name drug** tier payment level.

Preferred Generic Drug — A covered **generic drug** product or other item that is identified on the **drug list** as **preferred** and is subject to the **preferred generic drug** tier payment level.

Preferred Participating Pharmacy – A **participating pharmacy** which has a written agreement with BCBSNM to provide pharmaceutical services to **members** or an entity chosen by BCBSNM to administer its prescription drug program that has been designated as a **preferred participating pharmacy**.

Preferred Specialty Drug — A covered **specialty drug** which appears on the applicable **drug list** as **preferred specialty drug**. The **drug list** is available by accessing the website at www.bcbsnm.com/prescription-drugs/managing-prescriptions/drug-lists.

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

Rare Disease — A disease or condition that affects fewer than two-hundred thousand (200,000) people in the United States.

Summary of Benefits and Coverage (SBC) — A summary of the **benefits** and exclusions required to be given prior to or at the time of enrollment to a prospective subscriber or covered person by BCBSNM.

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

Specialty Drugs — Prescription Drugs that: a) are high cost; b) are used in limited patient populations or indications; c) are typically self-injected; d) have limited availability, require special dispensing or delivery, and/or patient support is required and, therefore, are difficult to obtain via traditional **pharmacy** channels; and/or e) require complex reimbursement procedures. These drugs must be purchased through the designated BCBSNM **specialty pharmacy** in order to be covered unless coverage is specifically described elsewhere in this rider and/or is required by applicable law or regulation. **specialty drugs**, when covered, are subject to the applicable Tier 6 **copayment** level, same as any other covered drug, according to the tier structure of the drug plan noted in your **Summary of Benefits and Coverage (SBC)** (see "Member **Copayments** and **Coinsurance**" section of this rider).

Specialty Drug List — A list of the names of **specialty drugs** which must be purchased through BCBSNM's **specialty pharmacy provider**. The **specialty drug list** is subject to periodic review and change

by BCBSNM. If you need a list of **specialty pharmacy** drugs, request it from a Customer Service Advocate or visit the BCBSNM website at www.bcbsnm.com/prescription-drugs/managing-prescriptions/drug-lists.

HOW THE PRESCRIPTION DRUG PROGRAM WORKS

When you are being treated for an illness or accident, your doctor may prescribe certain drugs or other **pharmacy** items as part of your treatment. Your coverage includes **benefits** for drugs that are self-administered and other items listed below. This rider explains which drugs and other items are covered and the **benefits** available for them under this drug plan portion of your **health care benefits** plan. The **benefits** described in this rider are subject to all of the terms and conditions described in the health **benefits** plan booklet. For example, **benefits** will be provided only if drugs and supplies are **medically necessary**. Please see the **Medical Limitations and Exclusions** section of your **benefit booklet** for a full list of exclusions that apply to all health care services, including **prescription drugs** and other items under this rider.

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

Note: Prescription drugs that are approved by the FDA through the accelerated approval program may be considered **experimental/investigational**.

Cancer Clinical Trial mean 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.

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

Covered Medications and Other Items — The following drugs, supplies, and other products are covered only when dispensed by a **preferred participating** or **participating pharmacy** under the **retail pharmacy** or **specialty pharmacy drug programs** or when ordered through the designated Mail Order Service vendor:

- **Prescription drugs**, prenatal vitamins, and medicines, unless listed as an exclusion when purchased from a **pharmacy**.
- **Specialty drugs** such as, but not limited to, self-administered injectable drugs such as growth hormone, Copaxone, Avonex. Most injectable drugs require **prior authorization** from BCBSNM. Some self-administered drugs, whether injectable or not, are identified as **specialty drugs** and must be acquired through BCBSNM's designated **specialty pharmacy provider** to be covered.
- Vaccinations for flu or pneumonia, or Zostavax® vaccinations when received from certain **participating pharmacies**. For a list of **Pharmacies** that are contracted with BCBSNM to provide this service, go to the BCBSNM website at www.bcbsnm.com/prescription-drugs/pharmacies.
- Insulin, glucagon, prescriptive oral agents for controlling blood sugar levels, and insulin needles, syringes, and other diabetic supplies (e.g., glucagon emergency kits, autolets, lancets, lancet devices, blood glucose and visual reading urine and ketone test strips). There is a separate **copayment** for each item purchased. These items are not covered as a supply or medical equipment expense under the medical portion of your health care **benefits** plan. See "Supplies, Equipment, and Prosthetics" in your **benefit booklet** for a list of diabetic equipment that *is* covered under the medical portion of your **health care benefits** plan.

Note: For **members** covered under **PPO** medical plans only, some of these items may also be purchased from an **out-of-network pharmacy**. For details, see **Retail Pharmacy Program** below.

