BlueCross BlueShield of New Mexico

BlueEdge℠ A Preferred Provider Option (PPO) Plan

To be used in conjunction with the BlueEdge HSA 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

NM477915 (07/26)

IMPORTANT NOTICE

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

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

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

3. Cost-sharing and benefits limitations for a Medically Necessary, non-emergent Health Care Service where no Participating Provider is available to render the service shall be the same as if the service was rendered by a Participating Provider.

4. If a Covered Person pays a Nonparticipating Provider more than the in-network cost-sharing amount for services provided under circumstances giving rise to a surprise bill, the Nonparticipating Provider shall refund the Covered Person within forty-five calendar days of receipt of payment from the health insurance carrier any amount paid in excess of the in-network cost-sharing amount.

5. If a Nonparticipating Provider has not made a full refund to the Covered Person of the amount paid in excess of the in-network cost-sharing amount within forty-five calendar days of receipt, interest shall accrue at the rate set for payment of interest on a health plan's liability for clean Claims submitted by eligible Providers to a health plan pursuant to Chapter 59A, Article 16 NMSA 1978.

6. A Covered Person may seek recovery of the refund of the amount they have paid in excess of the in-network cost-sharing amount that a Nonparticipating Provider owes, plus interest, by filing an appeal with the Office of Superintendent of Insurance.

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 the next business day.)

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

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

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

Prior Authorizations: Medical/Surgical Services and Prescription Drugs **-** For Prior Authorization requests, call a Health Services representative, Monday through Friday 8:00 A.M. - 5:00 P.M., MT. Written requests should be sent to the address given above. If you need Prior Authorization assistance between 5:00 P.M. - 8:00 A.M. or on weekends, call Customer Service. (**NOTE:** 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 and Substance Use Disorder, call the Behavioral Health Unit (BHU):

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

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: Claims Payments and Appeals** for details on submitting Claims. **NOTE:** Do not submit drug plan Claims to BCBSNM.

Please send drug Claim forms to Prime Therapeutics at:

PO Box 25136
Lehigh Valley, PA 18002-5136

Common Websites
Provider network information: www.bcbsnm.com/blueppo
Drug Lists: www.bcbsnm.com/nm/documents/rx-drugs/drug-lists/performance-full-nm-2026.pdf
Claim forms: formfinder.hcsc.net/formfinder/search-display.do?portal=pub_mem&state=NM
For other information, or to e-mail your question to BCBSNM: www.bcbsnm.com/member

A message from

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO

This plan is underwritten by Blue Cross and Blue Shield of New Mexico (BCBSNM), your partner in health care. Like most people, you probably have many questions about your coverage. This Benefit Booklet contains a great deal of information about the services and supplies for which benefits will be provided under your plan. This Benefit Booklet complies with all elements required of an evidence of coverage form. This Benefit Booklet, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this Benefit 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 the Group. **Section 10: Definitions** will explain the meaning of many of the terms used in this Benefit Booklet. Whenever the terms "we", "us", or "ours" is used, we mean BCBSNM. When the terms "you", "your", or "yours" is used, we mean all Eligible Family Members who are covered under this plan.

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

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 Identification (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.

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

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SECTION 1: HOW TO USE THIS BENEFIT BOOKLET

This Benefit Booklet describes the medical/surgical, prescription drug, and Mental Health/Substance Use Disorder coverage available to Members of this Managed Care Medical Plan, and the plan's benefit limitations and exclusions.

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

Definitions

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

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 Group 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 Group Health Care Plan with BCBSNM.

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

Provider Network Directory

The Provider network directory is available through the BCBSNM website at www.bcbsnm.com/blueppo. It lists all Providers and their qualifications in the BCBSNM Preferred Provider (PPO) network and Participating Pharmacies. It also provides links to the listings of Preferred Providers in other states. If you want a paper copy of a directory, you may request one from Customer Service.

NOTE: Although Provider directories are current as of the date shown at the bottom of each page, they can change without notice. To verify a Provider's status or if you have any questions about the directory, contact a Customer Service Advocate or visit www.bcbsnm.com/blueppo.

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

IMPORTANT INFORMATION ABOUT ACCESS TO PRESBYTERIAN HEALTHCARE SERVICES

Participating Network Providers are always subject change.

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

Presbyterian Healthcare Services (PHS) has Providers in several communities in New Mexico. We call these Providers PHS Providers. To determine if a PHS Provider is an PPO Participating Provider, 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 PPO 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 Non-Participating 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 PPO 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 PPO 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 PPO Participating Providers for the following services: primary care and OB/GYN.

For help with determining whether a PHS Provider is an PPO 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 **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.

NOTE: Prescription Drugs that are approved by the FDA through the accelerated approval program may be considered Experimental/Investigational and may not be covered.

