BlueCross BlueShield of New Mexico

Blue Advantage HMO Group

(for use with your Group Blue Advantage HMO 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

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IMPORTANT NOTICE

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

1. Cost-sharing and benefits limitations for an emergency health care service rendered by a Nonparticipating Provider shall be the same as if rendered by a Participating Provider. Prior Authorization shall not be required for emergency Health Care Services.
2. Cost-sharing and benefits limitations for a Medically Necessary, non-emergent Health Care Service rendered by a Nonparticipating Provider at a participating Facility where the covered person has no ability or opportunity to choose to receive the service from a Participating Provider shall be the same as if the service was rendered by a Participating Provider.
3. Cost-sharing and benefits limitations for a Medically Necessary, non-emergent Health Care Service where no Participating Provider is available to render the service shall be the same as if the service was rendered by a Participating Provider.

CUSTOMER ASSISTANCE

When you have a **non-medical** benefit question or concern, call BCBSNM Monday through Friday from 6:00 A.M. – 7:00 P.M. and 8:00 A.M.- 5:00 P.M. Mountain Time (MT) on Saturdays and most holidays. (If you need assistance outside normal business hours, you may call the Customer Service telephone number and leave a message. A Customer Service Advocate will return your call by 5:00 P.M. the next business day.) You may either call toll-free or visit the BCBSNM office in Albuquerque at:

Street address: 4373 Alexander Blvd. NE

Toll-free telephone number: 1-800-423-1630

Send all written inquiries to: Blue Cross and Blue Shield of New Mexico
P.O. Box 660058 Dallas, TX 75266-0058

Prior Authorization: Medical/Surgical Services and Prescription Drugs—For Prior Authorization requests, call a Health Services representative at 1-505-291-3585 or 1-800-325-8334. Monday through Friday 8:00 A.M. - 5:00 P.M., Mountain Time (MT). Written requests should be sent to the address given below:

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

NOTE: If you need Prior Authorization assistance between 5:00 P.M. and 8:00 A.M. MT or on weekends, call Customer Service. If you call after normal Customer Service hours, you will be asked to leave a message.

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

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

Monday through Friday 7:00 A.M. – 5:00 P.M. MT:
1-888-898-0070

Claim Submission:

Send medical/surgical Claims* to:

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

Send Mental Health and Substance Use Disorder Claims to:

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

***Exceptions to Claim Submission Procedures**—Claims for Health Care Services received from Providers that do not contract **directly** with BCBSNM, should be sent to the Blue Cross and Blue Shield Plan in the state where services were received. See *Section 8: Claim Payments and Appeal* for details on submitting Claims. **NOTE: Do not submit drug plan Claims to BCBSNM.**

Please send drug Claim forms to:

Prime Therapeutics
PO Box 25136
Lehigh Valley, PA 18002-5136

Common Websites:
For *Provider network* information, visit the BCBSNM website at www.bcbsnm.com/bluehmo.
For *Drug Lists*, visit www.bcbsnm.com/nm/documents/rx-drugs/drug-lists/medical-drug-list-nm-2026.pdf

For *Claim forms*, visit www.bcbsnm.com/form-finder?type=member&state=NM For *other* information, or to email your question to BCBSNM, visit the BCBSNM website at www.bcbsnm.com/member/member-resources/member-services.

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

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

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO AND YOUR GROUP

Welcome to the Health Care Benefit plan for eligible Subscribers of your Group and their Eligible Family Members. This plan is underwritten by Blue Cross and Blue Shield of New Mexico (BCBSNM), your partner in Health Care. Like most people, you probably have many questions about your coverage. This Benefit Booklet contains a great deal of information about the services and supplies for which benefits will be provided under your plan. This booklet complies with all elements required of an evidence of coverage form. This booklet, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this booklet shall be valid until approved by an executive officer of the insurance company and unless such approval and countersignature be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions. Please read your entire Benefit Booklet very carefully. We hope that most of the questions you have about your coverage will be answered.

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

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

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

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

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

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

Sincerely,

Janice Torrez, President
Blue Cross and Blue Shield of New Mexico

If You Live Outside New Mexico

HMO-Participating Providers outside New Mexico and Nonparticipating Providers do not know what services need Prior Authorization under this medical plan, which is administered by BCBSNM. In these cases, it is your responsibility to make sure is obtained when needed. **Please make sure you are aware of Prior Authorization requirements in *Section 4: Utilization Management.*** You may be responsible for all charges if you or your Provider do not receive Prior Authorization from **BCBSNM** for certain services. **All questions about your plan benefits should be directed to BCBSNM - not to the BCBS Plan in your state of residency. NOTE: This is a Managed Care medical plan that generally provides benefits ONLY for services received from a BCBS *HMO* (or HMO-Participating) Provider.** Under the Managed Care plan, if you obtain non-emergency services from a Nonparticipating (non-HMO) Provider, the services will usually NOT be covered. Exceptions to this requirement are listed in *Section 3: How Your Plan Works*. It is YOUR responsibility to determine if a Provider is in the national BCBS HMO-Participating Provider network.

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SECTION 1: HOW TO USE THIS BENEFIT BOOKLET

This Benefit Booklet describes the coverage available to Members of this plan and the benefit limitations and exclusions.

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

DEFINITIONS

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

SUMMARY OF BENEFITS AND COVERAGE (SBC)

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

IDENTIFICATION (ID) CARD

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

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

PROVIDER NETWORK INFORMATION

In order to receive benefits for non-emergency services, you need to use Providers who are in the BCBSNM HMO-Participating Provider network. (You have coverage for Nonparticipating Provider services only during an emergency, when referred to a Nonparticipating Provider by BCBSNM, because it has been determined that medically necessary Covered Services are not reasonably available, or otherwise when Prior Authorization has been obtained due to Medical Necessity). The Provider network information is available through the BCBSNM website at: www.bcbsnm.com/bluehmo. It lists all Providers and their qualifications in the BCBSNM HMO-Participating Provider network and Participating Pharmacies. (If you want a paper copy of a Provider network directory, you may request one from Customer Service. It will be mailed to you free of charge.) To verify a Provider's status or if you have any questions about the Provider network information directory, contact a Customer Service Advocate or visit www.bcbsnm.com/bluehmo.

If required by applicable law, BCBSNM's access plan is available upon request, free of charge electronically, but printed copies are $3.75 per booklet (cost includes shipping to a single location).

Attention Members: Please report directory errors. To suggest directory updates, such as a doctor is accepting new patients but the directory says they are not, please send an email to:

Provider_Directory_Changes_NM@bcbsnm.com. You can also call 1-877-269-1244.

IMPORTANT INFORMATION ABOUT ACCESS TO PRESBYTERIAN HEALTHCARE SERVICES

Participating Network Providers are always subject to change.

As required by law, you will be notified if your Provider is terminated from the Network.

Presbyterian Healthcare Services, or ***PHS*** has Providers in several communities in New Mexico. We call these Providers ***PHS Providers***. Network access to a PHS Provider is an HMO-Participating Provider is based on where you live. New Mexico is divided into two geographical areas: (1) the four counties of Bernalillo, Sandoval, Torrance, and Valencia that we call ***Metro Counties*****;** and (2) all other counties in New Mexico that we call ***Regional Counties***.

Using the table below, you can determine if a particular PHS Provider is an HMO-Participating Provider for you in most situations:

	Your residence is in a Metro County	**Your residence is in a Regional County**
PHS Provider is in a Metro County	PHS Provider is a Nonparticipating Provider	PHS Provider is a Participating Provider
PHS Provider is in a Regional County	PHS Provider is a Participating Provider	PHS Provider is a Participating Provider

There are a few situations that fall outside of the above table.

PHS **Urgent Care** clinics are HMO-Participating Providers for all Members.

For **emergency services**, call 911 or go to the nearest Hospital, including any PHS Hospital.

If your residence is in a Metro County, PHS Providers in a Metro County are HMO-Participating Providers for the following services: Transplants, neurology, neurosurgery, pediatric endocrinology, pediatric heart surgery, pediatric neurology, pediatric pulmonology, pediatric ear-nose-throat, pediatric gastroenterology, pediatric hematology/oncology or neonatal intensive care, and MRIs at the Presbyterian MRI Center.

If your residence is in a Regional County, PHS Providers in a Metro County are Nonparticipating Providers for the following services: primary care and OB/GYN.

For help with determining whether a PHS Provider is an HMO-Participating Provider or a Nonparticipating Provider for you, please contact BCBSNM Customer Service (the phone number is at the bottom of this page).

DRUG PLAN BENEFITS

BCBSNM has Contracted with a separate pharmacy benefit manager to administer your Outpatient drug plan benefits. In addition to your Benefit Booklet, you will be sent important information about your drug plan benefits. See your separately issued *Drug Plan Rider* for more information about the drug plan.

Medically Necessary administration services of Medically Necessary drugs are covered provided that such services would not otherwise be excluded from coverage.

Finding a Pharmacy

Your prescription drug benefit is administered through the Prescription Drug Benefit Manager, Prime Therapeutics LLC. To find a Participating Pharmacy, visit the Prime Therapeutics website at:

www.MyPrime.com

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 Identification Card ,or visit www.bcbsnm.com/find-care 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.

BLUECARD® PROGRAM

As a Member of an HMO health plan administered by BCBSNM, you take your health plan benefits with you for Urgent Care Services across the country and around the world for emergency health care. You do not need to see a BlueCard® Participating Provider to obtain Out-of-Network Emergency Care services. The BlueCard® Program gives you access to HMO-Participating Providers almost everywhere you travel or live. More than 90 percent of all Hospitals and 80 percent of doctors in the United States contract with Blue Cross and Blue Shield (BCBS) Plans. You and your Eligible Family Members can receive the HMO-Participating Provider level of benefits – even when traveling or living outside of New Mexico – by using Health Care Providers that contract as HMO-Participating Providers with their local BCBS Plan. Instructions for locating an HMO-Participating Provider outside of New Mexico can be found on the BCBSNM website at:

provider.bcbs.com/app/public/#/one/city=&state=&postalCode=&country=&insurerCode=BCBSA_I&brandCode=BCBSANDHF&alphaPrefix=&bcbsaProductId.

LIMITATIONS AND EXCLUSIONS

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

PRIOR AUTHORIZATION

Prior Authorization Requirement

Certain types of care require Prior Authorization by us.

This means that you or your Provider must ask us to approve the care before you receive it. Please see *Section 4: Utilization Management*, for a thorough description of Prior Authorization review requirements.

A complete and current list of the services and prescription drugs that are subject to a prior authorization requirement can be found at www.bcbsnm.com/find-care/utilization-management/fully-insured.

You can also call BCBSNM Customer Service at the toll-free telephone number on the back of your Identification Card.

We may decline payment for unauthorized care. If your Provider is in-network, and you did not agree to receive unauthorized care, your Provider cannot bill you for the care. If you received unauthorized care from a Provider who is not in-network, you may be fully responsible for the resulting bills.

We do not require Prior Authorization for:

- Emergency services
- Contraception services that are not subject to any cost-sharing
- An obstetrical or gynecological ultrasound
- The following mental health and substance use disorder services:*
    - Acute or immediately necessary care
    - Acute episodes of chronic mental health or substance use disorder conditions
    - Initial in-network inpatient or outpatient substance use treatment services

*Please see the "Mental Health and Substance Use Disorder Service Coverage" section for additional information. Additionally, coverage for medication approved by the Federal Food and Drug Administration that is prescribed for the treatment of autoimmune disorder, cancer, rare disease or condition or substance use disorder is also not subject to prior authorization, pursuant to a medical necessity determination made by a health care professional from the same or similar practice specialty that typically manages the medical condition, procedure or treatment under review.

- The health care provider who is managing the patient's rare disease or condition must have a baseline understanding of the nature of the patient's rare disease or condition or seek the help of someone in the same or similar specialty and act under their direction even if that specialist is not available within the state.
- To ensure medically necessary determinations are completed in a timely manner, time frames for medically necessary determinations are as follows:
    - 7 seven business days standard determinations; and
    - 24 hours for emergency determinations when a delay in treatment could be harmful to you.

It is important to note that prior authorizations for the treatment of an autoimmune disorder, cancer, rare disease or condition or a substance use disorder, are allowed in cases in which a biosimilar, interchangeable biologic, or generic version is available.

However, we require authorization for continued inpatient care if you are admitted to a Hospital for emergency treatment, but your condition is stabilized. You or your Provider must notify us within 48 hours from when you begin receiving emergency inpatient treatment. If your condition makes it impossible to call within 48 hours, call as soon as possible after the emergency ends and your condition stabilizes.

Prior Authorization Process

Your in-network Provider is responsible for knowing what care requires Prior Authorization, and for submitting a Prior Authorization request to us.

We will give any Provider access to all necessary forms and instructions for making the request. An out-of-network Provider is not required to submit a Prior Authorization request for you. If you visit one of these Providers, and that Provider will not submit a Prior Authorization request, you may submit a Prior Authorization request on your own behalf, or on behalf of a dependent. We will help you obtain required documents and show you the guidelines that apply to the request. However, because your Provider should be able to gather required information and submit it sooner, we encourage you to have your Provider request Prior Authorization whenever possible.

Prior Authorization Review Timelines

If we do not deny a complete Prior Authorization request within these time frames the request is automatically approved:

- **Urgent Care or Prescription Drugs —** If you require urgent medical care, Behavioral Health Care or a prescription drug, we will resolve the request within 24 hours.
- **Non-Urgent Medicine —** if you do not have an urgent need for a prescription drug, we will resolve the request within three business days if your Provider:
  - Uses the Prior Authorization request form approved by the New Mexico Office of Superintendent of Insurance. Available at www.osi.state.nm.us/.
  - Requests an exception from an established step therapy process.
  - Requests to prescribe a drug that we do not usually cover.
- **Other Requests —** We will resolve all other requests within seven (7) business days unless a shorter time frame is required by law.

Meeting these time frames depends on our receipt of sufficient information to evaluate the request. Our Utilization Management staff can answer questions your Provider might have concerning required information or any aspect of the request submission process. If we require additional information to evaluate a request, we will request it from your Provider. Your Provider will have at least 4 hours to provide requested information in connection with an urgent Prior Authorization request, and at least two calendar days for any other type of request.

Why We Review

Our review of a Prior Authorization request will determine if the proposed care involves a Covered Service, is Medically Necessary and whether an alternative type of care should be pursued instead of, or before, the requested care. Our decisions concerning Medical Necessity and care alternatives will be guided by current clinical care standards and will be made by an appropriate medical professional.

Prior Authorization does not guarantee payment. We are not required to pay for an authorized service if your coverage ends before you receive the service.

After Care Review

If you received care without a Prior Authorization, we may allow your Provider to request authorization retrospectively. Our Utilization Management team will assist your Provider in the submission of a retrospective authorization request. However, we do not routinely authorize care retrospectively. To avoid uncertainty, it is always best to request Prior Authorization.

Behavioral Health Care

Requests for Behavioral Health Care and prescriptions are subject to the same prior and retroactive authorization processes and timelines as requests for medical care and prescriptions.

Authorization Denial

We will inform you in writing if we deny a prior or retroactive authorization request. Our notice to you will explain why we denied the request and will provide you with instructions for disputing our decision if you disagree. A summary of the dispute resolution process can be found in the Claims Payments and Appeals section of your plan Benefit Booklet. You have a right to request information about the guidance we followed to deny your request, even if you do not dispute our decision.

HEALTH AND WELLNESS MAINTENANCE AND IMPROVEMENT PROGRAMS

BCBSNM offers programs for the purposes of medical management, quality improvement, and behavioral and physical health wellness, maintenance, or improvement over and above the standard plan benefits. Health and

Wellness Maintenance and Improvement Programs including Well onTarget®, wellness-related tools, education, and other items to assist members in behavior change and on their wellness journey. Included are online wellness tools such as a health and wellness library, health risk assessments, education about a variety of health topics to assist in managing chronic conditions, smoking cessation please see your attached Drug Plan Rider for detailed treatment items), behavioral health, pregnancy support, and community resources. In addition, BCBSNM provides support to Members to assist them in accessing flu shot clinics and other recommended preventive health screenings. These programs may allow for a reward for participation in any program offered or administered by BCBSNM or any retailer, Provider, or manufacturer chosen by BCBSNM to administer such a program

BCBSNM offers education and resources to improve self-management of chronic disease and health conditions including, asthma, heart disease, depression, diabetes, high blood pressure, high cholesterol, low back pain, pain management and pregnancy. Our health advisors and case managers may reach out to you, or you can call us to request a Case Manager at 1-800-325-8334.

Wellness benefits and rewards offered on a uniform availability and non-discriminatory basis for all members.

Discount programs for various health behavior wellness or insurance-related items and services may also be available from time to time. These discounts and services may change at any time and BCBSNM does not guarantee that a particular discount or service will be available at any given time. For details of current discounts or other programs available, please contact a Customer Service representative by calling the phone number on the back of your ID Card.

VIRTUAL VISITS

A Virtual Visit Provider through interactive video via online portal or mobile application. Virtual Visits provide access to designated Providers who can provide diagnosis and treatment of non-emergency medical conditions, Mental Health and other conditions in situations that may be handled without a traditional office visit, Urgent Care visit or Emergency Care visit.

The Member cost hare for Virtual Visit will be the same as or better than in person primary care visits. See the column titled Limitations, Exceptions & Other Important Information is your *Summary of Benefits* for the Member cost share that applies to Virtual Visits for primary care office visit.

TELEMEDICINE MEDICAL SERVICES

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

The Member cost share reflected on your *Summary of Benefits* for primary care or specialist office visits and for Mental Health and Substance Use Disorder is the same as visits delivered via Telemedicine.

IDENTITY THEFT PROTECTION SERVICES

As a Member, BCBSNM makes available at no additional cost to you, identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by BCBSNM's designated outside vendor and acceptance or declination of these services is optional to Member. Members who wish to accept such identity theft protection services will need to individually enroll in the program online at www.bcbsnm.com or telephonically by calling the toll-free telephone number on your Identification Card. Services may automatically end when the person is no longer an eligible Member. Services may change or be discontinued at any time with or without notice and

BCBSNM does not have guarantee that a particular vendor or service will be at any given time. The services are provided as a convenience and are not considered covered benefits under this benefit program.

CUSTOMER SERVICE

If you have any questions about your coverage, call or email BCBSNM's Customer Service department. Customer Service Advocates are available Monday through Friday from 6:00 A.M. – 7:00 P.M. and 8:00 A.M. – 5:00 P.M., MT on Saturdays and most holidays. If you need assistance outside normal business hours, you may call the Customer Service telephone number and leave a message. A Customer Service Advocate will return your call by 5:00 P.M. the next business day.

Customer Service representatives can help with the following:

- Answer questions about your benefits
- Assist with Prior Authorization requests
- Check on a Claims status
- Help you change your PCP selection
- Order a replacement ID Card, Provider directory, Benefit Booklet, or forms

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

Website: www.bcbsnm.com

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

Website: www.bcbsnm.com

Behavioral Health Customer Service

When you have questions about your Mental Health and Substance Use Disorder benefits, call the BCBSNM Behavioral Health Unit (BHU) 24 hours/day, 7 days/week for assistance.

Toll-free: 1-(888)-898-0070

Deaf and Speech Disabled Assistance

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

Translation Assistance

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

After Hours Help

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

- Leave a message for BCBSNM to call you back on the next business day
- Leave a message saying you have a complaint or appeal

BLUE ACCESS FOR MEMBERS℠

To help Members track Claim payments, make Health Care choices, and reduce Health Care costs, BCBSNM maintains a flexible array of online programs and tools for Health Care plan Members. The online *Blue Access for Members*℠ (BAM) tool provides convenient and secure access to Claim information and account management features and the Cost Estimator tool. While online, Members can also access a wide range of health and wellness programs and tools, including a health assessment and personalized health updates, and a program in which Members can earn merchandise for making healthy lifestyle choices and for participating in various activities. To access these online programs, go to www.bcbsnm.com, log into Blue Access for Members℠, and create a user ID and password for instant and secure access.

If you need help accessing the BAM site, call:

BAM Help Desk (toll-free): 1-(888)-706-0583

Help Desk Hours: Representatives are available 24 hours a day, 7 days a week.

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

HEALTH CARE FRAUD INFORMATION

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

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

SECTION 2: ENROLLMENT AND TERMINATION INFORMATION

WHO IS ELIGIBLE

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

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

Unless otherwise specified in the Group Contract, all active employees who have completed the Employee Probationary Period, if any, and who are regularly working the minimum number of hours specified in the Group Contract and their Eligible Family Members are eligible for coverage. (No such Probationary Period may exceed 90 days unless permitted by applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations. BCBSNM reserves the right to restrict such Probationary Period to a 90-day period in order to assure compliance with Affordable Care Act requirements. If BCBSNM records show that your Group has a Probationary Period that exceeds the time period permitted by applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations, then BCBSNM reserves the right to begin your coverage on a date that BCBSNM believes is within the required period. Regardless of whether BCBSNM exercises that right, your Group is responsible for your Probationary Period. If you have questions about your Probationary Period or the number of hours you must work per week or to learn of any other eligibility criteria specified by your Group, contact your Group's benefits administrator.)

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

No eligibility rules or variations in premium will be imposed based on your health status, medical condition, Claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability or any other health status related factor. You will not be discriminated against for coverage under this plan on the basis of race, color, national origin, religion, disability or perceived disability, blindness, partial blindness, limb loss or absence, age, sex, gender identity/transgender status, sexual orientation, ancestry, or marital status. Variations in the administration, processes or benefits of this policy that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

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

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

IF YOUR EMPLOYER OFFERS RETIREE BENEFITS

If your employer's plan also covers retirees, retirees under the age of 65 who meet the employer's eligibility requirements for plan participation are also eligible. To be eligible for continued coverage in this plan, the retiree must also be residing within the BCBSNM HMO Plan Service Area at least six months out of the year.

NOTE: If you are a retiree covered under this plan, please contact your employer's benefits administrator for eligibility criteria applicable to you.

ELIGIBLE FAMILY MEMBERS

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

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

- The Subscriber's legal spouse.
- The Subscriber's Domestic Partner. (**NOTE:** Domestic Partner coverage is available at your employer's discretion. Contact your employer for information on whether Domestic Partner coverage is available for your Group.)
- The Subscriber's Eligible Child or the Eligible Child of the Subscriber's spouse or Domestic Partner (provided your employer covers Domestic Partners) through the end of the month in which the Child reaches age 26. (Once a covered Child reaches age 26, the Child is automatically removed from coverage - unless the Child is an Eligible Family Member under this plan due to a disability as described below.)
- The Subscriber's unmarried Child or the unmarried Child of the Subscriber's spouse or Domestic Partner (provided your employer covers Domestic Partners) age 26 or older who was enrolled as the Subscriber's covered Child in this health plan at the time of reaching the age limit, and who is medically certified as disabled, chiefly dependent upon the Subscriber for support and maintenance, and incapable of self-sustaining employment by reason of their disability. (Such condition must be certified by a Physician and BCBSNM. Also, a Child may continue to be eligible for coverage beyond age 26, only if the condition began before or during the month in which the Child would lose coverage due to their age. BCBSNM must receive written notice of the disabling condition within 31 days of the Child's attainment of the limiting age.) For additional detail, see *Section 9: General Provisions, Disabled Children Continued Coverage*.

  www.bcbsnm.com/docs/forms/group/nm/grp-disabled-dependent-form-nm.pdf
- The Subscriber's dependent student on Medically Necessary leave of absence.

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

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

- Eligible foster Child of the Subscriber or the Subscriber's spouse or Domestic Partner (provided your employer covers Domestic Partners).

A Child meeting the criteria above is an *Eligible Child* whether or not the Subscriber or the Subscriber's spouse or Domestic Partner (provided your employer covers Domestic Partners) is the Custodial or noncustodial parent, and whether or not the Eligible Child is Claimed on income tax, employed, married, attending school or residing in the Subscriber's home, except that once the Subscriber or the Subscriber's spouse or Domestic Partner is no longer a legal guardian of a Child or there is no longer a court order to provide coverage to a Child, the Child must be eligible as a natural Child, legally adopted Child, eligible foster Child, or stepchild of the Subscriber or the Subscriber's spouse or Domestic Partner in order to retain eligibility as a family member under this health plan.

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

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

In addition, you and your Domestic Partner will meet the terms of this definition as long as neither you nor your Domestic Partner has signed a Domestic Partner affidavit or declaration with any other person within 12 months prior to designating each other as Domestic Partners hereunder.

- Is currently legally married to another person.
- Has any other Domestic Partner, spouse, or spouse equivalent of the same or opposite sex.

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

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

The federal government does not recognize Domestic Partners as qualified Eligible Family Members and therefore, the premium paid for their coverage cannot be pre-tax. In addition, the employee must pay tax on the portion of the premium paid by the employer for the Domestic Partner and their covered children. Employees wanting to change benefit elections involving a Domestic Partner must adhere to the same rules regarding Special Enrollment Events.

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

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

Information for Noncustodial Parents

When a Child is covered by the plan through the Child's noncustodial parent, then the plan will:

- Provide such information to the Custodial parent as may be necessary for the Child to obtain benefits through the plan
- Permit the Custodial parent or the Provider (with the Custodial parent's approval) to submit Claims for Covered Services with the approval of the noncustodial parent
- Make payments on Claims submitted in accordance with the above provision directly to the Custodial parent, the Provider, or the state Medicaid agency as applicable

MEDICARE-ELIGIBLE MEMBERS

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

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

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

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

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

If Medicare is Primary

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

APPLYING FOR COVERAGE OR REINSTATEMENT

You may apply for coverage or reinstatement for yourself and/or your eligible spouse and/or dependents (see below) by contacting your Group and following their enrollment process **within 31 days** after becoming eligible according to the terms of the Group Contract. The Application(s) for coverage may or may not be accepted, for example, if the applicant does not live within the Service Area or the application has missing information. (BCBSNM cannot use genetic information or require genetic testing in order to limit or deny coverage.)

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

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

INITIAL AND ANNUAL OPEN ENROLLMENT PERIODS / EFFECTIVE DATES OF COVERAGE

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

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

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

You and/or your Eligible Family Members' Effective Date of Coverage will be determined by the plan in accordance with this section, *Initial and Annual Open Enrollment Periods/Effective Dates of Coverage* and the *Special Enrollment Periods/Effective Dates of Coverage* section below. Your Effective Date of Coverage will depend upon the date your application and all supporting documentation is received. Please review the information below that describes typical enrollment situations to determine what documentation may be required to support a Special Enrollment and contact your employer to determine your Effective Date of Coverage.

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

SPECIAL ENROLLMENT PERIODS / EFFECTIVE DATES OF COVERAGE

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

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

Special Enrollment Events:

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

- You gain access to new health care plans as a result of a permanent move.
- You demonstrate to the plan, in accordance with the guidelines issued by the plan, that you meet other exceptional circumstances as the plan may provide.

Other Special Enrollment Events / Effective Dates of Coverage:

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

- Loss of eligibility as a result of:
  - Legal separation, divorce, or dissolution of a Domestic Partnership, provided your employer covers Domestic Partners.
  - Cessation of dependent status (such as attaining the limiting age to be eligible as a dependent Child under the plan).
  - Death of an Employee.
  - Termination of employment, reduction in the number of hours of employment.
- Loss of coverage due to a plan no longer offering benefits to the class of similarly situated individuals that include you.
- Your employer ceases to contribute towards your or/your dependent's coverage (excluding COBRA continuation coverage).
- COBRA continuation coverage is exhausted.
- Loss of Minimum Essential Coverage. Loss of Minimum Essential Coverage does not include failure to pay premiums on a timely basis, including a failure to pay COBRA premiums, or situations allowing for a Rescission.
- Loss of eligibility for coverage. This does not include loss of eligibility for COBRA continuation coverage.

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

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

WHO IS NOT ELIGIBLE

The following individuals are not eligible for this coverage:

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

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

WHEN COVERAGE BEGINS

You and/or your Eligible Family Members' Effective Date of Coverage will be determined by the plan in accordance with the sections above entitled *Initial and Annual Open Enrollment Periods/Effective Dates of Coverage* and *Special Enrollment Periods/Effective Dates of Coverage*. Your Effective Date of Coverage will depend upon the date your application and all supporting documentation is received. Please review the information

below that describe typical enrollment situations to determine what documentation may be required to support a Special Enrollment and contact your employer to determine your Effective Date of Coverage.

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

CHANGES TO COVERAGE

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

Your ability to change coverage types (e.g., from Family to Individual coverage, etc.) will depend on the rules and regulations set forth by your employer, including those described in the sections above entitled *Initial and Annual Open Enrollment Periods/Effective Dates of Coverage* and *Special Enrollment Periods/Effective Dates of Coverage.* Please contact your employer for further information on when you can change your coverage type or remove a person from your coverage.

ADDING A FAMILY MEMBER TO COVERAGE

A Subscriber may apply for coverage of an Eligible Family Member (such as a new spouse or a newborn Child) as provided under the *Special Enrollment Events/Effective Dates of Coverage* section above. **Within 31 days** of acquiring the newly Eligible Family Member, the Subscriber must:

- Request that the employer notify BCBSNM of the change
- Complete and submit all necessary enrollment/change forms and legal documentation of proof of dependency
- Pay any additional premium or other employee contribution for coverage

Adding a Spouse or a Domestic Partner

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

Adding an Eligible Child

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

Newborn Children

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

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

Adopted Children/Foster Children

A Child placed in the Subscriber's home for the purposes of adoption or foster care may be added to coverage as soon as the Child is placed in the home. However, application for coverage for adopted children can be made as

late as **30 days** following legal adoption without being considered late. Although a Child over the age of 18 is not eligible for adoption, an adopted Child (or a foster Child) is covered as any other Child, subject to the same Eligible Child age limitations and restrictions. **NOTE:** An adopted Child or foster Child who is not enrolled within 30 days of adoption or placement in the home for adoption or foster care will be considered a Late Applicant unless the Child was previously enrolled in a Group Health Care Plan or other Creditable Coverage within 30 days of their adoption or placement for adoption or foster care and has had prior Creditable Coverage since that date with no significant lapse (i.e., 95 or more days).

Legal Guardianship

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

Stepchild

Application for coverage must be made for a stepchild **within 30 days** of the marriage to the stepchild's biological parent.

Court Ordered Coverage for Children

When an employee or employer is required by a court or administrative order to provide coverage for an Eligible Child, the Eligible Child may be enrolled in the Subscriber's Family Coverage, or Employee/Children coverage, if available and will **not** be considered a Late Applicant. If not specified in the court or administrative order, the Eligible Child's Effective Date of Coverage will be the date the order has been filed as public record with the State or the effective date of Family Coverage, or Employee/Children coverage, if available, whichever is later. BCBSNM must receive a copy of the court or administrative order.

LATE APPLICANT

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

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

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

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

RE-ENROLLMENT

If a previously covered employee and/or Eligible Family Member is re-enrolled in this Group plan, they will usually be considered a Late Applicant. See *Leave of Absence* and *Special Enrollment Periods/Effective Dates of Coverage* section above for exceptions and details.

Any individual whose previous BCBSNM contract was terminated for Good Cause is not eligible to re-enroll in this plan, unless approved in writing by the plan. (Members currently enrolled in continuation coverage may not re-enroll once coverage is terminated, unless eligibility under this plan is re-established.)

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

NOTIFICATION OF ELIGIBILITY AND ADDRESS CHANGES

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

Employees and Their Eligible Family Members

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

State Continuation Coverage

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

COBRA Continuation Policy Members

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

COVERAGE TERMINATION

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

Your coverage may be terminated for any of the following reasons:

- When you are no longer eligible for coverage under the plan. The last day of coverage is the last day of the month that you become ineligible.
- The plan terminates.
- When the Subscriber **dies**. (Surviving Eligible Family Members remain covered through the last-paid billing period.)
- If this plan is primary over **Medicare** due to federal laws and regulations, when the Medicare-Eligible Member *chooses* Medicare as their primary coverage. (See *Medicare-Eligible Members*, earlier in this section, for information on coverage options for Members who are entitled to Medicare.)
- When the Member acts in a **disruptive** manner that prevents the orderly business operation of any Network Provider or dishonestly attempts to gain a financial or material advantage.
- When **Group coverage is discontinued** for the entire Group or for the employee's or Subscriber's enrollment classification due to BCBSNM terminating such coverage.
- When the Group gives BCBSNM or BCBSNM gives the Group a minimum **30 days' advance written notice**.
- When an employee **retires.** (The retiree and their Eligible Family Members may be eligible for continuation coverage through federal law. See *How to Continue Coverage*, later in this section. Certain retirees who were covered under the plan after retirement are allowed to remain covered under this plan.)

- When the Subscriber moves to a primary residence or place of employment **outside the geographic area** serviced by BCBSNM. (See *How to Continue Coverage*, later in this section.)

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

Additional Family Member Termination Reasons

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

- At the end of the **last-paid billing period**
- At the end of the month when a Child **no longer qualifies as an Eligible Child** under the terms set by the plan (e.g., a Child is removed from placement in the home or reaches the Eligible Child age limit)
- At the end of the month following the date of a final **divorce** decree or **legal separation** for a spouse
- At the end of the month following the dissolution of a Domestic Partnership, provided your employer covers Domestic Partners

If a family member is being removed from coverage because of losing their eligibility under the terms set by the plan (for reasons other than reaching the Eligible Child age limit), the enrollment/change form must be received by your Group/benefit administrator **within 30 days** following the effective date of the change. In these cases, the Member will be removed from coverage as of the end of the month following the change in their eligibility status and your employer is responsible to adjust payroll deductions if necessary. BCBSNM and the Providers of care may recover benefits erroneously paid on behalf of the removed Member.

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

Voluntary Termination of Coverage

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

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

Termination and Continuation of Coverage or Extension of Benefits

See *How to Continue Coverage* for more information.

Leave of Absence

During a leave of absence covered by the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), coverage will continue as provided by law. Contact your benefits administrator for information.

NOTIFICATION

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

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

- Changes in federal and state law

- Changes to coverage classifications
- After giving the employer 60 days written notice

HOW TO CONTINUE COVERAGE

If you lose coverage under this plan, you may be able to continue coverage for a limited period of time.

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

Continuation Coverage

Your Group may be subject to the provisions for continuation of plan coverage under federal law (COBRA or USERRA) or state law (six-month continuation). If so, employees and their covered family members (excluding Domestic Partners if your Employer has not chosen to extend continued coverage to them) 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 within the applicable time periods as specified by law for federal continuation (COBRA), state continuation, Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) continuation, and/or extension of benefits due to total disability.

In addition, if you elect state continuation coverage, you may not later enroll in federal continuation coverage. Refer to *Section 11: Continuation Coverage Rights under COBRA* or contact your benefits administrator for details about enrolling in continuation coverage.

Continuation Benefits

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

Federal Continuation (COBRA)

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

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

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

- The first of the month when you become entitled to Medicare.
- When the employer discontinues offering this plan to employees (If this plan is replaced by another health care plan, continuation coverage will also be replaced by the new plan.) **Exception:** If your Group declares bankruptcy and you are covered under this plan as a retiree, you and your Eligible Family Members may be eligible for continued coverage.

- When you become covered under another Group Health Care Plan.
- When the continuation period expires. (If this employer's plan is still being administered by BCBSNM, you will have the option of changing to the conversion coverage provided by BCBSNM and described under *Conversion to Individual Coverage*, later in this section.)

State Continuation Coverage

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

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

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

Call a Customer Service Advocate for more information.

Premium Payments

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

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

USERRA Continuation Coverage

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

Extension of Benefits

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

An extension of benefits is available if you:

- Were Totally Disabled on the date of the Group's termination
- Incur an expense directly resulting from that particular disability that would have been a Covered Service before termination

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

CONVERSION TO INDIVIDUAL COVERAGE

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

- Termination of employment
- A Member no longer meets the eligibility requirements of the plan
- The period of continuation coverage expires
- A covered family member loses coverage for one of the following reasons:
    - Divorce or legal separation from the Subscriber
    - Disqualification of the Member under the definition of an Eligible Family Member
    - Death of the Subscriber
    - An employee becomes primary under Medicare, leaving Eligible Family Members without coverage

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

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

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

- When Group coverage under this plan was discontinued for the entire Group or the employee's enrollment classification
- When you reside outside of or move out of New Mexico

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

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

SECTION 3: HOW YOUR PLAN WORKS

PCPS AND OTHER HMO-PARTICIPATING PROVIDERS

This health care plan is a Managed Health Care Plan (MHCP) that generally provides benefits **only** for services received from a BCBSNM *HMO* (or HMO-Participating) Provider. Under the Managed Care plan, if you obtain non-emergency services from a Nonparticipating (non-HMO) Provider, the services will usually not be covered. Exceptions to this requirement are listed in this *Section 3, Exceptions for Nonparticipating Providers*.

Your Primary Care Provider (PCP)

In order to receive coverage under your health plan, each Member must choose a PCP at the time of enrollment. If you do not select a PCP during enrollment, you will be assigned to a PCP in your area. You may choose a different one for each family member. For more information about how to select a PCP and for a list of PCPs and other HMO-Participating Providers, check your Provider directory, visit the *Provider Finder*® website www.bcbsnm.com/bluehmo, or contact Customer Service at the toll-free number on the back of your Identification Card.

A PCP should be chosen for an eligible newborn before the Child's birth, but no later than **31 days** following birth, to ensure continuous coverage from birth. For Dependent children, you may designate any Participating Provider who specializes in pediatric care as their PCP.

Changing PCPs

You may select a new PCP at any time by requesting the change on an enrollment/change form, or by calling a BCBSNM Customer Service representative and notifying them of the change. The change will be effective immediately and BCBSNM will mail you a new Identification Card with the change. To have medical records transferred from one Physician to another, contact your former PCP. You are responsible for any charges related to transferring medical records.

Visiting Your PCP

To avoid possible delays when scheduling an appointment, please follow these steps:

- For **routine appointments** or **sudden illnesses** call your PCP's office and identify yourself as a BCBSNM Member. You will be given instructions to follow.
- To receive office care **after your PCP's normal business hours** or on weekends and holidays, you should call your PCP (or the Physician who is on call for the PCP) and request instructions. Upon arriving for an appointment, show your BCBSNM Plan ID Card to the Provider's receptionist.