Nonprescription **enteral nutritional products** and **special medical foods** only when either:

- Delivered through a **medically necessary** enteral access tube that has been surgically placed (e.g., gastrostomy, jejunostomy).
- Meeting the definition of **special medical foods**. These products must be ordered by a physician and **prior authorization** received from BCBSNM in order to be covered.
- Treatment with FDA-approved **prescription drugs** to assist you with quitting tobacco use or smoking.

Prior Authorization — Certain **prescription drugs**, injectable medications, and **specialty pharmacy** drugs may require **prior authorization** from BCBSNM. A list of drugs requiring **prior authorization** is on the BCBSNM website at www.bcbsnm.com/prescription-drugs/managing-prescriptions/drug-lists. Your Physician can request the necessary **prior authorization**.

NOTE: **Prior authorization** requirements do not apply to covered prescription drugs for the treatment of a **substance use disorder**, an auto-immune disorder, or cancer, or a **rare disease** when determined to be **medically necessary**, except when a biosimilar, interchangeable biologic, or a generic version is available. Standard **medical necessity** determinations will be made by a health care professional from the same or similar practice specialty that typically manages the medical condition, within seven (7) days, and emergency **medical necessity** determinations will be made within twenty-four (24) hours if a delay in treatment could: (1) seriously jeopardize your life or overall health; (2) affect your ability to regain maximum function; or (3) subject you to severe and intolerable pain.

Step Therapy

The step therapy program helps manage costs of expensive drugs by redirecting patients, when appropriate, to equally effective less expensive, generic alternatives. The program requires that

members starting a new drug treatment use **generic drugs** first when appropriate. **generic drugs**, which are tested and approved by the U.S. Food & Drug Administration (FDA), have been shown to be safe and effective. If the generic alternative is not effective, a **brand-name drug** may then be acquired in the second step. You will be required to pay the applicable **copayment** for **brand-name drugs**. Although you may currently be on therapy, your request for non-**generic drug** alternatives may need to be reviewed to see if the criteria for coverage of further treatment have been met. A documented treatment with a generic or brand therapeutic alternative medication may be required for continued coverage of the **brand-name drug**.

NOTE: Continued coverage of a prescription drug, that is the subject of a granted step therapy exception request, will be provided for no less than the duration of the therapeutic effect of the drug.

Contraceptive Drug and Devices – Covered contraceptive drugs and devices are posted on the BCBSNM website www.bcbsnm.com/prescription-drugs/managing-prescriptions/drug-lists. This list is also available by contacting Customer Service at the toll-free number on **your identification card**.

Additionally, when received from a **participating pharmacy**:

- At least one **generic drug** or therapeutic equivalent in each category of contraception approved by the FDA will be covered with no **coinsurance**, **deductible**, **copayment**, or benefit maximums.
- Up to a 6-month supply of contraceptives is available, if prescribed by your **physician** and are self-administered.

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

Orally Administered Anticancer Medications – **Benefits** are available for **medically necessary** orally administered anticancer medication that is used to kill or slow the growth of cancerous cells. Your **deductible** your **copayment** amount or **coinsurance** amount will not apply to orally administered anticancer medications when received from a **participating pharmacy**. Coverage of prescribed orally administered anticancer medications when received from a **non-preferred specialty pharmacy provider** or **non-participating pharmacy** will be provided on a basis no less favorable than intravenously administered or injected cancer medications. If you have questions about your **benefits** for **orally administered anticancer medications**, you may contact Customer Service at the toll-free number on **your identification card**.

Retail Pharmacy Program — Your drug plan provides access to the **pharmacies** in the retail pharmacy network. In order to receive maximum **benefits**, items must be purchased from a **preferred participating** or **participating pharmacy**.

For a list of **preferred participating** and **participating pharmacies**, call Customer Service at the phone number on the back of **your identification card** and request a Provider directory — or visit the BCBSNM website at www.bcbsnm.com/. The **pharmacies** that are participating in the BCBSNM **retail pharmacy program** may change from time to time. You should check with your **pharmacy** before obtaining drugs or supplies to make certain of its participation status.

You must present your BCBSNM identification card to the pharmacist at the time of purchase to receive this benefit. You do not receive a separate prescription drug plan **identification card**; use your BCBSNM administered health care **plan identification card** to receive all medical/surgical and **prescription drug benefits** described in this rider. Your drug plan **copayment** amounts are listed on your **Summary of Benefits and Coverage (SBC)**. You are responsible for paying **copayments**, any pricing differences when

applicable, and limited or non-**covered services**. No **claim** forms are required when you purchase your prescriptions at a **preferred participating** or **participating pharmacy**.

Note: **Specialty drugs** must be purchased from the BCBSNM designated **specialty pharmacy provider** in order to be covered unless coverage is specifically described elsewhere in this rider and/or is required by applicable law or regulation.