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 number on the back of your ID Card or visit www.bcbsnm.com/find-care/medical-rx for more information about covered therapeutic equivalents or therapeutic alternatives. To request an exception, you, your prescribing health care Provider, or your authorized representative, can call the number on the back of your ID Card.

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

BlueCard®

As a Member of a PPO 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 Preferred Providers almost everywhere you travel or live. Almost 90% of Physicians in the United States contract with Blue Cross and Blue Shield (BCBS) Plans. You and your Eligible Family Members can receive the Preferred Provider level of benefits – even when traveling or living outside New Mexico – by using health care Providers that contract as Preferred Providers with their local BCBS Plan. Instructions for locating a Preferred Provider outside New Mexico can be found on the BCBSNM website:

provider.bcbs.com

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/where-you-go-matters/utilization-management/fully-insured. You can also call BCBSNM Customer Service at the toll-free telephone number on the back of your ID 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:

- Seven (7) calendar days standard determinations
- 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 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 (3) 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 required 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 this 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, 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.

BCBSNM offers education and resources to improve self-management of chronic disease and health condition 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 are offered on a uniform availability and non-discriminatory basis for all Members.

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

Virtual Visits

A Virtual Visit provided 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 managed without a traditional office visit, Urgent Care visit or Emergency Care visit.

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

Telemedicine Services

We cover 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 and Mental Health disorders in situations that may be managed 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. We do not impose any unique conditions or originating site restrictions.

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 ID 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 available at any given time. The services are provided as a convenience and are not considered covered benefits under this benefit program.

Customer Service

If you have any questions about your coverage, call or e-mail BCBSNM's Customer Service department. Customer Service Advocates are available Monday through Friday from 6:00 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 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 Claim's status
- Order a replacement ID Card, Provider directory, Benefit Booklet, or forms

For your convenience, the toll-free Customer Service number is printed at the bottom of every page in this Benefit Booklet. Refer to Customer Assistance on the inside cover of this Benefit 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 e-mail 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 our 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 automated 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

Special Beginnings®

This is a maternity program that helps you better understand and manage your pregnancy. You should enroll in the program within three months of becoming pregnant, by calling:

Toll-free: 1-888-421-7781

Blue Access For Members℠

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

If you need help accessing the BAM site, call:

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

Help Desk 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 update 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 extremely 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 ID Card.
- Reside or work in the geographic area (Service Area) served by the plan network. You may call Customer Service at the number shown on the back of your ID Card to determine if you reside or work in the Service Area or log on to the web site at www.bcbsnm.com.

No eligibility rules or variations in premium will be imposed on you based on your specific health status, medical condition, Claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status-related factor. You will not be discriminated against for coverage under this plan on the basis of race, religion, color, national origin, 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.

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 child - An eligible spouse or Eligible Child (as defined below) who has applied for and been granted coverage under the Subscriber's policy based on 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 Eligible Child through the end of the month in which the child reaches age 26 (Once a covered child reaches age 26, the child is automatically removed from coverage and 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 age 26 or older who was enrolled as the Subscriber's covered child in this Group Health Care 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. The form may be located at www.bcbsnm.com/docs/forms/group/nm/grp-disabled-dependent-form-nm.pdf

  Also, a child may continue to be eligible for coverage age 26 or older only if the condition began before or during the month in which the child would lose coverage due to their age. BCBSNM must receive written notice of the disabling condition within 31 days of the child's attainment of the limiting age and subsequently, as may be required by BCBSNM, but not more frequently than annually after the two-year period following the child's attainment of the limiting age of 26.

- The Subscriber's Domestic Partner (**NOTE:** Not all governing bodies of the entities have approved allowing an employee's Domestic Partner and their children to be eligible for insurance coverage. Check with your benefits administrator for more information.)

- The Subscriber's dependent student on Medically Necessary leave of absence

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

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

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

- Once the Subscriber is no longer a legal guardian of a child or there is no longer a court order to provide coverage to a child, the child must be eligible as a natural child, legally adopted child, foster child, or stepchild of the Subscriber in order to retain eligibility as a family member under this Group Health Care 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 considered by BCBSNM to be 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 of 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 employees 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 qualifying 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.

Applying For Coverage Or Reinstatement

An eligible person can apply for coverage or reinstatement, including for their Eligible Family Members, by contacting your Group and following their enrollment process within 31 days after becoming eligible according to the terms of the Group Contract.

NOTE: BCBSNM cannot use genetic information or require genetic testing in order to determine or to limit or deny coverage.

When Coverage Begins

BCBSNM will determine your Effective Date of Coverage according to the provisions of the Group Contract. Contact your employer to determine your Effective Date of Coverage.

We do 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, we will not cover those charges incurred after your Effective Date that are covered under the prior benefit plan.

Changes To Coverage

After initial enrollment, you may need to add Eligible Family Members to, or remove them from your coverage, update your address, or switch from individual to 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. Please contact your employer to find out when you can change your coverage type or remove a person from your coverage.