Upon arriving for an appointment, show your BCBSNM Plan ID Card to the Provider's receptionist.

Cancelling an Appointment

If you need to cancel an appointment, notify your PCP as soon as possible, but at least 12 hours before the scheduled appointment. You may be charged a fee for a missed appointment. This plan will not pay for such a charge. If you are going to be late for an appointment, please notify your PCP's office; you may be asked to reschedule.

HMO-Participating Specialists and Hospitals

If you need care that is not available from your PCP, including primary coordination of care for a chronic medical condition of sufficient severity to require coordination of care by a specialist, your PCP may recommend that you visit another, more appropriate HMO-Participating Specialist or Facility. **You do not need a referral** from your PCP before seeking care from any **HMO-Participating Provider** Facility, specialist, or other Health Care Provider. With BCBSNM, you have the freedom of going directly to the HMO-Participating Provider of your choice and receiving benefits for Covered Services. **Remember:** Providers without a BCBSNM HMO-Participating Provider contract, and their services, will **not** be covered except in those limited circumstances outlined in this section.

Keep Your PCP Informed

Although you do not need a PCP referral before arranging to receive Covered Services from another HMO-Participating Provider, you should consult with your PCP if possible. Your PCP knows you and your medical history and may be able to suggest a course of treatment or a particular specialist that is more appropriate than the one you may be considering. Also, many specialists and Facilities will not take patients who have not been referred to them by a Physician.

Prior Authorization Needed for Some Services

Your PCP is also aware of the types of services that require **Prior Authorization** from BCBSNM and is familiar with the kind of medical information BCBSNM needs in such cases.

Non-Emergency Hospital Admissions

This plan will cover a Medically Necessary inpatient stay for a Covered Service if you are admitted to an HMO-Participating Provider Facility by your PCP or by an HMO-Participating Specialist. All inpatient Admissions are subject to Prior Authorization, except in the case of emergency.

Selecting an HMO-Participating Provider

Check your Provider directory or visit the *Provider Finder*® website www.bcbsnm.com/bluehmo for a list of HMO-Participating Providers. **Attention Members: Please report directory errors**. To suggest directory updates, such as a doctor is accepting new patients but the directory says they are not, please send an email to Provider_Directory_Changes_NM@bcbsnm.com. You can also call 1-877-269-1244.

If a Provider is a Nonparticipating Provider and non-emergency services have not been authorized by BCBSNM in advance, the services will be denied, and you will be fully responsible for paying the Health Care Provider's bill for a covered procedure.

Nonparticipating Provider Services

If you visit a **Nonparticipating Provider** for non-Emergency Care without first obtaining Prior Authorization from BCBSNM, **the services will not be covered except in the limited circumstances outlined in this section.**

Except in Emergencies, BCBSNM will generally NOT Prior Authorize services of a Nonparticipating Provider if the services could be obtained from an HMO-Participating Provider. Prior Authorizations for such services are given only under very special circumstances related to **Medical Necessity** and **lack of HMO-Participating Provider availability** in the HMO-Participating Provider network. Before BCBSNM may deny a request for specialist services that are unavailable from an HMO-Participating Provider, the request for a specialist similar to the type of specialist to whom the Prior Authorization is requested. BCBSNM will NOT approve a Prior Authorization request based on non-medical issues such as whether or not you or your doctor prefer the Nonparticipating Provider or find the Provider more convenient. Regardless of Medical Necessity or non-medical issues, Nonparticipating Providers' services are NOT covered under this plan, *except during an emergency,* if you do not first obtain Prior Authorization.

This plan does **not** cover service received outside the United States unless there is an emergency and/or is listed as an exception under *Exceptions for Nonparticipating Providers*. See *Where to Send Claim Forms* in *Section 8: Claims Payments and Appeals* for more information about filing Claims for out-of-country services.

Exceptions for Nonparticipating Providers

If Medically Necessary non-emergency services are not reasonably available from an HMO-Participating Provider, the Member's PCP or other HMO-Participating Provider must request and obtain Prior Authorization from BCBSNM for the Member to receive those services from a Nonparticipating Provider. Before BCBSNM may deny that Prior Authorization, the request must be reviewed by a specialist similar to the type of specialist to whom a referral is requested. In determining whether the non-emergency services are not reasonably available from an HMO-Participating Provider, BCBSNM will consider the following criteria:

- Availability – Is the HMO-Participating Provider available to see the Member in a timely fashion as dictated by the clinical situation?
- Competency – Does the HMO-Participating Provider have the necessary training or expertise required to provide the service or treatment?
- Geography – Is the HMO-Participating Provider located within a reasonable distance from the Member's residence? A reasonable distance is defined as travel that will not place the Member at any medical risk.
- Continuity – Does the requested Nonparticipating Provider have a well-established professional relationship with the Member and is providing ongoing treatment of a specific medical problem?

If authorization is obtained in advance for a Nonparticipating Provider to perform non-emergency services, the Nonparticipating Provider:

- May bill you for any amounts in excess of the BCBSNM Covered Charge, in addition to your Copayment
- Is not responsible for obtaining any necessary approvals on your behalf
- May or may not file Claim(s) for you

Emergency Care

If you visit a Nonparticipating Provider for Emergency Care services, you will receive benefits only for the initial treatment, which includes emergency room services and, if you are hospitalized **within 48 hours** of an emergency, the related inpatient hospitalization. (Office, Urgent Care Facility, and Retail Health Clinic services are not considered *Emergency Care* for purposes of this provision.) Non-emergency services provided in an emergency room for treatment of Mental Health or Substance Use Disorder will be paid the same as emergency Care services. You do not need authorization before seeking *emergency* services in an emergency room. However, you should call BCBSNM within 48 hours of receiving the emergency room care (or as soon as possible). **Care obtained from a Nonparticipating Provider without Prior Authorization in any other setting (e.g., Physician's office or Urgent Care center) will not be covered.**

Prior Authorization must be obtained by BCBSNM for all non-emergent follow-up care (which is no longer considered Emergency Care) in order to be covered.

Urgent Care

If you need Urgent Care while in your community for a condition that is not life-threatening but that requires medical attention, call your PCP and request an immediate appointment, if available. If not available, ask your PCP to recommend another Provider, or visit the nearest Participating Provider Urgent Care center. If you need Urgent Care while in the Service Area but outside of your community, visit the nearest Participating Provider Urgent Care center.

If you are traveling outside the Service Area and need Urgent Care, call 1-800-810-BLUE (2583). You will be given the name and phone number of a local Provider who will be able to call BCBSNM for eligibility information and will submit a Claim to the local Blue Cross Blue Shield Plan. *You will also need to call your PCP and request that they call BCBSNM for* ***Prior Authorization*** *to visit an out-of-network Provider.* Non-Emergency Care outside the Service Area, including Urgent Care, from a Provider that does not contract directly with BCBSNM must have been obtained through Prior Authorization by BCBSNM.

Ancillary Providers in a Hospital

When you are admitted to an HMO-Participating Provider Hospital or other HMO-Participating treatment Facility and the Admission is covered under the plan, you will receive benefits for services received during the Admission from a Nonparticipating Provider, anesthesiologist, radiologist, pathologist, assistant surgeon, emergency room Physician, and/or other Hospital based Physician. Please call customer service at the number on the back of your ID Card if you have any questions about the benefits described in this section or how your Claims are paid.

Transition of Care

This provision applies to both Continuity of Care and Transition of Care. If your Health Care Provider leaves the BCBSNM Provider network (for reasons other than failure to meet applicable quality standards, including medical competence, professional behavior, fraud) or if you are a new Member and your Provider is not in the Provider network when you enroll, BCBSNM may authorize you to continue an ongoing course of treatment with the Provider for a transitional period of time of not less than 30 days or other period as required by federal and state law. 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 degenerative, disabling or potentially disabling, congenital, or 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.
- Ongoing institutional or inpatient care.
- The second or third trimester of pregnancy, through the postpartum period; or
- An ongoing course of treatment for a health condition for which a treating Physician or Health Care Provider attests that discontinuing care by that Physician or Health Care Provider would worsen the condition or interfere with anticipated outcomes. The period will be sufficient to permit coordinated transition planning consistent with your condition and needs. Special provisions may apply if the required transitional period exceeds 30 days. Call the BCBSNM Customer Service department for details.

Note: You have the right to appeal any decision made for a request for Benefits under this provision, as explained in *Section 8: Claims Payments and Appeals*.

Out-of-Country Services

Non-Emergency Care received when traveling outside of the United States will be covered provided such care is Medically Necessary and does not constitute a service(s) excluded under this plan. See *Section 8: Claims Payments and Appeals* for more information about filing Claims for out-of-country services.

The above situations are the only instance in which a Member may receive benefits for the Covered Services of a Nonparticipating Provider.

PLAN YEAR

A Plan Year is a benefit period of one year which begins on the contract date/contract anniversary and ending on the day before the next contract anniversary. Please contact your employer for Plan Year information.

BENEFIT LIMITS

There is no general lifetime maximum benefit under this plan. (See the *Summary of Benefits for details.*)

Benefits are determined based upon the coverage in effect on the day a service is received, an item is purchased, or a Health Care expense is incurred. For Inpatient Services, benefits are based upon the coverage in effect on the date of Admission, except that if you are an inpatient at the time your coverage either begins or ends, benefits for the Admission will be available only for those Covered Services received on and after your Effective Date of Coverage or those received before your termination date.

COST-SHARING FEATURES

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

In order to receive a specific service or benefit covered under this plan, you must pay a Deductible, Copayment (fixed- dollar- amount) and/or Coinsurance to the Health Care Provider. See your *Summary of Benefits* for specific cost-sharing information.

DEDUCTIBLE

The Deductible is the amount of Covered Charges incurred by a Member that the Member must pay in a Plan Year before this plan begins to pay its percentage of that Member's Covered Charges incurred during that same plan Year. If the Plan Year Deductible has been met while you are an Inpatient and the Admission continues into a new Plan Year, no additional Deductible is applied to that Admission's Covered Services. However, all other Covered Services received during the new Plan Year are subject to the Deductible for the new Plan Year.

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

Individual Deductible

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

Family Deductible

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

What Is Subject to the Deductible

The following are **applied** to the Plan Year Deductible.

- Charges covered under your *Drug Plan Rider*, depending on your plan
- Coinsurance amounts

COPAYMENTS

Copayments for specific services are listed on your *Summary of Benefits.* The Copayment amount varies depending on the place of service and on the type of Provider. For example, depending on the Plan option chosen, the Copayment for an office visit to a PCP may be lower than the Copayment for a specialist visit.

Other Fixed- Dollar Copayments

Besides office visits, other services may also be subject to a fixed Copayment amount. These services may also require Coinsurance and a Deductible, with the exception of Copayment plans described above, or such plans that only require that you pay a fixed Copayment amount for **certain** services, with no Deductible or Coinsurance to pay in addition for these services, depending on the plan option chosen. See the *Summary of Benefits* for more information.

Drug Plan Copayment

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

COINSURANCE

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

Drug Plan Coinsurance

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

OUT-OF-POCKET LIMIT

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

Individual Limit

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

Family Limits

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

What Is Included in the Out-of-Pocket Limits

The following amounts are applied to the Out-of-Pocket Limits:

- Fixed-dollar Copayments
- Coinsurance amounts
- Plan Year Deductible
- *Drug Plan Rider* Copayments and/or Coinsurance amounts
- Charges covered under your *Drug Plan Rider*

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

CHANGES TO THE COST-SHARING AMOUNTS

The benefits described in this Benefit Booklet and the associated Summary of Benefits and Coverage will only change upon approval of New Mexico's Office of the Superintendent of Insurance and when authorized by an officer of BCBSNM. If changes are made, the change applies only to services received after the change goes into effect (for Inpatient Services, benefits are determined based on the date you are admitted to the Facility). You will be notified if changes are made to this plan. If any benefit changes result in a premium increase, you will be given 60 days' notice of such changes.

If you must change from Individual Coverage to Family Coverage because you must add an Eligible Family Member to your coverage, you and your new Eligible Family Member must meet the higher Family Coverage Deductible and Out-of-Pocket Limit.

Exception: If you must switch to Family Coverage because of adding an eligible newborn Child within the time limits specified in Enrollment and Termination, you will not be required to meet the Family Coverage Deductible and Out-of-Pocket Limits for covered Hospital services related to routine newborn nursery care. However, the

newborn's pediatrician services for Routine Newborn Care will be subject to Family Coverage Deductible and Out-of-Pocket provisions.

If you lose an Eligible Family Member and must switch from Family to Individual Coverage, you will be given credit for all amounts applied to both the Family Coverage Deductible and the Family Coverage Out-of-Pocket Limit. However, you will not be given a refund for any amounts that are in excess of the new individual coverage amount.

Per New Mexico regulation, all cost-sharing (including Copayments, Deductibles, Coinsurance, or similar charges) required for Members by BCBSNM for Health Care Services shall be reasonable and shall include any applicable state and federal taxes.

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 mental illnesses, 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.

Cost-sharing means any Copayment, Coinsurance, Deductible or any other form of financial obligation of an enrollee other than a premium or a share of a premium, or any combination of any of these financial obligations.

SITE OF CARE/FACILITY OR CLINIC FEES/PROVIDER-BASED BILLING

Some Physician and other Professional Provider services may be subject to additional fees charged by Providers based on where services are rendered. Those facilities are obligated to inform you if they will charge additional fees, but if you are uncertain, you should ask your Provider in advance whether those services will be subject to additional Facility fees, clinic fees, or provider-based billing fees. You may be subject to additional cost-sharing if the Provider bills for those additional costs. If you receive services in a location affiliated with a hospital group, and the Provider issues charges for additional Facility fees, clinic fees, or provider-based billing fees, you may receive a separate Explanation of Benefits that reflects an additional cost sharing obligation. As an example, if you receive imaging services, lab services, Physical Therapy, or Specialist services from a Provider at a site affiliated with a hospital group, you may receive a Provider invoice and Explanation of Benefits reflecting an additional, or separate cost share obligation.

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 Services for Flu, Strep Throat, SARS, UTIs, HIV for prep only, and an illness subject to an active Public Health Emergency.

CONTRACEPTIVE COVERAGE

You are entitled to receive certain covered contraception services and supplies without cost-sharing and without prior approval from us. This means that you do not have to make a Copayment, Coinsurance, satisfy a Deductible or pay Out-of-Pocket for any part of contraception benefits listed in this summary if you receive them from an in-network Provider.

You may be required to pay a Copay, Coinsurance, and/or a Deductible if you receive a contraception service or supply from an out-of-Network Provider if the same service or supply is available in-network. You may also owe

cost-sharing if you receive a brand-name contraceptive when at least one generic or a therapeutic equivalent is available.

Covered Contraceptive Methods

Your plan covers these contraceptive methods:

Method
Sterilization Surgery for Women
Sterilization Surgery for Men
IUD Copper
IUD with Progestin
Implantable Rod
Shot/Injection
Oral Contraceptives (The Pill) (Combined Pill)
Oral Contraceptives (Extended/Continuous Use)
Oral Contraceptives (Mini Pill – Progestin Only)
Patch
Vaginal Contraceptive Ring
Diaphragm with Spermicide
Sponge with Spermicide
Cervical Cap with Spermicide
Condom
Spermicide
Emergency Contraceptive – *Plan B*
Emergency Contraceptive – *Ella*

Long Acting Reversible Contraceptives

The Long Acting Reversible Contraceptives (LARCs), including Intrauterine Devices (IUDs) covered without cost-sharing by your plan are listed here: www.bcbsnm.com/nm/documents/rx-drugs/member-contraceptive-list-nm.pdf Coverage with no cost-sharing also applies to IUD insertion and removal, including surgical removal, and to any

related medical examination when services are obtained from an in-network Provider. Coverage of LARCs with no cost-sharing also includes (pre-discharge) post-partum clinical services.

Oral Contraceptives

The oral contraceptives covered by your plan are listed here: www.bcbsnm.com/nm/documents/rx-drugs/member-contraceptive-list-nm.pdf

Six Month Dispensing

You are entitled to receive a six-month supply of contraceptives, if prescribed and self-administered, when dispensed at one time by your pharmacy. If you need to change your contraceptive method before the six-month supply runs out, you may do so without cost-sharing. You will not owe cost-sharing for any related contraceptive counseling or side-effects management.

Brand Name Drugs or Devices

Your plan may exclude or apply cost-sharing to a name-brand contraceptive if a generic or therapeutic equivalent is available within the same category of contraception. Please see the table of contraceptive categories above. Ask your Provider about a possible equivalent.

If your Provider determines that a brand-name contraceptive is Medically Necessary, your Provider may ask us to cover that contraceptive without cost-sharing. If we deny the request, you or your Provider can submit a grievance to contest that denial.

Vasectomies and Condoms

This plan covers vasectomies and condoms. No prescription or cost-sharing is required for coverage of condoms. Please see the section below on *Coverage for Contraception Where a Prescription Is Not Required* for instructions on reimbursement for condoms.

Sexually Transmitted Infections

Your plan covers, and no cost-sharing applies to, 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 infection, regardless of mode of transportation

NOTE: Preventive care for STIs will be provided at no charge, when obtained at a Participating Provider. Treatment, which means Medically Necessary care for management of an existing STI, will be provided at no charge, when obtained at a Participating Provider.

Coverage for Contraception Where a Prescription Is Not Required

Your plan covers contraception with no cost-sharing even when a prescription is not required. Contraceptive methods such as condoms or Plan B may fall into this category. You will not have to pay upfront for contraceptives that do not require a prescription when obtained through an in-network pharmacy. For all other purchases, you may submit a request for reimbursement as follows:

- Within 90 days of the date of purchase of the contraceptive method.
- Provide the covered Member's name, address, plan identification number and paid receipt and the Claim Form – Prescription Drug, also known as a reimbursement form, (available by contacting the Customer Service number on the back of your Identification Card or visiting www.bcbsnm.com), to the following:

Prime Therapeutics

PO Box 25136

Lehigh Valley, PA 18002-5136

If you submit your complete request for reimbursement electronically or by fax, we will reimburse you within 30 days of receiving the request. If you submit your complete request for reimbursement by U.S. mail, we will reimburse within 45 days. Failure to submit a complete request may lead to delays in reimbursement.

Availability of Out-of-Network Coverage

Under your plan, use of an out-of-Network Provider to prescribe or dispense contraceptive coverage is a covered benefit.

PRE-EXPOSURE PROPHYLAXIS COVERAGE SUMMARY

This summarizes HIV Pre-Exposure Prophylaxis (PrEP) medication coverage and essential PrEP services you are entitled to, and replaces any part of your insurance agreement with us that provides less favorable coverage:

Pre-Exposure Prophylaxis (PrEP)

Your plan includes coverage for PrEP medication, as appropriate for you, and essential PrEP related services without cost-sharing, the same as any other preventive drug or service. This means that you do not have to make a copayment, pay Coinsurance, satisfy a Deductible or pay out-of-pocket for any part of the benefits and services listed in this summary if you receive them from an in-Network Provider.

You may be required to pay a Copay, Coinsurance, and/or a Deductible if you receive PrEP medication or PrEP related services from an out-of-network Provider if the same benefit or service is available from an in-network Provider.

What is Covered?

- At least one FDA-approved PrEP drug, with timely access to the PrEP drug that is medically appropriate for the enrollee, as needed
- HIV testing
- Hepatitis B and C testing
- Creatinine testing and calculated estimated creatine clearance or glomerular filtration rate
- Pregnancy testing for individuals with childbearing potential
- Sexually transmitted infection screening and counseling
- Adherence counseling
- Office visits associated with each Preventive Service listed above
- Quarterly testing for HIV and STIs, and annually for renal functions, required to maintain a PrEP prescription

Grievance and Appeals Process

If you were charged cost-sharing for coverage of PrEP medication or PrEP related services on or after January 1, 2021, please call our customer service line at the phone number on the back of your ID card. If you would like to submit a grievance, please contact BCBSNM as detailed below.

If you are denied coverage of a PrEP related service(s), we will inform you in writing of the denial. Our notice to you will explain why we denied the coverage and will provide you with instructions for filing a grievance if you want to contest our decision. You, your designee, prescribing Physician or other prescriber can request a standard or expedited review of a PrEP coverage denial as follows:

Blue Cross Blue Shield of New Mexico
P.O. Box 660058 Dallas, TX 75266-0058
Medical/Surgical 1-800-205-9926
Mental Health/Substance Use Disorder 1-888-898-0070
Fax 1-505-816-3837 or toll free at 1-800-773-1521

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

Office of Superintendent of Insurance –MHCB
1120 Paseo De Peralta Santa Fe, NM 87501
1-505-827-3811 or toll free at 1-855-427-5674

Exception Process

If you have been denied coverage of a PrEP medication, we will inform you in writing of the denial. Our notice to you will provide you with instructions for filing an exception request if the medication that is most appropriate for your circumstances is not included in the drug formulary. You, your designee, prescribing Physician or other prescriber can request a standard or expedited review of a PrEP medication coverage denial. Please contact Customer Service at the number on the back of your ID card, to request a review.

Standard Review

We will review your request and issue a determination to you, your designee, prescribing Physician or other prescriber, within 72 hours following receipt of your request.

Expedited Review

If you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a non-formulary drug, you can request an expedited review. We will review your request and issue a determination to you, your designee, prescribing Physician or other prescriber, within 24 hours following receipt of your request.

If our initial determination is overturned, we will provide coverage for the PrEP medication or PrEP related service that is medically appropriate for you for the duration of the treatment.

For more information or assistance with your complaint, grievance or an exception request, you may contact the Managed Health Care Bureau (MHCB), of the Office of Superintendent of Insurance at:

Telephone:1-855-427-5674
Office of Superintendent of Insurance - MHCB
1120 Paseo De Peralta
Santa Fe, NM 87501
E-mail: mhcb.grievance@state.nm.us

COVERAGE FOR INDIVIDUALS WITH DIABETES

Your health benefits plan contract provides coverage for basic health services for individuals with Type 1 diabetes (insulin dependent diabetes), Type 2 diabetes (non-insulin dependent diabetes), and gestational

diabetes (individuals with elevated blood glucose levels induced by pregnancy). These basic health services consist of:

- Preventive care
- Emergency Care
- Inpatient and outpatient Hospital and Physician care
- Diagnostic laboratory services
- Diagnostic and therapeutic radiological services
- Prescription medications
- Treatment and supplies

This coverage is a basic Health Care Service that entitles you to the medically accepted standard of medical care for diabetes, when medically necessary, and will not be reduced or eliminated.

Generally, your Provider will diagnose you with diabetes and prescribe medically necessary Durable Medical Equipment (DME), diabetic testing supplies, insulin, or other prescription medications used for the treatment of diabetes. Generally, once a Provider diagnoses you with diabetes, any Provider can then prescribe medically necessary DME, diabetic testing supplies, insulin, or other prescription medications.

This section explains covered benefits and services. Nothing in this section of your plan contract shall be construed to require payment for diabetes resources that are not covered benefits or services.

Basic Health Care Services

Your health benefits plan covers the following benefits for diabetes self-management training provided by a certified, registered or licensed health care professional with recent education in diabetes management:

- Medically necessary visits upon the diagnosis of diabetes.
- Visits following a diagnosis indicating a significant change in your symptoms or condition that warrants changes in your self-management.
- Visits when re-education or refresher training is prescribed by your Provider with prescribing authority.
- Telephonic visits with a Certified Diabetes Educator (CDE). Approved diabetes educators may be required to be practitioners/Providers who are registered, certified or licensed health care professional with recent education in diabetes management.
- Medical nutrition therapy related to diabetes management.
- Medically necessary podiatric DME for the treatment of active diabetic foot ulcers, including topical oxygen therapy.

Prescription Medications, DME, Insulin and Supplies

Your plan contract covers DME, diabetic testing supplies, insulin or other prescription medications needed to monitor and control your diabetes as follows:

- Insulin pumps when medically necessary, prescribed by a Provider
- Blood glucose monitors, including those for individuals with disabilities
- Specialized monitors/meters for the legally blind
- Test strips for blood glucose monitors
- Visual reading urine and ketone strips
- Lancets and lancet devices
- Insulin

- Injection aids, including those adaptable to meet the needs of individuals with disabilities, including the legally blind
- Syringes
- Oral diabetic prescription medications for controlling blood sugar levels
- Glucagon emergency kits
- Medically necessary podiatric DME for prevention of feet complications associated with diabetes as follows:
    - therapeutic molded or depth-inlay shoes
    - functional orthotics
    - custom molded inserts
    - replacement inserts
    - preventive devices
    - shoe modifications for prevention and treatment

Your health benefits plan requires the use of approved DME brands that are purchased at in-network pharmacy, preferred vendor or preferred Durable Medical Equipment supplier.

This health benefits plan will also cover items not specifically listed as covered when new and improved DME and prescription medications for the treatment and management of diabetes are approved by the U.S. Food and Drug Administration. When such items are approved, we will update our formulary and other information to provide adequate access to these resources. Coverage of newly approved prescription medications for the treatment and management may be subject to Prior Authorization and step therapy requirements.

Prior Authorization

Medically necessary DME, diabetic testing supplies, insulin or other prescription medications used for the treatment of diabetes and covered under your health benefits plan can be subject to Prior Authorization and step therapy requirements. We will not require your Provider to submit more than one Prior Authorization request per policy year for any single medication or category of covered item, unless there is a change in your diagnosis, management or treatment of diabetes or its complications. The one Prior Authorization per year limitation applies to changes in the following:

- Prescribed dose of a medication;
- Quantities of supplies needed to administer a prescribed medication;
- Quantities of blood glucose self-testing equipment and supplies; or
- Quantities of supplies needed to use or operate devices for which an enrollee has received Prior Authorization during the policy year shall not be subject to additional Prior Authorization requirements in the same policy year if deemed medically necessary by the enrollee's health care practitioner.

Cost sharing

The amount you will pay for a preferred formulary prescription insulin, or a medically necessary alternative will not exceed a total of twenty-five dollars ($25.00) per thirty-day supply. Coverage of all other diabetes related benefits, treatment and supplies may be subject to cost sharing (Deductible, Copay and Coinsurance) consistent with the cost sharing imposed to other benefits under the same contract. This cost sharing will not exceed the cost sharing established for similar benefits under your health benefits plan.

Network Access

We maintain an adequate network of Providers, pharmacies, Durable Medical Equipment suppliers and other suppliers to provide you with adequate and timely access to medically necessary diabetes resources. If a

contract lapses or is terminated, we will ensure the availability and continuity of your care through another Network Provider or a single-case agreement with an out-of-network Provider.

Reimbursement

We guarantee coverage for the medically necessary DME, diabetic testing supplies, insulin or other prescription medications, in this section within the limits of your health benefits plan. We will reimburse you if the before mentioned benefits were not accessible in a timely manner and you incurred out of pocket expenses.

If you are unable to access medically necessary DME, diabetic testing supplies, insulin or other prescription medications covered under this health benefits plan in a timely manner, and when needed, you can:

- Contact us at the toll-free number on the back of your Identification Card and we will assist you with finding an In-Network Provider or refer you to an out-of-network Provider that can deliver the benefit or service in a timely manner; or
- Pay out of pocket and file a Claim with us as provided for in *Section 8: Claims Payment and Appeals* section of this Benefit Booklet.

We will reimburse you the amount of the covered benefit on the same basis as if the benefit was obtained in-network. Once we receive your written request and receipt for out-of-pocket expenses, we will reimburse you within 30 (thirty) days. If we fail to reimburse you in a timely manner, we will pay an interest rate of 18 % (eighteen percent) per year on the amount due.

If you are not satisfied with our resolution you can file a complaint with the Office of the Superintendent of Insurance at www.osi.state.nm.us/pages/misc/mhcb-complaint or by calling 1-855-427-5674, option 3.

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICE COVERAGE

Your coverage complies with requirements under the federal Mental Health Parity and Addiction Equity Act, and with new sections of the New Mexico Insurance Code Chapter 59A, pursuant to Senate Bill 273, Parity for Coverage of Mental Health and Substance Use Disorder (MH/SUD) Services. For additional information on these requirements or if you feel your rights have been violated, you may contact the NM Office of Superintendent of Insurance using this link: www.osi.state.nm.us/.

Your rights under these federal and state laws include:

- Generally, coverage in this plan does not impose stricter limitations or financial requirements to MH/SUD coverage than the limitations or financial requirements that are imposed on medical and surgical benefits.
- MH/SUD services that are offered must have treatment available in: psychiatry, psychology, social work, clinical counseling, addiction medicine counseling, and family and marriage counseling. These benefits are subject to network requirements, Provider scope of practice and credentialing, and may be subject to Medical Necessity review.
- Our authorization criteria must follow generally recognized standards of care established by evidence-based resources, including clinical practice guidelines and recommendations from MH/SUD care Provider professional associations and relevant federal government agencies.
- Federal and New Mexico law requires the plan not exclude coverage for MH/SUD services under the following circumstances:
    - Services that are available to you through federal or state laws for people with disabilities.
    - Services that are available to you through a public benefit program.

    - Services that have been court ordered and have been determined to be medically necessary by a Provider.
    - Services for individuals who have co-occurring diagnoses of Mental Health and Substance Use Disorders.
- MH/SUD Provider network –
    - We maintain an adequate network as required by New Mexico state-mandated network adequacy standards of qualified MH/SUD services Providers.
    - If the eligible services cannot be provided within our network, you will not have to pay extra for eligible services if similar services under your benefit plan are provided by an out-of-network Provider.
- Prior Authorization, including Recommended Clinical Review guidelines –
    - Certain types of services require Prior Authorization by us.
    - Prior Authorization cannot be taken back or changed after the Provider gives the services in good faith, except for cases of dishonesty, material misrepresentation, or violation of the Provider's contract.
    - We are prohibited from ordering Prior Authorization or referral for in-network service coverage for: acute or immediately necessary care, acute episodes of chronic MH/SUD conditions, initial in-network inpatient or outpatient SUD services.
    - Prior Authorization will be determined in discussion with your MH/SUD Provider for continuation of services, unless your eligibility in the plan ends.
    - Coverage for medication must be made according to a medical need.
    - For SUD medications, we cannot require Prior Authorization or *step therap*y (such as making you take additional steps before paying for medication prescribed by your Provider), unless there is a generic or a biosimilar (which means a biological medicine approved by the U.S. Food and Drug Administration or FDA that works in a similar way to its reference drug) equivalent.
- After beginning in-network MH/SUD treatment, we may require your Provider to notify us and/or develop and submit a treatment plan for continued treatment/services.
- We cannot limit coverage for MH/SUD services up to the point of relief of presenting signs and symptoms or to short-term care or acute treatment.
- Your length of time for treatment will be based on your Provider's recommendation and MH/SUD needs, which may be assessed in conjunction with accepted clinical practice guidelines and recommendations.
- Level of care determinations:
    - Level of care means the treatment setting or Facility type that is most appropriate to treat your condition.
    - Your MH/SUD Provider decides, in consultation with the health plan, what types of services you need and for how long, based on your diagnosis and generally recognized standards of care.
    - Services may include placement into a Facility that provides detoxification services, a Hospital, an in-patient rehabilitation treatment Facility or outpatient treatment program.
    - Changes in level and length of time of care will be determined by your Provider in consultation with the health plan and based on assessments of Medical Necessity using accepted clinical practice guidelines.
- At your request, we will provide coordination of care which means we may help communication between your MH/SUD service Provider and your Primary Care Provider to prevent any conflicts of care that could be harmful to you.
- We will make sure our MH/SUD policies are available to you.
- We protect your confidentiality when receiving MH/SUD treatment.
- We will not end coverage of your treatment without a discussion with your MH/SUD Provider and you.

- If your Claim is denied due to lack of *Medical Necessity*, you have a right to request the specific reasons for your denial.

NOTE: This information about Mental Health and Substance Use Disorder coverage does not create a private right of action.

SECTION 4: UTILIZATION MANAGEMENT

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

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

PRIOR AUTHORIZATION

Prior Authorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this plan. It ensures that the care and services described below for which you have obtained Prior Authorization will not be denied on the basis of Medical Necessity or Experimental/Investigational.

Prior Authorization the review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility at the time services are delivered and the other terms, conditions, limitations and exclusions of this Benefit Booklet.

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

Medically Necessary/Medical Necessity is defined as Health Care Services determined by a Health Care Provider, in consultation with the health insurance carrier, to be appropriate or necessary, according to:

- Any applicable generally accepted principles and practices of good medical care.
- Practice guidelines developed by the federal government, national or professional medical societies, boards and associations.
- Any applicable clinical protocols or practice guidelines developed by the health insurance carrier consistent with such federal, national and professional practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical or Mental Health condition, or Substance Use Disorder, illness, injury or disease.

Please 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.

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

Prior Authorization requests will be evaluated and you and/or the Provider notified of BCBSNM's decision within 7 business days of receiving the complete request (within 24 hours for Urgent Care requests). If requested services are not approved, the notice will include:

- The reasons for denial.
- A reference to the Health Care plan provisions on which the denial is based.
- An explanation of how you may appeal the decision if you do not agree with the denial (see *Section 8: Claims Payments and Appeals* and *If Your Prior Authorization Request is Denied*, later in this section).

HOW THE PRIOR AUTHORIZATION PROCEDURE WORKS

If you or your Provider call, BCBSNM's Health Services representative will ask for information about your medical condition, the proposed treatment plan, and the estimated length of stay (if you are being admitted). The health services representative will evaluate the information and notify the requesting Provider if benefits for the proposed hospitalization or other services have been approved through Prior Authorization. You or your Provider may also fax your Prior Authorization request. Please see the table below for telephone and facsimile numbers to initiate a Prior Authorization request.

Upon receipt by BCBSNM, information about the status of Prior Authorization request (including Recommended Clinical Review), is available to you in your online "Blue Access for Members" (BAM) tool. Refer to *Section 1: How to Use this Benefit Booklet* for additional information regarding BAM.

If the Admission or other services are not approved through Prior Authorization, you may appeal the decision as explained in *Section 8: Claims Payments and Appeals.*

SERVICES OF HMO-PARTICIPATING PROVIDERS

If the attending Physician is an HMO-Contracting Provider, obtaining Prior Authorization is not your responsibility it is the Provider's. PCPs and other HMO-Participating Providers contracting with BCBSNM must obtain Prior Authorization from BCBSNM (or from the Behavioral Health Unit (BHU), when applicable) in the following circumstances:

- When recommending any non-emergency Admission, re-Admission, or transfer.
- When a covered newborn stay in the Hospital longer than the birthing parent.
- Before providing or recommending a service listed under *Other Prior Authorizations*, later in this section.
- Before recommending that you go to a Nonparticipating Provider for whose services you expect to receive benefits. (Such requests may be denied.)

BCBSNM will advise you if a Prior Authorization request is denied.

NONPARTICIPATING PROVIDERS OR PROVIDERS OUTSIDE THE NETWORK

Except in Emergencies, BCBSNM must Prior Authorize a visit to a Nonparticipating Provider. If Prior Authorization is not obtained before a visit to a Nonparticipating Provider, benefits will not be available for the services.

Care received from a Nonparticipating Provider without a BCBSNM Prior Authorization is covered only if a delay in reaching an HMO-Participating Provider would result in death or disfigurement, jeopardize your health, or seriously impair the function of any bodily organ or part.

BCBSNM may deny Prior Authorization for a visit to a Nonparticipating Provider. Any non-emergency services received from a Nonparticipating Provider must be unavailable from an HMO-Participating Provider. If services are available within the BCBSNM HMO-Participating network, BCBSNM will not Prior Authorize a visit to a Nonparticipating Provider. If an HMO-Participating Provider is available in another city, you may have to travel to that city to receive benefits for non-Emergency Care. Also, this plan does not cover services received outside the United States, unless there is an emergency.

Most Prior Authorizations may be requested over the telephone. If a *written* request is needed, have your Provider call a Health Services representative at 1-505-291-3585 or toll-free at 1-800-325-8334, for instructions for filing a

written request for Prior Authorization. The Provider may call on your behalf, but it is your responsibility to ensure that BCBSNM is called when receiving out-of-network services.

For additional information about Prior Authorization for services outside of our Service Area, see the section entitled, *THE BLUECARD® PROGRAM*.

If a Nonparticipating Provider or Provider Outside the Network Recommends Services

Under very special medical circumstances, BCBSNM may Prior Authorize a visit to a Nonparticipating Provider. If a Provider recommends an Admission or a service that requires Prior Authorization, the Provider is not obligated to obtain the Prior Authorization for you. In such cases, it is your responsibility to ensure that Prior Authorization is obtained. If Prior Authorization is not obtained before services are received, you will be entirely responsible for the charges.

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

INPATIENT PRIOR AUTHORIZATION

Inpatient Admissions

Your Provider may need to obtain Prior Authorization from the plan for an inpatient Admission, if inpatient Admissions are identified as needing a Prior Authorization. In the case of an elective inpatient Admission, if services require an authorization, it is recommended that the call for Prior Authorization should be made at least two working days before you are admitted unless it would delay Emergency Care. In an emergency, it is recommended that Prior Authorization should take place within two working days after Admission, or as soon thereafter as reasonably possible.

Your Preferred Provider is required to obtain Prior Authorization for any inpatient Admissions that may require Prior Authorization. If Prior Authorization is not obtained for Inpatient Services and the services are denied as not Medically Necessary, the Participating Provider will be held responsible and will not be able to bill the Member for the services.

If the Physician or Provider of services is not a Preferred Provider then you, your Physician, Provider of services, or an authorized representative should obtain Prior Authorization by the plan by calling one of the toll-free numbers shown on the back of your Identification Card. The call should be made between 8:00 A.M. and 5:00 P.M. on business days and 8:00 A.M. and 11:00 A.M., MT on Saturdays, Sundays and legal holidays. Calls made after these hours will be recorded and returned no later than 24 hours after the call is received. We will follow up with your Provider's office. After working hours or on weekends, please call the toll-free number listed on the back of your Identification Card. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for Prior Authorization requirements are provided in keeping with applicable state and federal regulations**.**

When Prior Authorization of an inpatient Admission is obtained, a length-of-stay is assigned. Your Provider may seek an extension for the additional days if you require a longer stay. Benefits will not be available for room and board charges for medically unnecessary days. For more information regarding lengths of stay, refer to the **Length of Stay/Service Review** subsection of this Benefit Booklet.