You can use your **identification card** to purchase covered items only for yourself and covered family members. When coverage for you or a family member ends under the medical portion of your **health care benefits** plan, the **identification card** may not be used to purchase drugs or other items for the terminated member(s). If you do not have your **identification card** with you or if you purchase your drug or other item from an **out-of-network** retail **pharmacy** and it is eligible for coverage as indicated in the first paragraph of this **retail pharmacy program** section, you must pay for the purchase in full and then submit a **claim** directly to the BCBSNM **pharmacy benefit manager**, Prime Therapeutics, at the address below (do not send to BCBSNM). If not included in your enrollment materials, you can obtain the necessary **claim** forms from a Customer Service Advocate or on the BCBSNM website.

In such cases, you will be responsible for 50% of the **covered charge** (i.e., the BCBSNM contracted rate) applicable had you purchased these covered items at a **participating pharmacy**, plus the tiered **copayment** amount corresponding to these covered items under your particular drug plan. The 50% benefit reduction for **prescription drugs** purchased at a **non-participating pharmacy** does not apply to the **deductible** or **out-of-pocket** limit. However, no **deductible** or **coinsurance** will apply to orally administered anticancer medications when received from a **participating pharmacy. drug** plan **benefits** will be paid for the difference between the foregoing amounts that are your responsibility and any remaining **covered charges** up to the amount originally billed for these covered items by the **out-of-network** retail **pharmacy**. Claim forms may be obtained on the BCBSNM website at: https://wwwbcbsnm.com/docs/forms/claim/nm/rx-claim-form-nm.pdf.

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

If you are leaving the country or need an extended supply of medication, call Customer Service at least two weeks before you intend to leave. (Extended supplies or vacation overrides are not available through the Mail Order Service but may be approved through the Retail **Pharmacy** Program only. In some cases, you may be asked to provide proof of continued enrollment eligibility under the Retail **Pharmacy** Program.) Only up to one 90-day supply override may be allowed every 365 days.

One 30-day supply override for lost, stolen, and damaged medication may be allowed every 365 days,

Specialty Pharmacy Program

This program provides delivery of medications directly to your **provider's** office or to your home if you are undergoing treatment for a complex medical condition.

This drug plan covers only those **specialty drugs** that are listed on the **specialty drug list**. The **specialty drug list** is on the BCBSNM website at www.bcbsnm.com/prescription-drugs/managing-prescriptions/drug-lists or can be obtained from a Customer Service Advocate by calling the phone number on the back of your **identification card**. Your cost for **specialty drugs** is indicated under the "Member **Copayments** and **Coinsurance**" section below and you will be responsible for any **copayments**,

any pricing differences when applicable, non-Covered **specialty drugs**, and other limited or non-**covered services** that may apply to your coverage.

In order to received maximum benefits for **specialty drugs**, you must obtain the **specialty drugs** from a **preferred specialty pharmacy provider.** When you obtain **specialty drugs** from a **preferred specialty pharmacy provider,** you must pay the applicable **copayments** and **coinsurance** as well as any **deductibles** indicated in the Schedule of Benefits.

MedsYourWay™

MedsYourWay™ ("MedsYourWay") may lower your out-of-pocket costs for select **covered drugs** purchased at select in-network retail **pharmacies**. MedsYourWay is a program that automatically compares available drug discount card prices and prices under your benefit **plan** for select **covered drugs** and establishes your out-of-pocket cost to the lower price available. At the time you submit or pick up your prescription, present your BCBSNM **identification card** to the pharmacist. This will identify you as a participant in MedsYourWay and allow you the lower price available for select **covered drugs**.

The amount you pay for your prescription will be applied, if applicable, to your **deductible** and out-of-pocket maximum. Available select **covered drugs** and drug discount card pricing through MedsYourWay**™** may change occasionally. Certain restrictions may apply and certain **covered drugs** or drug discount cards may not be available for the MedsYourWay**™** program. You may experience a different out-of-pocket amount for select **covered drugs** depending upon which retail **pharmacy** is utilized.

Participation in MedsYourWay**™** is not mandatory and you may choose not to participate in the program at any time by contacting Customer Service at the toll-free telephone number on the back of your **identification card**.

For additional information regarding MedsYourWay**™**, please contact a Customer Service at the toll-free telephone number on the back of your **identification card**.

Mail Order Service

Except for supply limitations and nutritional products, all items that are covered under the Mail Order Service are the same items that are covered under the Retail **Pharmacy** Program and are subject to the same limitations and exclusions. To use the Mail Order Service, follow the instructions outlined in the materials provided to you in your enrollment packet. (If you do not have this information, call a Customer Service Advocate.)

Note: Prescription Drugs and other items may **not** be mailed outside the United States. Extended supplies or vacation overrides required when you are outside the country may be approved through the Retail **Pharmacy** Program only.

Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

IMPORTANT: Specialty drugs are not covered through the Mail Order Service. You must use the Specialty **Pharmacy** Provider designated by BCBSNM in order to receive **benefits** for **specialty drugs**.