Adding A Family Member To Coverage

A Subscriber may apply for coverage of an Eligible Family Member (such as a new spouse or a newborn child). Within 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, which may mean changing, for example, from individual to Family Coverage

Adding a Spouse or a Domestic Partner

If a Subscriber adds coverage for a spouse/Domestic Partner within 31 days of marriage, the effective date of the new Eligible Family Member's coverage will be no later than the first of the month following the date BCBSNM received the completed and signed enrollment/change application form. 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 and, if required, change from individual (or employee/child(ren) coverage, if applicable) to Family Coverage within 31 days of marriage, the spouse may not be added to coverage except as a Late Applicant (or as specified under **Special Enrollment** later in this section).

You may also have the option of applying for a two-person (employee + spouse) coverage type. Ask your employer which coverage types are available to you. For example, if you are applying for coverage for a new spouse and their Eligible Child(ren), you will have to change to Family Coverage. See **Adding an Eligible Child**, below.

Domestic Partners and their Eligible Children may be added to existing coverage only during the annual open enrollment period.

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 specified under **Special Enrollment**.

Newborn Children
If Family Coverage (or employee/children coverage, if available) is in effect, a newborn, natural child is covered from birth. (You should, however, submit an application to add the newborn as an Eligible Child as soon as possible after birth.) If, for example, Family Coverage is not in effect, you must add coverage for the newborn within 31 days of the birth in order for Routine Newborn Care to be covered, (e.g., if an employee/children coverage type is not available to your Group, you would need to switch to Family Coverage.). 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
A child placed in the Subscriber's home for the purposes of adoption may be added to coverage as soon as the child is placed in the home. However, application for coverage can be made as late as 31 days following legal adoption without being considered late. (Although a child over the age of 18 is not eligible for adoption, an adopted 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 31 days of adoption or placement in the home 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 and has had prior Creditable Coverage since that date with no significant lapse (i.e., 95 or more days).

Eligible Foster Children
Application for coverage must be made for an eligible foster child within 31 days from the date care is assumed by the Subscriber for such foster child.

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 31 days of the court or administrative order granting guardianship.

Stepchild
Application for coverage must be made for a stepchild within 31 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 the Subscriber has Individual coverage, they may be required to pay additional premium in order for the Eligible Child to be added.) If not specified in the court or administrative order, the Eligible Child's Effective Date of Coverage will be the date the order has been filed as public record with the State or the 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 for a Special Enrollment, applications from the following enrollees will be considered late:

- Anyone not enrolled within 31 days of becoming eligible for coverage under this plan (e.g., a newborn child added to coverage more than 31 days after birth when, for example, Family Coverage (or employee/children coverage, if available) is not already in effect, a child added more than 31 days after legal adoption, or a new spouse or stepchild added more than 31 days after marriage)
- Anyone enrolling on the Group's initial BCBSNM enrollment date who was not covered under the Group's prior plan (but who was eligible for such coverage)
- Anyone eligible but not enrolled during the Group's initial enrollment
- 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 under **Special Enrollment for Active Employees and Their Eligible Family Members** and **Switch Enrollment and Changes in Plan**, below.

Open Enrollment

Open enrollment is the period prior to the Group's anniversary date (ask your employer when your Group's open enrollment period is held). During the annual open enrollment period, any eligible employee and their Eligible Family Members may enroll as Members under this plan.

NOTE: Open enrollment is not available under an extension of benefits, direct-pay continuation, or conversion contract. If a Member does not enroll timely in these coverages, the Member may not enroll at a later date.

Switch Enrollment And Changes In Plan

If your employer offers employees more than one choice of health plan, your plan choice can only be changed outside open enrollment if you, as an active employee or Eligible Family Member of an active employee, are eligible for a Special Enrollment. (See **Special Enrollment for Active Employees and Their Eligible Family Members** for details.)

During an Open Enrollment Period

During an open enrollment period, the Subscriber and their Eligible Family Members may change coverage to one of the other health care plans for which the Subscriber meets eligibility requirements. This is the only period of time during which a Member may voluntarily change from one health care plan to another for which they are eligible.

Outside the Open Enrollment Period

If you or your covered family member must change to another health care plan being offered by the employer because of a change in the Subscriber's residency (i.e., moving outside a Service Area) or family status (i.e., a Special Enrollment qualifying event), an enrollment/change form must be submitted to BCBSNM as soon as possible (or, for continuation Members, the COBRA administrator). Your effective date under the new health plan will be the first of the month following your change in eligibility status. If you are switching to another health plan due to a Special Enrollment, the effective date of change is explained below.