For Behavioral Health Inpatient Hospital Admissions please see **Contacting Behavioral Health** section below.

Prior Authorization not required for Maternity care and Treatment of Breast Cancer unless Extension of Minimum Length of Stay Requested

Your plan is required to provide a minimum length of stay in a Hospital Facility for the following:

- Maternity Care:
    - 48 hours following an uncomplicated vaginal delivery

    - 96 hours following an uncomplicated delivery by caesarean section
- Treatment of Breast Cancer:
    - 48 hours following a mastectomy
    - 24 hours following a lymph node dissection

You or your Provider will not be required to obtain Prior Authorization from BCBSNM for a length of stay less than 48 hours (or 96 hours) for Maternity care or less than 48 hours (or 24 hours) for Treatment of Breast Cancer. If you require a longer stay, you, your authorized representative, or your Provider must seek an extension for the additional days by obtaining Prior Authorization from BCBSNM.

OUTPATIENT SERVICE REVIEW

If Prior Authorization is required, the review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Benefit Booklet. BCBSNM recommends you confirm with your Provider if Prior Authorization has been obtained.

There may be general categories of Covered Services that require Prior Authorization.

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

To determine if a specific Behavioral Health service or category requires Prior Authorization, visit our website at www.bcbsnm.com/find-care/where-you-go-matters/utilization-management/fully-insured for the required Prior Authorization list, which is updated when new services are added or when services are removed. You can also call the Behavioral Health Unit at 1-888-898-0700.

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

Summary of Contact Information for Prior Authorization, Customer Service, Claim Submission and Appeal (or Reconsideration) Processes for Medical/Surgical and Mental Health and Substance Use Disorder Services:			
Process:	**Type of Service:**	**Phone/Fax:**	**Send to:**
Request Prior Authorization	Medical/Surgical	Phone: 1-800-325-8334 Fax: 1-866-589-8523	BCBSNM P.O. Box 660058 Dallas, TX 75266-0058
	Mental Health / Substance Use Disorder	Phone: 1-888-898-0070 Fax: 1-877-361-7659 or 1-312- 946-3737	BCBSNM BH Unit P.O. Box 660058 Dallas, TX 75266-0058
	Medical/Surgical	Phone: 1-800-423-1630	BCBSNM P.O. Box 660058 Dallas, TX 75266-0058

Customer Service Inquiry	Mental Health/ Substance Use Disorder	Phone: 1-888-898-0070	BCBSNM BH Unit P.O. Box 660058 Dallas, TX 75266-0058
Submit Claim (post- service)	Medical/Surgical		BCBSNM P.O. Box 660058 Dallas, TX 75266-0058
	Mental Health/ Substance Use Disorder		BCBSNM BH Unit P.O. Box 660058 Dallas, TX 75266-0058
Request appeal or reconsideration of Claim or Prior Authorization decision	Medical/Surgical	Phone: 1-800-205-9926	BCBSNM Appeals Unit P.O. Box 660058 Dallas, TX 75266-0058
	Mental Health/ Substance Use Disorder	Phone: 1-888-898-0070	BCBSNM Appeals Unit P.O. Box 660058 Dallas, TX 75266-0058
Grievance Assistance-Office of Superintendent of Insurance (OSI), Managed Health Care Bureau	Medical/Surgical; Mental Health/Substance Use Disorder	Phone: 1-855-427-5674	Office of Superintendent of Insurance 1120 Paseo De Peralta Santa Fe, NM 87501

NOT OBTAINING INPATIENT PRIOR AUTHORIZATION

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

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

* Noncovered and denied services are not applied to any Deductible or Out-of-Pocket Limit. You are responsible for paying this amount for out-of-network services.

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

OTHER PRIOR AUTHORIZATION

In addition to Prior Authorization review for all non-emergency Inpatient Services, Prior Authorization is required for certain other services listed below. Most Prior Authorizations may be requested over the telephone. If a written request is needed, have your Provider call a Health Services representative at 1-505-291-3585 or toll-free at 1-800-325-8334, for instructions for filing a written request for Prior Authorization. An out-of-network Provider, or an out-of-state Network Provider may call on your behalf, but it is your responsibility to ensure that BCBSNM is

called. HMO-Providers that contract directly with BCBSNM are responsible for requesting all necessary Prior Authorizations for you. (See *Inpatient Prior Authorization* for further information regarding inpatient Prior Authorization requirements.)

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

No Prior Authorization Received:	**Claim Disposition: HMO-Participating**	**Claim Disposition: Nonparticipating**
Service is Medically Necessary	Claim is paid based on Member's benefit plan	Claim is paid based on Member's benefit plan
Service is not Medically Necessary	Claim is denied; Member is held harmless	Claim is denied;

BCBSNM will send a written response to you, your Physician and the Hospital or Facility with a determination of your Prior Authorization review within seven (7) business days after BCBSNM receives the request for Prior Authorization review of a non-Urgent Care request.

A Prior Authorization request involving Urgent Care is any request for medical care or treatment with respect to which the application of the time periods for making non-Urgent Care determinations could, based on reasonable medical probability, seriously jeopardize your life or health or your ability to regain maximum function; or in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Prior Authorization request. BCBSNM will respond to you no later than 24 hours after receipt of a complete request for Prior Authorization involving Urgent Care.

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

IF YOUR PRIOR AUTHORIZATION REQUEST IS DENIED

BCBSNM has established written procedures for reviewing and resolving your concern(s). There are two different procedures depending upon the type of issue involved - pre-service or post-service. This is a summary of the procedures that apply to Prior Authorization request(s) (*pre-service Claim(s)*). For appeal(s) involving post-service Claim(s) payment(s) or denial(s); see *Section 8: Claims Payment and Appeals*.

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

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

PRIOR AUTHORIZATION RENEWAL

A Prior Authorization issued by BCBSNM shall not expire sooner than sixty (60) days from the date of approval unless an earlier expiration is warranted by the clinical criteria. BCBSNM will allow a request for the extension of an approved authorization if supported by the clinical criteria and BCBSNM medical policy.

LENGTH OF STAY/SERVICE REVIEW

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

Upon completion of the inpatient or emergency Admission review, BCBSNM will send you, your Physician, Behavioral Health Practitioner and/or the Hospital or Facility with a determination on the approved length of service or length of stay.

An extension of the length of stay/service will be based solely on whether continued inpatient care or other Health Care Services are Medically Necessary. If the extension is determined not to be Medically Necessary, the coverage for the length of stay/service will not be extended, except as otherwise described in the *Claim Payments and Appeals* section under this Benefit Booklet.

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

RECOMMENDED CLINICAL REVIEW

A Recommended Clinical Review is a type of Prior Authorization that is voluntary. BCBSNM will review the request to determine if it meets approved BCBSNM medical policy and site or level of care review criteria for medical and Behavioral Health Services. Once a decision has been made on the services reviewed as part of the Recommended Clinical Review process, they will not be reviewed for Medical Necessity again on a retrospective basis. Submitted services (subject to Medical Necessity review) not included as part of Recommended Clinical Review may be reviewed retrospectively.

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

Recommended Clinical Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitation and exclusions under this Benefit Booklet. Please coordinate with your Provider to submit a request for Recommended Clinical Review. If you believe you were denied benefits in error, you may request a review of any Adverse Determination pursuant to the *Summary of Health Insurance Grievance Procedures* in *Section 8*.

Because Recommended Clinical Review is a voluntary type of Prior Authorization, the process is subject to the same protections and timelines as Prior Authorizations. Please see information in *Section 1: How To Use This Benefit Booklet, Prior Authorization, Prior Authorization Review Timelines* and *Authorization Denial*.

CONTACTING BEHAVIORAL HEALTH

You, your Physician or Provider of services or your authorized representative may contact BCBSNM for a Prior Authorization by calling the toll-free number shown on the back of your Identification Card and follow the prompts to the Behavioral Health Unit. During regular business hours (7:00 A.M. and 5:00 P.M., MT, on business days), the caller will be routed to the appropriate Behavioral Health clinical team for review. Residential treatment and Outpatient requests should be requested during regular business hours. After 5:00 PM, on weekends, and on holidays, the same Behavioral Health line is answered by clinicians available for Inpatient acute Recommended Clinical Review only.

General Provisions Applicable to All Recommended Clinical Review

No Guarantee of Payment

A **Recommended Clinical Review** is not a guarantee of benefits or payment of benefits by BCBSNM. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Benefit Booklet. Even if the service has been approved on **Recommended Clinical Review**, coverage or payment can be effected for a variety of reasons. For example, the Member may have become ineligible as of the date of service or the Member's benefits may have changed as of the date of service. If you believe you were denied benefits in error, you may request a review of any Adverse Determination pursuant to the *Summary of Health Insurance Grievance Procedures* in *Section 8:Claims Payments and Appeals*.

Request for Additional Information

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

POST-SERVICE MEDICAL NECESSITY REVIEW

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or Post-Service Claims request, is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms Member eligibility, availability of benefits at the time of service, and reviews necessary clinical documentation to ensure the service was Medically Necessary. A Post-Service Medical Necessity Review may be performed when a Prior Authorization was not obtained prior to services being rendered under certain circumstances. HMO-Participating Providers are required to submit appropriate documentation in response to a Post-Service Medical Necessity Review Claim request by BCBSNM. Members are not responsible for providing such documentation. If an HMO-Participating Provider's Claim is denied because BCBSNM determined that the services were not Medically Necessary, the Member is not financially responsible and is held harmless.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

No Guarantee of Payment

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

Request for Additional Information

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

SECTION 5: COVERED SERVICES

This section describes the services and supplies covered by this Health Care plan, subject to the limitations and exclusions in *Section 3: How Your Plan Works* and *Section 6: General Limitations and Exclusions*. All payments are based on Covered Charges as determined by BCBSNM. Please see *Section 3: How Your Plan Works, Exceptions for Nonparticipating Providers,* and *Emergency Care and Urgent Care,* later in this section, for more details.

Please note that services must be determined to be Medically Necessary by your Provider in consultation with BCBSNM's medical director in order to be covered under this plan.

Coverage of items and services provided to you is subject to BCBSNM policies and guidelines, including, but not limited to, medical, medical management, utilization or clinical review, Utilization Management, and clinical payment and coding policies, which are updated throughout the Plan Year. These policies are resources utilized by BCBSNM when making coverage determinations and lay out the procedure and/or criteria to determine whether a service, procedure, treatment, Facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Service or is Experimental/Investigational/Unproven, Cosmetic, or a convenience item. Updates to these policies during the Plan Year will not expand the list of Covered Services for which Prior Authorization is required unless a Covered Service is added, safety or other concerns have arisen, authorization is given by the Superintendent of Insurance or other regulator, or there are changes in nationally recognized clinical guidance. Additional information can be found in *Section 6: General Limitations and Exclusions.*

The clinical payment and coding policies are intended to ensure accurate documentation for services performed and require all Providers to submit Claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act (*HIPAA*) approved code sets. Under the clinical payment and coding policies, Claims are required to be coded correctly according to industry standard coding guidelines including, but not limited to:

- Uniform Billing (*UB*) Editor
- American Medical Association (*AMA*)
- Current Procedural Terminology (*CPT*®)
- CPT® Assistant
- Healthcare Common Procedure Coding System (*HCPCS*)
- ICD-10 CM and PCS
- National Drug Codes (*NDC*);
- Diagnosis Related Group (*DRG*) guidelines
- Centers for Medicare and Medicaid Services (*CMS*) National Correct Coding Initiative (*NCCI*) Policy Manual
- CCI table edits and other CMS guidelines

Coverage for Covered Services is subject to the code edit protocols for services/procedures billed and Claim submissions are subject to applicable Claim review which may include, but is not limited to, review of any terms of benefit coverage, Provider contract language, medical and medical management policies, utilization or clinical review or Utilization Management policies, clinical payment and coding policies as well as coding software logic, including but not limited to lab management or other coding logic or edits.

Any line on the Claim that is not correctly coded and is not supported with accurate documentation (where applicable) may not be included in the Covered Charge and will not be eligible for payment by the plan. The clinical payment and coding policies apply for purposes of coverage regardless of whether the Provider rendering the item or service or submitting the Claim is participating or Nonparticipating. The most up-to-date medical policies and clinical procedure and coding policies are available at medicalpolicy.bcbsnm.com/home.html?corpEntCd=NM and

www.bcbsnm.com/provider/standards-requirements/standards/clinical-payment-coding-policies or by contacting a Customer Service Representative at the number shown on your Identification Card.

MEDICALLY NECESSARY SERVICES

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

Medically Necessary/Medical Necessity is defined as Health Care Services determined by a Provider, in consultation with the health insurance carrier, to be appropriate or necessary, according to:

- Any applicable generally accepted principles and practices of good medical care.
- Practice guidelines developed by the federal government, national or professional medical societies, boards and associations.
- Any applicable clinical protocols or practice guidelines developed by the health insurance carrier consistent with such federal, national and professional practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical or mental health and Substance Use Disorder condition, illness, injury or disease.

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

NOTE: Because a Health Care Provider prescribes, orders, recommends, or approves a service does not make it Medically Necessary or make it a Covered Service, even if it is not specifically listed as an exclusion. Medical Necessity is determined by your Provider, in consultation with the health plan based on the criteria above.

If Medicare is Primary

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

In order to receive benefits:

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

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

AMBULANCE SERVICES

This plan covers Ambulance services in an emergency when a Member requires emergency Health Care Services under circumstances that a reasonable layperson to believe that transportation in any other vehicle would result in jeopardy to your physical or mental health.

In determining whether you acted in good faith as a Reasonable/Prudent Layperson when obtaining emergency ambulance Services, we will take the following factors into consideration:

- Whether a Reasonable/Prudent Layperson who possesses average knowledge of health and medicine would have believed that transportation in any other vehicle would have endangered your health.
- Whether you were advised to seek an Ambulance Service by your Practitioner/Provider or by our staff. Any such advice will result in reimbursement for all Medically Necessary services rendered, unless otherwise limited or excluded under this Agreement.
- Ground or air Ambulance Services to any Level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols Ambulance Service (ground or air) to the coroner's office or to a mortuary is not Covered, unless the Ambulance had been dispatched prior to the pronouncement of death by an individual authorized under state law to make such pronouncements.

When you cannot be safely transported by any other means in a non-emergency situation, this plan also covers Medically Necessary Ambulance transportation to a Health Care Facility with appropriate facilities, or from one Hospital to another.

In determining whether Ambulance Services are reimbursable, BCBSNM will take the following factors into consideration:

- A reasonable person's belief that the circumstances required immediate medical care that could not wait until the next working day or next available appointment
- The time of day the care was provided
- The presenting symptoms
- Any circumstances which precluded use of the HMO's established procedures for obtaining Emergency Care

Outside the Service Area

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

Air Ambulance

Ground Ambulance is usually the approved method of transportation. This plan covers air Ambulance when Medically Necessary.

Exclusions

This plan does **not** cover:

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

HYPNOTHERAPY

Benefits for Medically Necessary hypnotherapy are available when provided by a Provider trained in the use of hypnosis.

HYPERBARIC OXYGEN THERAPY

Benefits will be provided for Medically Necessary hyperbaric oxygen therapy.

AUTISM SPECTRUM DISORDERS

This plan covers the Habilitative Treatment and rehabilitative treatment of Autism Spectrum Disorder through Speech Therapy, Occupational Therapy, Physical Therapy, and Applied Behavioral Analysis (ABA) therapies with no age restrictions or age limits for the Member or lifetime/annual benefit limits. Providers must be credentialed to provide such therapy.

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

Services not approved through Prior Authorization by BCBSNM must be performed in accordance with a treatment plan and must be Medically Necessary or benefits for such services may be denied. **NOTE:** Habilitative Services are defined as Occupational Therapy, Physical Therapy, Speech Therapy and other Health Care Services that help you keep, learn, or improve skills and functioning for daily living, as prescribed by your Physician pursuant to a treatment plan. Examples include therapy for a Child who isn't walking or talking at the expected age and includes therapy to enhance the ability of a Child to function with a Congenital, Genetic or Early Acquired disorder. These services may include Physical Therapy and Occupational Therapy, speech-language pathology, and other services for people with disabilities in a variety of Inpatient and/or outpatient settings, with coverage as described in this Policy. Information on how to contact BCBSNM regarding Prior Authorizations is found in *Section 4: Utilization Management, Outpatient Service Review*.

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

Regardless of the type of therapy received, Claims for services related to Autism Spectrum Disorder should be mailed to BCBSNM.

Blue Cross and Blue Shield of New Mexico
Attn.: BH Unit
P.O. Box 660058
Dallas, TX 75266-0058
1-888-898-0070

Exclusions

This plan does **not** cover:

- Any Experimental, long-term, or maintenance treatments not required under state law unless listed above. 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 that are not Medically Necessary.
- Services in accordance with a treatment plan that has not been approved through Prior Authorization by BCBSNM.
- Respite services or care.
- Sensory Integration Therapy (SIT).
- Music therapy, vision therapy, or touch therapy.
- Floor time.
- Facilitated communication.
- Elimination diets; nutritional supplements; intravenous immune globulin infusion; secretin infusion.
- Chelation therapy.
- Hippotherapy, animal therapy, or art therapy.

DENTAL-RELATED SERVICES AND ORAL SURGERY

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

Dental and Facial Accidents

Benefits for Covered Services for the treatment of Accidental Injuries to the jaw, mouth, face or Sound Natural Teeth are generally subject to the same limitations, exclusions and Member cost-sharing provisions that would apply to similar services when not Dental-Related (e.g., x-rays, Medical Supplies, Surgical Services.) This also includes services or supplies provided for the treatment of an Accidental Injury resulting from an act of domestic violence or a medical condition.

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

Facility Charges and General Anesthesia for Dental-Related Services

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

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

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

Reminder: If Hospital Covered Services are recommended by a Nonparticipating Provider, you are responsible for assuring that your Provider obtains Prior Authorization for outpatient Covered Services or benefits may be denied.

Oral Surgery

This plan covers the following Medically Necessary oral surgical procedures only including:

- Medically Necessary orthognathic surgery
- External or intraoral cutting and draining of cellulitis (not including treatment of Dental-Related abscesses).
- Incision of accessory sinuses, salivary glands or ducts
- Lingual frenectomy
- Removal or biopsy of tumors or cysts of the jaws, cheeks, lips, tongue, roof or floor of mouth when pathological examination is required
- Removal of exostoses or bony impacted teeth
- Medically Necessary oral surgery to treat infections or abscess of the teeth that involved the fascia or have spread beyond the dental space.
- Removal of infected teeth in preparation for an organ transplant, joint replacement surgery or radiation therapy of the head and neck

TMJ/CMJ Services

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

Exclusions

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

- Surgeon's or Dentist's charges for noncovered dental services.
- Hospitalization or general anesthesia for the patient's or Provider's convenience.
- Any service related to a dental procedure that is not Medically Necessary.
- Any service related to a dental procedure that is excluded under this plan for reasons other than being Dental-Related, even if hospitalization and/or general anesthesia is Medically Necessary for the procedure being received (e.g., Cosmetic procedures, Experimental procedures, services received after coverage termination, work-related injuries, etc.).
- Nonstandard services (diagnostic, therapeutic, or surgical).
- Removal of tori.
- Procedures involving orthodontic care, the teeth, dental implants, periodontal disease, noncovered services, or preparing the mouth for dentures.
- Duplicate or *spare* Appliances.
- Personalized restorations, Cosmetic replacement of serviceable restorations, or materials (such as precious metals) that are more expensive than necessary to restore damaged teeth.

- Dental treatment or surgery, such as extraction of teeth or application or cost of devices or splints, unless required due to an Accidental Injury and covered under *Dental and Facial Accidents* or *TMJ/CMJ Services*, above.
- Dentures, artificial devices and/or bone grafts for denture wear, including implants.

NOTE: Please see your Dental Rider for more detail.

DIABETIC SERVICES

Diabetic persons are entitled to the same benefits for Medically Necessary Covered Services as are other Members under the Health Care plan, including diabetes self-management education and diabetic supplies and equipment. Please refer to the *Coverage for Individuals with Diabetes* provision of *Section 3: How Your Plan Works*, for more information.

EMERGENCY CARE AND URGENT CARE

Acute medical Emergency Care is available 24 hours per day, 7 days a week.

Emergency Care

This plan covers medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to 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, or poisoning. Non-emergency services provided in an emergency room for treatment of Mental Health or Substance Use Disorder will be paid the same as Emergency Care services.

Emergency Room and Ambulance Services

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

Acute Emergency Care is available 24 hours per day, 7 days a week. If services are received in an emergency room or other trauma center, the condition and treatment must meet the definition of Emergency Care in order to be covered. Services received in an emergency room that do not meet the definition of Emergency Care may be reviewed for appropriateness and may be denied.

You do not need BCBSNM authorization before seeking **emergency room or emergency Ambulance** Services from either an HMO-Participating or a Nonparticipating Provider. **Nonparticipating Provider care received without a Prior Authorization in any other setting (e.g., Physician's office or Urgent Care center) will not be covered.** (See *Section 4: Utilization Management* for more information about Prior Authorization requirements.) emergency room and Ambulance services for a condition that meets the definition of *Emergency Care* will be covered within the limits of the Health Care plan. Non-emergency services provided in an emergency room for treatment of Mental Health conditions or Substance Use Disorders will be paid the same as E*mergency Care* services. Services for conditions that do *not* meet the definition of *Emergency Care* and have not been approved through Prior Authorization will **not** be covered.

What to Do

In an emergency:

- If cardiopulmonary resuscitation (CPR) is necessary or if there is an immediate threat to life or limb, **call 911.**

- If you do not call 911, and you are:
  - In the Service Area (i.e., New Mexico): **Either call your PCP** or **go directly to an HMO-participating Hospital.** If due to the severity of the medical problem, you are unable to reach an HMO-participating Hospital, **go to the nearest medical Facility or trauma center.**

Emergency 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 Nonparticipating Provider 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.

Follow-Up Care

Once you are discharged from the emergency room or inpatient setting, follow-up care from a Nonparticipating Provider **must** be approved through Prior Authorization 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.

Filing Claim(s) for Service(s) of a Nonparticipating Provider

When you receive the itemized bill from the Hospital or emergency room Physician; send it to BCBSNM or the local BCBS Plan in the state where services were received. See *Section 8: Claims Payments and Appeals* for more information on filing Claims.

Urgent Care

The Urgent Care Copayment and/or Coinsurance will apply to care received in an Urgent Care Facility (including Hospital-based Urgent Care centers). Covered Services received in an emergency room or other trauma center may be subject to an emergency room Deductible depending upon your plan and your condition must meet the definition of *emergency* in order to be covered.

Urgent Care Center Copayments or Coinsurance

When you visit an HMO-Participating Provider Urgent Care Facility, you pay a Copayment or Coinsurance for the covered visit. If you visit a Nonparticipating Provider Urgent Care Facility, services will **not** be covered unless such services meet one of the criteria listed in *Section 3: How Your Plan Works* as being eligible for a benefit exception for Nonparticipating Providers.

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

- Call your PCP and request an immediate appointment (if available).
- Visit the nearest BCBSNM HMO-Participating Provider Urgent Care center.
- If there is not a BCBSNM HMO-Participating Provider center nearby, call your PCP and ask for BCBSNM Prior Authorization to visit another Facility or other appropriate Provider. If you do not receive Prior Authorization **before** receiving treatment from a Nonparticipating Provider, you are responsible for the entire cost of the service.
- If you are away from home and need Urgent Care, call a Customer Service Advocate who will connect you with the BlueCard® Program. If you prefer, you may contact a BlueCard® representative directly at 1-(800)-810-BLUE (2583). The BlueCard® representative will give you the name and telephone number of a local Provider who will be able to call BCBSNM Customer Service for eligibility information and will submit a Claim to the local affiliated HMO Plan. You will also need to call your PCP and have them call BCBSNM

for Prior Authorization to visit an out-of-network Provider. **Urgent Care and follow-up care from Providers who do not participate with BCBSNM must always be approved through Prior Authorization by BCBSNM.**

Exclusions

This plan does **not** cover:

- The non-emergent 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/RELATED SERVICES FOR CHILDREN UP TO AGE 21

This plan covers the cost of hearing aids, the fitting and dispensing fees for hearing aids and ear molds limited to one hearing aid per ear every 36 months for Members up to 21 years old.

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

HOME HEALTH CARE/HOME INTRAVENOUS (I.V.) SERVICES

Conditions and Limitations of Coverage

If you are homebound (unable to receive medical care on an outpatient basis), this plan covers Home Health Care Services and home I.V. services (also known as home infusion therapy and includes, but is not limited to, I.V. antibiotics, Chemotherapy, and fluids) provided under the direction of a Physician. Nursing management must be through a Home Health Care Agency approved by BCBSNM. Home Health Care Services is limited to 100 visits per year. A *visit* is one period of home health service of up to four hours.

Prior Authorization Required

Before you receive Home Health Care Services and home I.V. therapy, your Physician or Home Health Care Agency must obtain **Prior Authorization** from BCBSNM.

Covered Services

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

- Skilled Nursing Care provided on an intermittent basis by a Registered Nurse or Licensed Practical Nurse.
- Physical, Occupational, or Respiratory therapy provided by licensed or certified Physical, Occupational, or Respiratory Therapists.
- Speech Therapy provided by a speech pathologist or an American Speech and Hearing Association certified Speech Therapist.
- Intravenous medications and other prescription drugs ordinarily not available through a retail pharmacy if **Prior Authorization** is received from BCBSNM.
- Drugs, medicines, or laboratory services that would have been covered during an inpatient Admission.
- Enteral Nutritional supplies (e.g., bags, tubing). (For Enteral Nutritional formulas, see your separately issued *Drug Plan Rider.*)
- Medical Supplies.

- Skilled services by a qualified aide to do such things as change dressings and check blood pressure, pulse, and temperature.

Cost-Sharing

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

Exclusions

This plan does **not** cover:

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

HOSPICE CARE SERVICES

Conditions and Limitations

This plan covers inpatient and home Hospice services for a Terminally Ill Member received during a Hospice Benefit Period when provided by a Hospice program and Prior Authorization is obtained by BCBSNM. If you need an extension of the Hospice Benefit Period, the Hospice agency must provide a new treatment plan and the attending Physician must recertify your condition to BCBSNM.

Covered Services

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

- Visits from Hospice Physicians.
- Skilled Nursing Care by a Registered Nurse or Licensed Practical Nurse.
- Physical and Occupational Therapy by licensed or certified Physical or Occupational Therapists.
- Speech Therapy provided by an American Speech and Hearing Association certified therapist.
- Medical Supplies.
- Drugs and medications for the Terminally Ill Patient.
- Medical social services provided by a qualified individual with a degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training and experience. (Such services must be recommended by a Physician to help the Member or their family deal with a specified medical condition.)
- Services of a home health aide under the supervision of a Registered Nurse and in conjunction with Skilled Nursing Care.
- Medically Necessary non-emergency ground ambulance transportation, to an in-network Provider.
- Nutritional guidance and support, such as intravenous feeding and hyperalimentation.

- Respite care for a period not to exceed five continuous days for every 60 days of Hospice Care and no more than two respite care periods during each Hospice Benefit Period. (Respite care provides a brief break from total care-giving by the family.)

Cost-Sharing

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

Exclusions

This plan does **not** cover:

- Food, housing, or delivered meals
- Homemaker and housekeeping services
- Comfort items
- Private duty nursing
- Supportive services provided to the family of a Terminally Ill Patient when the patient is not a Member of this plan
- Care or services received after the Member's coverage terminates

HOSPITAL/OTHER FACILITY SERVICES

Blood Services

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

Inpatient Services Prior Authorization Required

Prior Authorization is required for all Admissions before you are admitted to the Hospital or other inpatient treatment Facility (e.g., Skilled Nursing Facility, Residential Treatment Center, physical rehabilitation Facility, long-term acute care (LTAC). If you do not obtain Prior Authorization, benefits for covered Facility services may be denied. All inpatient Admissions are subject to Prior Authorization, except in the case of emergency.

Nonparticipating Provider Facility services are covered only for **Emergency Care** or if **Prior Authorization** for such services is received from BCBSNM. (You may be required to travel to another city to receive services from an HMO-Participating Provider Facility.)

Covered Services

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

Medical Detoxification

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

Exclusions

This plan does not cover:

- Admissions related to Noncovered services or procedures.
- Custodial Care Facility Admissions.

Outpatient or Observation Services

Coverage for outpatient or observation services and related Physician or other Professional Provider services for the treatment of illness or Accidental Injury depends on the type of service received.

INFUSION THERAPY

Infusion therapy means the administration of medication through a needle or catheter. It is prescribed when a patient's condition is so severe that it cannot be treated effectively by oral medications. Typically, *infusion therapy* means that a drug is administered intravenously, but the term also may 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.

Some outpatient infusion services for routine maintenance drugs have been identified as capable of being administered, outside of an outpatient Hospital setting. Member Out-of-Pocket expenses may be lower when services are provided by a Professional Provider in an Infusion Suite, a home or an office, instead of a Hospital. Non-maintenance outpatient infusion therapy services will be covered the same as any other illness. The Summary of Benefits (SBC) describes the applicable cost share for infusion therapy services.

Covered services include:

- Infusion and injectable therapy

For more information, you may contact a Customer Service Advocate at the toll-free number on your Identification Card.

LAB, X-RAY, OTHER DIAGNOSTIC SERVICES

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

- Artery calcification testing.
- X-ray and radiology services, ultrasound, and imaging studies.
- Laboratory and pathology tests.
- EKG, EEG, and other electronic diagnostic medical procedures.
- Genetic testing. (Tests such as amniocentesis or ultrasound to determine the gender of an unborn Child are not covered.)
- Infertility-related testing.
- PET (Positron Emission Tomography) scans, cardiac CT scans.
- MRIs.
- Psychological or neuropsychological testing.
- Audiometric (hearing) and vision tests for the diagnosis and/or treatment of an Accidental Injury or an illness.

Coronary Artery Calcification Tests

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

- Each covered Member who is between the ages of 45 and 65 years of age
- Covered Members at five-year intervals who have previously received a CT scan measuring CAC with a score of zero

NOTE: All services, including those for which Prior Authorization is required, must meet the standards of Medical Necessity criteria established by BCBSNM and will not be covered if excluded for any reason under this plan. Gynecological or obstetrical ultrasounds do not require Prior Authorization. The Medical Necessity requirements do not apply to mandated benefits, unless permitted by law.

Diagnostic and Supplemental Breast Examinations

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

Biomarker Testing

This plan provides benefits for Medically Necessary Biomarker Testing for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of a disease or condition.

MATERNITY/REPRODUCTIVE SERVICES AND NEWBORN CARE

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

Family Planning and Infertility-Related Services

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

Family Planning

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

- Health education.
- Tubal ligation; sterilization implant; copper intrauterine device; intrauterine device with progestin; implantable rod; contraceptive shot or injection; combined oral contraceptives; extended or continuous use oral contraceptives; progestin-only oral contraceptives; patch; vaginal ring; diaphragm with spermicide; sponge with spermicide; cervical cap with spermicide; condoms; spermicide alone; vasectomy; ulipristal acetate; levonorgestrel emergency contraception; and any additional method categories of contraception approved by the FDA.
- Pregnancy testing and counseling.

For these following covered family planning services, no Coinsurance, Deductible, Copayment, or benefit maximums will apply when received from an HMO-Participating Provider.

- Clinical contraceptive services such as consultations, examinations, procedures (including for immediate [pre-discharge] post-partum long acting reversible contraception, or 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.
- Surgical sterilization procedures (other than hysterectomy), including tubal ligations and vasectomies.

When obtaining the items noted above, you may be required to pay the full cost and then submit a Claim form with itemized receipts to BCBSNM for reimbursement. Please refer to *Section 8: Claims Payment and Appeals* section of this Benefit Booklet for information regarding submitting Claims.

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

Covered contraceptive drugs and devices are posted on the BCBSNM website: www.bcbsnm.com/nm/documents/rx-drugs/member-contraceptive-list-nm.pdf, or available by contacting Customer Service at the toll-free number on your Identification Card.

Infertility-Related Services

This plan covers diagnosis and Medically Necessary treatments for physical conditions causing infertility. 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.

Exclusions

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

- Sterilization reversal
- Infertility treatments (except for diagnosis and medically indicated treatments for physical conditions causing infertility) 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

Pregnancy-Related/Maternity Services

Like any other service, Maternity care must be received from a PCP or other women's Health Care HMO-Participating Provider. Therefore, once your pregnancy is confirmed, you may choose either your PCP or another women's Health Care HMO-Participating Provider to provide Maternity care and receive benefits for Covered Services. The Provider is then responsible for notifying BCBSNM of any Admissions. If you are pregnant, you or your Physician should call BCBSNM for Admission notification before your Maternity due date, soon after your pregnancy is confirmed. 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 **denied**. (If you are out-of-area and need emergency services, also notify BCBSNM, your PCP, or HMO-Participating Provider **within 48 hours** or as soon as possible.)

If there is no PCP or HMO-Participating Provider in your area able to provide Maternity services, you or your Provider may request authorization from BCBSNM to recommend you to a women's Health Care Provider.

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

NOTE: You are not required to notify BCBSNM of your pregnancy.

NOTE: You are not required to obtain a referral or authorization from a PCP or other women's Health Care HMO-Participating Provider before obtaining Covered Services from any HMO-Participating Provider specializing in obstetrics or gynecology. However, before obtaining Covered obstetrical or gynecological care, the HMO-

Participating Provider must comply with certain policies and procedures required by this plan, including Prior Authorization and referral policies. For a list of HMO-Participating Providers who specialize in obstetrics or gynecology, visit www.bcbsnm.com or contact Customer Service at the toll-free number on the back of your Identification Card.

Nonparticipating Provider

If you are pregnant on the date you enroll in the BCBSNM-administered Managed Care Medical Plan 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 HMO-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.

Covered Services

Covered Pregnancy-Related Services include:

- Hospital or other Facility charges for semiprivate room and board and ancillary services, including the use of labor, delivery, and recovery rooms. (This plan covers all Medically Necessary hospitalization, including at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a C-section delivery. **NOTE:** Newborns who are not eligible for coverage under this plan will not be covered beyond the 48 or 96 hours required under federal law.)
- Routine or complicated delivery, including prenatal and postnatal medical care of an Obstetrician, Certified Nurse-Midwife or Licensed Midwife. (Expenses for prenatal and postnatal care are included in the total Covered Charge for the actual delivery or completion of pregnancy.) The office visit during which a pregnancy is confirmed is subject to the Member cost-sharing provisions that apply to any other Office Visit. **NOTE:** Home births are not covered unless the Provider has an HMO-Participating Provider contract with their local BCBS Plan and is credentialed to provide the service.
- Postpartum care in the home rendered by a person with appropriate licensure, training and experience to provide Postpartum care. Services provided shall include, but not be limited to, parent education, assistance and training in breast and bottle feeding, and the performance of any necessary and appropriate clinical tests.
- Pregnancy-related diagnostic tests, including genetic testing or counseling when **Prior Authorization** has been obtained by BCBSNM. (Services must be sought due to a family history of a gender-linked genetic disorder or to diagnose a possible congenital defect caused by a present, external factor that increases risk, such as advanced maternal age or Alcohol Abuse. For example, tests such as amniocentesis or ultrasound to determine the gender of an unborn Child are **not** covered.) See *Section 4: Utilization Management* for more information about Prior Authorization requirements.
- Alpha-fetoprotein IV screening to screen for certain genetic abnormalities.
- Necessary anesthesia services by a Provider qualified to perform such services, including Acupuncture used as an anesthetic during a covered surgical procedure and administered by a Physician, a licensed Doctor of Oriental Medicine, or other practitioner as required by law.
- When necessary to protect the life of the infant or birthing parent, coverage for transportation, including air transport, for the medically high-risk pregnant woman with an impending delivery of a potentially viable infant to the nearest available Tertiary Care Facility for newly born infants. (See *Ambulance Services*, earlier in this section, for details.)
- Services of a Physician who actively assists the operating surgeon in performing a covered surgical procedure when the procedure requires an assistant.
- Spontaneous, or therapeutic abortion prior to full term.
- Abortion prior to full term for rape, incest, or life endangerment. (Copayment or Coinsurance will be based on the place of treatment at the time of pregnancy termination.)

This plan does **not** cover care for planned 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). See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

Special Beginnings

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

1-888-421-7781

Newborn Care

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

Newborn Eligibility

If you do not elect to add coverage for your newborn within 31 days, and wish to add the Child to coverage later, the Child is considered a Late Applicant unless eligible for a Special Enrollment. **NOTE:** If the parent of the newborn is a covered Child of the Subscriber (i.e., the newborn is the Subscriber's grandchild), services for the newborn are not covered except for the first 48 hours of Routine Newborn Care (or 96 hours in the case of a C-section).

Routine Newborn Care

If both the birthing parent's charges and the baby's charges are eligible for coverage under this plan, no additional Copayment, Deductible or inpatient Admission 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.

Covered Services

Covered Services for initial Routine Newborn Care include:

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

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

Extended Stay Newborn Care

A newborn who is enrolled for coverage within the time limits specified in *Section 2: Enrollment and Termination Information* is also covered if they stay in the Hospital longer than the birthing parent.

The baby's services will be subject to a separate Deductible, Copayment and/or Coinsurance and Out-of-Pocket Limit.

PHYSICIAN VISITS/MEDICAL CARE

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

This plan covers Medically Necessary care provided by a Physician or other Professional Provider for an illness or Accidental Injury.

Office Visits and Consultations

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

Allergy Care

This plan covers Medically Necessary, FDA-approved allergy care and therapeutic injections administered in a Provider's office or in a Facility.

Breastfeeding Support and Services

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

COVID-19 and Public Health Emergencies

Covered Services for vaccines, diagnostic testing, and treatment for COVID-19, or any disease or condition which is the cause of, or subject of, a public health emergency, will be as shown on your Summary of Benefits. Covered Services include testing / screening for pneumonia and influenza, treatment for pneumonia when due to or a result of COVID-19 infection, and treatment for influenza when a co-infection with COVID-19.