90 Day My Way Program

The Mail-Order **Pharmacy** Program provides delivery of covered maintenance **prescription drugs** directly to your home address. If you and your covered Dependents elect to use the mail order service, refer to

the Schedule of **Benefits** for Outpatient Prescription Drugs and Related Services for applicable payment levels.

You must fill these Maintenance Prescription Drugs through the Mail-Order **Pharmacy** or one of the extended supply **pharmac**ies in order to receive **Benefits**. For a listing of maintenance **prescription drugs**, you may visit the website at www.bcbsnm.com/prescription-drugs/managing-prescriptions/drug-lists or contact Customer Service at the toll-free number on your **identification card**.

Benefits are available for the original Prescription Order plus one refill at a Retail **Pharmacy** for maintenance **prescription drugs**. For the third fill of the medication, **Benefits** are only available for maintenance **prescription drugs** through the mail-order **pharmacy** program or through one of the Extended Supply **Pharmacies**. **Benefits** are not available if you continue to fill your Prescription Order for maintenance **prescription drugs** at a **pharmacy** not participating in the mail-order **pharmacy** or extended prescription drug supply program.

All items that are covered under the mail-order **pharmacy** program are subject to the same limitations and exclusions as the retail **pharmacy** program. Items covered through a specialty **pharmacy** are not covered through the mail-order **pharmacy** program**.**

Note: **Prescription drugs** and other items may not be mailed outside the United States.

Some drugs may not be available through the mail-order **pharmacy** program. If you have any questions about this mail-order **pharmacy** program, need assistance in determining the amount of your payment or need to obtain the mail-order prescription form, you may access the website at www.bcbsnm.com/ or contact Customer Service at the toll-free number on your **identification card**. Mail the completed form, your Prescription Order(s) and payment to the address indicated on the form.

Your cost will be the appropriate **deductible**, and/or **copayment** amount indicated in the **Summary of Benefits and Coverage (SBC)** for Outpatient Prescription Drugs and Related Services.

If you send an incorrect payment amount for the Prescription Order dispensed, you will: (1) receive a credit if the payment is too much; or (2) be billed for the appropriate amount if it is not enough.

Member Copayments and Coinsurance — For covered Prescription Drugs, insulin, diabetic supplies, and nutritional products, you pay the applicable tiered **copayment** or applicable **coinsurance** (see below), not to exceed the actual retail price, for each prescription filled or item purchased (not to exceed supply limitations described below). See your *Summary of **Benefits** and Coverage* for your **copayment** or applicable **coinsurance** amounts.

The amount you may pay per 30-day supply of a covered insulin drug, or a **medically necessary** alternative, shall not exceed $25 when obtained from a **preferred participating** or **participating pharmacy.**

Certain covered drugs may be available at no cost through a **participating pharmacy** for the following categories of medication: severe allergic reactions, hypoglycemia, opioid overdoses, and nitrates. For further information, call the number on the back of your identification card.

Select covered drugs determined by the **plan** may be covered with no **member** cost share to make these medications more affordable to **members**.

Each **calendar plan year**, the **copayments** and/or **coinsurance** percentage amounts, are applied to you or your family's applicable annual prescription drug Out-of-Pocket limit in combination with your medical and behavioral **benefits** plan for that **calendar plan year**. Any pricing differences between the cost of **brand-name drugs** and their generic equivalents that you pay under this drug plan portion of your **health care benefits** plan are **not** applied to you or your family's applicable annual prescription drug Out-of-Pocket limit in combination with your medical and **behavioral health benefits** plan for that calendar plan year. After you have met the prescription drug Out-of-Pocket limit in combination with your medical and **behavioral health benefits** plan during a single **calendar plan year**, BCBSNM pays 100% of your covered Prescription Drugs, insulin, diabetic supplies, and nutritional products under this drug plan for the remainder of that **calendar plan year**. Noncovered charges may not be used to meet the prescription drug Out-of-Pocket limit in combination with your medical and **behavioral health benefits** plan.

Your drug plan offers several benefit design **copayment** options for when you purchase drugs or supplies from a **preferred participating** or **participating pharmacy** a BCBSNM designated **specialty pharmacy provider**, or BCBSNM- designated Mail Order Service vendor (see below for an example of a 6-Tier **Copayment** Drug Plan and how it works). When you need a prescription order filled, you should use a **preferred participating** or **participating pharmacy**. Each prescription or refill is subject to the **copayment** and/or **coinsurance** shown on the SBC.

When you go to a **preferred participating pharmacy** or a **participating pharmacy**, you must pay any **copayment**, **deductible** (if any), and any applicable pricing differences. You may be required to pay for limited or non-**covered services**. No claim forms are required. If you are unsure whether a **pharmacy** is a **preferred participating pharmacy** or a **participating pharmacy**, you may access the website at www.bcbsnm.com/prescription-drugs/managing-prescriptions/drug-lists or contact Customer Service at the toll-free number on your **identification card**.