Special Enrollment For Active Employees And Their Eligible Family Members

There are four instances (qualifying events) in which an eligible person can obtain a Special Enrollment right (See definition in **Section 10: Definitions**). You have a limited amount of time during which you may request a Special Enrollment. If you do not request Special Enrollment within the time period specified below, you will be considered a Late Applicant.

NOTE: There are no Special Enrollments for persons applying for any continuation, conversion coverage, or

extension of benefits due to disability if offered under your plan. You must enroll in these coverages timely.

Qualifying Events

The four instances of Special Enrollment are:

1. Loss of Prior Coverage

An eligible employee who declined coverage when initially eligible because of having other comprehensive medical coverage and who later involuntarily loses the other coverage (or who reaches a lifetime maximum under the prior benefit plan), may apply for coverage for themselves and Eligible Family Members. (The Eligible Family Members need not have been covered under the prior benefit plan when the employee has been granted a Special Enrollment under this provision.) Currently enrolled employees may also add Eligible Family Members to coverage under this provision if the Eligible Family Member had prior Creditable Coverage that was involuntarily lost or had reached lifetime benefit maximum under the other carrier's benefit plan. (See **Section 10: Definitions, Involuntary Loss of Coverage**.)

If a completed and signed enrollment/change form is received by the employer within 31 days of losing the other coverage (or within 31 days of receiving the first denial notice informing the employee or Eligible Family Member that they had reached a lifetime limit), the applicant(s) will not be considered late.

Documentation from the prior carrier supporting the fact that the person had prior Creditable Coverage that was lost involuntarily may be submitted at a later date with the employer's approval, but the employee must submit the completed and signed enrollment/change form within 31 days of the loss of coverage (or denial notice).

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

If the employee lost prior coverage, Special Enrollment is available to the current employee and any Eligible Family Members of the employee (including spouse). If an Eligible Family Member of the current employee lost prior coverage, Special Enrollment is available for the affected Eligible Family Member and the employee (no other Eligible Family Members). The choice to quit paying premiums, for example, because the Subscriber or one family member under the other carrier's benefit plan reaches a lifetime benefit maximum in not an example of involuntary loss of coverage for the entire family. However, in the case of one Eligible Family Member losing prior coverage, although all family members may not be eligible for a Special Enrollment, Eligible Family Members may be enrolled at the same time as the special Enrollee, subject to Late Applicant provisions. Also, in order to be eligible for a Special Enrollment due to loss of prior coverage, the declining person must have completed a waiver of coverage statement when first eligible to enroll, and the reason stated for declining coverage must have been due to having other coverage. If an employee requests a Special Enrollment for self only, Eligible Family Member(s) only, or both, BCBSNM requires proof of loss of coverage or proof of the date of the event.

2. Change in Family Status

An employee who acquires a new Eligible Family Member due to marriage, birth, adoption, or placement for adoption may apply for a Special Enrollment in this plan for themselves and other family members who are eligible for coverage under this plan. Application for Special Enrollment of the employee and their Eligible Family Members will not be considered late if submitted within 31 days of the marriage, birth, adoption, or placement of the Eligible Child in the Subscriber's home. If submitted more than 31 days following the change in family status, Special Enrollment is not available.

- **Newborn or Adopted Child:** For a change in family status due to birth of an eligible newborn or adoption of a child, coverage begins on the date of birth or adoption (or, if earlier, on the date of placement in the Subscriber's home).
- **Marriage:** The Effective Date of Coverage for all persons granted a Special Enrollment due to marriage will be the same as the new spouse's Effective Date of Coverage as described under **Adding an Eligible Family Member to Coverage**.
- **Eligible Foster Child:** For a change in family status due to assumption of care by the Subscriber of an eligible foster child, coverage begins on the date care is assumed by the Subscriber.

This right to Special Enrollment upon a change in family status applies to the employee and to all Eligible Family Members.

Establishing a new Domestic Partnership and adding a child to coverage due to a court order are not considered a change in family status for purposes of the **Special Enrollment** provision.

3. Loss of Medicaid/SCHIP Eligibility

If an eligible employee or their Eligible Family Member is not currently enrolled in the plan and loses eligibility under Medicaid or under a State Child Health Plan (SCHIP), the person losing such coverage may enroll in the plan without being considered a Late Applicant. To be eligible for Special Enrollment, the person must apply for coverage under the Group Health Care Plan no later than 60 days after the date of termination of Medicaid or SCHIP coverage. (In order for an Eligible Family Member to be eligible for Special Enrollment, the employee must be covered under the employer Group Health Care Plan. If the employee is not enrolled in the plan when the Eligible Family Member becomes eligible for assistance, the employee must enroll into the plan at the same time as the Eligible Family Member.)

Documentation from the state supporting the fact that the person had Medicaid/SCHIP coverage that was lost involuntarily may be submitted at a later date with the employer's approval, but the employee must submit the completed and signed enrollment/change form within 60 days of the loss of coverage.