A public health emergency exists when declared by the state of New Mexico or federal government.

Genetic Inborn Errors of Metabolism

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

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

Special Medical Foods

Special Medical Foods are covered only when prescribed by a Physician for treatment of genetic orders of metabolism, and the Member is under the Physician's ongoing care. Special Medical Foods are not for use by the general public and may not be available in stores or supermarkets. Special Medical Foods are not those foods included in a healthy diet intended to decrease the risk of disease, such as reduced-fat foods, low sodium foods, or weight loss products.

Injections and Injectable Drugs

This plan covers most FDA-approved therapeutic injections administered in a Provider's office. However, this plan covers some injectable drugs only when **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.)

Proposed new uses for injectable drugs previously approved by the FDA will be evaluated on a medication-by-medication basis.

Benefits will be provided for orally administered cancer medications or self-injected cancer medications that are used to kill or slow the growth of cancerous cells.

NOTE:. Benefits will not be provided for any self-administered drugs dispensed by a Physician. This exclusion does not apply to drugs that are required to be administered by a health care Provider. Select medications may be excluded from the medical benefit when a self-administered formulation of the product is available. Call a BCBSNM Customer Service Advocate if you have any questions about this policy.

Mental Health Evaluation Services

This plan covers medication checks and intake evaluations for Mental Health, Alcohol, and Substance Use Disorder.

Inpatient Medical Visits

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

- Visits for a condition requiring **only** medical care, unless related to Hospice Care
- Consultations (including second opinions) and, if surgery is performed, inpatient visits by a Provider who is not the surgeon and who provides medical care **not** related to the surgery
- Medical care requiring **two or more** Physicians at the same time because of multiple illnesses
- Initial Routine Newborn Care for a newborn added to coverage within the time limits specified in *Section 2: Enrollment and Termination Information*

PREVENTIVE SERVICES

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

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

- Evidence-based items or services that have in effect a rating of *A* or *B* in the current recommendations of the United States Preventive Services Task Force (*USPSTF*).
- Immunizations for routine use that have in effect a recommendation by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (*CDC*) with respect to the individual involved.
- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (*HRSA*) for infants, children, and adolescents.

- With respect to women, to the extent not described in item the first bullet above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.

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

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

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

The Preventive Services described in the bulleted list above may change as USPSTF, CDC, HRSA guidelines and state mandated preventive services are modified. For more information, you may visit the BCBSNM website at: www.bcbsnm.com/provider/clinical/clinical-resources/preventive-care-guidelines or contact Customer Service at the toll-free number on your BCBSNM health plan Identification Card.

Preventive drugs (including both prescription and over-the-counter products) that meet the preventive recommendations outlined above fall within a category of the current *A* or *B* recommendations of the United States Preventive Services Task Force and that are listed on the ACA No-Cost Preventive Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any Copayment amount, Coinsurance amount, Deductible, or dollar maximum when obtained from a Participating Pharmacy. Drugs on the No-Cost Preventive Drug List that are obtained from a Nonparticipating Pharmacy, may be subject to Copayment Amount, Coinsurance Amount, Deductibles, or dollar maximums, if applicable.

A Copay waiver can be requested for drugs or immunizations that meet the preventive recommendations outlined above that are not on the No-Cost Preventive Drug List.

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

The list below is subject to change. You can contact Customer Service at 1-(800)-423-1630.

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

- Abdominal aortic aneurysm screening for men ages 65 to 75 who have ever smoked
- Clinicians offer or refer adults with a Body Mass Index (BMI) of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions
- Unhealthy alcohol and drug use screening and counseling
- Blood pressure screening
- Colorectal cancer screening for adults age 45 and over
- Depression screening
- Physical activity counseling for adults who are overweight or obese and have additional cardiovascular disease factors for cardiovascular disease
- HIV screening for all adults at higher risk
- HIV preexposure prophylaxis (PrEP) with effective antiretroviral therapy for persons at high risk of HIV acquisition
- The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
  - Haemophilus influenzae type b (Hib)
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster (Shingles)
  - Human papillomavirus

    - Influenza (Flu shot or Flu mist)
    - Measles, Mumps, Rubella
    - Meningococcal
    - MPOX
    - Pneumococcal
    - RSV
    - Tetanus, Diphtheria, Pertussis (DTap/Tdap/Td)
    - Varicella
    - COVID-19
- Obesity screening and counseling in midlife
- Sexually transmitted infections (STI) counseling
- Tobacco use screening and cessation interventions for Tobacco Users (for more information about tobacco cessation Covered Drugs, please see your Drug Plan Rider
- Syphilis screening for adults and adolescents at higher risk
- Exercise interventions to prevent falls in adults age 65 and older who are at increased risk for falls
- Hepatitis C virus (HCV) screening infection in adults aged 18 to 79 years
- Hepatitis B virus screening for adults and adolescents at high risk for infection
- Counseling Children, adolescents and young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer
- Lung cancer screening in adults 50 and older who have a 20-pack a year smoking history and currently smoke or have quit within 15 years
- Screening for high blood pressure in adults age 18 years or older
- Screening for abnormal blood glucose and type II diabetes as part of cardiovascular risk assessment in adults who are overweight or obese
- Low to moderate-dose statin for the prevention of cardiovascular disease (CVD) for adults aged 40 to 75 years with:
    - No history of CVD
    - One or more risk factors for CVD (including but not limited to dyslipidemia, diabetes, hypertension, or smoking)
    - A calculated 10-year CVD risk of 10% or greater
- Tuberculin testing for adults 18 years or older who are at risk of tuberculosis

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

- Bacteriuria urinary tract screening or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk of breast or ovarian cancer
- Breast cancer chemoprevention counseling for women at higher risk
- Breastfeeding comprehensive lactation support and counseling from trained Providers, as well as, access to breastfeeding supplies for pregnant and nursing women. Electric breast pumps are limited to one per benefit period
- Cervical cancer screening
- Chlamydia infection screening for younger women and women at higher risk
- Counseling for pregnant women to promote healthy weight gain and preventing excess gestational weight gain
- Domestic and interpersonal violence screening and counseling for all women
- Daily supplements of .4 to .8 mg of folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women after 24 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women
- Hepatitis B screening for pregnant women at their first prenatal visit
- HIV screening and counseling for women

- Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older
- Osteoporosis screening for women over age 65 and younger women with risk factors
- Perinatal depression screening and counseling
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant Tobacco Users
- Sexually transmitted infections (STI) counseling
- Syphilis screening for all pregnant women or other women at increased risk
- Breast cancer mammography screening for women age 40-74. Also covers additional imaging and pathology evaluation, if indicated to complete the initial screening for malignancies.
- Aspirin use for pregnant woman to prevent preeclampsia
- Screening for preeclampsia in pregnant woman with blood pressure measurements throughout pregnancy
- Urinary incontinence screening
- Well-Woman visits

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

- Anxiety screening for Children and adolescents
- Depression screening for adolescents
- Fluoride chemoprevention supplements for Children without fluoride in their water source
- Fluoride varnish to primary teeth of all infants and Children starting at the age of primary tooth eruption
- Gonorrhea preventive medication for the eyes of all newborns
- HIV screening for adolescents at higher risk
- Obesity screening and counseling
- Sexually transmitted infections (STI) prevention and counseling for adolescents
- Vision screening for Children and adolescents (please see your Pediatric Vision Rider for more details)
- Tobacco use interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged Children and adolescents
- Well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorder when provided as part of a well-baby or well-child visit
- The following immunization vaccines for Children from birth to age 18 (doses, recommended ages, and recommended populations vary):
    - Diphtheria, Tetanus, Pertussis (DTap/Tdap/Td)
    - Haemophilus influenzae type b (Hib)
    - Hepatitis A
    - Hepatitis B
    - Human papillomavirus (HPV)
    - Inactivated Poliovirus
    - Influenza (Flu shot or Flu mist)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Rotavirus
    - RSV
    - Varicella
    - COVID-19

Exclusions

This plan does **not** cover:

- Employment physicals, insurance examinations, or examinations at the request of a third party (the requesting party may be responsible for payment); premarital examinations; sports or camp physicals; any other non-preventive physical examination.
- Routine eye examinations; or any related service or supply.

NOTE: Routine Screening Mammography does **not** include *diagnostic mammography* which is a mammogram done after an abnormal finding has first been detected or screening the opposite breast when the other breast has cancer. Routine screening mammography includes one baseline mammogram for persons age 35-39. One mammogram biennially for person 40-49, and one mammogram annually for person age 50 and older.

NOTE: Routine colonoscopy includes a follow-up colonoscopy after a positive non-invasive stool-based screening or direct visualization screening; but, does **not** include colonoscopy done for follow-up of colon cancer.. A colonoscopy is still considered a routine screening colonoscopy if, during the colonoscopy, **previously unknown** polyps are found and removed, or any pathology exam on a polyp biopsy is performed as part of the screening procedure. There would be no Member cost-share for the polyp removal and anesthesia during the Routine Screening Colonoscopy. Colonoscopies performed to remove **known** polyps are not Routine Screening Colonoscopies.

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

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

PSYCHOTHERAPY (MENTAL HEALTH AND SUBSTANCE USE DISORDER)

NOTE: You do not receive a separate Mental Health/Substance Use Disorder ID Card; use your BCBSNM ID Card to receive all medical/surgical and Mental Health/Substance Use Disorder services covered under this plan.

Outpatient professional Behavioral Health Services do not require a referral.

Medical Necessity

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

Medically Necessary/Medical Necessity is defined as Health Care Services determined by a Provider, in consultation with the health insurance carrier, to be appropriate or necessary, according to:

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

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

Prior Authorization Requirements

In order to receive benefits:

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

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

Note: If covered Mental Health or Substance Use Disorder services are found to be Medically Necessary and Prior Authorization is granted, it will not be rescinded or modified after your Providers renders services, except in cases of fraud or violation of the Providers contract with BCBSNM.

Prior Authorization requirements do not apply to covered prescription drug for the treatment of Substance Use Disorders, when determined to be Medically Necessary, except when a generic version is available.

Services Requiring Prior Authorization

Inpatient Mental Health and Substance Use Disorder services (e.g., Residential Treatment Centers) may need to be approved by the Behavioral Health Unit at the phone number listed on the back of your ID Card.

You or your Physician should call the Behavioral Health Unit **prior to or at the time of your** scheduled treatment.

The BHU Call Center is open 24/7 to assist Members and Providers with emergency Admission inquiries and to respond to crisis calls.

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

For more information about which Mental Health or Substance Use Disorder services do not require Prior Authorization, please see the *Mental Health and Substance Use Disorder Service Coverage* provision in *Section 3: How Your Plan Work*s.

Note: For Mental Health or Substance Use Disorder services, Prior Authorization determinations will be made in consultation with your Participating Provider, for the continuation of services in chronic or stable conditions, or additional services. Additionally, the coverage, including short-term or acute care, will not be limited, including duration, up to the point of relief of presenting signs and symptoms.

Covered Services/Providers

Covered Services include care and treatment for Mental Health and Substance Use Disorder, such as solution-focused evaluative and therapeutic Mental Health services (including individual and group psychotherapy) received as Inpatient Services, Outpatient Services, an IOP (Intensive Outpatient Program), or an Inpatient or Outpatient treatment program. Treatment programs are not subject to limited days, visits, or dollar limits, as long as they are Medically Necessary. Mental Health conditions that respond to and require long-term treatment with medications and/or therapeutic treatment including schizophrenia, bipolar disorder, and chronic depression are also covered.

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

Note: At your request, BCBSNM may facilitate communication between Mental Health or Substance Use Disorders services Providers and your designated Primary Care Provider, to ensure coordination of care to prevent any conflicts of care that could be harmful.

Residential Treatment Centers

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

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

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

Exclusions

This plan does **not** cover:

- Psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education.
- Services billed by a school, halfway house or group home, or their staff Members; foster care; spas/resorts; or wilderness, summer camp, or ranch programs.
- Maintenance therapy or care provided after you have reached your rehabilitative potential.
- Biofeedback, or behavior change seminars.
- Religious or pastoral counseling.
- Custodial Care.
- Hospitalization or Admission to a Skilled Nursing Facility (SNF), nursing home, or other Facility for the primary purposes of providing Custodial Care service, convalescent care, rest cures, or domiciliary care to the patient.
- Services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness. **NOTE:** This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and Mental Health conditions).
- Any care that is patient-elected and is not considered Medically Necessary.
- Care that is mandated by court order or as a legal alternative, and lacks clinical necessity as diagnosed by a licensed Provider; services rendered as a condition of parole or probation.
- Special education, school testing and evaluations, counseling, therapy, or care for learning deficiencies or educational and developmental disorders; behavioral problems unless associated with manifest Mental Health or other disturbances.
- Non-national standard therapies, including those that are Experimental as determined by the Mental Health professional practice.
- The cost of any damages to a treatment Facility.

REHABILITATION AND OTHER THERAPY

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

Acupuncture and Chiropractic Services

This plan covers Acupuncture and Chiropractic Services when administered by a licensed Provider acting within the scope of licensure and when necessary for the treatment of a medical condition. **NOTE:** If your Provider charges for other services in addition to Acupuncture or chiropractic, the other services will be covered according to the type of service being claimed. For example, Physical Therapy services from a Provider on the same day as an Acupuncture or Chiropractic Service will apply toward the *Short-Term Rehabilitation* benefit.

The Acupuncture benefit is limited to 20 visits per Plan Year unless the service is prescribed by a Provider for habilitative or rehabilitative purposes.

Chiropractic services are limited to 20 visits per year unless medically necessary care prescribed as a component of habilitative or Rehabilitative Services.

Note: Benefits for Chiropractic Services will not be subject to a Copayment or Coinsurance that exceeds the Copayment or Coinsurance shown on your Summary of Benefits under primary care visits.

Cardiac and Pulmonary Rehabilitation

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

Chemotherapy and Radiation Therapy

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

Approved Clinical Trials

If you are a participant in an Approved Clinical Trial, you may receive coverage for certain Routine Patient Care Costs incurred in the trial. The trial must be conducted as part of a scientific study of a new therapy or intervention for the prevention of reoccurrence, early detection, or treatment of cancer or other Life-Threatening Disease of Condition. The persons conducting the trial must provide BCBSNM with notice of when the Member enters and leaves a qualified Approved Clinical Trial and must accept BCBSNM's Covered Charges as payment in full (this includes the health care plan's payment plus your share of the Covered Charge).

The Routine Patient Care Costs that are covered must be the same services or treatments that would be covered if you were receiving standard cancer or other Life-Threatening Disease or Condition treatment. Benefits also include FDA-approved prescription drugs that are not paid for by the manufacturer, distributor, or supplier of the drug. (Member cost-sharing provisions described under your separately issued *Drug Plan Rider* will apply to these benefits.) If benefits for services provided in the trial are denied, you may contact the Office of Superintendent of Insurance for an expedited appeal.

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

Benefits for Covered Services for Routine Patient Care costs are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law. Benefits are not available under this section for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial. If benefits for services provided in the trial are denied, you may contact the Office of Superintendent of Insurance for an expedited appeal.

Dialysis

This plan covers the following services:

- Home hemodialysis when Prior Authorization is obtained by BCBSNM
- Dialysis when Prior Authorization is obtained by BCBSNM
- Continual ambulatory peritoneal Dialysis (CAPD)
- Apheresis and plasmapheresis
- The cost of equipment rentals and supplies for home Dialysis

Habilitative and Rehabilitative Services

Benefits will be provided for Medically Necessary Habilitative Services and Rehabilitative Services, which includes coverage for Prosthetic and custom orthotic devices. Habilitative and Rehabilitative Services are not subject to restrictions or limits.

Routine Foot Care

This plan covers Medically Necessary routine foot care, when obtained from a licensed Provider.

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

Prior Authorization Required

An inpatient Short-Term Rehabilitation treatments, including Skilled Nursing Facility and physical rehabilitation Facility Admissions, are subject to **Prior Authorization** from BCBSNM.

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

Covered Services

This plan covers the following Short-Term Rehabilitation services for the Medically Necessary treatment of Accidental Injury or illness:

- Occupational Therapy performed by a licensed Occupational Therapist or other eligible Professional Provider acting within the scope of their license.
- Physical Therapy performed by a Physician, licensed Physical Therapist, or other Professional Provider acting within the scope of their license (such as a Doctor of Oriental Medicine).
- Joint and spinal manipulation services when administered by a licensed Provider acting within the scope of licensure and when necessary for the treatment of Accidental Injury or medical condition.
- Speech Therapy, including audio diagnostic testing, performed by a properly accredited Speech Therapist or other eligible Provider acting within the scope of their license for the treatment of communication impairment or swallowing disorders caused by disease, trauma, congenital anomaly, or a previous treatment or therapy.
- Inpatient physical rehabilitation and Skilled Nursing Facility services when **approved through Prior Authorization** by BCBSNM.
- Massage therapy when prescribed by a licensed Provider.

Cost-Sharing

Your Copayment or Coinsurance and Deductible will be the same amount as shown on your *Summary of Benefits* under primary care visits for Covered Services aimed at maximizing level of function, returning to a prior level of

function, or maintaining or slowing the decline of function when these services are provided by a licensed or certified Physical Therapist, Occupational Therapist, Speech Therapist, or other eligible Provider acting within the scope of their license. Other Covered Services are subject to usual Member cost-sharing features such as Copayment or Coinsurance or Deductible based on the type of Provider, place of treatment or type of service.

Benefit Limits

Benefits are limited as specified in the *Summary of Benefits.* **NOTE:** Long-term therapy, maintenance therapy, and therapy for chronic conditions are **not** covered. This plan covers Short-Term Rehabilitation only.

Exclusions

This plan does **not** cover:

- Maintenance therapy or care provided after you have reached your rehabilitative potential except as required under New Mexico State law. (Even if you have not reached your rehabilitative potential, this plan does not cover services that exceed the maximum benefit limits, if any.)
- Therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay, except as required by law and described in this ***Covered Services*** section under *Autism Spectrum Disorders*. (See *Section 8: Claims Payments and Appeals, Early Developmental Delay and Disability* for reimbursement of certain services provided to Eligible Children by the Department of Health.).
- Services provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered Provider.
- Therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights).
- Private room expenses unless your medical condition requires isolation for protection from exposure to bacteria and diseases (e.g., severe burns or conditions that require isolation according to public health laws).
- Speech Therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic nor therapeutic; other speech services that can be carried out by the patient, the family, or caregiver/teacher.
- Herbs, homeopathic preparations, or nutritional supplements.
- Services of a massage therapist or Rolfing.

Services or supplies for:

- Intersegmental traction
- All types of home traction devices and equipment
- Vertebral axial decompression sessions
- Surface 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

RETAIL HEALTH CLINIC CARE

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

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

SUPPLIES, EQUIPMENT AND PROSTHETICS

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

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

Breast Pumps

This plan covers the rental of Hospital grade breast pumps (but 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, and are not subject to Coinsurance, Deductible, Copayment or benefit maximums when received from an HMO-Participating 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 one per benefit period.

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

Durable Medical Equipment and Appliances

This plan covers the following item**:**

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

This plan covers the rental (or at the option of BCBSNM, the purchase of) Durable Medical Equipment (including repairs to or replacement of such purchased items), when prescribed by a covered Health Care Provider and required for therapeutic use.

Medical Supplies

This plan covers the following Medical Supplies, not to exceed a **30-day supply** purchased during any 30-day period, unless otherwise indicated:

- Colostomy bags, catheters
- Gastrostomy tubes
- Hollister supplies
- Tracheostomy kits, masks
- Lamb’s wool or sheepskin pads

- Ace bandages, elastic supports when billed by a Physician or other Provider during a covered office visit
- Slings
- Support hose prescribed by a Physician for treatment of varicose veins (6 pairs per Plan Year)

Orthotics and Prosthetic Devices

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

- Surgically implanted Prosthetics or devices, including, but not limited to, penile implants required as a result of illness or Accidental Injury.
- Externally attached Prostheses to replace a limb or other body part lost after Accidental Injury or surgical removal; their fitting, adjustment, repairs and replacement.
- Replacement of Prosthetics only when required because of wear (and the item cannot be repaired) or because of a change in your condition.
- Breast Prosthetics when required as the result of a mastectomy and mastectomy bras.
- Functional orthotics only for patients having a locomotive problem or gait difficulty resulting from mechanical problems of the foot, ankle, or leg (a functional orthotic is used to control the function of the joints).
- Orthotics (e.g., collars, braces, molds) prescribed by an eligible Provider to protect, restore, or improve impaired body function.

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

Exclusions

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

- Air conditioners, biofeedback equipment, humidifiers, purifiers, self-help devices, or whirlpools.
- Items that are primarily 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.
- Dental Appliances.
- Accommodative orthotics (deal with structural abnormalities of the foot, accommodate such abnormalities, and provide comfort, but do not alter function).
- 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.
- Orthopedic shoes, unless joined to braces. (Diabetic Members should refer to the *Coverage for Individuals with Diabetes* provision of *Section 3: How Your Plan Works* for information about covered podiatric equipment and orthopedic shoes.)
- Equipment or supplies not ordered by a Health Care Provider, including items used for comfort, convenience, or personal hygiene.
- Duplicate items; repairs to duplicate items; or the replacement of items because of loss, theft, or destruction.

- Stethoscopes or blood pressure monitors.
- Voice synthesizers or other communication devices.
- Eyeglasses or contact lenses or the costs related to prescribing or fitting of glasses or contact lenses, unless listed as covered; sunglasses, special tints, or other extra features for eyeglasses or contact lenses.
- Syringes or needles for self-administering drugs. (Coverage for insulin needles and syringes and other diabetic supplies not listed as covered in this section is described under your separately issued *Drug Plan Rider.*)
- Items that can be purchased over-the-counter, including but not limited to dressings for wounds (i.e., bed sores) and burns, gauze, and bandages.
- Items not listed as covered.

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 as, 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: (1) a change in your physiological condition; (2) an irreparable change in the condition of the device or in part of the device; or (3) the condition of the device, or the part of 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 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 device and custom orthotics will not be provided when solely for comfort or convenience.

SURGERY AND RELATED SERVICES

All Inpatient surgical procedures are subject to Prior Authorization except in the case of an emergency.

Surgeon's Services

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

Cochlear Implants

This plan covers cochlear implantation of a hearing device (such as an electromagnetic bone conductor) to facilitate communication for the profoundly hearing impaired, including training to use the device.

Mastectomy and Reconstructive Surgery Services

This plan covers Medically Necessary hospitalization related to a covered mastectomy (including at least 48 hours of inpatient care following a mastectomy and 24 hours following a lymph node dissection).

This plan also covers reconstructive breast surgery following a covered mastectomy. Coverage is limited to:

- Surgery of the breast/nipple on which the mastectomy was performed, including tattooing procedures
- The initial surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications following the mastectomy, including treatment of lymphedema

This plan does **not** cover subsequent procedures to correct unsatisfactory Cosmetic results attained during the initial breast/nipple surgery or tattooing, or breast surgery.

Obesity (Bariatric) Surgery and Weight Loss Programs

Surgical treatment of Morbid Obesity is covered only if it is Medically Necessary and Prior Authorization has been obtained from BCBSNM before treatment begins. Bariatric surgery is covered for patients with a Body Mass Index (BMI) of 35 kg/m^2 or greater who are at high risk for increased morbidity due to a specific obesity related co-morbid medical conditions; and if a Member meets these criteria and all other requirements of this plan. Dietary evaluations and counseling for the medical management of Morbid Obesity are also covered.

Reconstructive Surgery

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

- An Accidental Injury
- A disease process or its treatment
- A functional congenital defect (any condition, present from birth, that is significantly different from the common form; for example, a cleft palate or certain heart defects)

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

Exclusions

This plan does **not** cover:

- Cosmetic or plastic surgery or procedures, such as breast augmentation, rhinoplasty, and surgical alteration of the eye that does not materially improve the physiological function of an organ or body part (unless covered under *Mastectomy Services*).
- Procedures to correct cosmetically unsatisfactory surgical results or surgically induced scars.
- Refractive keratoplasty, including radial keratotomy, or any procedure to correct visual refractive defect.
- Subsequent surgical procedures needed because you did not comply with prescribed medical treatment or because of a complication from a previous noncovered procedure (such as a noncovered organ Transplant, or previous Cosmetic surgery).
- The insertion of artificial organs, or services related to Transplants not specifically listed as covered under *Transplant Services*.

- Standby services unless the procedure is identified by BCBSNM as requiring the services of an assistant surgeon and the standby Physician actually assists.

Anesthesia Services

This plan covers necessary anesthesia services, including Acupuncture used as an anesthetic, when administered during a covered surgical procedure by a Physician, certified Registered Nurse anesthetist (CRNA), or other practitioner licensed to provide anesthesia. (See Rehabilitation and Other Therapy for information about Acupuncture benefits.)

Exclusions

This plan does **not** cover local anesthesia, except for preventive colonoscopies. (Coverage for surgical procedures includes an allowance for local anesthesia because it is considered a routine part of the surgical procedure.)

Assistant Surgeon Services

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

Exclusions

This plan does **not** cover:

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

TRANSPLANT SERVICES

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

Anatomical Gift Nondiscrimination

BCBSNM will not deny, reduce, or limit covered benefits for Transplant Services solely on the basis of a covered person's physical or mental disability, nor will BCBSNM penalize or otherwise reduce or limit the reimbursement or provide monetary or nonmonetary incentives to a health care Provider to induce that health care Provider not to provide an organ Transplant or associated care to a covered person with a physical or mental disability.

Facility Must Be in Transplant Network

Benefits for Covered Services will be approved only when the Transplant is performed at a Facility that contracts with BCBSNM, another Blue Cross Blue Shield (BCBS) Plan or the national BCBS Transplant network, for the Transplant being provided. Your BCBSNM case manager will assist your Provider with information on the exclusive network of Contracted facilities and required approvals. Call BCBSNM Health Services at 1-505-291-3585 or toll-free at 1-800-325-8334 for information on these BCBSNM Transplant programs.

Effect of Medicare Eligibility on Coverage

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

Organ Procurement or Donor Expenses

If a Transplant is covered, the surgical removal, storage, and transportation of an organ acquired from a cadaver is also covered. If there is a living donor that requires surgery to make an organ available for a covered Transplant,

coverage is available for expenses incurred by the donor for surgery, organ storage expenses, and inpatient follow-up care only.

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

Bone Marrow, Cornea or Kidney

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

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

Cost-Sharing Provisions

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

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

This plan covers Transplant-Related Services for a **heart, heart-lung, liver, lung or pancreas-kidney** Transplant. Services are subject to Prior Authorization. All other limitations, requirements, and exclusions of this *Transplant Services* provision apply to these Transplant-Related Services. See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

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

Covered Services

This Plan covers Transplant-Related Services. Services are subject to **Prior Authorization**. All other limitations, requirements, and exclusions of this *Transplant Services* provision apply to these Transplant-Related Services.

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

Covered Transplants:

- Kidney
- Liver
- Pancreas
- Intestine
- Heart
- Lung

- Multi-visceral (3 or more abdominal organs)
- Simultaneous multi-organ Transplants- unless Investigational
- Pancreas islet cell infusion
- Meniscal Allograft
- Autologous
- Meniscal Allograft
- Autologous Chondrocyte Implantation – knee only
- Bone marrow Transplant including peripheral blood bone marrow, stem cell harvesting and transplantation (stem cell Transplant); following high dose Chemotherapy. **Bone marrow Transplants are covered for the following indications multiple myeloma:**
    - Leukemia
    - Aplastic anemia
    - Lymphoma
    - Severe Combined Immunodeficiency Disease (SCID)
    - Wiskott-Aldrich syndrome
    - Ewing's Sarcoma
    - Germ cell tumor
    - Neuroblastoma
    - Wilms Tumor
    - Myelodysplastic syndrome
    - Myelofibrosis
    - Sickle cell disease
    - Thalassemia major

Recipient Travel and Per Diem Expenses

If BCBSNM requires you (i.e., the Transplant recipient) to temporarily relocate outside of your city of residence to receive a covered Transplant, travel to the city where the Transplant will be performed is covered. A standard **per diem** benefit **($150)** will be allocated for lodging expenses for the recipient and one additional adult traveling with the Transplant recipient. If the Transplant recipient is an eligible Child under the age of 18, benefits for travel and **per diem** expenses for two adults to accompany the Child are available.

Your case manager may approve travel and per diem lodging allowances based upon the total number of days of temporary relocation, up to the $10,000 benefit maximum.

Travel expenses are not covered and **per diem** allowances are not paid if you *choose* to travel to receive a Transplant for which travel is not considered Medically Necessary by the case manager or if the travel occurs more than five days before or more than one year following the Transplant or re-transplant date.

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

Transplant Exclusions

This plan does **not** cover:

- Transplant-Related Services for a Transplant that did not receive Prior Authorization from BCBSNM.
- Any Transplant or organ-combination Transplant not listed as covered;
- Implantation of artificial organs or devices (mechanical heart, unless covered under BCBSNM Medical Necessity Guidelines).
- Nonhuman organ Transplants, except for porcine (pig) heart valve are for complications of Noncovered Transplants or follow-up care related to such Transplants.
- Care for complications of noncovered Transplants or follow-up care related to such Transplants.
- Transplants or related services when Transplant is received at a Facility that does not contract directly with a BCBSNM Participating Provider or through the BCBS Transplant network(except cornea, kidney, or bone marrow).
- Expenses incurred by a Member of this plan for the donation of an organ to another person.
- Drugs that are self-administered or for use while at home unless specifically covered under this plan.
- Donor expenses after the donor has been discharged from the Transplant Facility.
- Lodging expenses in excess of the per diem allowance, if available, and food, beverage, or meal expenses.
- Travel or per diem expenses:
    - Incurred **more than five days before** or **more than one year following** the date of transplantation.
    - If the recipient's case manager indicates that travel is not Medically Necessary.
    - Related to a kidney Transplant (unless services are determined to not be reasonably available by your Provider within your community without travel). In determining whether the services are not reasonably available within your community, BCBSNM will consider the following criteria:
        - Availability – are the kidney Transplant services available in your community in a timely fashion as dictated by the clinical situation?
        - Competency – does the Provider of kidney Transplant services in your community have the necessary training or expertise required to provide the service or treatment?
        - Geography – is the Provider of kidney Transplant services in your community located within a reasonable distance from your residence? A reasonable distance is defined as travel that will not place you at any medical risk.
        - Continuity – Does the Provider of kidney Transplant services outside of your community have a well-established professional relationship with you and is providing ongoing treatment related to kidney Transplantation?
- Moving expenses or other personal expenses (e.g., laundry or dry-cleaning expenses; telephone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items).
- Expenses charged only because benefits are available under this provision (such as transportation received from a Member of your family, or from any other person charging for transportation that does not ordinarily do so).

SECTION 6: GENERAL LIMITATIONS AND EXCLUSIONS

These general limitations and exclusions apply to **all** services listed in this Benefit Booklet and your *Drug Plan Rider.* Also see *Section 5: Covered Services* for specific benefit limitations and exclusions.

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

Associated Services

If a service is not covered, HMO will not cover any services related to it, except for routine patient care for participants in an Approved Clinical Trial. Related services are:

- Services in preparation for the noncovered service
- Services in connection with providing the noncovered service
- Hospitalization required to perform the noncovered service
- Services that are usually provided following the noncovered service, such as follow-up care or therapy after surgery

Before Effective Date of Coverage

This plan does not cover any service received, item purchased, prescription filled, or Health Care expense incurred before your Effective Date of Coverage. If you are an inpatient when coverage either begins or ends, benefits for the Admission will be available only for those Covered Services received on and after your Effective Date of Coverage or those received before your termination date.

Biofeedback

This plan does not cover services related to biofeedback, except for treatment for Raynaud's disease or phenomenon and urinary or fecal incontinence.

Blood Services

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

Cannabis

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

Complications of Noncovered Services

This plan does not cover any services, treatments, or procedures required as the result of complications of a Noncovered Service, treatment, or procedure (including but not limited to services determined not Medically Necessary and the exclusions set forth in this Section, i.e.: Cosmetic Services, Experimental procedures, Hair Loss Treatment, Medical Tourism).

Exception: This plan does cover unrelated services when a patient is hospitalized for a noncovered service and needs services not related to the noncovered service. For example, if a patient breaks a leg while in the Hospital for a noncovered service, we may cover the services to treat the broken leg since it's unrelated to the noncovered service.

Convalescent Care or Rest Cures

This plan does not cover convalescent care or rest cures.

Cosmetic Services

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

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

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

Custodial Care

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

Dental-Related Services and Oral Surgery

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

Domiciliary Care

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

Duplicate (Double) Coverage

This plan does not cover amounts already paid by Other Valid Coverage or that would have been paid by Medicare as the primary carrier if you were entitled to Medicare, had applied for Medicare, and had Claimed Medicare benefits. See *Section 7: Coordination of Benefits and Reimbursement* for more information. Also, if your prior coverage has an extension of benefits provision, **this plan will not cover** charges incurred after your Effective Date of Coverage under this plan that are covered under the prior plan's extension of benefits provision.

Duplicate Testing

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

Experimental, Investigational, or Unproven Services

This plan does not cover any treatment, procedure, Facility, equipment, drug, device, or supply not accepted as *standard medical practice* (as defined) or those considered Experimental, Investigational, or Unproven, unless for Acupuncture rendered by a licensed Doctor of Oriental Medicine or unless specifically listed as covered under

Autism Spectrum Disorders or under *Cancer Clinical Trials* in *Section 5: Covered Services* and mandated by law. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted when services were administered, the service is Experimental and will not be covered. To be considered Experimental, Investigational, or Unproven, one or more of the following conditions must be met:

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

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

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

The service must be Medically Necessary and not excluded by any other contract exclusion.

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

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

Food or Lodging Expenses

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

Genetic Testing or Counseling

This plan does not cover services related to genetic counseling and testing that are not Medically Necessary.

Hair Loss Treatments

This plan does not cover wigs, artificial hairpieces, hair Transplants or implants, or medication used to promote hair growth or control hair loss, even if there is a medical reason for hair loss.

Hearing Examinations, Procedures and Aids

This plan does not cover audiometric (hearing) tests **unless (**1) required for the diagnosis and/or treatment of an Accidental Injury or an illness, or (2) covered as a preventive *screening* service (a preventive screening does *not*

include a hearing test to determine the amount and kind of correction needed), or (3) covered as part of the hearing aid benefit and described under *Hearing Aids/Related Services* in *Section 5: Covered Services.*

Home Health, Home I.V. and Hospice Services

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

Infertility Services/Artificial Conception

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

This plan does not cover infertility testing, treatments, or related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization.

This plan does not cover reversal of a prior sterilization procedure. (Certain treatments of medical conditions that sometimes result in restored fertility may be covered; see *Maternity/Reproductive Services and Newborn Care* in *Section 5: Covered Services*.)

Late Claim Filing

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

Learning Deficiencies/Behavioral Problems

This plan does not cover special education, counseling, therapy, diagnostic testing, treatment, or any other service for learning deficiencies or chronic behavioral problems associated with educational needs only. See *Autism Spectrum Disorders* in *Section 5: Covered Services* for details about mandated coverage for children with these diagnoses.

Limited Services/Covered Charges

This plan does not cover amounts in excess of Covered Charges or services that exceed any maximum benefit limits listed in this Benefit Booklet, or any amendments, riders, addenda, or endorsements.

Local Anesthesia

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

Long-Term and Maintenance Therapy

This plan does not cover long-term therapy whether for physical or for Mental Health conditions, even if Medically Necessary and even if any applicable benefit maximum has not yet been reached, except that medication management for chronic conditions is covered. Therapies are considered long-term if measurable improvement is not possible **within two months** of beginning therapy. Long-term therapy includes treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Treatment of chronic conditions is not covered. (Chronic conditions include, but are not limited to, muscular dystrophy, Down's

syndrome, and cerebral palsy.) **NOTE:** This exclusion does **not** apply to benefits for medication or medication management or to certain services required to be covered under New Mexico state law for children with Autism Spectrum Disorders.

This plan does not cover maintenance therapy or care or any treatment that does not significantly improve your function or productivity, or care provided after you have reached your rehabilitative potential (unless therapy is covered during an approved Hospice Benefit Period). In a dispute about whether your rehabilitative potential has been reached, you are responsible for furnishing documentation (e.g., medical records, Physician's letters, progress notes) from your Physician supporting their opinion.

Medical Necessity Guidelines Determinations

Any technologies, procedures, or services for which Medical Necessity Guidelines have been developed by BCBSNM are either limited or excluded as defined in the Medical Necessity Guidelines. **Exception:** The fact that this plan covers certain services that are excluded under BCBSNM Medical Necessity Guidelines and certain services defined as Experimental or as maintenance therapy but which must be covered under New Mexico state law (such as Cancer Clinical Trials and Applied Behavioral Analysis) does not mean that any other services will be or should be covered when contraindicated by BCBSNM Medical Necessity Guidelines. Only covered Acupuncture and those services mandated by state law will be excepted from this BCBSNM standard Medical Necessity Guidelines exclusion.

Medical Tourism

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

Medically Unnecessary Services

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

BCBSNM, in consultation with the Provider, determines whether a service or supply is Medically Necessary and whether it is covered. Because a Provider prescribes, orders, recommends, or approves a service or supply does *not* make it Medically Necessary or make it a Covered Service, even if it is not specifically listed as an exclusion.

No Legal Payment Obligation

This plan does not cover services for which you have no legal obligation to pay or that are free, including:

- Charges made only because benefits are available under this plan
- Services for which you have received a professional or courtesy discount
- Volunteer services
- Services provided by you for yourself or a covered family member, by a person ordinarily residing in your household, or by a family member
- Physician charges exceeding the amount specified by Centers for Medicare & Medicaid Services (CMS) when primary benefits are payable under Medicare

NOTE: The *No Legal Payment Obligation* exclusion does not apply to services received at Department of Defense facilities or covered by Indian Health Service/Contract Health Services, and Medicaid, or certain services that are reimbursed to the Department of Health according to the *Early Developmental Delay and Disability* provision in *Section 8: Claim Payments and Appeals*.