In network: In network **pharmacy** claims apply to the in-network **deductible** (if applicable). **Coinsurance** and/or **copayment** amounts paid at an in-network **pharmacy** would only apply to your in-network Out-of-Pocket limit.

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

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

- **Tier 1** includes mostly **preferred generic drugs** and may contain some **brand-name drugs.**
- **Tier 2** includes mostly **non-preferred generic drugs** and may contain some **brand-name drugs.**
- **Tier 3** includes mostly **preferred brand-name drugs** and may contain some **generic drugs.**
- **Tier 4** includes mostly **non-preferred brand-name drugs** and may contain some **generic drugs.**
- **Tier 5** includes mostly **preferred specialty drugs** and may contain some **generic drugs.**
- **Tier 6** includes mostly **non-preferred specialty drugs** and may contain some **generic drugs.**

To verify your payment amount for a drug, visit www.bcbsnm.com and log into Blue Access for Members or call the number on the back of your **identification card**. **Benefits** are described on the **Summary of Benefits and Coverage (SBC)**.

For additional information, please refer to the Outpatient Prescription Drug section as shown in the **Summary of Benefits and Coverage (SBC)**.

See your SBC for the drug plan **copayment** and/or **coinsurance** option that corresponds to the health **benefits** plan you have chosen.

For example, if the health benefits plan you chose features this option: $0/$10/$35/$75/$150/$250		
Six-Tier Plan		
Preferred Participating Retail Pharmacy One **copay** per 30-day supply, up to a 30-day supply Extended Supply (if allowed by the Prescription order) – one **copay** per 30-day supply, up to a 90-day supply. Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.	Tier 1/ **preferred generic**	No **copay**
	Tier 2/ **non-preferred generic**	Charge $10 **copay**
	Tier 3/ **preferred brand name** (no **generic** equivalent)	Charge $35 **copay**
	Tier 4/ **non-preferred brand name** (no **generic** equivalent)	Charge $75 **copay**
Participating Pharmacy Retail Pharmacy One **copay** per 30-day supply, up to a 30-day supply	Tier 1/ **preferred generic**	Charge $10 **copay**
	Tier 2/ **non-preferred generic**	Charge $20 **copay**
	Tier 3/ **preferred brand name** (no **generic** equivalent)	Charge $55 **copay**
	Tier 4/ **non-preferred brand name** (no **generic** equivalent)	Charge $95 **copay**
Specialty Pharmacy Program Coverage for **specialty drugs** are limited to a 30-day supply. However, some **specialty drugs** have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30 day-supply. Cost-share will be based on the day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.	Tier 5/ **preferred specialty** (no **generic** equivalent)	Charge $150 **copay**
	Tier 6/ **non-preferred specialty** (no **generic** equivalent)	Charge $250 **copay**

For all **brand-name drug** with an FDA-approved **generic** equivalent, if you or your **provider** order the brand-name, you will pay the **copay**, PLUS the **difference in cost** between the **brand-name drug** and its **generic** equivalent. Any "differences" between the cost of the **generic** equivalent and the cost of the **brand name drug** will not apply to the **deductible** and Out-Of-Pocket maximum and will continue to be applicable after the Out-Of-Pocket maximum is met.	
Select vaccinations received from certain **Participating Pharmacies.** For a list of covered vaccinations see your **drug list** at www.bcbsnm.com/prescription-drugs/managing-prescriptions/drug-lists.	No **copay** or **coinsurance**
Mail Order Service (available for Tiers 1, 2, 3, or 4 only; Specialty Drugs are **not** covered through Mail Order Service) Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed**.**	**copay** or **coinsurance** for Tier 1, 2, 3, or 4 drug — depending on **generic/brand** and **drug list** status
Nonprescription **Enteral Nutritional Products** and **Special Medical Foods** (requires **prior authorization**)	**coinsurance** of 50% of **covered charges**
Certain prescription drugs for treatment of mental illness, **behavioral health**, and **substance use disorders** from **participating pharmacies**. Please see your Drug List at: www.bcbsnm.com/prescription-drugs/managing-prescriptions/drug-lists, for more information.	No **copay** or **coinsurance**

The amount you may pay per 30-day supply of a covered insulin drug, or a **medically necessary** alternative, shall not exceed $25, when obtained from a **preferred participating** or **participating pharmacy.**

Except as may be specified elsewhere in this rider, drugs and supplies must be purchased from a **participating pharmacy**, or a BCBSNM-designated **specialty pharmacy provider**, or BCBSNM designated Mail Order Service vendor in order to be covered under your drug plan.