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

If the employee lost Medicaid/SCHIP coverage, Special Enrollment is available to the current employee and any Eligible Family Members of the employee (including spouse). If an Eligible Family Member of the current employee lost Medicaid/SCHIP coverage, Special Enrollment is available for the affected Eligible Family Member and the employee (no other Eligible Family Members).

4. Medicaid/SCHIP Group Health Care Plan Premium Assistance Eligibility

A state may offer premium subsidies through Medicaid or a State Child Health Plan (SCHIP) to low-income children and their families for qualified employer-sponsored coverage. This includes premium assistance for continuation coverage under federal or state law. Therefore, if an eligible employee or an Eligible Family Member is not enrolled in the plan and later becomes eligible for Group Health Care Plan premium assistance under Medicaid or under SCHIP, the eligible person may enroll in the plan without being considered a Late Applicant. To be eligible for Special Enrollment, the affected person must apply for coverage through the employer no later than 60 days after becoming eligible for premium assistance. (In order for a family member to be eligible for Special Enrollment, the employee must be covered under the employer's health plan. If the employee is not enrolled in the plan when the Eligible Family Member becomes eligible for assistance, the employee must enroll in the plan at the same time as the Eligible Family Member.)

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

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

The current employee who is eligible but not enrolled for coverage under the terms of the Group Health Care Plan (or a dependent of such an employee who is eligible but not enrolled for Group Health Care Plan coverage under such terms) may enroll in the Group Health Care Plan upon becoming eligible for a state premium assistance subsidy under Medicaid or SCHIP if Special Enrollment is requested in a timely manner.

Applying for Special Enrollment

Application for Special Enrollment must be made within the time period specified for each of the qualifying events above in order to qualify you and/or your Eligible Family Member(s) for a Special Enrollment right (switch enrollment may be available to Members who are offered more than one plan option). Please contact your benefits administrator for details about Special Enrollment privileges that apply to you and your Eligible Family Members.

Waiving Coverage

If an employee declines to enroll in this Group Health Care Plan when initially eligible to do so, the employee must sign a waiver of coverage statement and submit it to the employer. It is very important that the employee indicate the reason for declining coverage. If the employee declined coverage due to having other health care coverage and later involuntarily loses the other coverage, the employee and their Eligible Family Members may be eligible to enroll in the employer's Group Health Care Plan as special Enrollees. An employee waiver of coverage statement, indicating that coverage is being declined due to having coverage, must be submitted to the employer within 31 days of becoming eligible for coverage under the employer's Group Health Care Plan. If you later lose the other coverage and wish to enroll in the plan as a result, you will also need to submit proof that you had the required Creditable Coverage.

If you do not enroll an Eligible Family Member when they are initially eligible, you do not need to sign a waiver of coverage statement. However, if the affected family member later loses the other coverage and requests a Special Enrollment, you will need to submit proof that the family member had the required Creditable Coverage.

If the person declining coverage later requests a Special Enrollment, but no such proof of loss or prior coverage is provided, or if the reason for declining coverage is not due to having other coverage, they will be ineligible for Special Enrollment. If the person chooses to enroll anyway, the person will be considered a Late Applicant.

Coverage Effective Date

If a Member is granted a Special Enrollment due to involuntary loss of coverage, due to premium assistance eligibility, or due to marriage, and all required documentation is received timely by the employer, coverage will begin no later than the first day of the month after the employer received the request for Special Enrollment. However, for a change in family status due to birth of an eligible newborn or adoption of a child, coverage begins on the date of birth or adoption.

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

Re-Enrollment

If a previously covered employee and/or Eligible Family Member is re-enrolled in this Group Health Care Plan, they will usually be considered a Late Applicant. See **Leave of Absence or Military Service**, later in this section and **Special Enrollment**, earlier in this section, for exceptions and details.

Any individual whose previous BCBSNM contract was terminated for Good Cause is not eligible to re-enroll in this plan, unless approved in writing by BCBSNM. (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 31 days following any changes that may affect theirs 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 from your 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 Health Care Plan are responsible for completing and submitting signed enrollment/change forms to your employer.

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

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

- The employee terminates employment or otherwise loses eligibility according to the terms of the Group Contract. If the Group or Subscriber fails to notify BCBSNM within 30 days to remove an ineligible person from coverage, BCBSNM may recover any payment made on the ineligible person's behalf.

- When the premium payment or other employee contribution for coverage is not received on time (Coverage will be suspended if premium is not paid when it is due. If premium is not received within 30 days after its due date, the Group or affected Member(s) will be terminated at the end of the last-paid billing period. Any Claims for Medically Necessary services received during the 30-day Group grace period will be covered.)

- When the Member begins a leave of absence or enters the armed forces for more than 30 days or as provided by law. (See **Leave of Absence or Military Service**, later in this section.)