Noncovered Providers of Service

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

- Member of your immediate family or a person normally residing in your home
- Physician, other person, supplier, or Facility (including staff members) that are not specifically listed as covered in this Benefit Booklet, such as a:
  - Health spa or health fitness center (whether or not services are provided by a licensed or registered Provider)
  - School infirmary
  - Halfway house
  - Massage therapist
  - Private sanitarium
  - Dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group
  - Homeopathic or naturopathic Provider

Non-Emergency Services

This plan **does not cover** non-emergency services outside the United States.

Nonmedical Expenses

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

- Adoption or surrogate expenses.
- Educational programs such as behavior modification and arthritis classes.
- Vocational or training services and supplies.
- Mailing and/or shipping and handling.
- Missed appointments; *get-acquainted* visits without physical assessment or medical care; telephone consultations; filling out of Claim forms; copies of medical records; interest expenses.
- Modifications to home, vehicle, or workplace to accommodate medical conditions; voice synthesizers; other communication devices.
- Membership at spas, health clubs, or other such facilities.
- Personal convenience items such as air conditioners, humidifiers, exercise equipment, or personal services such as haircuts, shampoos, guest meals, and television rentals, Internet services.
- Personal comfort services, including homemaker and housekeeping services, except in association with respite care covered during a Hospice Admission.
- Moving expenses or other personal expenses (e.g., laundry or dry-cleaning expenses; phone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items).
- Physicals or screening examinations and immunizations given primarily for insurance, licensing, employment, camp, medical research programs, sports, or for any non-preventive purpose.
- Hepatitis B immunizations when required due to possible exposure during the Member's work.
- Court or police-ordered services unless the services would otherwise be covered, or services rendered as a condition of parole or probation.
- The cost of any damages to a treatment Facility that are caused by the Member.

Nonparticipating Provider Services

This plan **does not cover** non-emergency services provided by a Nonparticipating Provider unless **Prior Authorization** for such services is received from BCBSNM. You will be financially responsible for the services of a Nonparticipating Provider if you did not receive, in advance, a valid authorization from BCBSNM. **NOTE:** When Prior Authorization is requested, BCBSNM may require that you travel to another city to receive services from an HMO-Participating Provider.

Except in Emergencies, BCBSNM will generally NOT approve Prior Authorization services of a Nonparticipating Provider if the services could be obtained from an HMO-Participating Provider. Prior Authorizations for such services are given only under very special circumstances related to **Medical Necessity** and **lack of Provider availability in the BCBSNM HMO-Participating Provider network.** BCBSNM will NOT approve a Prior Authorization request based on non-medical issues such as whether or not you or your doctor prefer the Nonparticipating Provider or find the Provider more convenient. Regardless of Medical Necessity or non-medical issues, Nonparticipating Providers' services are NOT covered under this plan, except during an emergency, if you do not first obtain Prior Authorization.

NOTE: If your Health Care Provider leaves the BCBSNM HMO-Participating 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 HMO-Participating Provider network when you enroll, BCBSNM may authorize you to continue an ongoing course of treatment with the Provider for a transitional period of time of not less than 30 days. (If necessary and ordered by the treating Provider, BCBSNM may also approve Prior Authorization for transitional care from other Nonparticipating Providers.) The period will be sufficient to permit coordinated transition planning consistent with your condition and needs. Special provisions may apply if the required transitional period exceeds 30 days. If you have entered the third trimester of pregnancy at the effective date of enrollment, the transitional period shall include post-partum care directly related to the deliver. Call the BCBSNM Customer Service department for details.

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 a Nonparticipating Provider. Services of a Nonparticipating Provider are not covered in such instances of extended coverage.

Nonprescription Drugs

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

Nutritional Supplements and Counseling

This plan does not cover vitamins, dietary/nutritional supplements, special foods, formulas, birthing parent's milk, or diets, unless:

- A prescription is required for the product, including Medically Necessary nutritional supplements for prenatal care
- It is a product that meets the specific conditions set forth for coverage under your Drug Plan Rider
- Nutritional counseling is Medically Necessary

Post-Termination Services

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

- Prior Authorization for such service, item, or drug was received from BCBSNM.
- The service, item, or drug was needed because of an event that occurred while you were covered. (If you are an inpatient when coverage ends, benefits for the Admission will be available only for those Covered Services received before your termination date.)

Prescription Drugs

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

Private Duty Nursing Services

This plan does not cover private duty nursing services.

Sexual Dysfunction Treatment

This plan does not cover services related to the treatment of sexual dysfunction**.**

Specified Sex-Trait Modification Procedures

This plan does not cover Specified Sex-Trait Modification Procedures.

Supplies, Equipment and Prosthetics

In addition to services excluded by the other general limitations and exclusions listed throughout this section*,* see *Supplies, Equipment and Prosthetics* in *Section 5: Covered Services* for additional exclusions.

Surgery and Related Services

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

Testing

This plan does not cover 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).
- Allergen specific IgG measurement**.**

Therapy and Counseling Services

This plan does not cover therapies and counseling programs other than the therapies listed as covered in this Benefit Booklet. In addition to treatments excluded by the other general limitations and exclusions listed throughout this section*,* **this plan does not cover** services such as, but not limited to:

- Recreational, sleep, crystal, primal scream, sex, and Z therapies.
- Self-help, stress management and codependency programs.
- Smoking/tobacco use Cessation Counseling programs that do not meet the standards described in *Section 10: Definitions, Cessation Counseling.*
- Speech Therapy or diagnostic testing related to the following conditions: learning disorders, whether or not they accompany intellectual disability; deafness; personality, developmental, voice, or rhythm disorders when these conditions are not the direct result of a diagnosed neurological, muscular, or structural abnormality involving the speech organs; or stuttering at any age. (**NOTE:** Does not apply to Autism Spectrum Disorder.)
- Services of a massage therapist or rolfing.

- Transactional analysis, encounter groups, and transcendental meditation (TM); moxibustion; sensitivity or assertiveness training.
- Vision therapy; orthoptics.
- Pastoral, spiritual, or religious counseling.
- Supportive services provided to the family of a Terminally Ill Patient when the patient is not a Member of this plan.
- Therapy for chronic conditions such as, but not limited to, cerebral palsy or developmental delay, except as required by law and described in *Section 5: Covered Services*, *Autism Spectrum Disorders*. (See *Section 8: Claim Payments and Appeals, Early Developmental Delay and Disability*, for coverage of certain services provided to eligible children by the Department of Health.)
- Any therapeutic exercise equipment for home use (e.g., treadmill, weights).

Thermography

This plan does not cover thermography (a technique that photographically represents the surface temperatures of the body).

Transplant Services

Please see *Transplant Services* in *Section 5: Covered Services* for specific Transplant services that are covered and related limitations and exclusions. In addition to services excluded by the other general limitations and exclusions listed throughout this section, **this plan does not cover** any other Transplants (or organ-combination Transplants) or services related to any other Transplants.

Travel or Transportation

This plan does not cover travel expenses, even if travel is necessary to receive Covered Services unless such services are eligible for coverage under *Transplant Services* or *Ambulance Services* in *Section 5: Covered Services*.

Veteran's Administration Facility

This plan does not cover services or supplies furnished by a Veterans Administration Facility for a service connected disability or while a Member is in active military service.

Viscosupplementation

This plan does not cover viscosupplementation (intra-hyaluronic acid injection).

Vision Services

This plan does not cover any services related to refractive keratoplasty (surgery to correct nearsightedness) or any complication related to keratoplasty, including radial keratotomy or any procedure designed to correct visual refractive defect (e.g., farsightedness or astigmatism). **This plan does not cover** eyeglasses, contact lenses, prescriptions associated with such procedures, and costs related to the prescribing or fitting of glasses or lenses, unless listed as covered under *Supplies, Equipment and Prosthetics* in *Section 5: Covered Services* or under your vision care rider, if applicable. **This plan does not cover** sunglasses, special tints, or other extra features for eyeglasses or contact lenses unless listed under your vision care rider, if applicable (please see your Vision Rider for more details).

War-Related Conditions

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

Work-Related Conditions

This plan does not cover services resulting from work-related illness or injury, or charges resulting from occupational accidents or sickness covered under:

- Occupational disease laws
- Employer's liability
- Municipal, state, or federal law (except Medicaid)
- Workers' Compensation Act

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

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

- You fail to file a Claim within the filing period allowed by the applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations.
- You obtain care not authorized by Workers' Compensation insurance.
- Your employer fails to carry the required Workers' Compensation insurance. (The employer may be liable for an employee's work-related illness or injury expenses.)
- You fail to comply with any other provisions of the law.

NOTE: This *Work-Related Conditions* exclusion does not apply to an executive employee or sole proprietor of a professional or business corporation who has affirmatively elected not to accept the provisions of the New Mexico Workers' Compensation Act. You must provide documentation showing that you have waived Workers' Compensation and are eligible for the waiver. (The Workers' Compensation Act may also not apply if an employer has less than 3 employees or employs certain types of laborers excluded from the Act.)

SECTION 7: COORDINATION OF BENEFITS (COB) AND REIMBURSEMENT

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

This plan contains a coordination of benefits (COB) provision that prevents duplication of payments. When you are enrolled in any Other Valid Coverage, the combined benefit payments from all coverages cannot exceed 100 percent of BCBSNM's Covered Charges. (Other Valid Coverage is defined as all other Group and individual (or direct-pay) insurance policies or Health Care plans including Medicare, but excluding Indian Health Service and Medicaid coverages, that provide payments for medical services and are considered Other Valid Coverage for purposes of coordinating benefits under this plan.)

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

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

The following rules determine which coverage pays first:

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

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

Child — For a Child whose parents are not separated or divorced, the longest covered parent'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**. In the absence of a court decree which specifies which parent is financially responsible for the Child's health care expenses:
    - The plan of the Custodial parent pays first
    - The plan of the noncustodial parent pays second
    - The plan of the spouse of the parent with physical custody (i.e., the stepparent) pays third

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

Longer/Shorter Length of Coverage — When none of the above applies, the plan in effect for the longest continuous period of time pays first. (The start of a new plan does not include a change in the amount or scope of

benefits, a change in the entity that pays, provides, or administers the benefits, or a change from one type of plan to another.)

Responsibility for Timely Notice — BCBSNM is not responsible for coordination of benefits if information is not provided regarding the application of this provision.

Facility of Payment — Whenever any other plan makes benefit payments that should have been made under this plan, BCBSNM has the right to pay the other plan any amount BCBSNM determines will satisfy the intent of this provision. Any amount so paid will be considered to be benefits paid under this plan, and with that payment BCBSNM will have fulfilled its obligation to coordinate benefits appropriately.

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

REIMBURSEMENT

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

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

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

SECTION 8: CLAIMS PAYMENTS AND APPEALS

IMPORTANT NOTE ABOUT FILING CLAIMS

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

Legal Actions. Per New Mexico state law, no action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

CLAIM FORMS AND PROOF OF LOSS

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

IF YOU HAVE OTHER VALID COVERAGE

When you have Other Valid Coverage that is *primary* over this plan, you need to file your Claim with the other coverage first. After your other coverage (including Health Care insurance, dental or vision plan, Medicare, automobile, or other liability insurance, Workers' Compensation, etc.) pays its benefits, a copy of their payment explanation form must be attached to the Claim sent to BCBSNM or to the local BCBS Plan, as instructed under *Where to Send Claim Forms* later in this section.

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

HMO-PARTICIPATING PROVIDERS

PCPs and other HMO-Participating Providers file Claims with BCBSNM (or their local, affiliated BCBS Plan) and payment is made directly to them. Be sure that these Providers know you have Managed Care (HMO) Health Care coverage administered by BCBSNM. Do **not** file Claims for these services yourself. Also, HMO-Participating Providers have specific timely filing limits in their contracts with BCBSNM (usually 180 days). The contract language lets Providers know that they may not bill the employer or any Member if they do not meet that filing limit for a service and the Claim for that service is denied.

PROVIDER NETWORK

HMO-Participating Providers are not required to comply with any specified numbers, targeted averages, or maximum durations of patient visits. You will not be held liable to an HMO-Participating Provider for any sums owed to the Provider by BCBSNM.

NONPARTICIPATING PROVIDERS

A Nonparticipating Provider is one that does not have an HMO-Participating Provider agreement. If your Nonparticipating Provider does not file a Claim for you for Emergency Care, submit a separate Claim form for each family member as the services are received. Attach itemized bills and, if applicable, your Other Valid Coverage's payment explanation, to a *Member Claim Form.* (Forms can be printed from the BCBSNM website at www.bcbsnm.com or requested from a Customer Service Advocate.) Complete the Claim form using the instructions on the form. (See special Claim filing instructions for out-of-country Claims under *Where to Send Claim Forms* later in this section.) Payment normally is made to the Contracted Provider. However, if you have already paid the Provider for the services being Claimed, your Claim must include evidence that the charges were paid in full. Upon approval of the Claim, BCBSNM will reimburse you for Covered Services, based on Covered Charges, less any required Member Copayment. You will be responsible for charges not covered by the plan.

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

Office of Superintendent of Insurance – MHCB

1120 Paseo De Peralta

Santa Fe, NM 87501

1-505-827-3811 or toll-free at 1-855-427-5674

Fax: 1-505-827-6341, Attn: MHCB

Email: mhcb.grievance@state.nm.us

ITEMIZED BILLS

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

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

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

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

WHERE TO SEND CLAIM FORMS

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

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

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

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

Mental Health/Substance Use Disorder Claims

Claims for covered Mental Health and Substance Use Disorder services received in New Mexico should be submitted to:

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

Drug Plan Claims

If you purchase a prescription drug or other item covered under the drug plan from a Nonparticipating Pharmacy or other Provider in an emergency, or if you do not have your ID Card with you when purchasing a prescription or other covered item, you must pay for the prescription in full and then submit a Claim to BCBSNM's pharmacy benefit manager. **Do not send these Claims to BCBSNM.** The bills or receipts must be issued by the pharmacy and must include the pharmacy name and address, drug name, prescription number, and amount charged. Refer to your Drug Rider for further Claims submission information. You may also contact Customer Service for assistance or the BCBSNM website bcbsnm.com/docs/forms/claim/nm/rx-claim-form-nm.pdf. Please send prescription drug Claims to:

Prime Therapeutics
PO Box 25136
Lehigh Valley, PA 18002-5136

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

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

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

www.bcbsglobalcore.com/Account/Login/

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

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

Service Center

P.O. Box 72017

Richmond, VA 23255- 2017

IF YOU HAVE MEDICARE

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

Filing Claims if Medicare is Primary

If you have Medicare and Medicare is primary over this plan (i.e., you are retired, a dependent of a retiree, or a Member that has exhausted the end-stage renal disease coordination time period under Medicare), when you receive Health Care, be sure to present both your Medicare ID Card and your **Group** plan ID Card issued by BCBSNM. Always present your Medicare ID Card to your Health Care Providers so that they will bill Medicare first. After Medicare has paid its portion **for services received in New Mexico,** a Claim should automatically be sent by the Medicare Part B carrier or Part A intermediary to BCBSNM for secondary benefit determination. (If your Claims are not being sent by Medicare to BCBSNM, please call a Customer Service Advocate to verify that the correct Medicare HIC number is on file for you. Also, in order to ensure that Claims are filed properly, the Provider must have information from the ID Cards issued to you by **both** Medicare and BCBSNM.)

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

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

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

Medicare-Covered Facility Services

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

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

Medicare-Covered Non-Facility Services

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

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

Services Not Covered by Medicare

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

When an EOMB is Not Required

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

- Services received outside the Medicare territorial limits.
- Services from Providers with whom you have privately Contracted. (BCBSNM will estimate what Medicare would have paid had you not privately Contracted with the Provider and had submitted the Claim to Medicare for payment.)
- Services received from licensed professional clinical Mental Health counselors (LPCC) and licensed marriage and family therapists (LMFT). (However, you will need **Prior Authorization** from BCBSNM in order to receive benefits for covered Mental Health and Substance Use Disorder services received from LPCC and LMFT Providers.)

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

Services Outside Medicare Territorial Limits

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

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

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

CLAIMS PAYMENT PROVISIONS

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

After a Claim has been processed, the Subscriber will receive an *Explanation of Benefits* (EOB). The EOB indicates what charges were covered and what charges, if any, were not. After reviewing the EOB, if the Member needs to contact the OSI, the Member can locate the contact information inside the EOB under the textbox titled *Office of Superintendent of Insurance*. **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:

- The reasons for denial.
- A reference to the Health Care plan provisions on which the denial is based.
- An explanation of how you may appeal the decision if you do not agree with the denial. (See *Complaints/Appeals Summary*, later in this section.) **You also have 180 days** following request of notification of an adverse benefit determination in which to appeal a decision to BCBSNM; however, you may exceed the 180- day limit when appealing to the Managed Health Care Bureau of the Office of Superintendent of Insurance**.**

Covered Charge

Provider payments are based upon HMO-Participating Provider agreements and Covered Charges as determined by BCBSNM. For services received outside of New Mexico, Covered Charges may be based on the local plan practice (e.g., for out-of-state Providers that contract with their local Blue Cross and Blue Shield Plan, the Covered Charge may be based upon the amount negotiated by the other plan with its own Contracted Providers). You are responsible for paying Copayments, Deductibles, Coinsurance, and noncovered expenses. For covered emergency services received in foreign countries, BCBSNM will use the exchange rate in effect on the date of service in order to determine billed charges.

HMO-Participating Providers

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

Nonparticipating Providers

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

Accident-Related Hospital Services

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

Assignment of Benefits

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

Early Developmental Delay and Disability

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

Medicaid

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

Medicare

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

Overpayments

If BCBSNM makes an erroneous benefit payment to the Subscriber or Member for any reason (e.g., Provider billing error, Claims processing error), BCBSNM may recover overpayments from you.

Pricing of Noncontracted Provider Claims

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

- 100% of the base Medicare Allowable for inpatient Facility Claims
- 300% of the base Medicare Allowable for outpatient Facility Claims
- 200% of the base Medicare Allowable for freestanding ambulatory surgical 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 Noncontracted Providers are excluded from this Noncontracted Provider pricing method. These include:

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

NOTE: Non-emergency services are generally **not covered** under HMO or EPO plans when received out-of-network from Noncontracted Providers. The pricing methods above apply **only** when the Claim for out-of-network services has been authorized for payment and does not satisfy any of the conditions below:

Benefits for Emergency Care

If you receive treatment from a Nonparticipating Provider for Emergency Care, BCBSNM will review and process payment consistent with the in-Network benefit for the Covered Services provided. Non-emergency services provided in an emergency room for treatment of Mental Health or Substance Use Disorder will be paid the same as Emergency Care services.

Pricing for the following categories of Claims for **Covered Services** from Noncontracted Providers will be priced at billed charges, or at an amount negotiated by BCBSNM with the Provider, or other amount allowed by law, such as the New Mexico Surprise Billing Protection Act of the federal No Surprise Act , whichever is less:

- For HMO health plans, services from Noncontracted Providers that satisfy at least one of the two conditions below and, as a result, are eligible for coverage under HMO and EPO health plans:
    - Covered Services from Noncontracted Providers within the United States that are classified as *Unsolicited Providers* as determined by the Member's Host Plan while outside the Service Area of BCBSNM
    - **Prior Authorization of transition** of care services received from Noncontracted Providers

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

- Covered Services required during an emergency, excluding Covered Services received in an Ambulance
- Non-emergent Covered Services that have been approved through Prior Authorization, if needed, and are rendered at a Contracted Facility where:
    - A Contracted Provider is unavailable
    - A Noncontracted Provider renders unforeseen Covered Services
    - A Noncontracted Provider renders Covered Services for which you did not give specific consent to the Noncontracted Provider to render

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

INTER-PLAN ARRANGEMENTS

Blue Cross and Blue Shield of New Mexico (BCBSNM) has a variety of relationships with other Blue Cross and/or Blue Shield Plans under their Licensed Controlled Affiliates (*Licensees*). Generally, these relationships are called *Inter-Plan Arrangements*. These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association (*Association*). Whenever you obtain healthcare services outside of the Service Area, the Claims for these services may be processed through one of these Inter-Plan Arrangements, which includes the BlueCard® program.

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

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

Inter-Plan Arrangements link the BCBSNM Provider network with other individual Blue Cross Blue Shield networks across the country to provide you broad access to **HMO** Contracted Providers. **HMO** Contracted Providers may be Contracted with either BCBSNM or the Host Blue. **HMO** Noncontracted Providers are not Contracted with either BCBSNM, or the Host Blue.

When services are received by you outside of the State of New Mexico for either **HMO** Contracted or Noncontracted Providers, the Host Blue will provide BCBSNM with a Covered Charge based on what it uses for its own local Members for services received from either **HMO** Contracted or Noncontracted Providers in the state where the Host Blue is located.

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

BLUECARD® PROGRAM

Services Received from HMO Contracted Providers outside New Mexico:

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

Whenever you receive Out-of-Area Covered Services outside of the Service Area and the Claim is processed through the BlueCard® Program, the amount you pay for Covered Services, if not a flat dollar Copayment, is based on the lower of:

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

If the services are provided by an **HMO** 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 an **HMO** Contracted Provider, you will receive the benefit of the payment/rate negotiated by the Host Blue with the Provider. As always, you will be responsible for any applicable Deductible, Copay and/or Coinsurance amounts (*Member Share*). The amount that BCBSNM pays together with your Member Share is the total amount the **HMO** 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 made to correct for over or underestimation or underestimation of modifications of past pricing of Claims, as noted above. However, such adjustments will not affect the price we use for your Claim because they will not be applied after a Claim has already been paid.

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

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

Federal law or state law(s) may require a surcharge, tax, or other fee(s) that apply 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 an HMO Noncontracted Provider Outside of New Mexico

Out-of-Area Covered Services for HMO plans refers to Emergency Care obtained outside the geographic area of the Service Area. Any other services will not be covered when processing through any Inter-Plan Arrangements, unless authorized by **your HMO** Primary Care Physician (*PCP*).

If services are provided by an **HMO** Noncontracted Provider, the Provider may, but is not required to submit Claims on your behalf. If the **HMO** Noncontracted Provider does not submit Claims on your behalf, you will be required to submit the Claims directly to the Host Blue at www.bcbsglobalcore.com/Account/Login.

Member Liability Calculation

In General

Under Inter-Plan Arrangements, when services are received outside the state of New Mexico from an **HMO** Noncontracted Provider, the Covered Charge will be determined by the Host Blue servicing area or by applicable laws, including but not limited to statutes, ordinances, judicial decisions and regulations will be passed on to BCBSNM. BCBSNM will use the Host Blue's Covered Charge as its Covered Charge so that your Claim can be processed timely. BCBSNM's Covered Charge will be an amount up to but not in excess of the Covered Charge the Host Blue has passed on to BCBSNM. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

Under Inter-Plan Arrangements, when services are received outside the state of BSBSNM from an **HMO** Noncontracted Provider, the Covered Charge will be determined by the Host Blue servicing area or by applicable laws, including but not limited to statutes, ordinances, judicial decisions and regulations will be passed on to BCBSNM. BCBSNM will use the Host Blue's Covered Charge as its Covered Charge so that your Claim can be processed timely. BCBSNM's Covered Charge will be an amount up to but not in excess of the Covered Charge the Host Blue has passed on to BCBSNM. 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 (i) billed charges for Covered Services, (ii) the payment we would make if the healthcare services had been obtained within our Service Area, (iii) a special negotiated payment as permitted under the Inter-Plan Arrangements; or (iv) for Professional Providers, make a payment based on publicly available data and historic reimbursement to Providers for the same or similar professional services, adjusted for geographical differences where applicable; or (v) for Hospital or Facility Providers. make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or Facility. In these situations, the Member may be responsible for the difference between the amount that the Noncontracted Provider bills and the payment that BCBSNM will make for Covered Services as set forth in this paragraph.

Emergency Care Services:

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

Blue Cross Blue Shield Global Core

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

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

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

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 your 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.

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

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

SUMMARY OF HEALTH INSURANCE GRIEVANCE PROCEDURES

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

Blue Cross Blue Shield of New Mexico

P.O. Box 660058 Dallas, TX 75266-0058

or from OSI by calling:

1-505-827-3811 or toll-free at 1-855-427-5674

PRIOR AUTHORIZATION

How does Prior Authorization for a Health Care service work?

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

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

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

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

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

How long does a Prior Authorization take?

Standard timeline Prior Authorization decision: The insurer must make an initial decision within 7 working days. A standard decision timeline applies to benefit certification requests that are not urgent. For example, a standard benefit certification request may involve surgical care, like routine hip replacement surgery. An insurer must make an initial decision on a standard request for an exception to an insurer's step therapy requirements or drug formulary within 24 hours for Urgent Care requests and 72 hours for standard care request. A step therapy requirement means trying a less expensive drug before *stepping up* to a more expensive option. Asking for an exception to this requirement means asking to skip the less expensive drug. A drug formulary exception request means to ask for coverage of a medication not on the formulary.

What if I need services in a hurry?

Urgent Care situation: An **Urgent Care situation** is a situation in which a decision from the insurer is needed quickly because:

- Delay would jeopardize your life or health
- Delay would jeopardize your ability to regain maximum function
- The Physician with knowledge of your medical condition **reasonably** requests an expedited decision
- The Physician with knowledge of your medical or behavioral health condition, believes that delay would subject you to severe pain that cannot be adequately managed without the requested care or treatment
- The medical or behavioral health demands of your case require an expedited decision

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

IMPORTANT: If you are facing an emergency, you should seek medical care immediately and then notify your insurer as soon as possible. The insurer will guide you through the Claims process once the emergency has passed.

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

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

Appeals of Denials

What types of decision can be appealed?

You may request appeals of two different types of decisions:

Adverse determinations: An Adverse Determination by an insurer includes any decision to deny or limit your coverage based on Medical Necessity. This Medical Necessity denial can happen pre-service, through a denial of a Prior Authorization, or post-service, when an insurance company refuses to pay a Claim. If an insurance company has adversely determined that your ongoing course of treatment that has been previously covered will no longer be covered, the insurer must notify you before ending or limiting that coverage. This type of denial may also include a refusal to cover a service for which benefits might otherwise be provided because the service is determined to be Experimental, Investigational, or not medically necessary or appropriate.

An adverse denial may also include a decision by the plan to retroactively end your coverage or stop offering you coverage in the future based on your eligibility for coverage. For example, an insurance company's decision to stop offering you coverage because they believe you moved out of state is an Adverse Determination. **You may request an appeal of any type of an Adverse Determination**.

Administrative decision: You may also request an appeal if you object to how the insurer handles other matters, such as its administrative practices that affect the availability, delivery, or quality of Health Care Services; Claims payment, handling, or reimbursement for Health Care Services; or if your coverage has been terminated.

How to Appeal a Decision or File a Grievance

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

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

Blue Cross Blue Shield of New Mexico

P.O. Box 660058 Dallas, TX 75266-0058

Medical/Surgical 1-800-205-9926

Mental Health/Substance Use Disorder 1-888-898-0070

Fax 1-505-816-3837 or toll-free at 1-800-773-1521

Always contact your insurance company first about filing an appeal or grievance and specifically ask for assistance filing an appeal or grievance.

If the insurance company is non-responsive or if you have further questions about your rights, you may also contact the New Mexico Office of Superintendent of Insurance Managed Health Care Bureau team at:

Office of Superintendent of Insurance MHCB

PO Box 1689

Sante Fe, NM 87504-1689

or

1120 Paseo De Peralta

Santa Fe, NM 87501

Phone: 1-505-827-3811 or toll-free at 1-855-427-5674

Fax: 1-505-827-6341, Attn: MHCB

Email: mhcb.grievance@state.nm.us

Who can request a review?

A review may be requested by you as the patient, your Provider, or someone that you select to act on your behalf. The patient may be the actual Subscriber or a dependent who receives coverage through the Subscriber. The person requesting the review is called the ***grievant.*** If you are selecting someone to act on your behalf, such as a Provider, you may need to fill out a form designating that person to be your representative in the appeal.

Appealing an adverse Medical Necessity or coverage determination - first level review

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

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

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

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

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

How long does a first level internal review take?

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

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

The medical director denied my request - now what?

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

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

How long do I have to make my decision?

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

What happens during a panel review?

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

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

The insurer's internal panel must complete its review within 30 days following your original request for an internal review of a request for Prior Authorization or within 60 days following your original request if you already received the services. You will be notified within 2 days after the panel decision. If you fail to provide records or other information that the insurer needs to complete the review, you will be given an opportunity to provide the missing items, *but the review process may take much longer and you will be forced to wait for a decision.*

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

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

Yes. If your request has been reviewed by the insurer's panel and you are still dissatisfied with the decision, you will have **4 months** from date of the panel to request a review by an IRO.

What's an IRO and what does it do?

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

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

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

How long does an IRO review take?

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

Review by the Superintendent of Insurance

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

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

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

REVIEW OF AN ADMINISTRATIVE DECISION

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

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

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

The insurer will mail a decision to you within 30 days after receiving your request fora review of an administrative decision.

Can I appeal the decision from the internal reviewer?

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

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

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

If you are unable to prepare for the committee hearing within the time set by the insurer, you may request that the committee hearing be postponed for up to 30 days. The reconsideration committee will mail its decision to you within 7 days after the hearing.

How can I request an external review?

If you are dissatisfied with the reconsideration committee's decision, you may ask the Superintendent to review the matter within **20 days** after you receive the written decision from the insurer. You may submit the request to OSI using forms that are provided by your insurer. Forms are also available on the OSI website located at www.osi.state.nm.us/pages/misc/mhcb-complaint. You may also call OSI to request the forms at 1-505-827-3811 or toll-free at 1-855-427-5674.

How does the external review work?

Upon receipt of your request, the Superintendent will request that both you and the insurer submit information for consideration. The insurer has 5 days to provide its information to the Superintendent, with a copy to you. You may also submit additional information including documents and reports for review by the Superintendent. The Superintendent will review all of the information received from both you and the insurer and issue a final decision within 60 days after receipt of the complete request for external review.. If you need extra time to gather information, you may request an extension of up to 90 days. Any extension will cause the review process and decision to take more time.

GENERAL INFORMATION

Confidentiality

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

Any data or information pertaining to diagnosis, treatment, or health of any covered person obtained from the covered person, from any Provider, or from any other source, shall be held in confidence as otherwise required or permitted by New Mexico or federal law. Confidential data or information shall not be disclosed to any person except:

- To the extent that it may be necessary to carry out the purposes of rules issued by New Mexico or federal lawmakers.
- Upon the express consent of the covered person with disclosure not exceeding a period of 24 months.
- Pursuant to state or court order for the production of evidence or the discovery thereof.
- In the event of Claim or litigation between a covered person and the Health Care Insurer wherein such data or information is pertinent.
- Where otherwise required or permitted by New Mexico or federal law.

Special needs and cultural and linguistic diversity

Information about the grievance procedures will be provided in accessible means or in a different language upon request in accordance with applicable state and federal laws and regulation. Call the consumer assistance number on the back of your insurance card for assistance.

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

SECTION 9: GENERAL PROVISIONS

ADVANCE DIRECTIVES

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

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

APPLICATION STATEMENT

As of the date of issue of this policy, no misstatements, except willful or fraudulent misstatements, made by the applicant in the application for this policy shall be used to void the policy or to deny a Claim for loss incurred or disability (as defined in the policy). In the event a misstatement in an application is made that is not fraudulent or willful, the issuer of the policy may prospectively rate and collect from the insured the premium that would have been charged to the insured at the time the policy was issued had such misstatement not been made.

AVAILABILITY OF PROVIDER SERVICES

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

CATASTROPHIC EVENTS

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

CHANGES TO THE BENEFIT BOOKLET

BCBSNM may amend this Benefit Booklet when authorized by an officer of BCBSNM. BCBSNM will give your Group at least 60 days prior written notice of an amendment to this Benefit Booklet. No employee of BCBSNM may change this Benefit Booklet by giving incomplete or incorrect information, or by contradicting the terms of this Benefit Booklet. Any such situation will not prevent BCBSNM from administering this Benefit Booklet in strict accordance with its terms. See the inside back cover for further information.

CONSUMER ADVISORY BOARD

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

DISABLED CHILDREN CONTINUED COVERAGE

BCBSNM, which provides for coverage of an Eligible Child of the Subscriber until the attainment of the limiting age of 26 for Eligible Children, shall not terminate the coverage of a Child while the Child is, and continues to be both incapable of self-sustaining employment, by reason of intellectual disability or physical disability, and chiefly dependent upon the Subscriber for support and maintenance. However, proof of the incapacity and dependency of the Child must be furnished to BCBSNM by the Subscriber within 31 days of the Child's attainment of the limiting age and subsequently, as may be required by BCBSNM, but not more frequently than annually after the two-year

period following the Child's attainment of the limiting age of 26. Please call the Customer Service phone number at the bottom of the page for assistance in obtaining a copy of a disabled dependent certification form.

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 participating or not. BCBSNM is not liable for any loss or injury caused by any Health Care Provider by reason of negligence or otherwise.

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

DISCLOSURE AND RELEASE OF INFORMATION

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

ENTIRE CONTRACT

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

EXECUTION OF PAPERS

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

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 Benefit Booklet, the terms of this section will apply. However, definitions set forth in the *Federal No Surprises Act Definitions* provision of this section are for purposes of this section only.

Federal No Surprises Act Definitions

The definitions below apply only to this *Federal Balance Billing and Other Protections* section. To the extent the same terms are also defined in *Section 10: Definitions* in this Benefit Booklet, those terms will apply only to their use in the Benefit Booklet or this *Federal Balance Billing and Other Protections* section, respectively.

Emergency Medical Condition means, for purposes of this section only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant parent their unborn Child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

Emergency services means, for purposes of this section only,

- A medical screening examination performed in the emergency department of a Hospital or a freestanding emergency department
- Further medical examination or treatment you receive at a Hospital, regardless of the department of the Hospital, or a freestanding emergency department to evaluate and treat an emergency medical condition until your condition is stabilized

- Covered Services you receive from a Nonparticipating Provider during the same visit after your emergency medical condition has stabilized unless:
    - Your Nonparticipating Provider determines you can travel by non-medical or non-emergency transport
    - Your Nonparticipating Provider has provided you with a notice to consent form for balance billing of services
    - You have provided informed consent

Nonparticipating Emergency Facility means, for purposes of this section only, with respect to a covered item or service, an emergency department of a Hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSNM for furnishing such item or service under the plan.
Nonparticipating Provider means, for purposes of this section only, with respect to a covered item or service, a Physician or other health care provider who does not have a contractual relationship with BCBSNM for furnishing such item or service under the plan.

Participating Facility means, for purposes of this section only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSNM setting a rate (above which the Provider cannot bill the Member) for furnishing such item or service under the plan, regardless of whether the Provider is considered a Preferred or in-network Provider for purposes of in-network or out-of-network benefits under the plan.

Participating Provider means, for purposes of this section only, with respect to a Covered Service, a Physician or other health care provider who has a contractual relationship with BCBSNM setting a rate (above which the Provider cannot bill the Member) for furnishing such item or service under the plan, regardless of whether the Provider is considered a Preferred or in-network Provider for purposes of in-network or out-of-network benefits under the plan.

Qualifying payment amount means, for purposes of this amendment only, a median of Contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

Recognized amount means, for purposes of this amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the qualifying payment amount or billed charges.

Federal No Surprises Act Surprise Billing Protections

The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Nonparticipating Providers and nonparticipating emergency facilities. The items and services included in these protections (*Included Services*) are listed below.

- Emergency services obtained from a Nonparticipating Provider or Nonparticipating emergency Facility
- Covered non-emergency services performed by a Nonparticipating Provider at a Participating Facility (unless you give written consent and give up balance billing protections)
- Air Ambulance Services received from a Nonparticipating Provider, if the services would be covered if received from a Participating Provider

Claim Payments

For Included Services, the plan will send an initial payment or notice of denial of payment directly to the Provider within thirty (30) calendar days after receiving the Claim.

Cost-Sharing

For non-emergency services performed by Nonparticipating Providers at a Participating Facility, and for emergency services provided by a Nonparticipating Provider or Nonparticipating emergency Facility, the

Recognized Amount is used to calculate your cost-share requirements, including Deductibles, Copayments, and Coinsurance.

For air Ambulance Services received from a Nonparticipating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate your cost-share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the qualifying payment amount or billed charges.

For Included Services, these cost-share requirements will be counted toward your Participating Provider Deductible and/or Out-of-Pocket Limit, if any.

Federal No Surprises Act Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If you receive emergency services from a Nonparticipating Provider or Nonparticipating emergency Facility, the most the Nonparticipating Provider or Nonparticipating emergency Facility may bill you is your in-network cost-share. You cannot be balance billed for these emergency services unless you give written consent and give up your protections not to be balanced billed for services you receive after you are in a stable condition.

When you receive covered non-emergency services from a Nonparticipating Provider at a participating Facility, the most those Nonparticipating Providers may bill you is your plan's in-network cost-share requirements. When you receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a participating Facility, Nonparticipating Providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at participating facilities, Nonparticipating Providers can't balance bill you unless you give written consent and give up your protections.

If your plan includes air Ambulance Services as a Covered Service, and such services are provided by a Nonparticipating Provider, the most the Nonparticipating Provider may bill you is your in-network cost-share. You cannot be balance billed for these air Ambulance Services.

FREEDOM OF CHOICE OF HOSPITAL AND PRACTITIONER

Within the area and limits of coverage offered to Subscribers and selected by the Subscriber in the application for insurance, the right of a person to exercise full freedom of choice in the selection of a Hospital for Hospital care or of a Practitioner of the Healing Arts, or Optometrist, Psychologist, Podiatrist, Physician Assistant, Certified Nurse-Midwife, Registered Lay Midwife, or Registered Nurse in expanded practice, for treatment of an illness or injury within that practitioner's scope of practice shall not be restricted under any new policy of health insurance, contract, or Health Care plan. Any person insured or Claiming benefits under any such health insurance policy, contract, or Health Care plan providing within its coverage for payment of Covered Service benefits, or indemnity for Hospital care or treatment of persons for the cure or correction of any physical or Mental Health condition shall be deemed to have complied with the plan requirements as to submission of proof of loss upon submitting written proof supported by the certificate of any Hospital currently licensed by the department of health or any Practitioner of the Healing Arts, or Optometrist, Psychologist, Podiatrist, Physician Assistant, Certified Nurse-Midwife, Registered Lay Midwife or Registered Nurse in expanded practice.