You may not be required to pay the difference in cost between the **allowable amount** of the **brand-name drug** and the **allowable amount** of the **generic drug** if there is a medical reason (e.g., adverse event) you need to take the **brand-name drug** and certain criteria are met. Your **physician** can submit a request to waive the difference in cost between the **allowable amount** of the **brand-name drug** and **allowable amount** of the **generic drug**. In order for this request to be reviewed, your **physician** must send in a MedWatch form to the Food and Drug Administration (FDA) to let them know the issues you experienced with the generic equivalent. Your Physician must provide a copy of this form when requesting the waiver. The FDA MedWatch form is used to document adverse events, therapeutic inequivalence/failure, product quality problems, and product use/medication error. This form is available on the FDA website. If the waiver is granted, applicable **deductible**, **copayments** and/or **coinsurance** amounts will still apply. For additional information, contact the customer service number on the back of your **identification card** or visit www.bcbsnm.com/prescription-drugs/managing-prescriptions/drug-lists.

Program Type	Supply	Copayment Requirements

	Maximum	
Nonprescription Nutritional Products	30-day supply during any 30-day period	**Coinsurance of 50%** of **Covered charges** (includes prescriptions for **enteral nutritional products** and **special medical foods** as described under "Covered Drugs and Other Items")
Participating retail pharmacy and **specialty pharmacy provider**	During each one month period, a **30-day supply**	One **copayment** for a 30-day supply.
Retail **pharmacy** Extended Supply	During each three-month period, a **90-day supply** when purchased from a **preferred participating pharmacy** enrolled in BCBSNM's **extended retail prescription drug supply program**.	**Copayments** for a 90-day supply. If less than a 90-day supply is ordered, three **copayments** for a 90-day supply will still apply.
Mail Order Service (Tiers 1, 2, 3, and 4 only)	During each three-month period, a **90-day supply**	**Copayments** for a 90-day supply.

https://www.bcbsnm.com//rx-drugs/pharmacy/pharmacy-programs

Supply Limitations - For each **copayment** and/or **coinsurance** listed for your drug plan, you can obtain the following supply of a single Prescription Drug or other item covered under this rider (unless otherwise specified):

Dispensing Limits — In addition to the supply limits stated above and regardless of the quantity of a covered drug prescribed by a Physician, BCBSNM has the right to establish dispensing limits on covered drugs and over-the-counter contraceptives. These limits, which are based upon FDA dosing recommendations and nationally recognized clinical guidelines, identify gender or age restrictions, and/or the maximum quantity of a drug (or member of a drug class) that can be dispensed to you over a specific period of time. Such limits are in place to encourage appropriate drug use and patient safety, and to reduce waste and stockpiling of drugs. **Benefits** for a covered drug may also be denied if the drug is dispensed or delivered in a manner intended to avoid the BCBSNM established dispensing limit. If you need a drug quantity that exceeds the dispensing limit, ask your doctor to submit a request for review to BCBSNM on your behalf. The Prior Authorization request will be approved or denied after the clinical information submitted by the prescribing doctor has been evaluated by BCBSNM. Some drugs covered under your **plan** may be subject to certain supply/fill limitations pursuant to diagnoses or new-to-therapy requirements, plan design, and/or state or federal regulations. For specific drugs supply/fill information, please call the customer service toll-free number located on your **identification card**.

Multi-Category Split Fill Program — If this is your first time using select medications in certain drug classes (e.g., medications for cancer, multiple sclerosis, lung disorders etc.) or if you have not filled one of these medications recently, you may only be able to receive a partial fill (14-15 day supply) of the medication for up to the first 3 months of therapy. This is to help see how the medication is working for you. If you receive a partial fill, Your **copayment** Amount and/or **coinsurance** Amount after your **deductible** may be adjusted to align with the quantity of medication dispensed. If the medication is

working for you and your **physician** wants you to continue this medication, you may be eligible to receive up to a 30-day supply after completing up to 3 months of the partial supply. For a list of drugs that are included in this program, please visit website. Call the number on the back of your **identification card** if you have any questions.

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

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

- Brand Proton Pump Inhibitors (PPI)
- Prescription Drugs if there is an over-the-counter product available with the same active ingredient(s), in the same strength, unless otherwise determined by the Plan, at its sole discretion.
- Herbal or homeopathic preparations
- Drugs which by law do not require a prescription order from an authorized health care practitioner (except insulin, insulin analogs, insulin pens, oral agents for controlling blood sugar level, and vaccinations administered through certain Participating **Pharmacies**).
- Legend Drugs or covered devices for which no valid prescription order is obtained.
- Non-commercially available compounded medications, regardless of whether or not one or more ingredients in the compound requires a prescription (Non-commercially available compounded medications are those made by mixing or reconstituting ingredients in a manner or ratio that is inconsistent with United States Food and Drug Administration- approved indications provided by the ingredients' manufacturers.
- Prescriptions or other covered items purchased from a non-participating **pharmacy provider** or other **provider** unless eligible for **benefits** in an **emergency** situation (as defined in your **benefit booklet**) or for **members** covered under PPO medical plans, as listed under "Retail Pharmacy Program," and purchased from a non-participating retail **pharmacy**.
- Refills before the normal period of use has expired, in excess of the number specified by the **physician**, or requested more than one year following the **physician's** original order date (Some prescriptions may be subject to a shorter refill window. Please call customer service for details.).
- Replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced.
- Infertility medications
- Over-the-Counter products except as required to be covered under applicable federal or state law.
- Nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum, or Prescription Drugs that have over-the-counter equivalents.