- When the Member materially fails to abide by the rules, policies, or procedures of this plan or fraudulently provides or materially misrepresents information affecting coverage. If a Member knowingly gave false material information in connection with the eligibility or enrollment of the Subscriber or any of their Eligible Family Members, BCBSNM may terminate the coverage of the Subscriber and their Eligible Family Members retroactively to the date of initial enrollment. The Subscriber is liable for any benefit payments made as a result of such improper actions.

- When the Subscriber dies (Surviving Eligible Family Members remain covered through the last-paid billing period.)

- If this plan is primary over Medicare due to federal laws and regulations when the Medicare-eligible Member chooses Medicare as their primary coverage (See **Medicare-Eligible Members**, 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 enrollment classification

- When the Group gives BCBSNM or BCBSNM gives the Group a minimum 30 day advance written notice

If you believe your coverage was cancelled due to health status or health requirements, race, gender, age, or sexual orientation, you may appeal such termination to the Office of Superintendent of Insurance. Also, BCBSNM will not cancel your coverage for nonpayment if such a cancellation would constitute abandonment of a Member who is hospitalized and receiving treatment for a life-threatening condition. In addition, BCBSNM will not cancel

your coverage if you refuse to follow a prescribed course of treatment. Before terminating your coverage for reasons other than nonpayment of premium, BCBSNM must provide you written notice at least 30 calendar days in advance. The notice must be in writing and dated, state the reason for cancellation and the date on which it becomes effective, provide you the list of circumstances under which your coverage cannot be cancelled, and provide you information about appealing your termination to the Office of Superintendent of Insurance.

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 **l**ast-paid billing period for Family Coverage
- At the end of the month when a child no longer qualifies as an Eligible Child under the plan (e.g., a child is removed from placement in the home or reaches the Eligible Child age limit)
- At the end of the month following the date of a final divorce decree or legal separation for a spouse
- At the end of the month when the Subscriber gives a minimum 30-day advance notice in writing to end coverage for a covered family member(s), according to the rules of your plan as established by your employer
- At the end of the month following the dissolution of a Domestic Partnership

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

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 their benefits administrator. If voluntary termination is allowed under your plan outside the annual renewal period, coverage will end the first of the month following receipt of the enrollment/change form. Voluntarily terminated Members may re-enroll under the plan only as Late Applicants (except as provided under *Special Enrollment*). Also, these Members are **not** eligible for any extension of benefits or federal continuation or conversion coverage. Voluntarily terminated Members may apply for individual coverage offered by BCBSNM; a health statement will be required, and the application may be denied.

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

Termination and Continuation Coverage or Extension of Benefits

See **How to Continue Coverage**, later in this section, for more information.

Leave of Absence or Military Service
Coverage will end for a Subscriber and their Eligible Family Members at the end of the month during which the leave began. During a leave of absence covered by the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), coverage will continue as provided by law.

Contact your benefits administrator for information.

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 responsibility to advise Members of 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 (for example, to a new age category or geographic location, or from an individual to Family Coverage type)
- After giving the employer and/or Subscriber 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 is no Special Enrollment under these provisions. You must enroll timely to qualify for continued coverage.

Continuation Coverage
Your Group may be subject to the provisions for continuation of plan coverage under federal law (COBRA or USERRA). If so, employees and their covered family members (excluding Domestic Partners 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 in a timely fashion

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.)
- 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**.)

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

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 claim an extension of benefits, you must notify BCBSNM within 31 days of the Group's coverage termination date and provide evidence of your total disability.

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

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

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

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

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

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

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

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

Benefits otherwise payable under a converted or separate policy may be reduced so they are not, during the first Plan Year of the converted or separate policy, in excess of those that would have been payable under the policy from which conversion is exercised. Benefits, if any otherwise payable under a converted or separate policy are not payable for a loss claimed under the policy from which conversion is exercised. Any probationary or waiting period set forth in the converted or separate policy is deemed to commence on the effective date of the applicant's coverage under the original policy.

SECTION 3: HOW YOUR PLAN WORKS

Benefit Choices

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

Your Choices

Preferred Provider Services	Provider Services
• You pay an annual Deductible and a lower percentage of Covered Charges (Coinsurance) after the Deductible is met. • You have a lower annual Out-of-Pocket Limit. • The Provider files Claims for you. • The Provider will not bill you for amounts above the Covered Charge.* • Preferred Providers that contract directly with BCBSNM will obtain necessary Prior Authorizations for you. • Preferred Provider (PPP) and non-PPP Preferred Provider charges are subject to Deductible and Coinsurance (see **Cost-Sharing Feature**s for details).	• You pay a higher annual percentage of Covered Charges after the Deductible is met. • You have a higher annual Out-of-Pocket Limit to meet for Nonpreferred Provider benefit level. • You may need to file Claims. • You may have to pay amounts above the Covered Charge.***** • You are responsible for Admission review and other Prior Authorizations.