FREEDOM OF CHOICE OF INDEPENDENT SOCIAL WORKER

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

HOLD-HARMLESS

The contracts between BCBSNM and its HMO-Participating Providers include a *hold harmless* clause which provides that an HMO plan Member cannot be liable to the Provider for monies owed by BCBSNM for Health Care Services covered under the HMO health plan.

INDEPENDENT CONTRACTORS

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

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

MEMBER RIGHTS

All Members have these rights:

- The right to available and accessible services, when Medically Necessary, as determined by your primary care or treating Physician in consultation with BCBSNM, 24 hours per day, 7 days a week, or Urgent or Emergency Care services, and for other health services as defined by your Benefit Booklet.
- The right to receive information about BCBSNM, our services, practitioners and Providers and Member rights and responsibilities.
- The right to participate with practitioners in making decisions about your Health Care.
- The right to make recommendations regarding BCBSNM's Member rights and responsibility policy.
- The right to be treated with courtesy and consideration, and with respect for your dignity and your need for privacy.
- The right to have their privacy respected, including the privacy of medical and financial records maintained by BCBSNM and its Health Care Providers as required by law. For more information on BCBSNM's Privacy Practices including Personal Health Information or genetic information please visit:

  www.bcbsnm.com/legal-and-privacy/privacy-notice-and-forms
- The right to be provided with information concerning BCBSNM's policies and procedures regarding products, services, Providers, and appeals procedures and other information about the company and the benefits provided.
- The right to choose a PCP within the limits of the covered benefits and plan network, including the right to refuse care of specific practitioners.
- The right to all the rights afforded by law, rule, or regulation as a patient in a licensed Health Care Facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language you understand.
- The right to receive from your Physician(s) or Provider, in terms that you understand, an explanation of your complete medical condition, recommended treatment, risk(s) of treatment, expected results and reasonable medical alternatives, irrespective of BCBSNM's position on treatment options. If you are not capable of understanding the information, the explanation shall be provided to your next of kin, guardian, agent or surrogate, if able, and documented in your medical record.
- The right to prompt notification of termination or changes in benefits, services or Provider network.
- The right to file a complaint or appeal with BCBSNM or with the Office of Superintendent of Insurance and to receive an answer to those complaints in accordance with existing law.

- The right to request information about any financial arrangements or provisions between BCBSNM and its Network Providers that may restrict referral or treatment options or limit the services offered to Members.
- The right to adequate access to qualified health professionals near your work or home within the BCBSNM Service Area (the state New Mexico).
- The right to affordable health care, with limits on out-of-pocket expenses, including the right to seek care from a Nonparticipating Provider, and an explanation of your financial responsibility when services are provided by a Nonparticipating Provider, or provided without required Prior Authorization.
- 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 Management 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. and the right to request the assistance of the Office of Superintendent of Insurance.

MEMBER RESPONSIBILITIES

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

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

MEMBERSHIP RECORDS

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

OUT-OF-NETWORK CARE AND BILLS

If you receive care under any of the circumstances below from a Provider who is not in your network, these are your rights:

If you receive Emergency Care out-of-network, including air Ambulance service:

- You are only responsible for paying what you would owe for the same care from an in-network Provider or Facility.
- You do NOT need to get Prior Authorization for emergency services.
- Your care can continue until your condition has stabilized. If you require additional care after stabilization, call Customer Service at the number on the back of your ID card and we will help you receive that care from an in-network Provider.
- You cannot be balance billed.

If you receive care from an out-of-network Provider at an in-network Facility, such as a Hospital that is in your plan, you are only responsible for paying what you would owe for the same care from an in-network Provider if:

- You did not consent to services from an out-of-network Provider,
- You were not offered the service from an in-network Provider, or
- the service was not available from an in-network Provider – as determined by your Health Care Provider and BCBSNM.

If you get a bill from an out-of-network Provider under any of the above circumstances that you do not believe is owed:

- Call us first at the Customer Service number on the back of your ID card. We will try to the resolve the issue with the Provider on your behalf.
- Contact the New Mexico Office of Superintendent of Insurance if the problem has not been resolved by us — www.osi.state.nm.us/pages/misc/mhcb-complaint or 1-855-427-5674.

To help stop improper out-of-network bills, we will:

- Notify you if your Provider leaves our network and allow you transitional care with that Provider at the in-network Benefit level for up to 90 days depending on your condition and course of treatment.
- Verify the accuracy of our Provider directory information at least every 90 days.
- Confirm whether a Provider is in-network if you contact Customer Service at the number on the back of your ID card. If our Provider directory or one of our representatives provides inaccurate information that you rely on in choosing a Provider, you will only be responsible for paying your in-network cost-sharing amount for care received from that Provider.

You have the right to receive notice of the following before you receive out-of-network care at an in-network Facility:

- A good faith estimate of the charges for out-of-network care.
- At least five days to change your mind before you receive a scheduled out-of-network service. If you choose to receive out of network care you will be responsible for out-of-network charges that we do not cover.
- A list of in-network Providers and the option to be referred to any such Provider who can provide necessary care.

If you pay an out-of-network Provider more than we determine you owe:

- The Provider will owe you a refund within 45 days of receipt of payment by us.
- If you do not receive a refund within that 45-day period, the Provider will owe you the refund plus interest.
- You may contact the New Mexico Office of Superintendent of Insurance at www.osi.state.nm.us/pages/misc/mhcb-complaint and 1-855-427-5674 for assistance or to appeal the Provider's failure to provide a refund. You need to file the appeal within 180 days of the 45-day refund period expiration.

PAYMENT OF CLAIMS

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

PHYSICAL EXAMINATION AND AUTOPSY

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

RELIGIOUS AND MORAL EXEMPTION AND ELIGIBLE ORGANIZATION ACCOMMODATION

A certification(s) may have been provided to BCBSNM that your Group Health Care Plan is established or maintained by an objecting organization(s) as defined in 45 C.F.R. 147.132(a), or 45 C.F.R. 147.133(a), as modified or replaced, and qualifies for a religious or moral 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 or Moral Exemption*). Provided that the Religious or Moral Exemption is satisfied for your Group Health Care Plan, then coverage under your Group Health Care 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 or Moral Exemption should be directed to your Group.

In addition, a certification(s) may have been provided to BCBSNM that your Group Health Care Plan is established or maintained by an organization(s) that is an *eligible organization(s)* as defined in 45 C.F.R. 147.131(c), 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 Care Plan will not include coverage for some or all of such contraceptive services, but will be provided through BCBSNM at no cost share. Please call Customer Service at the number on the back of your ID Card for more information. If you have questions regarding the certification(s), you may contact your Group. For other questions about the Eligible Organization Accommodation, you may contact Customer Service at the number on the back of your ID Card.

SENDING NOTICES

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

TIME PAYMENT OF CLAIMS

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

TRANSFER OF BENEFITS

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

SECTION 10: DEFINITIONS

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

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

Adjustment Factor — The percentage by which the Medicare Allowable amount is multiplied in order to arrive at the *Noncontracting Allowable Amount*. Adjustment Factors will be evaluated and updated no less than every two years.

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

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

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

Ambulance Service — Means any transportation service designated and used or intended to be used for the transportation of sick or injured persons.

Ambulatory Surgical Facility — A Facility where Health Care Providers perform surgeries, including diagnostic and preventive surgeries that do not require Hospital Admission.

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

Applied Behavioral Analysis (ABA) — A scientific approach based on the principles of learning and behavior that uses evidence-based techniques to help individuals learn new skills and reduce challenging behaviors.

Approved Clinical Trial — 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 and is not designed exclusively to test toxicity or disease pathophysiology. The trial must be:

- Conducted under an Investigational new drug application reviewed by the United States Food and Drug Administration.
- Exempt from obtaining an Investigational new drug application.
- Approved or funded by:

    - The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, or a cooperative group or center of any of the foregoing entities.
    - A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs.
    - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes for Health for center support groups.

- The United States Departments of Veterans Affairs, Defense, or Energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States Secretary of Health and Human Services to:
  - Be comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
  - Provide unbiased scientific review by individuals who have no interest in the outcome of the review.

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

Behavioral Health Services — Professional and ancillary services for the treatment, habilitation, prevention and identification of mental illnesses, Substance Use Disorders and trauma spectrum disorders, including inpatient, detoxification, residential treatment and partial hospitalization, intensive outpatient therapy, outpatient therapy and all medications, including brand-name pharmacy drugs when generics are unavailable.

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

Biomarker Testing – The 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.

Blue Access for Members℠ (BAM) — Online programs and tools that BCBSNM offers its Members to help track Claims payments, make Health Care choices, and reduce Health Care costs.

BlueCard® — BlueCard® is a national program that enables Members of one Blue company to obtain Health Care Services while traveling or living in an area served by another Blue company. You do not need to see a BlueCard® Participating Provider to obtain Out-of-Network Emergency Care Services. The program links participating healthcare Providers with the independent Blue companies across the country and in more than 200 countries and territories worldwide, through a single electronic network for Claims processing and reimbursement.

BlueCard® Access — The term used by Blue Cross and Blue Shield companies for national doctor and Hospital finder resources available through the Blue Cross and Blue Shield Association. These Provider location tools are useful when you need Urgent Health Care services outside New Mexico. Call BlueCard® Access at 1-800-810-BLUE (2583) or visit the BlueCard® Doctor and Hospital Finder at provider.bcbs.com/app/public/#/one/city=&state=&postalCode=&country=&insurerCode=BCBSA_I&brandCode=BCBSANDHF&alphaPrefix=&bcbsaProductId.

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

Cancer Clinical Trial — A course of treatment provided to a patient for the prevention of reoccurrence, early detection or treatment of cancer for which standard cancer treatment has not been effective or does not exist. It does not include trials designed to test toxicity or disease pathophysiology but must have a therapeutic intent and be provided as part of a study being conducted in a Cancer Clinical Trial in New Mexico. The scientific study must have been approved by an institutional review board that has an active federal-wide assurance of protection for human subjects and include all of the following: specific goals, a rationale and background for the study, criteria for patient selection, specific direction for administering the therapy or intervention and for monitoring

patients, a definition of quantitative measures for determining treatment response, methods for documenting and treating adverse reactions, and a reasonable expectation based on clinical or pre-clinical data, that the treatment will be at least as effective as standard cancer treatment. The trial must have been approved by a United States federal agency or by a qualified research entity that meets the criteria established by the federal National Institutes of Health for grant eligibility.

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

Certified Nurse-Midwife — Any person who is licensed by the Board of Nursing as a Registered Nurse and who is licensed by the New Mexico Department of Health as a Certified Nurse-Midwife.

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

Cessation Counseling — As applied to the *smoking/tobacco use cessation* benefit described in *Section 5: Covered Services*, *Preventive Services*, Cessation Counseling means a program, including individual, group, or proactive telephone quit line, and medication therapy including treatment items detailed in your attached Drug Plan Rider, that:

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

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

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

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

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

Claim — A request from a Provider for payment for Health Care Services rendered.

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

Coinsurance — A cost-sharing method that requires a covered person to pay a stated percentage of medical or pharmaceutical expenses after the Deductible amount, if any, is paid; Coinsurance rates may differ for different types of services under the same health benefits plan.

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

Contracted — When a Provider has a contract with BCBSNM or another BCBS Plan to bill BCBSNM (or other BCBS Plan) directly and to accept this health plan's payment (provided in accordance with the provisions of the contract) plus the Member's share (Coinsurance, Deductibles, Copayments, etc.) as payment in full for Covered Services.

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

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

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

Covered Charge — The amount that BCBSNM allows for Covered Services using a variety of pricing methods and based on generally accepted Claim coding rules. The Covered Charge for services from *Contracted Providers* is the amount the Provider, by contract with BCBSNM (or another entity, such as another BCBS Plan), will accept as payment in full under this health plan.

> **Medicare Allowable** — The amount allowed by CMS for Medicare-Participating Provider services, which is also used as a base for calculating Noncontracted Provider Claims payments for some Covered Services of Noncontracted Providers under this health plan. The Medicare Allowable amount will not include any additional payments that are not directly tied to a specific Claim, for example, medical education payments.
>
> **Noncontracting Allowable Amount** — The maximum amount, not to exceed billed charges, that will be allowed for a Covered Service received from a Noncontracted Provider in most cases. The BCBSNM Noncontracting Allowable Amount is based on the **Medicare Allowable** amount for a particular service, which is determined by the Centers for Medicaid and Medicare Services (CMS).

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

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

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

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

Deductible —A fixed dollar amount that a covered person may be required to pay during a benefit period before the health insurance carrier begins payment for covered benefits; health benefits plans may have both individual and family Deductibles and separate Deductibles for specific services.

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

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

Developmental Disability — A developmental level or status that is attributable to a cognitive or physical impairment, or both, originating before the age of 22. Such an impairment is likely to continue indefinitely and results in substantial functional or adaptive limitations. Examples of Developmental Disabilities include, but are not limited to, Intellectual Disability, pervasive Developmental Disorders, learning disorders, developmental coordination disorder, communication disorders, cerebral palsy, epilepsy, blindness, deafness, mutism, and muscular dystrophy.

Diagnostic Breast Examination – A Medically Necessary and clinically 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, or detected by another means of examination.

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

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

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

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

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

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

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

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

Drug List — A list of prescription drugs that are preferred for use by BCBSNM for retail and mail-order pharmacy benefits. The list is subject to periodic review and change by BCBSNM. BCBSNM - Contracted Providers should have received a copy of the list. If you need a list of commonly prescribed drugs on the BCBSNM Drug List, request it from a Customer Service Advocate or visit the BCBSNM website. See your separately issued *Drug Plan Rider* for details.

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

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

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

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

- The Subscriber's legal **spouse**.
- The Subscriber's **Domestic Partner**. (**NOTE:** Domestic Partner coverage is available at your employer's discretion. Contact your employer for information on whether Domestic Partner coverage is available for your Group.)
- The Subscriber's Eligible Child or the Eligible Child of the Subscriber's Domestic Partner (provided your employer covers Domestic Partners) through the end of the month in which the Child reaches **age 26**. (Once a covered Child reaches age 26, the Child is automatically removed from coverage and rates adjusted accordingly - unless the Child is an Eligible Family Member under this plan due to a disability as described below.)
- The Subscriber's **unmarried** Child or the **unmarried** Child of the Subscriber's Domestic Partner (provided your employer covers Domestic Partners) age 26 or older who was enrolled as the Subscriber's covered Child in this health plan at the time of reaching the age limit, and who is medically certified as **disabled,** chiefly dependent upon the Subscriber for support and maintenance, and incapable of self-sustaining employment by reason of their disability. (Such condition must be certified by a Physician and BCBSNM. Also, a Child may continue to be eligible for coverage beyond age 26 only if the condition began before or during the month in which the Child would lose coverage due to their age. BCBSNM must receive written notice of the disabling condition within 31 days of the Child's attainment of the limiting age.)
- The Subscriber's dependent student on Medically Necessary leave of absence.

Emergency Care — Health Care procedures, treatments or services, excluding ambulance transport services, which procedure, treatment or service is delivered to a covered person after the sudden onset of what reasonably appears to be a medical or behavioral health condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention, regardless of eventual diagnosis, could be

expected by a reasonable layperson to result in jeopardy to a person's physical or mental health or to the health or safety of a fetus or pregnant person, serious impairment of bodily function, serious dysfunction of a bodily organ or part or disfigurement to a person.

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

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

Experimental, Investigational or Unproven — Any treatment, procedure, Facility, equipment, drug, device, or supply (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 Experiment or Investigational, treatment must meet all five of the following criteria:

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

Prescription drugs that are approved by the FDA through the accelerated approval program may be considered Experimental/Investigational.

Facility —An entity providing a Health Care Service, including:

- A general, specialized, Psychiatric or Rehabilitation Hospital
- An Ambulatory Surgical Center
- A cancer treatment center
- A birth center
- An inpatient, outpatient or residential drug and alcohol treatment center
- A laboratory, diagnostic or other outpatient medical evaluation or testing center
- A Health Care Provider's office or clinic
- An Urgent Care center
- Any other therapeutic health care setting

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

FDA — The United States Food and Drug Administration.

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

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

Group — A bonafide employer covering employees of such employer for the benefit of persons other than the employer; 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 — The Group administration document, the Group's application to the plan (Benefit Program Application), this Benefit Booklet, the Summary of Benefits and Coverage, and any other applications, riders, enclosures, addenda exhibits, and Amendments, or Endorsements, if any, between the plan and the Group, referred to as the Group Contract.

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

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

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

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

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

Health Care Services — A service, supply or procedure for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease, including, to the extent covered by the health benefits plan, a physical or Behavioral Health Service.

Health Maintenance Organization (HMO) — Any person who undertakes to provide or arrange for the delivery of basic Health Care Services to Subscribers on a prepaid basis, except for Subscriber responsibility for Copayments or Deductibles.

HMO-Participating Provider — Either a Facility (i.e., a Hospital) or a Professional Provider (i.e., a Physician) that, for the service being provided, contracts with BCBSNM as an HMO-Participating Provider, either directly or indirectly, or with the National BCBS Transplant Network to provide Health Care Services to Members with an expectation of receiving payment (other than Copayments, Coinsurance, or Deductibles) directly or indirectly from BCBSNM. An HMO-Participating Provider also agrees to bill BCBSNM and to accept this plan's payment (provided in accordance with the provisions of the contract) plus the Member's Copayment, Coinsurance or Deductibles as payment in full for Covered Services. BCBSNM, as Claims Administrator, will pay the HMO-Participating Provider directly.

The contracts between BCBSNM and its Providers include a *hold harmless* clause so that an HMO Member cannot be liable to the Provider for moneys owed by BCBSNM for services covered under this plan.

BCBSNM may add, change, or terminate specific HMO-Participating Providers at its discretion or recommend a specific Provider for specialized care as Medical Necessity warrants. HMO-Participating Providers are not required by BCBSNM to comply with any specified numbers, targeted averages, or maximum durations of patient visits.

HMO-Participating Specialist — A Health Care practitioner who has an HMO-Participating Provider contract with BCBSNM but is **not** specially Contracted as a *PCP*. A specialist does not include Hospitals or other treatment facilities, Urgent Care Facilities, pharmacies, equipment suppliers, Ambulance companies, or similar ancillary Health Care Providers.

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

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

Home Health Care Services — Covered Services, as listed under *Home Health Care/Home Intravenous (I.V.) Services* in *Section 5: Covered Services,* that are provided in the home according to a treatment plan by a certified Home Health Care Agency under active Physician and nursing management. Registered Nurses must coordinate the services on behalf of the Home Health Care Agency and the patient's Physician.

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

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

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

Hospital — A Facility offering Inpatient Services, nursing and overnight care for three or more individuals on a 24-hours-per-day, seven-days-per-week basis for the diagnosis and treatment of physical, behavioral or rehabilitative health conditions.

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

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

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

Independent Social Worker — A person licensed as an Independent Social Worker by the board of social work examiners.

Infusion Suite — An alternative to Hospital and clinic-based infusion settings where specialty medications can be infused.

Inpatient Services — Care provided while you are confined as an inpatient in a Hospital or treatment center for at least 24 hours. Inpatient Services include, but are not limited to, semi-private room accommodations, general nursing care, meals, and special diets or parenteral nutrition when Medically Necessary, Physician and surgeon services, use of all Hospital facilities when use of such facilities is determined to be Medically Necessary by your treating Physician, pharmaceuticals and other medications, anesthesia and oxygen services, special duty nursing when Medically Necessary, Radiation Therapy, inhalation therapy, and administration of whole blood and blood components when Medically Necessary.

Intellectual Disability – Neurodevelopmental conditions are conditions that affect a person's Cognitive and Adaptive functioning. Cognitive functioning measures multiple mental abilities, such as the ability to process information, learn, and problem solve. Adaptive functioning measures how well a person can live independently by measuring their ability to perform daily tasks and function within a social environment.

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

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

- Anyone not enrolled **within 31 days** of becoming eligible for coverage under this health care plan (e.g., a newborn Child added to coverage **more than 31 days** after birth, a Child added **more than 31 days** after legal adoption, a new spouse or stepchild added more than 31 days after marriage).
- Anyone enrolling on the Group's initial BCBSNM enrollment date who was not covered under the Group's prior plan (but who was eligible for such coverage).
- Anyone eligible but not enrolled during the Group's initial enrollment.
- Anyone who voluntarily terminates their coverage and applies for reinstatement of such coverage at a later date (except as provided under the USERRA of 1994). Please see your employer for specifics on the reinstatement process.

Learning Disability — A disorder indicating that a Child has difficulty in one or more areas of learning, even when overall intelligence or motivation is not affected. The diagnosis requires persistent difficulties in reading, writing, arithmetic or mathematical reasoning skills during formal years of schooling. Symptoms may include inaccurate or slow and effortful reading, poor written expression that lacks clarity, difficulties remembering number facts or inaccurate mathematical reasoning.

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

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

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

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

- Prior, concurrent, and retrospective review of the Medical Necessity and appropriateness of services or site of services
- Contracts with selected Health Care Providers.

- Financial incentives or disincentives for covered persons to use specific Providers, services, prescription drugs, or service sites
- Controlled access to and coordination of Health Care Services by a case manager
- Payor efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care

Managed Health Care Plan (MHCP) — A policy, contract, certificate, or agreement offered or issued by a Health Care insurer, Provider service network or a plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of Health Care Services, except as otherwise provided in this subsection. A MHCP either requires a covered person to use, or creates incentive, including financial incentives, for a covered person to use Health Care Providers managed, owned, under contract with or employed by the Health Care insurer.

Maternity/Pregnancy Related — Any condition that is related to pregnancy. Maternity care includes prenatal and postnatal care and care for the complications of pregnancy, such as ectopic pregnancy, spontaneous abortion (miscarriage), elective abortion, or C-section.

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

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

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

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

Medically Necessary, Medical Necessity — *Medical Necessity* or *Medically Necessary* means Health Care Services determined by a Provider, in consultation with the health insurance carrier, to be appropriate or necessary, according to:

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

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

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

Mental Health — A clinically significant behavioral or psychological syndrome or condition that causes distress and disability and for which improvement can be expected. Mental Health does not include Developmental Disabilities, autism or Autism Spectrum Disorders, drug or Alcohol Abuse, or Learning Disabilities. Treatment programs are not subject to limited days, or dollar limits, as long as they are Medically Necessary and have been Prior Authorized. Mental Health conditions that respond to and require long-term treatment with medications and/or therapeutic treatment such as schizophrenia, bi-polar disorder, and chronic depression are also covered.

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

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

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

Noncontracting Allowable Amount — See definition of *Covered Charge* earlier in this section.

Nonparticipating Provider — An appropriately licensed Health Care Provider that has **not** Contracted directly with a BCBS Plan to be a part of the BCBS HMO-Participating Provider Network.

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

- Morbid Obesity.- A body mass index (BMI) equal to or greater than 40 kg/m^2.
- A BMI equal to or greater than 35 kg/m^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

Obstetrician-Gynecologist — A Physician (OB-GYN) who is eligible to be or who is board certified by the American board of Obstetricians and Gynecologists or by the American College of Osteopathic Obstetricians and Gynecologists.

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

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

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

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

OSI — The Office of Superintendent of Insurance.

Other Providers — Clinical Psychologists and the following masters-degreed psychotherapists (an independently licensed Professional Provider with either an M.A. or M.S. degree in psychology or counseling): licensed Independent Social Workers (L.I.S.W.); licensed professional clinical Mental Health counselors (L.P.C.C.); masters-level Registered Nurse certified in psychiatric counseling (R.N.C.S.); licensed marriage and family therapist (L.M.F.T.). For Substance Use Disorder services, a Provider also includes a licensed Alcohol and Drug Abuse counselor (L.A.D.A.C.).

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

Out-of-Pocket Limit — The maximum amount of Deductibles, Coinsurance, and Copayments for HMO-Participating Provider or for Nonparticipating Provider services that you pay for most Covered Services in a Plan Year. After the applicable Out-of-Pocket Limit is reached, this plan pays **100 %** of your HMO-Participating Provider Covered Charges for the rest of that Plan Year, not to exceed any benefit limits.

Outpatient Services — Medical/Surgical Services received in the outpatient department of a Hospital, observation room, emergency room, Ambulatory Surgical Facility, freestanding Dialysis Facility, or other covered outpatient treatment Facility. Outpatient care includes partial hospitalization (a nonresidential program that includes from 5-12 hours of continuous Mental Health or Substance Use Disorder care during any 24 hour period in a treatment Facility).

Outpatient Surgery — Any Surgical Services that are 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.

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

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

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

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

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

Plan Year — A Plan Year is a period of one year which begins on the contract date/contract anniversary and ending on the day before the next contract anniversary. Please contact your employer for Plan Year information.

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

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

Practitioner of the Healing Arts — Any person holding a license or certificate authorizing the licensee to offer or undertake to diagnose, treat, or operate on, or prescribe for any human pain, injury, disease, deformity, physical, or Mental Health condition pursuant to:

- The Chiropractic Physician Practice Act

- The Dental Health Act
- The Medical Practice Act
- The Acupuncture and Oriental Medicine Practice Act

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

Primary Care Provider (PCP) — A Health Care professional who, within the scope of their license, supervises, coordinated, and provides initial and basic care to covered persons, who initiates their referral for specialist care, and who maintains continuity of patient care. Primary Care Providers shall include but not be limited to general practitioners, family practice, Physicians, internists, pediatricians, and Obstetricians-Gynecologists, Physician Assistants and nurse practitioners. Pursuant to 13.10.21.7 NMAC, other Health Care professionals may also serve as primary care practitioners.

Prior Authorization — A voluntary or mandatory pre-service determination, including a Recommended Clinical Review, that a health insurer makes regarding your eligibility for services, based on Medical Necessity, the appropriateness of site of services, and the terms of your plan.

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

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

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

Provider — A licensed Health Care professional, Hospital or other Facility authorized to furnish Health Care Services.

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

Network Provider: A Network Provider agrees to provide Health Care Services to Members with an expectation of receiving payment (other than Copayments, Coinsurance or Deductible) directly or indirectly from BCBSNM (or other entity with whom the Provider has Contracted). A Network Provider agrees to bill BCBSNM (or other contracting entity) directly and to accept this plan's payment (provided in accordance with the provisions of the contract) plus the Member's share (Coinsurance, Deductibles, Copayments, etc.) as payment in full for Covered Services. BCBSNM (or other contracting entity) will pay the Network Provider directly. BCBSNM (or other contracting entity) may add, change, or terminate specific Network Providers at its discretion or recommend a specific Provider for specialized care as Medical Necessity warrants**.**

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

Nonpreferred Provider: Providers that have not Contracted with BCBSNM, either directly or indirectly (for example, through another BCBS Plan). These Providers may have *participating-only* or *HMO* Provider agreements, but are not considered Preferred Providers and are not eligible for Preferred Provider coverage under your health plan - unless listed as an exception under *Exceptions for Nonpreferred Providers*.

Participating Pharmacy: A retail supplier that has Contracted with BCBSNM or its authorized representatives to dispense prescription drugs and medicines, insulin, diabetic supplies, and nutritional products to Members covered under the drug plan portion of this plan and that has contractually accepted the terms and conditions as set forth by BCBSNM and/or its authorized representatives. Some Participating Pharmacies are Contracted with

BCBSNM to provide specialty drugs to Members; these pharmacies are called *Specialty Pharmacy Providers* and some drugs must be dispensed by these Specialty Pharmacy Providers in order to be covered.

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

PPO Specialist: A Practitioner of the Healing Arts who is in the Preferred Provider Network -but does not belong to one of the specialties defined above as being for a *primary preferred provider* (or *PPP*).

Preferred Provider: A Provider who has Contracted with BCBSNM as a Preferred Provider but does not practice in one of the primary preferred provider medical specialties.

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

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

QCMSO — A Qualified Child Medical Support Order.

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

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

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

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

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

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

Residential Treatment Center — A Facility offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, and structure 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 availability and on-site nursing care and supervision for at least one shift a day with on call availability for other shifts.

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

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

Routine Newborn Care — Care of a Child immediately following 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

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

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

Routine Screening Colonoscopy/Mammogram — Tests to screen for occult colorectal and/or breast cancer in persons who, at the time of testing, are not known to have active cancer of the colon or breast, respectively. (If there is a history of colon or breast cancer, for the purposes of the *Preventive Services* benefit, a cancer is no longer active if there has been no treatment for it and no evidence of recurrence for the previous three years.) Routine screening tests are performed at defined intervals based on recommendations of national organizations as summarized in the BCBSNM Preventive Care Guidelines. Routine screening tests do not include tests (sometimes called *surveillance testing*) intended to monitor the current status or progression of a cancer that is already diagnosed.

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

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

Service Area — The geographic area where BCBSNM is authorized to provide services as a Health Maintenance Organization, which is state-wide and includes all counties in New Mexico.

Short-Term Rehabilitation — Inpatient, outpatient, office-and home-based occupational, physical, and Speech Therapy techniques that are Medically Necessary to restore and improve lost bodily functions following illness or

Accidental Injury. (This does not include services provided as part of an approved home health or Hospice Admission, which are subject to separate benefit limitations and exclusions, and does not include Alcohol or Drug Abuse rehabilitation.)

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

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

- Is licensed in accordance with state or local law
- 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 Care or educational care

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

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

Special Enrollment — When an otherwise eligible employee or Eligible Family Member did not enroll in the plan when initially eligible, there are certain instances (or *qualifying events*) during which the employee and their Eligible Family Members, if any, may enroll in the plan at a later date - or more than 31 days after becoming eligible - and not considered Late Applicants. The *Special Enrollment* period is the period of time during which an otherwise Late Applicant may apply for coverage outside the annual open enrollment period.

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

Specified Sex-Trait Modification Procedures — Any pharmaceutical or surgical intervention that is provided for the purpose of attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex either by: (1) intentionally disrupting or suppressing the normal development of natural biological functions, including primary or secondary sex-based traits; or (2) intentionally altering an individual's physical appearance or body, including amputating, minimizing or destroying primary or secondary sex-based traits such as the sexual and reproductive organs. Such term does not include procedures undertaken (1) to treat a person with a medically verifiable disorder of sexual development, or (2) for purposes other than

attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex.

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

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

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

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

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 the health insurance carrier.

Supplemental Breast Examination – A Medically Necessary and clinically appropriate examination of the breast using breast magnetic resonance imaging of 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.

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

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

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

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

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

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

Totally Disabled — With respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a similarly situated person who is in good health.

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

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

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

- The life or health of the covered person would otherwise be jeopardized
- The covered person's ability to regain maximum function would otherwise be jeopardized
- In the opinion of a Physician with knowledge of the covered person's medical condition, delay would subject the covered personal to severe pain that cannot be adequately managed without care or treatment
- The medical exigencies of the case require expedited care
- The covered person's Claim otherwise involves Urgent Care

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

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

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

SECTION 11: CONTINUATION COVERAGE RIGHTS UNDER COBRA

This notice contains important information about your possible right to COBRA continuation coverage, which is a temporary extension of coverage under this Group Health Care Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), for certain larger Group employers. COBRA continuation coverage may be available to you and to other members of your family who are covered under the Health Care plan when you would otherwise lose your Group health coverage. Contact your employer to determine if you or your Group are eligible for COBRA continuation coverage.

This notice generally explains:

- COBRA continuation coverage
- When it may become available to you and your family if your Group is subject to the provisions of COBRA
- What you need to do to protect your right to receive it

This notice gives only a summary of COBRA continuation coverage rights. For more information about the rights and obligations under the plan and under federal law, contact the plan administrator or see *Section 2: Enrollment and Termination Information* of this Benefit Booklet.

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

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of Health Care plan coverage when coverage would otherwise end because of a life event known as a *qualifying event*. Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a *qualified beneficiary*. A qualified beneficiary is someone who will lose coverage under the Health Care plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, Domestic Partners (if your employer has chosen to extend continued coverage to them), and eligible children of employees may be qualified beneficiaries. Under the plan, generally most qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Contact the employer and/or COBRA administrator for specific information for your plan.

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

- Your hours of employment are reduced
- Your employment ends for any reason other than your gross misconduct

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

- Your spouse dies
- Your spouse's hours of employment are reduced
- Your spouse's employment ends for any reason other than 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 (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 of these cases, you must make sure that the plan administrator is notified of the second qualifying event **within 60 days** of the second qualifying event. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

IF YOU HAVE QUESTIONS

If you have questions about COBRA continuation coverage, contact the plan administrator or the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

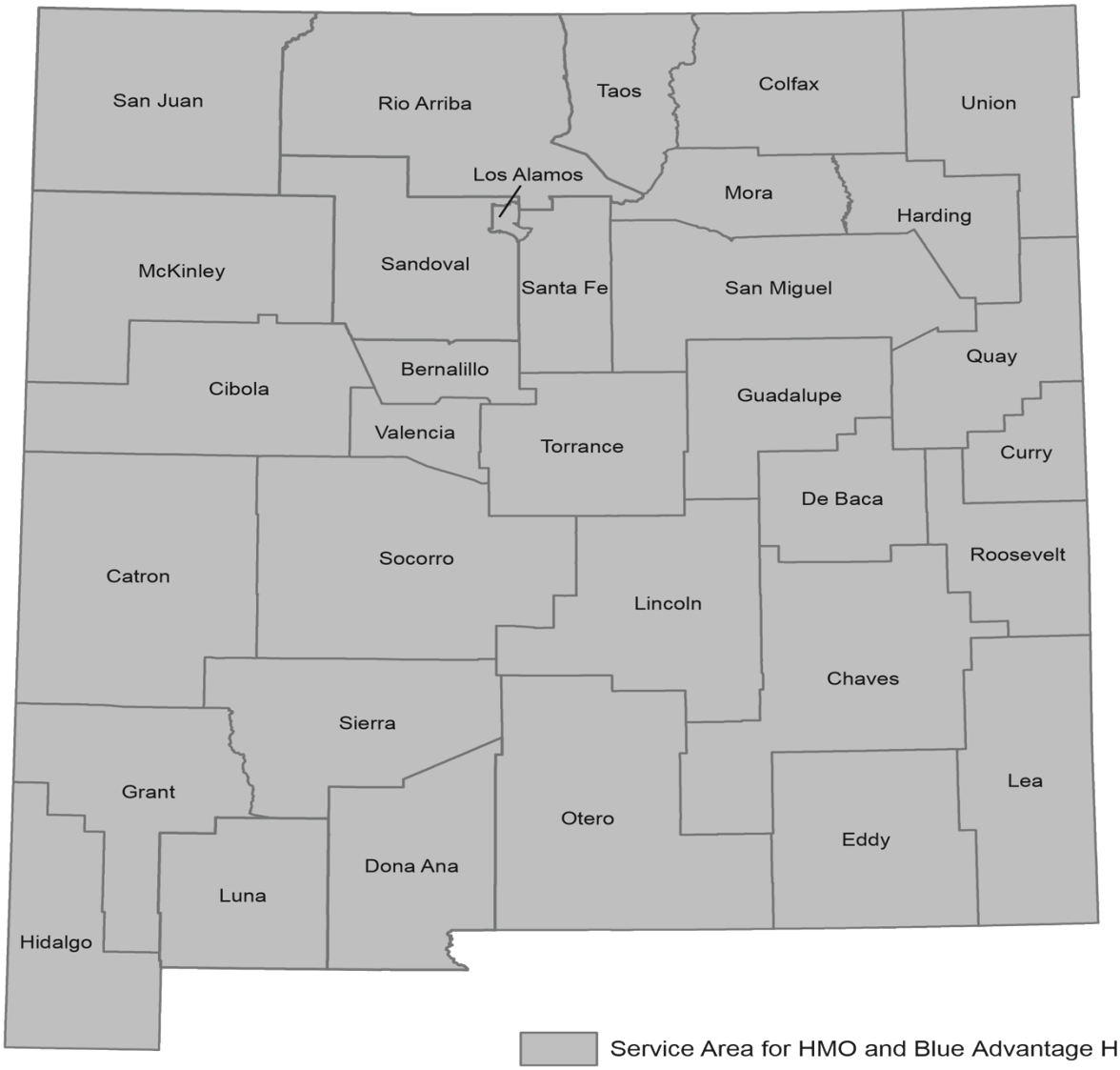
In order to protect your family's rights, you should keep the plan administrator informed of any changes in the addresses of family Members. You should also keep a copy, for your records, of any notices you send to your plan administrator.

PLAN CONTACT INFORMATION

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

BlueCross BlueShield of New Mexico

New Mexico HMO Service Area



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

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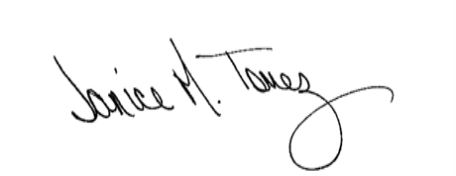
6 Tier Copayment Drug Plan Rider for Group HMO Coverages

BlueCross BlueShield of New Mexico

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

By:



Janice Torrez, President

Blue Cross and Blue Shield of New Mexico

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Definitions

Brand-Name Drug — A drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand-Name Drug. There may also be situations where a drug's classification changes from Generic to Preferred or Nonpreferred Brand-Name due to a change in the market resulting in the Generic Drug being a single source, or the drug product database information changing, which would also result in a corresponding change to your payment obligations from Generic to Preferred or Nonpreferred Brand-Name. These classification changes will occur no more frequently than every 120 days.

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

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

Drug List — A list of all drugs that are covered under the *Covered Medications and Other Items* section of this rider. A current list is available on our website at:

myprime.com/content/dam/prime/memberportal/WebDocs/2026/Formularies/HIM/2026_NM_6T_HIE.pdf

You may also contact a customer service representative at the telephone number shown on the back of your identification card for more information.