- Drugs or other items for the treatment of sexual or erectile dysfunction.
- Devices, Technologies, and/or **durable medical equipment** of any type (even though such devices may require a prescription order) such as, but not limited to, therapeutic devices, including support garments and other non-medicinal substances, artificial appliances, digital health technologies and/or applications, or similar devices (except disposable hypodermic needles and syringes for self-administered injections).
- Medications or preparations used for cosmetic purposes (such as preparations to promote hair growth or medicated cosmetics).
- Tretinoin (sold under such brand names as Retin-A) for cosmetic purposes if you are age 40 or above.
- Nonprescription **enteral nutritional products** that are taken by mouth, unless the patient meets criteria for **genetic inborn errors of metabolism** and the product obtains **prior authorization** by BCBSNM, or nonprescription nutritional products that have not obtained **prior authorization** by BCBSNM.
- Drugs in a drug class where there is an over-the-counter alternative available, unless otherwise determined by the **group health plan**.
- Drugs that are repackaged by a company other than the original manufacturer.
- Shipping, handling, or delivery charges
- Appetite suppressants or diet aids; weight reduction drugs; food or diet supplements and medication prescribed for body building or similar purposes.
- Prescription drugs for the purpose of weight reduction or control, except for medically necessary treatment of obesity and morbid obesity.
- Ordinary foodstuffs that might be part of an exclusionary diet; any product that does not have and/or require a Physician's prescription; food items purchased at a health food, vitamin or similar store; foods purchased on the Internet.
- Drugs without superior clinical efficacy which have lower cost therapeutic equivalents or therapeutic alternatives.
- Covered drugs, devices, or other **pharmacy** services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not **benefits** are, or could upon proper claim be, provided under Workers' Compensation law.
- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of an **identification card**.
- Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under the medical portion of **health care benefits** plan, or for which **benefits** have been exhausted.
- Any Prescription Drug for which the FDA has determined its use to be contraindicated for the treatment of the particular condition for which the drug has been prescribed.
- Administration or injection of any drugs, except select vaccinations as covered through your **pharmacy benefits**

- Any drugs which are not approved by the FDA for a particular diagnosis or indication, or when used for an indication other than the indication for which the FDA approval is given, except when:
    - Recognized as safe and effective for the treatment of that indication in one or more of the standard medical reference compendia, including the "AMA drug evaluations," the "American Hospital formulary service drug information," and "drug information for the healthcare Provider.
    - When provided for **cancer clinical trials**, pursuant to Section 59A-22-43 NMSA
    - As otherwise required under applicable law or regulation
- Devices and Pharmaceutical Aids
- Institutional packs
- Surgical Supplies
- Ostomy Products
- Diagnostic Agents, except diabetic test strips
- General Anesthetics
- Bulk Powders
- Any Prescription Drug/Product which is not listed on the Drug List unless specifically described elsewhere in this drug rider and/or is required to be covered by applicable law or regulation.
- Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.
- Any self-administered drugs dispensed by a Physician.
- New to Market FDA Approved Drugs are subject to review by Prime Therapeutics Pharmacy & Therapeutics (P&T) Committee prior to coverage of the drug.

Drug Exclusions – Some equivalent drugs are manufactured under multiple names. In some cases, the Plan may limit **benefits** to only one of the equivalents available. If you do not accept the therapeutic equivalents that are covered under your Prescription Drug program, the drug purchased will not be covered under any Benefit level.

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

Exception Request

You or your **provider** can ask for a **drug list** exception if your drug is not on the **drug list** (also known as a formulary). To request this exception, you or your **provider** can call the number on the back of your **identification card** to ask for a review. If you have a health condition that may jeopardize your life, health or keep you from regaining function, or your current drug therapy uses a non-covered drug, you or your **provider** may be able to ask for an expedited review process. The **plan** will let you and your **provider** know the coverage decision within 24 hours after we receive your request for an expedited review. If the coverage request is denied, the **plan** will let you and your **provider** know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may **appeal** the decision according to the appeals process you will receive with the denial determination. For questions about grievance and **appeal** procedures, please see Claims Payments and Appeals, specifically the Questions and Answers that begin with "If my initial request is denied, how can I **appeal** this decision?" A determination will be made within 72 hours following receipt of the request and notice of the

determination will be provided to the insured. If an exception request is granted, the plan will provide coverage of the noncovered drug for the duration of the prescription, including refills.

In the case of exigent circumstances, an enrollee, their designee, or their prescribing **physician** may request an expedited exception process. An exigent circumstance exists when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function or if the enrollee is undergoing a current course of treatment using non-formulary drugs. The determination must be made within 24 hours following receipt of the request and if the exception is granted, the **plan** will provide coverage of the non-formulary drug for the duration of the exigency.