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

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

Preferred Providers Versus Nonpreferred Providers

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

Nonpreferred Providers are Providers that have not contracted with BCBSNM, either directly or indirectly, to be part of the Preferred or PPO Provider network. (These Providers may have Participating Provider agreements but are not considered Preferred. See **Section 8: Claims Payments and Appeals, Filing Claims** for more information.)

When you receive treatment or schedule a surgery or Admission, ask each of your Providers if they are a Preferred Provider. (A Physician's or other Provider's contract may be separate from the Facility's contract.)

Pursuant to 13.10.22.8C (1) NMAC, a Member shall not be held liable for payment of services if a BCBSNM Participating Provider mistakenly makes a referral to a Nonparticipating Provider unless BCBSNM has notified the Member in writing concerning the use of Nonparticipating Providers and informed the Member that BCBSNM will not be responsible for future payment to the Nonparticipating Provider.

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

Provider Directory And Online Provider Finder®

When you need medical care, there are a variety of ways you can choose a Primary Preferred Provider (PPP) or other Preferred Provider in your area. You can also access Behavioral Health Services Providers and Participating Pharmacies.

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

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

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

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.

Web-Based BCBSNM Provider Finder®

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

www.bcbsnm.com

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

Paper Provider Network Directory

If you want a paper copy of a BCBSNM Preferred Provider Network Directory, you may request one from BCBSNM Customer Service. You may also call BCBSNM and request a paper copy of a BCBS Provider directory from another state.

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

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

Providers Outside New Mexico

Out-of-state Providers that contract with their local Blue Cross and/or Blue Shield Plan and international Providers that contract with the Blue Cross and Blue Shield Association as Preferred Providers are also eligible for the Preferred Provider level of benefits for Covered Services, listed on the **Summary of Benefits**.

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

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

BCBSNM Website

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

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

National Website

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

Blue Cross and Blue Shield Association website:
www.bcbsglobalcore.com/Account/Login

National Phone Number
Call BlueCard® Access at the phone number below for the names and addresses of doctors and Hospitals in the area where you or an Eligible Family Member need care. When you call, a BlueCard® representative will give you the name and telephone number of a local Provider (you will be asked for the zip code in the area of your search) who will be able to call Customer Service for eligibility information and will submit a Claim for the services provided to the local BCBS Plan, call 1-800-810-BLUE (2583).

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

1-800-810-BLUE (2583)

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.

Benefit Limits
There is no general lifetime maximum benefit under this plan.

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
In most cases, you will have to meet a Deductible and pay a percentage of the Covered Charge (Preferred Providers will not bill you for amounts in excess of the Covered Charge). Refer to your **Summary of Benefits** for details.

Deductible
The Deductible is the amount of Covered Charges that you must pay in a Plan Year before this plan begins to pay its share of the applicable (Preferred or Nonpreferred Provider) Covered Charges you incur during the same Plan Year.

Individual Deductible
There are two individual Deductible amounts indicated on your **Summary of Benefits**. Once a Member's Deductible payments for Preferred Provider services reach the individual Preferred Provider Deductible amount, this plan will begin paying its share of that Member's covered Preferred Provider charges. The Member must meet the higher Nonpreferred Provider Deductible before this plan begins to pay its share of their Covered Charges from Nonpreferred Providers.

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

Family Deductible
An entire family meets the annual Deductible when the total Deductible amount for all family members reaches the amount specified on your **Summary of Benefits**. (Once an individual family member's Deductible is met, no

more charges incurred by that Member may be used to satisfy the applicable family Deductible. The Deductible amounts for the remaining family members are combined to satisfy the total family Deductible.)

What Is Not Subject to the Deductible
The charges for the following services are not applied to the annual Deductible when obtained by a Preferred Provider:

- Charges covered under your **Drug Plan Rider**
- Preventive Services
-
- COVID-19 services, testing and vaccines

Admissions Spanning Two Plan Years
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.

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

Office Visit
When you receive office services from a Preferred Provider, Deductible and Coinsurance will apply for the covered office visit charges. The cost share amounts for Primary Preferred Provider (PPP) and PPO Specialist office visits are listed on the **Summary of Benefits**. However, all other services received during the office visit (such as Physical Therapy or Chemotherapy) will be subject to regular Deductible and/or Coinsurance requirements as listed on the **Summary of Benefits**.

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

Preferred (PPO) Specialist is a Practitioner of the Healing Arts who is in the Preferred Provider Network but does not belong to one of the specialties defined above as being for a Primary Preferred Provider (or PPP). A PPO Specialist does not include Hospitals or other treatment facilities, Urgent Care facilities, pharmacies, equipment suppliers, Ambulance companies, or similar ancillary health care Providers.