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

Generic Drug — A drug that has the same active ingredient as a Brand-Name Drug and is allowed to be produced after the Brand-Name Drug's patent has expired. In determining the brand or generic classification for covered drugs, BCBSNM uses the generic/brand status assigned by a nationally recognized provider of drug product database information. Authorized generic drugs, may be identified as a *generic* by the drug product database, manufacturer, or Pharmacy, but they are not considered *generic* for coverage purposes. Generic Drugs are identified within the Drug List which is available on the BCBSNM website at (you may also contact a customer service advocate for more information):

myprime.com/content/dam/prime/memberportal/WebDocs/2026/Formularies/HIM/2026_NM_6T_HIE.pdf

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.

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 disease etc.) or if you have not filled one of these

medications within 120 days, you may receive a partial (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 and/or Coinsurance after your Deductible will be adjusted to align with the quantity of medication dispensed. If the medication is working for you and your physician wants you to continue on 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 the www.bcbsnm.com/rx-drugs/pharmacy/pharmacy-programs website.

Nonpreferred Brand-Name Drug — A covered Brand-Name Drug product or other item that is identified on the Drug List as nonpreferred and is subject to the Nonpreferred Brand-Name Drug tier payment level. The Drug List is available by accessing the website at:

myprime.com/content/dam/prime/memberportal/WebDocs/2026/Formularies/HIM/2026_NM_6T_HIE.pdf

Nonpreferred Generic Drug — A covered Generic Drug product or other item that is identified on the Drug List as nonpreferred and is subject to the Nonpreferred Generic Drug tier payment level. The Drug List is available by accessing the website at:

myprime.com/content/dam/prime/memberportal/WebDocs/2026/Formularies/HIM/2026_NM_6T_HIE.pdf

Nonpreferred Specialty Drugs — A Specialty Drug, which may be Generic or Brand Name Drug, that is identified on the Drug List as a Nonpreferred Specialty Drug and is subject to the Nonpreferred Specialty Drug payment level. The Drug List is available by accessing the website at:

myprime.com/content/dam/prime/memberportal/WebDocs/2026/Formularies/HIM/2026_NM_6T_HIE.pdf

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 should be purchased by these specially contracted providers in order to be receive maximum benefits.

Permitted Premium Payments — Premium payments from:

- The member
- The member's family
- Required entities (the entities the law requires Blue Cross and Blue Shield to accept premium payments for this policy from, which as of the coverage date currently are Ryan White HIV/AIDS programs, under title XXVI of the Public Health Service Act, Indian tribes, tribal organizations and urban Indian organizations; and State and Federal programs, as described in 45 C.F.R. § 156. 1250)
- Private non-profit foundations that make premium assistance available to the member:
  - For the entire coverage period of the member's policy
  - Based solely on financial criteria
  - Regardless of the member's health status
  - Regardless of which insurance issuer and/or benefit plan the applicant chooses. Blue Cross and Blue Shield does not accept premium payments from any other third party, which are referred to in this policy as *Prohibited Third Party Premium Payments*

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

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

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

myprime.com/content/dam/prime/memberportal/WebDocs/2026/Formularies/HIM/2026_NM_6T_HIE.pdf

Preferred Generic Drug — A covered Generic Drug product or other item that is identified on the Drug List as preferred and is subject to the Preferred Generic Drug tier payment level. The Drug List is available by accessing the website at:

myprime.com/content/dam/prime/memberportal/WebDocs/2026/Formularies/HIM/2026_NM_6T_HIE.pdf

Preferred Participating Pharmacy — A Participating Pharmacy which has a written agreement with BCBSNM to provide pharmaceutical services to members or an entity chosen by BCBSNM to administer its Prescription Drug program that has been designated as a *Preferred Participating Pharmacy*.

Preferred Specialty Drugs — A Specialty Drug, which may be a Generic or Brand Name Drug, that is identified on the Drug List as a Preferred Specialty Drug and is subject to the Preferred Specialty Drug payment level. The Drug List is available by accessing the website at:

myprime.com/content/dam/prime/memberportal/WebDocs/2026/Formularies/HIM/2026_NM_6T_HIE.pdf

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*.)

Prohibited Third Party Premium Payments — See definition of Permitted Premium Payments.

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

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 — Specialty Drugs are used to treat complex medical conditions, and are typically given by injection, but may be topical or taken by mouth. They also often require careful adherence to treatment plans, may have special handling or storage requirements, and may not be stocked by retail pharmacies. Some conditions such as hepatitis C, hemophilia, multiple sclerosis, and rheumatoid arthritis are treated with Specialty Drugs. In order to receive maximum benefits, these drugs should be purchased through an in-network specialty Pharmacy. Specialty Drugs, when covered, are subject to the Deductible (if applicable), and when the Deductible (if applicable) is met,

the applicable payment level applies according to the tier structure of the drug plan noted in your *Summary of Benefits and Coverage* (SBC) see *Member Copayments* 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:

myprime.com/content/dam/prime/memberportal/WebDocs/2026/Formularies/HIM/2026_NM_6T_HIE.pdf

How the Prescription Drug Program Works

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

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

NOTE: Prescription drugs that are approved by the FDA through the accelerated approval program may be considered Experimental/Investigational and may not be covered.

Positive changes (e.g., adding drugs to the Drug List, drugs moving to a lower payment tier) occur quarterly after review by the committee. Changes to the Drug List that could have an adverse financial impact to you (e.g., drug exclusion, drug moving to a higher payment tier, removal of a drug from the formulary, reclassification of a drug from a preferred to a non-preferred tier), occur no more frequently than quarterly. Unless a generic version of the Prescription Drug becomes available, we will not make another modification to coverage for the same prescription drug for at least one hundred twenty days. Adverse change to drugs requiring step therapy, prior authorization, or quantity limit occur no more frequently than annually. However, if a drug deemed unsafe by the FDA or has been removed from the market for any reason, changes to the Drug List may occur more frequently.

NOTE: At least sixty (60) days' advance written notice will be provided when one of the following changes will be made to the Drug List:

- Reclassification of a drug to a higher tier
- Reclassification of a drug from Preferred to Non-preferred, unless that drug moves to a lower tier
- An increase in cost-sharing, copayment, Deductible, or coinsurance for a drug
- Removal of a drug from the Drug List
- Addition of a Prior Authorization requirement
- Imposition or modification of a quantity limit for a drug

You will be notified of adverse changes, and the Drug List and any modifications will also be made available to you. You will be able to determine the Drug List that applies to you and whether a particular drug is on the Drug List by calling the customer service toll-free number on your identification card or accessing the BCBSNM website at:

myprime.com/content/dam/prime/memberportal/WebDocs/2026/Formularies/HIM/2026_NM_6T_HIE.pdf

All drugs listed on the Drug List are covered unless specifically 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 provide*r, 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 cosmetic, etc.).

Covered Medications and Other Items

The following drugs, supplies, and other products are covered only when dispensed by a Preferred Participating Pharmacy or a Participating Pharmacy under the Preferred Network 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. (**NOTE:** Prescription contraceptive devices fitted or inserted by, and purchased directly from, a physician are payable under the *Family Planning* benefit, if any, or the medical portion of your health care benefits plan.)
- Select 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/rx-drugs/pharmacy/find-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 should be acquired through BCBSNM's designated Specialty Pharmacy provider in order to receive maximum benefits.
- Insulin, glucagon, prescriptive oral agents for controlling blood sugar levels, and insulin needles, syringes, and other diabetic supplies (e.g., glucagon emergency kits, autolets, lancets, lancet Devices, blood glucose and visual reading urine and ketone test strips). (There is a separate Copayment amount due for each item purchased. These items are **not** covered as a supply or medical equipment expense under the medical portion of your health care benefits plan. See *Supplies, Equipment, and Prosthetics* in your *Benefit Booklet* for a list of diabetic equipment that *is* covered under the medical portion of your health care benefits plan.) **NOTE:** Durable medical equipment is **not** excluded for individuals with diabetes.
- Special Medical Foods for Genetic Inborn Errors of Metabolism consistent with NMSA 59A-22-41.1.
- Treatment with FDA-approved Prescription Drugs (including prescription and over-the-counter medications) for two 90-day treatment regimens when prescribed by a health provider without prior authorization to assist you with quitting tobacco use or smoking. Also included is the following without cost-sharing.
- Screening for tobacco use; and for those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering cessation attempt includes coverage for four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization.
- One product from each of the following categories are covered without cost-sharing for smoking cessation treatment when prescribed by a health provider:
    - Nicotine gum
    - Nicotine patch
    - Nicotine lozenge
    - Nicotine oral or nasal spray
    - Nicotine inhaler
    - Bupropion
    - Varenicline

NOTE: Covered Services for vaccines, diagnostic testing, and treatment for COVID-19 will be provided at no cost to you, to the fullest extent required by applicable law.

Prior Authorization

Certain Prescription Drugs may require prior authorization from BCBSNM. A list of drugs requiring prior authorization is on the BCBSNM website at:

myprime.com/content/dam/prime/memberportal/WebDocs/2026/Formularies/HIM/2026_NM_6T_HIE.pdf

Providers and members can obtain the prior authorization form by calling customer service at 1-800-432-0750 or through the website: myprime.com/en/forms/coverage-determination/prior-authorization.html. Your physician can request the necessary prior authorization.

NOTE: Prior Authorization requirements do not apply to covered prescription drugs for the treatment of substance use disorders, an auto-immune disorder, cancer, or a Rare Disease, when determined to be Medically Necessary, except when a biosimilar, interchangeable biologic, or 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 requires that the member has tried and failed prerequisite medication(s) before the plan will consider coverage of a targeted drug. A prerequisite drug is recognized as safe and works well in treating a specific medical condition, as well as being a cost-effective treatment option. A targeted drug is a less preferred or likely a more costly treatment option. If the member and his/her doctor decide that a prerequisite drug is not right for the member or is not as good in treating member's condition, the doctor should submit a request for coverage of the targeted drug. For additional information, please refer to the **Exceptions Process** section below.

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 therapeutic effect of the drug.

You should submit a prescription order to a Participating Pharmacy for one of these targeted medications, the pharmacist will be alerted if the online review of your prescription claims history indicates a prerequisite medication has not been previously tried. A list of step therapy medications is available to you and your health care practitioner on our website at: www.bcbsnm.com/rx-drugs/pharmacy/pharmacy-programs or contact customer service at 1-800-432-0750.

NOTE: Step therapy requirements do not apply to covered prescription drugs for the treatment of substance use disorders, an auto-immune disorder, cancer, or to covered prescription drugs for off-label use to treat a Rare Disease, when determined to be Medically Necessary, except when a biosimilar, interchangeable biologic, or generic version is available. Standard Medical Necessity determinations will be made by a health care professional from the same or similar 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.

Synchronization of Prescriptions

You will be able to synchronize your Prescription Drug refills for certain covered maintenance medications so that they are refilled on the same schedule for any given time period. When necessary to permit synchronization, BCBSNM will prorate daily cost-sharing rate to any covered maintenance medication dispensed by a Participating Pharmacy. Some prescriptions may be subject to a shorter refill window. Please call customer service at 1-800-432-0750 for details.

Benefits for Orally Administered Anticancer Medications

Benefits are available for medically necessary orally administered anticancer medication that is used to kill or slow the growth of cancerous cells. No Deductible, Copayment or Coinsurance amount will apply to orally administered anticancer medications when received from a Participating Pharmacy. However, for members enrolled in an HSA plan, the Deductible must be met first before the Copayment or Coinsurance will be waived for anticancer medications when received from a Participating Pharmacy consistent with how intravenously administered anticancer drugs are covered under the medical benefit. Coverage of prescribed orally administered anticancer medications when received from a Nonpreferred Specialty Pharmacy provider or Nonparticipating Pharmacies will be provided on a basis no less favorable than intravenously administered or injected cancer medications. If you have questions about your benefits for orally administered anticancer medications, you may contact customer service at the toll-free number on your ID card.

Benefits for Preventive Medications

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

Benefits for Contraceptive Drugs and Devices

Covered contraceptive drugs and devices are posted on the BCBSNM website www.bcbsnm.com/nm/documents/rx-drugs/member-contraceptive-list-nm.pdf. You may also refer to your Benefit Booklet, or contact customer service at the toll-free number on your ID card if you have other questions about covered contraceptive drugs and devices.

Additionally, the following will be covered with no Coinsurance, Deductible, Copayment, or benefit maximums:

- At least one Generic Drug, therapeutic equivalent or medically necessary alternative in each category of contraception approved by the FDA
- Up to a 6-month supply of contraceptives, 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 the ID card to request an expedited review.

To receive benefits for covered contraceptives that do not require a prescription, when not obtained from a Participating Pharmacy, you must pay for the purchase in full and then submit a claim directly to the BCBSNM Pharmacy Benefit Manager, Prime Therapeutics. You can obtain the necessary claim form from a customer service advocate or on the BCBSNM website. Benefits for over-the-counter contraceptives are available for up to a 30-day supply, during any 30-day period.

New-to-Market FDA Approved Drugs

New-to-Market FDA Approved Drugs are subject to review by Primes Therapeutics Pharmacy & Therapeutics (P&T) Committee prior to coverage of the drug.

Preferred Pharmacy Network

Your drug plan provides access to the pharmacies in the Preferred network. All covered must be purchased from a Preferred Participating Pharmacy or a Participating Pharmacy unless there is an emergency (as defined in your

benefit booklet). For a list of Preferred Participating Pharmacies and Participating Pharmacies, call customer service at the phone number on the back of your ID card and request a provider directory — or visit the BCBSNM website at www.bcbsnm.com/rx-drugs/pharmacy/find-a-pharmacy. The pharmacies that are participating in the BCBSNM Preferred Network may change from time to time. You should check with your Pharmacy before obtaining drugs or supplies to make certain of its participation status.

You must present your BCBSNM ID card to the pharmacist at the time of purchase to receive this benefit.

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

Upon receipt of a notice of claim, BCBSNM will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

NOTE: In order to receive maximum benefits, Specialty Drugs should be purchased from an in-network Specialty Pharmacy.

You can use your ID card to purchase covered items only for yourself and covered family members. When coverage for you or a family member ends under the medical portion of your health care benefits plan, the ID card may not be used to purchase drugs or other items for the terminated member(s). If you do not have your ID card with you or if you purchase your drug or other item from an out-of-network retail Pharmacy you must pay for the purchase in full and then submit a claim directly to the BCBSNM Pharmacy Benefit Manager, Prime Therapeutics, at the address below (do not send to BCBSNM). If not included in your enrollment materials, you can obtain the necessary claim forms from a customer service advocate or on the BCBSNM website.

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 plan. Claim forms may be obtained on the BCBSNM website at: bcbsnm.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 Preferred Pharmacy Network only. In some cases, you may be asked to provide proof of continued enrollment eligibility under the Preferred Pharmacy Network.) Only up to one 90-day supply override may be allowed each calendar year.

Specialty Pharmacy Program

This program provides delivery of medications directly to your Health Care Practitioner, administration location or to your home if you are undergoing treatment for a complex medical condition. To determine which drugs are Specialty Drugs, you should refer to Prescription Drug Section on the Plan's website at:

www.bcbsnm.com/nm/documents/rx-drugs/specialty-drug-list-nm.pdf or call the customer service toll-free number on your identification card. This drug plan covers only those Specialty Drugs that are listed on the Drug List. The Drug List can be obtained from a customer service advocate by calling the phone number on the back of your ID card or is on the BCBSNM website at:

myprime.com/content/dam/prime/memberportal/WebDocs/2026/Formularies/HIM/2026_NM_6T_HIE.pdf

Your cost for Specialty Drugs is indicated under the *Member Copayments and Coinsurance* section below and you will be responsible for the Copayments, any pricing differences when applicable, non-covered Specialty Drugs, and other limited or noncovered services that may apply to your coverage.

An example of the cost for Specialty Drugs is indicated under the *Member Copayments* section below and you will be responsible for any pricing differences when applicable, noncovered Specialty Drugs, and other limited or noncovered services that may apply to your coverage.

MedsYourWay™

MedsYourWay™ (*MedsYourWay*) is a program that automatically compares participating 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 select in network retail pharmacies.

Not all in-network retail pharmacies participate in drug discount card programs and not all drug discount card programs are participating under MedsYourWay. Arrangements between participating in-network retail pharmacies and the participating drug discount card programs control the selection of available drug discounts, which are subject to change.

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.

If the discount available through the participating drug discount card program is lower than the amount you would pay under your benefit plan, your out-of-pocket cost will reflect the full discount available through the drug discount card program. The full amount you paid for the prescription will be applied to your Deductible and out-of-pocket maximum, if applicable. 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 your Customer Service Representative at the toll-free telephone number on the back of your Identification Card.

For additional information regarding MedsYourWay, please contact a Customer Service Representative at the toll-free telephone number on the back of your Identification Card.

Mail Order Service

All items that are covered under the mail order service are subject to the same limitations and exclusions as the Preferred Pharmacy Network. To use the mail order service, follow the instructions outlined in the materials provided to you in your enrollment packet. (If you do not have this information, call a customer service advocate.) **NOTE:** Prescription Drugs and other items may **not** be mailed outside the United States.

IMPORTANT: Specialty Drugs are not covered through the mail order service. You must use a specialty Pharmacy provider designated by BCBSNM in order to receive benefits for Specialty Drugs.

Member Deductible and Copayments

For covered Prescription Drugs, insulin, diabetic supplies, and nutritional products, you pay the applicable tiered Copayment (see below), not to exceed the actual retail price, for each prescription filled or item purchased (not to exceed supply limitations described below).

NOTE: 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.

See your *SBC* for your Copayment amounts.

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

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

When you go to a Preferred Participating Pharmacy or a Participating Pharmacy, you must pay any Copayment, and any applicable pricing differences. Pursuant to New Mexico law, the calculation of your cost-sharing obligation for covered Prescription Drugs will be credited for the full value of any discounts provided or payments made by third parties at the time of the claim. Your cost-sharing obligation at the time of the claim includes any applicable copayment, coinsurance, Deductible, out-of-pocket maximum, or combination thereof. If the covered drug is subject to a manufacturer rebate, the amount you will pay at the point of sale will be reduced by the value of the rebate from the manufacturer to Prime. If the value of the Prescription Drug rebate exceeds the applicable copayment/coinsurance, the remainder of the rebate from that transaction will be credited to BCBSNM. The value of Prescription Drug rebates do not apply to your out-of-pocket maximum.

NOTE: If you participate in a High Deductible Health Plan, you must satisfy your plan's Deductible before discounts and rebate credits will be applied at the point of sale. You may be required to pay for limited or noncovered services. No claim forms are required. If you are unsure whether a Pharmacy is a Preferred Participating Pharmacy or a Participating Pharmacy, you may access the website at: www.bcbsnm.com/rx-drugs/pharmacy/find-a-pharmacy or contact customer service at the toll-free number on your ID card.

In-network

Pharmacy claims apply to in network Copayment amounts paid at an in-network Pharmacy would only apply to your in-network out-of-pocket limit.

Out-of-network

Pharmacy claims from an out-of-network Pharmacy apply to out-of-network Copayment amounts paid at an out-of-network Pharmacy would only apply to your out of network out-of-pocket limit. Any additional charge for using an out-of-network Pharmacy will not apply to your out-of-pocket amounts.

How Member Payment is Determined

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

- **Tier 1** includes mostly Preferred Generic Drugs and may contain some Brand Name Drugs.
- **Tier 2** includes mostly Nonpreferred 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 Nonpreferred 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 Nonpreferred Specialty Drugs and may contain some Generic Drugs.

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

To verify your payment amount for a drug, visit www.bcbsnm.com and log into Blue Access for Members or call the number on the back of your ID card. Benefits will be provided as shown on the *Summary of Benefits and Coverage (SBC)* of this policy.

For additional information, please refer to your Prescription Drug Section as shown on the *Summary of Benefits and Coverage* (SBC) of this policy.

See your *Summary of Benefits* for the drug plan Copayment option that corresponds to the health benefits plan you have chosen.

Except as may be specified elsewhere in this rider, drugs and supplies must be purchased from a Preferred Participating Pharmacy, a BCBSNM designated specialty Pharmacy provider, or BCBSNM designated mail order service vendor in order to be covered under your drug plan.

For example, if the health benefits plan you chose features this option: $0/$10/$50/$100/$150/$250		
Six-Tier Plan	Tier	Copay Amount
Preferred Participating Pharmacy Retail Pharmacy Up to a 30-day supply. Extended Supply (if allowed by the Prescription order) up to a 90-day supply. Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.	Tier 1[1]	$0 Copayment
	Tier 2[1]	$10 Copayment
	Tier 3[1,2]	$50 Copayment
	Tier 4[1,2]	$100 Copayment
Nonpreferred Participating Pharmacy Retail Pharmacy One Copayment amount up to a 30-day supply.	Tier 1[1]	$10 Copayment
	Tier 2[1]	$20 Copayment

	Tier 3[1,2]	$70 Copayment
	Tier 4[1,2]	$120 Copayment
Specialty Pharmacy Program 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[1,2]	$150 Copayment
	Tier 6[1,2]	$250 Copayment
[1] Deductible may Apply [2] For all Brand-Name Drugs with an FDA-approved generic equivalent, if you or your provider order the brand-name, you will pay the Copayment, PLUS the difference in cost between the Brand-Name Drug and its generic equivalent.		
Select vaccinations received from certain Participating Pharmacies. For a list of covered vaccinations see your Drug List at: www.myprime.com/content/dam/prime/memberportal/WebDocs/2026/Formularies/HIM/2026_NM_6T_HIE.pdf (For a list of Pharmacies that are contracted with BCBSNM to provide this service, go to the BCBSNM website at www.bcbsnm.com/rx-drugs/pharmacy/find-a-pharmacy).	No Copayment	
Certain Prescription Drugs for treatment of mental illness, behavioral health, and substance use disorders from Participating Pharmacies. For more information, please see your Drug List at: www.myprime.com/content/dam/prime/memberportal/WebDocs/2026/Formularies/HIM/2026_NM_6T_HIE.pdf.	**No Copayment**	
Mail Order Service (available for Tiers 1, 2, 3 and 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**.**	**3 times Copayment** for Tier 1, 2, 3 or 4 drugs. Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.	
Nonprescription Enteral Nutritional Products and Special Medical Foods (requires prior authorization)	**Coinsurance of 50%** of Covered Charges	

Under this drug plan, drugs are available at *tiered* Copayment levels. The benefits you receive and the amount you pay will differ depending upon the type of drugs, or diabetic supplies, or insulin and insulin syringes**,** or nutritional products obtained and whether they are obtained from or a BCBSNM-designated specialty Pharmacy provider**,** or BCBSNM designated mail order service vendor.

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.

When the Copayment for an item purchased under the drug plan is **greater** than the covered charge for the supply being purchased from a Participating Pharmacy, you pay the **least** of:

- Your Copayment.
- The Pharmacy's retail price.
- The covered charge (i.e., the BCBSNM-contracted rate). For claims submitted to the Pharmacy Benefit Manager for reimbursement, you are paid the **lesser** of:
  - The sum of the drug ingredient cost, the dispensing fee that would be payable to a Participating Pharmacy, and any sales tax minus the applicable member share.
  - The Pharmacy's retail price minus the applicable member share.

Supply Limitations

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

Program Type	Supply Maximum	Copayment Requirements
Nonprescription Nutritional Products	**30-day supply** during any 30-day period.	**Coinsurance of 50% of Covered Charges (includes prescriptions for Enteral Nutritional Products and Special Medical Foods as described under *Covered Drugs and Other Items*).**
Participating Retail Pharmacy and Specialty Pharmacy Provider	During each one-month period, a **30-day supply**.	**Copayment for a 30-day supply.**
Preferred Participating Retail Pharmacy	During each three-month period, up to 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.** Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.
Mail Order Service (Tiers 1, 2, 3, and 4 only)	During each three-month period, up to a **90-day supply**.	**Copayments for 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.

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. 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.

Controlled Substances

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

Drug Plan Exclusions

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

- Drugs/Products which are not included on the Drug List unless specifically covered elsewhere in this drug rider and/or such coverage is required in accordance with applicable law or regulatory guidance
- Prescription Drugs if there is an over-the-counter product available with the same active ingredient(s), in the same strength, unless otherwise determined by the plan
- Herbal or homeopathic preparations
- Administration or injection of any drugs, except select vaccinations as covered through your Pharmacy benefits
- 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.
- Noncommercially available compounded medications, regardless of whether or not one or more ingredients in the compound requires a prescription. Noncommercially available compounded medications are those made by mixing or reconstituting ingredient(s) in a manner or ratio that is inconsistent with United States Food and Drug Administration- approved indications provided by the ingredients' manufacturers).
- Replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced.
- Infertility medications such as: hormonal manipulation and excess hormones to increase the production of mature ova for fertilization.
- Over-the-counter products except as required to be covered under Affordable Care Act or as required by New Mexico state law.
- Drugs or other items for the treatment of sexual or erectile dysfunction devices.

- 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 nonmedicinal substances, artificial appliances, digital health technologies and/or applications or similar devices.
- 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) under the age of 11 or over the age of 39.
- Nonprescription Enteral Nutritional Products that are taken by mouth or delivered through a temporary nasoenteric tube (e.g., nasogastric, nasoduodenal, or nasojejunal tube), unless the patient meets criteria for Genetic Inborn Errors of Metabolism.
- Prescription Drugs in a drug class where there is an over-the-counter alternative available.
- Shipping, handling, or delivery charges.
- Appetite suppressants or diet aids; 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 determined to have inferior efficacy or significant safety issues.
- Covered drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under Workers' Compensation law.
- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of an identification card.
- Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under the medical portion of health care benefits plan, or for which benefits have been exhausted.
- Any Prescription Drug for which the FDA has determined its use to be contraindicated for the treatment of the particular condition for which the drug has been prescribed.
- Pharmaceutical, aids such as excipients found in the USP-NF (United States Pharmacopeia-National Formulary). An excipient is an inactive ingredient including, but not limited to, preservatives, solvents, ointment bases, and flavoring coloring diluting emulsifying and suspending agents.
- 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.
- Any self-administered drug dispensed by a health care provider.
- Prescription Drugs that have over-the-counter equivalents unless otherwise stated.
- Drugs that are not considered medically necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.
- Repackagers, institutional packs, clinic packs, or other custom packaging.

- Non-FDA approved Drugs.
- Bulk Powders.
- Diagnostic agents (except for diabetic testing supplies or test strips).
- Any portion of covered services or covered drugs paid for through Prohibited third-party payments.
- Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, Blue Cross and Blue Shield may limit benefits to only certain therapeutic equivalents/therapeutic alternatives. If you do not choose the therapeutic equivalents/therapeutic alternatives that are covered under your benefit, the drug purchased will not be covered under any Benefit level.
- New-to-market FDA-approved drugs which are subject to review by Prime Therapeutics Pharmacy and Therapeutic (P&T) Committee prior to coverage of the drug.

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

Exceptions Process

You or your provider can ask for a Drug List exception if your drug is not on the Drug List (also known as a formulary). Exceptions will be granted in the event the drug on the drug list has been or is reasonably expected to be less effective; or if the drug on the drug list has caused or is reasonably expected to cause adverse reactions. To request this exception, you or your provider can call the number on the back of your identification card to ask for a review. A determination will be made within 72 hours following receipt of the request and notice of the determination will be provided to the insured.

If you have a health condition that may jeopardize your life, health or keep you from regaining function, or your current drug therapy uses a noncovered drug, your provider may be able to ask for an expedited review process by marking the review as an urgent request. The plan will let you and your provider know the coverage decision within 24 hours after we receive your request for an expedited review.

If we do not deny a complete exception request within these timeframes, the request is automatically approved. If an exception request is granted, the plan will provide coverage of the drug for the duration of the prescription, including refills. If the coverage request is denied, the plan will let you and your provider know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination. For questions about grievance and appeal procedures, please see Section 8: 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.

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

All amounts payable to BCBSNM by employer for claim payments provided by BCBSNM under the Pharmacy benefit and applicable service charges pursuant to the terms of the agreement and all required, Deductible and Coinsurance amounts under the agreement shall be calculated on the basis of the Prescription Drug Program eligible charge or the agreed upon cost between the Participating Prescription Drug provider, and BCBSNM, whichever is less, except as otherwise mutually agreed to by the parties.

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

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

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

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

- You will have to pay the Coinsurance amount set out in this contract.
- For purposes of calculating your Coinsurance amount, the full amount of the Prescription Drug would be reduced by the discount. In our example, if the applicable discount were 20%, the $100 Prescription Drug bill would be reduced by 20% to $80 for purposes of calculating your Coinsurance amount.
- In our example, if your Coinsurance obligation is 5%, you will have to pay 5% of $80, or $4. You should note that your 5% Coinsurance amount is based upon the discounted amount of the prescription and not the full $100 bill.

The mail and specialty Pharmacy program is operated through a third party which may be an affiliate of or partially owned by Prime. Prime, for the administrative services that it provides as part of the mail-order and specialty pharmacy program, may keep as its fee a portion of the discounts and/or other allowances that it has negotiated with the mail-order and/or specialty pharmacy. 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.

BCBSNM pays Prime a Program Management Fee (PMF) on a per weighted claim basis. The amounts received by Prime from BCBSNM, pharmacies, manufacturers, or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to BCBSNM, administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. None of these fees will be passed on to you as expenses. The maximum that Prime has disclosed to BCBSNM that it will receive from any pharmaceutical manufacturer for manufacturer administrative fees is five and a half percent (5.5%) of the Wholesale Acquisition Cost (WAC) for all products of such manufacturer dispensed during any given calendar year to members of BCBSNM and other Blue Plan operating divisions or for which Claims are submitted to Prime at BCBSNM's request; provided, however, that BCBSNM will advise if such maximum has changed.

BCBSNM'S Separate Financial Arrangements with Pharmacy Managers

BCBSNM hereby informs you that it owns a significant portion of the equity of Prime and that BCBSNM has entered into one or more agreements with Prime or other entities (collectively referred to as *Pharmacy Benefit Managers*, or *PBMs*), for the provision of, and payment for, Prescription Drug benefits to all persons entitled to

Prescription Drug benefits under group health insurance policies and contracts to which BCBSNM is a party, including this contract. PBMs have agreements with pharmaceutical manufacturers to receive rebates for using their products.

The Pharmacy Benefit Manager(s) (PBM) negotiates rebate contracts with pharmaceutical manufacturers and has agreed to provide rebates made available pursuant to such contracts to the BCBSNM under the PBM's agreement with BCBSNM. This negotiation is conducted by the PBM for the benefit of BCBSNM and not for the benefit of the employer or covered persons. The PBM collects the rebates from the pharmaceutical manufacturers, for drugs covered under both the Prescription Drug program and medical benefit, and forwards the entire amount collected to BCBSNM (other than any interest or late fees earned on rebates received from manufacturers, which the PBM retains). Each year, BCBSNM will calculate a projection of the amount of rebates it expects to receive from the PBM. Such projections are referred to as the *Expected Rebates*. Expected Rebates are calculated based on a number of factors and projections for the Fee Schedule Period, such as employer specific demographics, retail, mail order and specialty Pharmacy utilization, cost of Prescription Drugs, the Plan's benefit design, and rebate arrangements entered into by the PBM, none of which BCBSNM directly controls. Additional information about rebates, the PBM and the Rebate Credit will be available upon request. The Rebate Credit provided at the point of sale will be provided from BCBSNM's own assets and may or may not equal the entire amount of rebates provided to BCBSNM by the PBM.

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

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 any portion of covered services or covered drugs paid for through Prohibited Third Party Premium Payments.

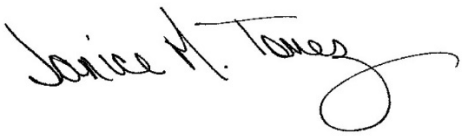
A message from:

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO

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

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

Sincerely,



Janice Torrez, President
Blue Cross and Blue Shield of New Mexico

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

THINGS YOU SHOULD KNOW

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

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

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

SCHEDULE OF BENEFITS

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

LOOKING UP INFORMATION

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

CURRENT DENTAL TERMINOLOGY (CDT)

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

PROOF OF LOSS

When BCBSNM receives a request for a Claim form or the notice of a Claim, BCBSNM will give the Member the Claim forms that we use for filing proof of loss. If the claimant does not receive these forms within 15 days after BCBSNM receives notice of Claim or the request for a Claim form, the claimant will be considered to meet the proof of loss requirements of this Plan if the claimant submits written proof of loss along with the character and the extent of the loss for which claim is made within 365 days after the date of the first service, except in the absence of legal capacity due to a serious health condition and unable to perform regular daily activities.

CUSTOMER SERVICE

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

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

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

HOW THIS DENTAL PLAN WORKS

BENEFIT PAYMENT FOR DENTAL SERVICES

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

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

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

HOW YOUR DENTAL COVERAGE WORKS

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

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

SELECTING A DENTIST

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

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

ALLOWABLE CHARGE

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

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

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

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

- Charges for any services which are not covered under this Dental Plan.

- Any Deductible and/or Coinsurance amounts which are applicable to your coverage.
- The difference, if any, between the Dentist's "billed charges" and the Allowable Charge for Covered Services.

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

BENEFIT PERIOD/POLICY YEAR

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

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

BENEFIT PERIOD MAXIMUM

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

DEDUCTIBLE REQUIREMENTS

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

COINSURANCE PERCENTAGE

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

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

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum amounts for Subscribers are shown on the ***Schedule of Benefits***. An Out-of-Pocket Maximum amount is the maximum amount of Deductible and Coinsurance that a Subscriber(s) pays for Covered Services received from a Participating Dentist during a Benefit Period. Once an Out-of-Pocket Maximum is paid, this Dental Plan will begin paying 100 percent of any Covered Charges received by such Subscriber(s) from a Participating Dentist for the rest of that Benefit Period, not to exceed any applicable benefit maximums.

CARE BY MORE THAN ONE DENTIST

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

PRETREATMENT ESTIMATE OF BENEFITS AND TREATMENT PLANS

A Pretreatment Estimate is a determination by BCBSNM before you receive certain specified services. It does not determine medical necessity, or guarantee coverage, instead Pretreatment Estimates identify this Dental Plan's

estimated financial liability **before** treatment is started. Such estimates are subject to change, according to the terms of your coverage, and may include an allowance for alternate Benefits (see "Alternate Benefits'' later in this section).

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

Responses to requests for Pretreatment Estimates will be delivered within five (5) business days.

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

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

ALTERNATE BENEFITS

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

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

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

BENEFIT PAYMENT FOR DENTAL SERVICES

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

Participating Dentists are Dentists who have signed an agreement with Blue Cross and Blue Shield of New Mexico to accept the Allowable Charge as payment in full. Such Participating Dentists have agreed not to bill you for Covered Service amounts in excess of the Allowable Charge. Therefore, you will be responsible only for any Coinsurance and/or Deductible amounts applicable to your Covered Services.

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

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

COVERED SERVICES

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

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

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

DIAGNOSTIC EVALUATIONS

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

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

Special Provisions

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

PREVENTIVE SERVICES

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

- Prophylaxis – professional cleaning, scaling and polishing teeth. Benefits are limited to **two** cleanings every **12 months**.
- Topical fluoride application Benefits for fluoride application are only available for Members under age 16 and are limited to two applications every 12 months.

Special Provisions Regarding Preventive Services

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

DIAGNOSTIC RADIOGRAPHS (X-RAYS)

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

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

MISCELLANEOUS PREVENTIVE SERVICES

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

- Sealants for Members up to age **19**. (Limited to **one** per permanent (first and second) molar per **every 60 months**.)
- Space maintainers for Members up to age **19.**

BASIC RESTORATIVE SERVICES

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

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

NONSURGICAL EXTRACTIONS

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

- Removal of retained coronal remnants – deciduous tooth
- Removal of erupted tooth

NONSURGICAL PERIODONTAL SERVICES

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

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

ADJUNCTIVE GENERAL SERVICES

Covered Services include:

- Emergency palliative treatment of dental pain (also called "palliative" treatment), but only when not performed in conjunction with a definitive treatment.
- Sedation and Nitrous Oxide

ENDODONTIC SERVICES

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

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

ORAL SURGERY SERVICES

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

- Surgical tooth extractions
- Alveoloplasty and vestibuloplasty
- Excision of benign odontogenic and malignant tumor/cysts
- Excision of bone tissue
- Incision and drainage of intraoral abscess
- Other Medically Necessary surgical and repair procedures not listed as an exclusion in this Plan

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

SURGICAL PERIODONTAL SERVICES

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

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

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

MAJOR RESTORATIVE SERVICES

Restorative services restore tooth structures lost as a result of dental decay or tooth fractures that cannot be restored with amalgam or composite-type filing material. Covered Services include:

- Single crown restorations
- Inlay/onlay restorations
- Labial veneer restorations

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

PROSTHODONTIC SERVICES

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

- Complete and removable partial dentures. (Benefits will be provided for the initial installation of removable complete, immediate, or partial dentures, including any adjustments, relines, or rebases during the six-month period following installation. Benefits for replacements are limited to once in any 60-month period, whether placement was under this Dental Plan or under any prior coverage.)
- Dentures reline/rebase procedures. (Limited to one in a 24-month period after the initial 6-month period following initial placement.)
- Fixed bridgework. (Benefits will be provided for the installation of bridgework, including inlays/onlays and crowns as retainers. Benefits are **limited to once every 60 months.**)
- Implant retained crowns, bridges, and dentures are subject to the alternate Benefit provision of the Plan.
- Endosteal, eposteal, and transosteal implants – one every 60 months only if determined to be a dental necessity.

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

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

MISCELLANEOUS RESTORATIVE AND PROSTHODONTIC SERVICES

Other restorative and prosthodontic services that are covered include:

- Prefabricated crowns – stainless steel and resin. (Limited to one per tooth every 60 months. These crowns are not intended to be used as temporary crowns.)
- Recementation of inlays/onlays, crowns, bridges, and post and core. (Limited to two cementations every 12 months. Recementation provided within six months of initial placement done by the same Dentist is considered part of the procedure and no additional Benefits will be provided for such charges.)
- Core build up, post and core, and prefabricated post and core are limited to 1 per tooth every 60 months.
- Crown and bridge repair services.
- Pulp cap – direct and indirect.
- Prosthodontic service adjustments. (Limited to **three** times per Appliance every **12 months**.)
- Repairs of inlays, onlays, veneers, crowns, fixed or removable dentures, including replacement or addition of missing or broken teeth or clasp. (Limited to once per tooth or clasp **every 60 months**.)