If your **provider** determines that a non-covered contraceptive is **medically necessary**, your **provider** may ask us to cover that contraceptive without cost-sharing.

Call the number on the back of your **identification card** if you have any questions.

BCBSNM'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

For **covered services** provided by Participating Prescription Drug Providers under the prescription drug benefit, all amounts payable to **claim administrator** by Employer for Claim Payments provided by **claim administrator** and applicable service charges pursuant to the terms of the Agreement shall be calculated on the basis of an amount mutually agreed upon by Employer and **claim administrator**. For **covered services** provided by the Participating Prescription Drug Providers under the prescription drug benefit, required **deductible** and Coinsurance amounts under the Agreement shall be calculated on the basis of the Allowable Charge, subsection (d)(i). All (1) amounts payable to **claim administrator** by Employer for Claim Payments provided by **claim administrator** for **covered services** provided by Non-Participating Prescription Drug Providers under the prescription drug benefit; and (2) required **deductible** and Coinsurance amounts for **covered services** provided by Non-Participating Prescription Drug Providers under the prescription drug benefit shall be calculated on the basis of the Allowable Charge, subsection (d)(ii).

Claim administrator hereby informs Employer and all **covered persons** that it has contracts, either directly or indirectly, with **participating prescription drug providers** for the provision of, and payment for, prescription drug services to all persons entitled to prescription drug **benefits** under individual certificates, group health insurance policies and contracts to which **claim administrator** is a party, including the **covered persons** under the Agreement, and that pursuant to **claim administrator's** contracts with **participating prescription drug providers**, under certain circumstances described therein, **claim administrator** may receive discounts for prescription drugs dispensed to **covered persons** under the Agreement. Actual Network savings achieved for **covered persons** will vary. Some rates are currently based on benchmark prices including, but not limited to, Wholesale Acquisition Cost ("WAC"), Average Sales Price ("ASP") and Average Wholesale Price ("AWP"), which are determined by third parties and are subject to change.

Employer understands that **claim administrator** may receive such discounts during the term of the Agreement. Neither **employer** nor **covered persons** hereunder are entitled to receive any portion of any such discounts except as such items may be indirectly or directly reflected in the service charges specified in the Agreement. The drug fees/discounts that **claim administrator** has negotiated with Prime Therapeutics LLC ("Prime") through the **Pharmacy** Benefit Management ("PBM") Agreement, will be used to calculate **covered persons deductibles** and **coinsurance** for both retail and mail/specialty drugs, except as otherwise mutually agreed to by the parties. Except for mail/specialty drugs, the PBM

Agreement requires that the fees/discounts that Prime has negotiated with **pharmacies** (or other suppliers) are passed through to **claim administrator**. For the mail-order **pharmacy** and specialty **pharmacy** program, which as of the Effective Date are partially owned by Prime and administered through Prime affiliates, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail-order pharmacy and/or specialty **pharmacy** program. **claim administrator** pays a fee to Prime for **pharmacy** benefit services, which may be included in the Administrative Charge charged by **claim administrator** to **employer**. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, **claims** processing, customer service response, and mail-order processing.

"Weighted Paid Claim" refers to the methodology of counting claims for purposes of determining **claim administrator**'s fee payment to Prime. Each retail (including claims dispensed through PBM's specialty **pharmacy** program) paid claim will be weighted according to the days' supply dispensed. A paid claim is weighted in thirty-four (34) day supply increments, so a 1-34 days' supply is considered 1 weighted claim, a 35-68 days' supply is considered 2 weighted claims, and the pattern continues up to 6 weighted claims for 171 or more days' supply. **claim administrator** pays Prime a Program Management Fee ("PMF") on a per weighted claim basis.

The amounts received by Prime from **claim administrator**, **pharmacies**, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to **claim administrator** (as described above), administrative fees charged by Prime to **pharmacies**, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to **employer** as expenses, or accrue to the benefit of **employer**, unless otherwise specifically set forth in the Agreement.

BCBSNM'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

BCBSNM hereby informs you that it owns a significant portion of the equity of Prime and that BCBSNM has entered into one or more agreements with Prime or other entities (collectively referred to as "**Pharmacy** Benefit Managers," or "PBMs"), for the provision of, and payment for, prescription drug benefits to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which BCBSNM is a party, including this Contract. PBMs have agreements with pharmaceutical manufacturers to receive rebates for using their products. In addition, Prime's mail order **pharmacy** and other PBM services operate through the same entity, Prime Therapeutics LLC.

Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of BCBSNM, but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufacturers to cover the administrative costs of processing late payments). BCBSNM may also negotiate rebate contracts with pharmaceutical manufacturers. BCBSNM may receive such rebates from Prime or pharmaceutical manufacturers. You are not entitled to receive any portion of any such rebates as they are calculated into the pricing of the product.