MEDICALLY NECESSARY ORTHODONTIC SERVICES

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

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

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

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

Special Provisions

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

TMJ/CMJ SERVICES

This Plan covers standard diagnostic, therapeutic, surgical and nonsurgical treatments of temporomandibular joint (TMJ) and craniomandibular joint (CMJ) disorders. Related orthodontic Appliances and treatment, crowns, bridges, and dentures are covered only if the disorder is the result of trauma.

LIMITATIONS AND EXCLUSIONS

These general ***Limitations and Exclusions*** apply to all services described in this Benefit Booklet. Dental coverage is limited to services provided by a Dentist, a dental auxiliary, or other Provider (as defined in the ***Definitions***) licensed to perform services covered under this Dental Plan.

Please note that in order to provide you with dental care Benefits at a reasonable cost, this Plan provides Benefits only for those Covered Services for eligible dental treatment that are determined by a Provider, in consultation with BCBSNM, to be Medically Necessary unless otherwise required by law.

No Benefits will be provided for procedures which are not Medically Necessary **unless otherwise required by law**. Medically Necessary generally means that a specific procedure provided to you is required for the treatment or management of a dental symptom or condition and that the procedure is the most efficient and economical procedure which can safely be provided to you.

The fact that a Dentist may prescribe, order, recommend, or approve a procedure does not of itself make such a procedure or supply Medically Necessary.

What is Not Covered:

No Benefits will be provided under this Dental Plan for the following:

1. Services or supplies when they are related to a non-covered service.
2. Amounts which are in excess of the Allowable Charge, as determined by BCBSNM.
3. Services and supplies for any illness or injury occurring on or after your coverage date as a result of war or an act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.
4. Services or supplies that do not meet accepted standards of dental practice.
5. Experimental, Investigational, and/or Unproven services and supplies and all related services and supplies.
6. Implants and any related services and supplies (other than crowns, bridges, and dentures supported by implants) associated with the placement and care of implants.
7. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
8. Services or supplies for which "discounts" or waiver of Deductible or Coinsurance amounts are offered.
9. Services rendered by a Dentist related to you by blood or marriage.
10. Services or supplies received from someone other than a Dentist, except for those services received from a licensed Dental Hygienist under the supervision and guidance of a Dentist, where applicable.
11. Claims for services which is for the same services performed on the same date for the same member.
12. Services or supplies to the extent payment has been made under Medicare or would have been made if you had applied for Medicare and claimed Medicare Benefits, or to the extent governmental units provide Benefits (some state or federal laws may affect how this exclusion is applied).
13. Charges for nutritional, tobacco, or oral hygiene counseling.
14. Charges for local, state, or territorial taxes on dental services or procedures.
15. Charges for the administration of infection control procedures as required by local, state, or federal mandates.
16. Charges for duplicate, temporary, or provisional prosthetic devices or other duplicate, temporary, or provisional Appliances.
17. Charges for telephone consultations, failure to keep a scheduled visit, completion of a Claim form, or forwarding requested records or x- rays.
18. Charges for prescription or nonprescription mouthwashes, rinses, topical solutions, preparations, or medicament carriers.

19. Charges for personalized restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for dental services rather than professionally accepted, necessary and appropriate treatment; except this exclusion will not apply to the Benefits provided for the Covered Services subject to the Alternate Benefit provision.
20. Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth precision attachments for partials and/or dentures and stress breakers.
21. Charges for partial or full denture or fixed bridge that includes replacement of a tooth that was missing prior to your Effective Date under this Dental Plan; except this exclusion will not apply if such partial or full denture or fixed bridge also includes replacement of a missing tooth that was extracted after your Effective Date.
22. Any services, treatments, or supplies covered under other hospital, medical and/or surgical coverage.
23. Dental services for treatment of congenital or developmental malformation, or services performed for cosmetic purposes including, but not limited to, bleaching teeth and grafts to improve aesthetics.
24. Case presentations or detailed and extensive treatment planning when billed separately.
25. Charges for occlusion analysis or occlusal adjustments.
26. Work- related conditions: Services or supplies for any illness or injury arising out of or in the course of employment for which Benefits are available under any Worker's Compensation Law or similar laws whether or not you make a Claim for such compensation or receive such Benefits.
27. Orthodontic treatment that is not Medically Necessary.
28. Gold foil restorations.
29. Cone beam imaging and cone beam MRI procedures.
30. Sealants for teeth other than permanent molars.
31. Localized delivery of antimicrobial agents or chemotherapeutic agents.
32. Comprehensive periodontal evaluations or problem-focused evaluations if provided on the same date as any other oral evaluation by the same Dentist.
33. Tests and oral pathology procedures or for re-evaluations.
34. Bitewings taken on the same date as full mouth films.
35. Nutritional, tobacco, and oral hygiene counseling.
36. Local anesthesia that is not considered inclusive with the dental procedure.
37. Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist on the same tooth.
38. Endodontic therapy is not a Covered Service if you discontinue treatment.
39. Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of preformed dowel and post, or post removal.
40. Prophylactic removal of third molars or impacted teeth (i.e., removal of asymptomatic, nonpathological teeth), or for complete bony impactions covered by another Dental Plan.
41. Surgical services related to a congenital malformation.
42. Biologic materials to aid in tissue regeneration.
43. Restoration of occlusion or incisal edges due to bruxism (grinding or clenching teeth) or harmful habits or to correct attrition, abrasion, abfraction, or erosion.
44. The replacement of a lost, missing or stolen Appliance and those for replacement of Appliances that have been damaged due to abuse, misuse, or neglect.
45. To alter, restore, or correct vertical dimension of occlusion. Such procedures may include, but are not limited to, equilibration dentures, crowns, inlays, onlays, bridgework, or other Appliances or services used for the

purpose of splinting, alter vertical dimension, or to restore occlusion or to correct attrition, abrasion, erosion, or abfractions.

46. Replacement of complete or partial dentures due to theft, misplacement, or loss.
47. Treatment to replace teeth that were missing prior to the Effective Date of Coverage.
48. Congenitally missing teeth.
49. Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.
50. Recementation of an orthodontic Appliance by the same Dentist who placed the Appliance and/or who is responsible for the ongoing care of the Member.
51. Replacement or repair of an orthodontic Appliance.
52. Orthodontic treatment for dental conditions that are primarily cosmetic in nature or when self-esteem is the primary reason for treatment that is not Medically Necessary.

This Plan does not cover services resulting from work-related illness or injury. This exclusion from coverage applies to charges resulting from occupational accidents or sickness covered under:

- Occupational disease laws
- Employer's liability
- Municipal, state, or federal law (except Medicaid)
- Workers' Compensation Act

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

This Plan does not cover charges for services resulting from a work-related illness or injury, **even if**:

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

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

CLAIM FILING PROCEDURES PARTICIPATING DENTISTS

Participating Dentists have agreed to submit Claims directly to BCBSNM for you. When you receive Covered Services from a network Dentist, simply show your Identification Card, and Claims submission will be handled for you. If you must see an Out-of-Network Dentist who is not a member of BCBSNM's Participating Dentist Network, you may have to file a Claim yourself. If so, you should follow the guidelines below.

FILING DENTAL CLAIMS

In order to obtain your dental Benefits under this Dental Plan, it is necessary for a Claim to be filed with the Dental Plan. Usually all you have to do is show your BCBSNM Identification Card to your Dentist. They will file your Claim for you. Remember, however, it is your responsibility to ensure that the necessary Claim information has been provided to the Dental Plan.

If you use an Out-of-Network Dentist and have to file a Claim yourself, you may call Customer Service at the number on your Identification Card for a Claim form. As soon as treatment has ended, ask your Dentist to complete and sign the ***Attending Dentist's Statement***. Once you complete the Claim form and attach the ***Attending Dentist's Statement***, you may send the Claim to:

Blue Cross and Blue Shield of New Mexico
C/O Dental Network of America, Inc.
P.O. Box 23090
Belleville, IL 62223-0090

If a Dentist will not complete the Attending Dentist's Statement or does not bill BCBSNM directly, it is the Member's responsibility to attach itemized bills that include all necessary information to the Claim form and submit it to BCBSNM. Balance due statements, cash register receipts, and canceled checks are **not** acceptable.

TIMELY FILING LIMITS

Participating Dentists must file all Claims **within 180 days** after the date of service. Any Claims filed after this time limit may be denied, unless BCBSNM is satisfied that there is a valid reason why the Participating Dentist could not submit his/her Claim within this time limit. Members shall have **365** days (one year) after the date of service to file Member submitted Claims.

If a Claim must be returned to the Subscriber for additional information, the Claim must be resubmitted to BCBSNM **within 45 days** of the date the Claim was returned to the Subscriber.

If a Member's coverage under this Dental Plan ends, Claims for Covered Services incurred during the Member's final Benefit Period must be filed **within 180 days** after the date of the coverage termination. Failure to file a Claim **within the 180 days** will result in loss of Benefits otherwise provided by this Dental Plan if, as a result of such failure by the Member, BCBSNM is unable to perform adequate Claims review.

IF YOU HAVE OTHER VALID COVERAGE

If this Dental Plan is secondary to another plan, you need to file your Claim with the other carrier first.

If a Dentist normally files Claims to BCBSNM and the other carrier does not pay the Dentist directly, the Dentist will need, from you, a copy of the other carrier's explanation of Benefits to include with the Claim sent to BCBSNM.

If an Out-of-Network Dentist does not file Claims for you, attach a copy of the Out-of-Network Dentist's explanation of Benefits to the Claim that you send to BCBSNM.

CLAIM FORMS AND ITEMIZED BILLS

All information on the Claim form and itemized statements must be readable. If information is missing on the Claim form or it is not readable, then BCBSNM will return it to the Subscriber or to the Dentist. **Handwritten entries added to a typed or computerized Claim form that change or add procedure codes are considered fraudulent and will require the Subscriber's and the Dentist's signatures acknowledging approval of such information.**

The information on the itemized bills is used to determine Benefits, so it must support information reported on the submitted Claim form. All Claims must include:

- Subscriber's Dental Plan ID number
- Subscriber's name and address
- Member's name
- Member's age and relationship to the Subscriber
- Other dental coverage in effect
- Date of service
- Type of treatment
- Itemization of charges
- Accident or surgery date (when applicable)
- Name and address of Dentist
- Dentist's tax ID number or social security number
- Member's signature
- Dentist's signature

If an itemized bill from the Dentist is not attached to a Claim form, the Dentist must complete the "Dentist Information Section" and the "Examination and Treatment Record" of the Attending Dentist's Statement and **must** sign the Claim form.

Benefits cannot be determined if documentation is missing or radiographs submitted are not of sufficient diagnostic quality to determine Benefits.

Separate Claim Forms Required – A separate Claim form is required for each Dentist for which you are requesting reimbursement. A separate Claim form is also required for each Member when charges for more than one family member are being submitted.

DENTAL CLAIM REVIEW PROCEDURES

If your Claim had been denied in whole or in part, you may ask for a review. The Dental Plan will review its decision in accordance with the procedure below.

If your Claim has been denied in whole or in part for lack of Medical Necessity, you may appeal the Dental Plan's decision.

You have 180 days following the notification of an adverse benefit determination in which to appeal a decision to BCBSNM, however, you may exceed the 180- day limit when appealing to the Consumers Assistance Bureau of the Office of Superintendent of Insurance.

For an appeal to BCBSNM, send your request to:

Blue Cross and Blue Shield of New Mexico
Dental Administrative Office
P.O. Box 23100
Belleville, IL 62223-0100

For an appeal to the Consumers Assistance Bureau of the Office of Superintendent of Insurance, send your request to:

Office of Superintendent of Insurance
Consumers Assistance Bureau
P.O. Box 1689
Santa Fe, NM 87504-1689
Tel: 1-855-4ASK-OSI
1- 855-427-5674

You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. While BCBSNM will honor telephone requests for information, such inquiries will not constitute a request for review.

You and your authorized representative may ask to see relevant documents and may submit written issues, comments, and additional medical information within 180 days after you receive notice of a denial or partial denial. BCBSNM will give you a written decision within 60 days after it receives your request for review.

If you have any questions about the Claim procedures or the review procedure, you may call Customer Service at the number listed on your Identification Card. Or you can write:

Blue Cross and Blue Shield of New Mexico
Dental Administrative Office
P.O. Box 23060
Belleville, IL 62223-0060

If you have a Claim for Benefits which is denied, in whole or in part, you may file suit in a state or federal court.

DENIALS

Denial of Services

A dental benefit may be denied if the dental service is determined to not be medically necessary based on a Dentist's opinion and a formal review process. Any determination must be consistent with medical necessity standards and appropriate clinical guidelines.

This Dental Plan will not deny any claim for services included, unless one of the following circumstances apply:

- Documentation for the claim provided by the person submitting the claim clearly fails to support medical necessity of the billed services.
- Another payer is responsible for the payment.
- Another payer has already paid the claim.
- The Claim was submitted fraudulently or was based on whole or material part on erroneous information provided to the plan by the provider, covered person or other person not related to the carrier.
- The person receiving care was not eligible for covered benefits on the date of service and the carrier did not know nor could have known of the person's eligibility status with the exercise of reasonable care.

Notice of Denial

If this Dental Plan denies a request, a written explanation of the basis for the denial must be delivered to the Member within 24 hours of the determination for emergency care and within 10 calendar days for all other care.

DEFINITIONS

This section defines certain words used in this dental Benefit Booklet.

Allowable Charge — The charge that BCBSNM will use as the basis for Benefit determination for Covered Services incurred by a Member under this Dental Plan. BCBSNM will use the following criteria to establish the Allowable Charge for Covered Dental Services:

Participating Dentists - the amount the Dentist has agreed to accept as full payment for Covered Services.

Out-of-Network Dentists - the Dentist's usual charge, not to exceed the Out-of-Network Allowance.

Appliance — A device used to provide a function or a therapeutic effect (e.g., a denture).

Benefit Booklet — This document explains the Benefits, limitations, exclusions, terms, and conditions of this Dental Plan coverage and all endorsements, amendments, and riders attached hereto, now and in the future.

Benefit Period — The period of time during which you receive Covered Services for which BCBSNM will provide Benefits. The Benefit Period is a period of one year which begins on your Effective Date. When you first enroll under this dental coverage, your first Benefit Period begins on your Effective Date and ends on December 31 of the same year.

Benefit Period Maximum — The maximum dollar amount BCBSNM will pay for all Covered Services for each Member during a Benefit Period, according to the terms of this Benefit Booklet and the coverage outlined in the ***Schedule of Benefits***. Each Member's Benefit Period Maximum amount is given on the ***Schedule of Benefits***. Orthodontic services, if covered under this Dental Plan, do not apply to the Benefit Period Maximum.

Benefits — The payment and reimbursement of any kind which you will receive from BCBSNM under this Dental Plan.

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

Calendar Year — The period of 12 months commencing on the first day of January and ending on the last day of the following December.

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

Coinsurance — The percentage of Allowable Charges for Covered Services for which the Member is responsible.

Contract — This agreement, including the application and any amendments between you and BCBSNM.

Course of Treatment — Any number of dental procedures or treatments performed by a Provider in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

Covered Service — A service or supply provided in this Benefit Booklet and given by a Dentist for which we will provide Benefits.

Deductible — A specified amount of Covered Services that the Member must incur before BCBSNM will begin to pay its share of the remaining Covered Services.

Dental Plan — This Benefit Booklet, ***Schedule of Benefits***, and your application for coverage under the Blue Cross and Blue Shield Dental Plan described in this booklet.

Dentist — A professional practitioner who holds a lawful license issued by any state of the United States, or its territories, authorizing the person to practice dentistry and dental surgery in such state or territory, including, but not limited to, a Doctor of Dental Surgery (DDS) or a Doctor of Medical Dentistry (DMD).

Eligible Members — Subscriber and family Members up to age 19.

Domestic Partner — A companion of the same or opposite sex with whom the Member has entered into a Domestic Partnership.

Domestic Partnership — A same-sex or opposite sex couple in a committed relationship, similar to a marriage, but without an official marriage license.

Effective Date — The date on which a Member's coverage under this Dental Plan begins.

Experimental, Investigational, or Unproven — A drug, device, biological product, or dental treatment or procedure is Experimental, Investigational, or Unproven if BCBSNM determines that:

- The drug, device, biological product, or dental treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product, or dental treatment or procedure is furnished.
- The drug, device, biological product, or dental treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.
- The prevailing opinion among peer reviewed dental and scientific literature regarding the drug, device, biological product, or dental treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Identification Card — The card BCBSNM gives to the Member which is used to confirm a Member's coverage. It may show such information as the Member's name, Member number, and plan number or name.

Medically Necessary (or Medical Necessity) — A specific procedure or supply provided to you is reasonably required in the judgement of a Provider, in consultation with BCBSNM, for the treatment or management of your specific dental symptom, injury, or condition and that the procedure performed is the most efficient and economical procedure that can safely be provided to you. The fact that a Dentist or Physician may prescribe, order, recommend or approve a procedure does not make such a procedure Medically Necessary. To be Medically Necessary, the procedure or supply must also conform to approved and generally accepted standards of accepted dental practice prevailing in the state when and where the procedure or supply is ordered. Such procedures or supplies are also subject to review and analysis by dental consultants retained by BCBSNM. These consultants review the Claim and diagnostic materials submitted in support of the Claim, and based upon their professional opinions, determine the necessity and propriety of treatment.

Member — An Eligible person who has enrolled for coverage.

Network Service Area — The geographic area designated by BCBSNM, within which the Benefits of this Dental Plan are available to Members. A Member may call the Customer Service Department at the number shown on the Identification Card to determine if he or she is in the Network Service Area, or visit the website at:

www.bcbsnm.com

Out-of-Network Allowance — The amount determined by BCBSNM as the maximum Provider charge eligible for Benefits. The Member will be responsible for the full amount by which the actual charges of an Out-of-Network Provider exceed the Out-of-Network Allowance.

Out-of-Network Dentist — A Dentist who has not entered into an agreement to be part of BCBSNM's Participating Dentist Network.

Out-of-Pocket Maximum — A specified amount of total Deductible and Coinsurance that a Member(s) must pay for Covered Services received from a Participating Dentist during a Benefit Period before BCBSNM begins to pay 100 percent of Allowable Charges for remaining Covered Services received by such Members(s) from a Participating Dentist during that Benefit Period, not to exceed any applicable Benefit Maximums.

Participating Dentist — A Dentist who has entered into an agreement to bill BCBSNM directly for Covered Services and to accept the Allowable Charge as payment for such Covered Services. Participating Dentists include the following:

- A Dentist who has entered into a Participating Provider Agreement with BCBSNM.
- A Dentist who has contracted directly with any division or subsidiary of Health Care Service Corporation (HCSC).
- A Dentist who is a member of any other network with which HCSC or any of its subsidiaries has contracted.

Pediatric Orthodontic Services — Coverage is limited to Children under age 19 with an orthodontic condition meeting Medical Necessity criterion (e.g., severe dysfunctional malocclusion).

Physician — A person who is a professional practitioner of a Healing Art defined and recognized by law and who holds a Physician license duly issued by the state or territory of the United States in which the person is authorized to practice medicine or surgery or other procedures and provide services within the scope of such license.

Policy Year — The 12-month period beginning January 1 of each year.

Proof of Loss — A formal statement or Claim regarding a loss which provides sufficient information to allow BCBSNM to determine its liability for Covered Services. This includes a completed Claim form; the Dentist's itemized statement of services rendered, and related charges; and medical records, when requested by BCBSNM, as provided under the utilization review procedures of this Dental Plan.

Provider — A hospital, other facility, Dentist, Physician, or other health care Provider that BCBSNM recognizes as a dental care professional or medical facility. The Provider must be licensed, certified, or registered by the state or jurisdiction where services are provided to perform designated dental care services. Services of such a Provider must be among those covered by this Dental Plan and are subject to review by a dental authority appointed by BCBSNM. A professional supplier of dental supplies and equipment is considered an "other health care Provider."

Subscriber — The person in whose name the Dental Plan coverage is established and to whom the Identification Card is issued.

Pediatric Dental

For Members under the age of 19

The following is a listing of common services available through your network of Participating Dentists. The Member's share of the cost is determined by whether care is received from a Participating or Out-of-Network Dentist. This information only provides highlights of the Pediatric Dental Plan. Please refer to the Pediatric Dental Rider for additional Benefit information.

In-Network Dental Benefits accumulate towards In-Network Medical Deductible and Out of Pocket Maximum and Out of Pocket Maximum and Out-of-Network Dental Benefits accumulate towards the Out-of-Network Medical Deductible and Out of Pocket Maximum.

SCHEDULE OF BENEFITS

Covered Services	***Participating Dentist***	***Out-of-Network Dentist*****
Diagnostic Evaluations	30% *after Medical Deductible*	50% *after Medical Deductible*
Preventive Services	30% *after Medical Deductible*	50% *after Medical Deductible*
Diagnostic Radiographs	30% *after Medical Deductible*	50% *after Medical Deductible*
Miscellaneous Preventive Services	30% *after Medical Deductible*	50% *after Medical Deductible*
Basic Restorative Services	30% *after Medical Deductible*	50% *after Medical Deductible*
Non-Surgical Extractions	30% *after Medical Deductible*	50% *after Medical Deductible*
Non-Surgical Periodontal Services	30% *after Medical Deductible*	50% *after Medical Deductible*
Adjunctive Services	30% *after Medical Deductible*	50% *after Medical Deductible*
Endodontic Services	30% *after Medical Deductible*	50% *after Medical Deductible*
Oral Surgery Services	30% *after Medical Deductible*	50% *after Medical Deductible*
Surgical Periodontal Services	30% *after Medical Deductible*	50% *after Medical Deductible*
Major Restorative Services	30% *after Medical Deductible*	50% *after Medical Deductible*
Prosthodontic Services	30% *after Medical Deductible*	50% *after Medical Deductible*
Miscellaneous Restorative and Prosthodontic Services	30% *after Medical Deductible*	50% *after Medical Deductible*
Pediatric Orthodontic Services: Coverage limited to children under age 19 with an orthodontic condition meeting Medical Necessity criterion (e.g., severe dysfunctional malocclusion) established by a Provider, in consultation with BCBSNM.	30% *after Medical Deductible*	50% *after Medical Deductible*

1 Deductible is waived for fluoride treatments; after Deductible for all other preventive services.

2 BCBS does not cover implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants.

** For Out-of-Network Dentist services, the Allowable Charge is the Provider's usual charge, not to exceed the amount that the Plan would reimburse a Participating Dentist for the same services**. The Member will be responsible for the full amount by which the actual charges of an Out-of-Network Dentist exceed the Allowable Charge.**

See your SBC for Deductible and maximum Out-of- Pocket Limit

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

Pediatric Vision Care Rider

BlueCross BlueShield of New Mexico

This *Pediatric Vision Care Rider* is made part of and is in addition to any information you may have in your Blue Cross and Blue Shield of New Mexico (BCBSNM) member benefit booklet. BCBSNM underwrites this *Pediatric Vision Care Rider* and has partnered with EyeMed Vision Care, LLC ("EyeMed"), also referred to as the "Vision Care Plan Administrator." EyeMed provides customer service and claims administration services to members enrolled in the pediatric vision care plan. The relationship between BCBSNM and EyeMed is that of independent contractors. Through our arrangement with EyeMed, you will have access to EyeMed's network of vision care Providers.

This *Pediatric Vision Care Rider* provides information about coverage for the routine vision care services outlined below, which are specifically excluded under your medical/surgical health care plan. **(Services that are covered under your medical/surgical plan are not covered under this *Pediatric Vision Care Rider*.) All provisions in the medical plan booklet apply to this *Pediatric Vision Care Rider* unless specifically indicated otherwise below.**

BY:

Janice Torrez, President
Blue Cross and Blue Shield of NM

This BCBSNM vision care plan allows members to select the Provider of their choice, in or out of the network. BCBSNM has designed benefit plans to deliver quality care, matched with comprehensive benefits, at the most affordable cost, through in-network services. You also have the flexibility to visit an out-of-network Provider, with a reduction in benefits.

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

Definitions:

Benefit Period — For purposes of this *Pediatric Vision Care Rider,* a period of time that begins on the later of: 1) the member's effective date of coverage under this *Pediatric Vision Care Rider,* or 2) the last date a Vision Examination was performed on the member or that Vision Materials were provided to the member, whichever is applicable. (A Benefit Period does not coincide with a calendar year and may differ for each covered member of a group or family.)

Medically Necessary Contact Lenses — Contact lenses may provide superior visual and physical results to spectacles in individuals with certain eye conditions. For purposes of this *Pediatric Vision Care Rider,* those conditions are limited to the following: keratoconus when the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses; high ametropia exceeding 12 D or +9 D in spherical equivalent; anisometropia of 3 D or more; patients whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Proof of Loss — A formal statement or Claim regarding a loss which provides sufficient information to allow BCBSNM to determine its liability for Covered Services. This includes a completed Claim form; the ophthalmologist's or optometrist's itemized statement of services rendered, and related charges; and medical records, when requested by BCBSNM, as provided under the utilization review procedures of this Vision Plan.

Provider — For purposes of this *Pediatric Vision Care Rider,* a licensed ophthalmologist or optometrist operating within the scope of his or her license or a dispensing optician. An "in-network" Provider is a Provider who has contracted with the vision care plan administrator, EyeMed. An "out-of-network" Provider has not contracted with EyeMed (even if such Provider is contracted with BCBSNM to render covered services under your medical/surgical health care plan).

Vision Examination — A vision testing exam, including a determination as to the need for correction of visual acuity and prescribing lenses, if needed, that is performed by a licensed physician or optometrist who is operating within the scope of his/her license. A Vision Examination (including dilation, if necessary) includes but is not limited to the following:

- One eye exam every 12 months
- One pair of standard eyeglass lenses or contact lenses every 12 months
- One frame every 12 months
- Minor repairs to eyeglasses
- Lens tinting if certain conditions are present
- Lenses to prevent double vision
- Case history, including chief complaint and/or reason for visit, patient medical/eye health history, and record of current medications; record of visual acuities with/without present correction, if applicable.
- Pupil responses, external exam findings, internal exam findings, screening of visual fields perception.
- Diagnosis/prognosis and/or specific recommendations

Vision Materials — Corrective lenses and/or frames or contact lenses.

Eligibility:

Children who are covered under a BCBSNM medical/surgical plan, up to age 19, are eligible for coverage under this *Pediatric Vision Care Rider.*

NOTE: Once coverage is lost under the medical/surgical plan, all benefits cease under this *Pediatric Vision Care Rider.* Extension of benefits due to disability, state or federal continuation coverage, and conversion option privileges are **not** available under this *Pediatric Vision Care Rider.*

Limitations and Exclusions:

In addition to the general limitations and exclusions listed in your medical/surgical plan benefit booklet, this *Pediatric Vision Care Rider,* does not cover services or materials connected with or charges arising from:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing.
- Aniseikonic lenses
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Any eye or Vision Examination, or any corrective eye wear required by an employer as a condition of employment, and safety eyewear.
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof.
- Plano nonprescription lenses or nonprescription sunglasses and/or contact lenses.
- 2 pairs of glasses in lieu of bifocals
- Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order.
- Services or materials provided by any other group benefit plan providing vision care; services covered under your medical/surgical plan.
- Replacement of lost, stolen, damaged, or broken materials, except in the next Benefit Frequency when Vision Materials would next become available, unless otherwise covered through warranty.
- Services of unlicensed personnel

How the Vision Care Plan Works:

Under the vision care plan option, you may visit any covered Provider and receive benefits for a Vision Examination. In order to maximize benefits for most covered Vision Materials, however, you must purchase them from an in-network Provider. (An "in-network" Provider is one who contracts with the vision care plan administrator, EyeMed, to provide services covered under this *Pediatric Vision Care Rider* to enrolled members. Providers who contract with BCBSNM are not considered "in-network" for purposes of this *Pediatric Vision Care Rider,* unless he/she also contracts with EyeMed.)

Before you go to an in-network vision care plan Provider for an eye examination, eyeglasses, or contact lenses, please call ahead for an appointment. When you arrive, show the receptionist your BCBSNM health care plan or your vision plan identification card (the ID numbers should be the same). If you forget to take your card, be sure to say that you are a member of the BCBSNM vision care plan so that your eligibility can be verified.

To locate an in-network vision care Provider, visit EyeMed's Web site at www.eyemed.com and use the Find a Provider link (choose the Select network for your search), or call 1-844-684-2257.

After you choose and order your eyeglasses or contacts from an in-network Provider, your eyewear will be dispensed by the Provider – generally within two to five business days from the date of the order. More delivery time may be needed for out-of-stock frames, ARC (anti-reflective coating), specialized prescriptions, or when an in-network Provider's frame that is not offered under EyeMed is selected. If you obtain glasses or contacts from an out-of-network Provider, you must pay the Provider in full and submit a claim to EyeMed for reimbursement (see "Claims Filing" for more information).

You may receive your eye examination and eyeglasses/contacts on different dates or through different Provider locations, if desired. However, complete eyeglasses must be obtained at one time, from one Provider. Continuity of

care will best be maintained when all available services are obtained at one time from one in-network Provider and there may be additional professional charges if you seek contact lenses from a Provider other than the one who performed your eye examination.

Fees charged for services other than a covered Vision Examination or covered Vision Materials and amounts in excess of those payable under this *Pediatric Vision Care Rider,* must be paid in full by you to the Provider, whether or not the Provider participates in the vision care plan network. Benefits under this *Pediatric Vision Care Rider* may not be combined with any discount, promotional offering, or other group benefit plans. Allowances are one-time use benefits; no remaining balances are carried over to be used later.

Pretreatment Estimate

A Pretreatment Estimate is not required for this Vision plan.

Claims Filing and Appeal Procedures: In-Network Vision Services

When you receive vision services at an in-network vision plan Provider location, you will not have to file a claim form. At the time services are rendered, you will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable copayments. You will also owe state tax, if applicable, and the cost of noncovered expenses (for example, vision perception training).

Claims for Out-of-Network Vision Services

When you receive covered vision services outside of the vision plan Provider network, you will need to file a claim form. You can obtain a claim form from an EyeMed Member Services Representative or by accessing the website at www.eyemed.com. Be sure to fill out the claim form completely. You must submit your claim form no more than **90 calendar days** after the services were provided. If you choose to go to an out-of-network Provider, please complete the following steps before submitting your claim form to EyeMed.

1. You are responsible for payment of vision care services at the time of service. BCBSNM (through the vision care plan administrator, EyeMed) will reimburse **you** for covered services. Please see the "Summary of Pediatric Vision Benefits," on the last page of this *Pediatric Vision Care Rider* for the list of qualified services and their reimbursement amounts.
2. Complete the Patient Information portion of your claim form.
3. Complete the Member/Employee Information Portion of your claim form. This information can be found on your ID card or by contacting your human resources or employee benefits department.
4. Complete the Provider Information portion of the form.
5. Sign the claim form. If the patient is a minor, the parent or legal guardian must sign the claim form.
6. Attach itemized receipts from your Provider to the claim form. (Facsimiles and photocopies of bills cannot be accepted; please keep copies for your records. Bills will not be returned.) Please include the following breakdown of costs for each itemized bill:
    - Exam
    - Frames
    - Lenses (specific prescription and type of lenses)
    - Contact lenses (specific prescription and type of lenses)

7. Mail the claim form to the following address:

First American Administrators
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Proof of Loss

When BCBSNM receives a request for a Claim form or the notice of a Claim, BCBSNM will give the Member the Claim forms that we use for filing proof of loss. If the claimant does not receive these forms within 15 days after BCBSNM receives notice of Claim or the request for a Claim form, the claimant will be considered to meet the proof of loss requirements of this Vision Plan if the claimant submits written proof of loss along with the character and the extent of the loss for which claim is made within 180 days after the date of the first service, except in the absence of legal capacity due to a serious health condition and unable to perform regular daily activities.

Customer Service:

Questions about services covered under the vision care plan, in-network vision plan Providers, or about benefits provided or denied under the plan can be directed to EyeMed seven days a week, Monday through Saturday 5:30 A.M. to 9:00 P.M., and Sunday 9:00 A.M. to 6:00 P.M. (Mountain Time) at 1-844-684-2257. An Interactive Voice Response unit is also available outside normal business operating hours. (Please direct member enrollment, termination, and other subscriber or dependent eligibility questions to BCBSNM—not to EyeMed.) Members using a TTY (Teletypewriter) because of a hearing or speech disability may access TTY services through calling or using a TTY machine to engage an operator at 711 and asking the operator to call EyeMed at 1-844-230-6498.

If a claim for benefits is denied (in whole or in part), EyeMed will notify you in writing of the specific reasons for the denial, and of the process for requesting a review of the denial.

Denials
Denial of Services

This Vision Plan will not deny any claim for services included, unless one of the following circumstances apply:

- Documentation for the claim provided by the person submitting the claim clearly fails to support medical necessity.
- Another payer is responsible for the payment.
- Another payer has already paid the claim.
- The Claim was submitted fraudulently or was based on whole or material part on erroneous information provided to the plan by the provider, covered person or other person not related to the carrier.
- The person receiving care was not eligible for covered benefits on the date of service and the carrier did not know nor could have known of the person's eligibility status with the exercise of reasonable care.

Notice of Denial

If this Vision Plan denies a claim, a written explanation of the basis for the denial will be sent to the Member within five (5) business days of the receipt of the claim.

Member Complaint Procedure

If you are dissatisfied with an EyeMed Provider's quality of care, services, materials or facility, or with EyeMed's Plan administration, you should first call EyeMed Customer Care Center at 1-844-684-2257 to request resolution. The EyeMed Customer Care Center will make every effort to resolve your matter informally.

If you are not satisfied with the resolution from the Customer Care Center service representative, you may file a formal complaint with EyeMed's Quality Assurance Department at the address noted below. You may also include written comments or supporting documentation.

The EyeMed Quality Assurance Department will resolve your complaint within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after EyeMed's receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.

Appealing Denied Claims:

If your claim is denied, in whole or in part, you may file an appeal. The appeal must be in writing and received by First American Administrators (FAA), a wholly-owned subsidiary of EyeMed, within 180 days of your notice of the denial. If you do not receive an EOB within 30 days of submission of your claim, you may submit an appeal within 180 days after this 30-day period has expired. Your written letter of appeal should include the following:

- The applicable claim number or a copy of the written denial or a copy of the EOB, if applicable.
- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.
- Additional information from the member's eye care Provider that will assist FAA in completing its review of the member's appeal, such as documents, records, questions, or comments.

The appeal should be mailed or faxed to the following address:

FAA/EyeMed Vision Care, LLC
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
Fax: 1-513-492-3259

FAA/EyeMed will review your appeal and notify you in writing of its decision.

For an appeal to the Consumers Assistance Bureau of the Office of Superintendent of Insurance, send your written letter of appeal to:

Office of Superintendent of Insurance Consumers Assistance Bureau
P.O. Box 1689
Santa Fe, NM 87504-1689
Call toll-free at 1-855-427-5674 or visit www.osi.state.nm.us

Summary of Pediatric Vision Benefits

	In-Network Benefits	Out-of-Network Benefits
Examination*	Member Copay	Member Copay
Eye Examination (with dilation as necessary)	No Charge	$30 (plan pays up to $30; member pays balance)
Eyeglass Benefit – Frame*		
Provider Designated Frames	Up to $100 (plan pays up to $100; member pays balance; 20% off balance over $100)	$50 (Plan pays up to $50; member pays balance)
Eyeglass Benefit – Spectacle Lenses*		
Clear plastic single-vision Lined bifocal Trifocal Lenticular lenses (any Rx)	No Charge	$25 $40 $55 $55 (Plan pays up to designated amount; member pays balance)
Contact Lens Benefit *		
Contact Lenses: Routine eye exams do not include Fitting and Follow-up Care. Materials Allowance including Contact Lens Evaluation. Fitting and Follow-up Care is administered with a separate discount and not part of the evaluation.	Up to $100 (plan pays up to $100; member pays balance)	$100 (plan pays up to $100; member pays balance)
Medically Necessary Contact Lenses ** Materials, Evaluation, Fitting & Follow-Up Care See the definition for "*Medically Necessary Contact Lenses*" on page 2 of this *Pediatric Vision Care Rider.*	No Charge	$210

* – Once every 12 months
** – Medically Necessary Contact Lenses (see definition on the first page of this document)

Discounts: In-network Providers may offer discounts on the price of such noncovered services as Oversize Lenses, Tinting of Plastic Lenses, Scratch- Resistant Coating, Polycarbonate Lenses[2], Ultraviolet Coating, Standard Anti-Reflective (AR) Coating, Premier AR Coating, Ultra AR Coating, Standard Progressive Lenses[3], Premium Progressive (Varilux®, etc.), Intermediate-Vision Lenses, High-Index Lenses, Polarized Lenses, Plastic Photosensitive Lenses, Scratch Protection Plans for Single Vision and Multifocal Lenses, and Fittings and Follow-ups. Provider-designated[1] frames are covered in full with no charge. Conventional Contact Lenses are 15% off balance over $100. Check with your Provider for more information. *Prices/discounts may vary by state and are subject to change without notice.*

1. Provider Designated Frames are available at most participating independent Provider offices. Provider Designated Frames are subject to change. Providers regularly update styles and brands of available children's eyewear.
2. Polycarbonate lenses are covered in full, including for monocular patients and patients with prescription +/- 6.00 diopters or greater.

3. Conventional bifocals will be supplied at no additional cost for anyone who is unable to adapt to progressive lenses; however, the cost of progressive lenses is not refundable. Note: Progressive addition multifocals can be worn by most people.

BlueCross BlueShield of New Mexico

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, religion, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	855-661-6965
300 E. Randolph St., 35th Floor	Fax:	855-661-6960
Chicago, IL 60601	Email:	civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

US Dept of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building	Complaint Portal:	ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Washington, DC 20201	Complaint Forms:	hhs.gov/civil-rights/filing-a-complaint/index.html

This notice is available on our website at bcbsnm.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.

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中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسي Farsi	توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

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