Drug Plan Copayment
When you purchase covered prescription drugs and other items through the drug plan, your responsibility may be either a fixed-dollar amount or a percentage of the Covered Charge. (You may also have to pay the difference between the cost of a brand-name drug and its generic equivalent.) See your **Drug Plan Rider** for more information about the amounts you pay under the drug plan.

Coinsurance
For some Covered Services, you must pay a percentage of Covered Charges (Coinsurance) after you have met your annual Deductible. After your share has been calculated, this plan pays the rest of the Covered Charge. You pay a lower percentage of Covered Charges when you visit a Preferred Provider.

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

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

Copayments and Coinsurance for Behavioral Health Services After the Deductible is Met
After the applicable Deductible has been met, you will no longer be responsible for Copayments or Coinsurance for covered Behavioral Health Services. For this purpose, Behavioral Health Services are defined as professional and ancillary services for the treatment, habilitation, prevention and identification of mental illnesses, substance abuse disorders and trauma spectrum disorders, including inpatient, detoxification, residential treatment and partial hospitalization, intensive outpatient therapy, outpatient and all medications, including brand-name pharmacy drugs when generics are unavailable. Refer to your **Summary of Benefits** for details.

Preferred Providers
When you receive Covered Services from a Preferred Provider, you pay an annual Deductible and, after meeting the Deductible, you pay a percentage of Covered Charges (Coinsurance) Preferred Provider office visit charges are subject to the Coinsurance or Deductible unless listed as otherwise on your **Summary of Benefits**.

Nonpreferred Providers
When you receive Covered Services from a Nonpreferred Provider, you have a higher Deductible amount to meet each year and you must pay a higher percentage of Covered Charges for Nonpreferred Provider services. If the Covered Charge is less than the billed charge, you will also be responsible for paying the difference when you receive services from a Nonpreferred Provider. See **Section 8: Claims and Appeals, Provider Payment Example**, for more information.

Out-Of-Pocket Limit

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

Individual Limits
Once your Coinsurance and Deductible amounts for Preferred Provider services in a Plan Year reach the individual Preferred Provider amount indicated on the **Summary of Benefits**, this plan pays 100% of most of your covered Preferred Provider charges for the rest of the Plan Year.

Once your Coinsurance amounts for Nonpreferred Provider services in a Plan Year reaches the higher individual Nonpreferred Provider amount indicated on the **Summary of Benefits**, this plan pays 100% of most of your covered Nonpreferred Provider charges for the rest of the Plan Year.

Family Limits
An entire family meets the Out-of-Pocket Limit during a Plan Year when the total Deductible, Coinsurance and Copayments for all family members reaches the amount specified in the **Summary of Benefits**. (When a Member meets the individual Out-of-Pocket Limit, no more charges incurred by that Member may be used to satisfy the family Out-of-Pocket Limit.) The Deductible, Coinsurance and Copayments for the remaining family members are combined to satisfy the family out-of-pocket.

What Is Not Included in the Out-of-Pocket Limits
The following amounts are not applied to the Out-of-Pocket Limits and are not eligible for 100% payment under this provision:

- Amounts in excess of Covered Charges
- Noncovered expenses

See the **Summary of Benefits** for your Deductible amounts, 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 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.

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.

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.

If your employer provided a choice of two or more benefit plan options and you wish to change to a lower or higher Deductible (and Out-of-Pocket Limit), you may do so only during your Group's annual renewal period.

No Cost-Sharing For In-Network Behavioral Health Services

Once you have met your Deductible,Cost-sharing is eliminated for all professional and ancillary services for the treatment, rehabilitation, prevention and identification of mental illnesses, substance abuse 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.

NOTE: Your Deductible must be met before cost sharing will be eliminated for these behavioral health services.

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 (EOB) 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 EOB 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 a Network Provider.

You may be required to pay a Copayment, 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
Condoms
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/docs/rx-drugs/nm/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 a 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
Once you have met your Deductible, this plan will cover vasectomies and condoms with no cost share. Please see the section below on **Coverage for Contraception Where a Prescription Is Not Required** for instructions on reimbursement for condoms.

Sexually Transmitted Infections (STI)
We cover, 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 from a Participating Provider. Treatment, which means Medically Necessary care for an existing STI, will be provided at no charge, when obtained from a Participating Provider.

Coverage for Contraception Where a Prescription Is Not Required
We cover 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 along with the Claim Form - Prescription Drug, also known as a reimbursement form, (available by calling the customer service number on the back of your ID Card or visiting www.bcbsnm.com), to the following address:

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 Network Provider.

You may be required to pay a Copayment, 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 a 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 Member, 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 Customer Service 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 by contacting:

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 1-833-415-0566

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:

Office of Superintendent of Insurance - MHCB
1120 Paseo De Peralta
Santa Fe, NM 87501
Telephone: 1-833-415-0566
E-mail: mhcb.grievance@state.nm.us

Coverage For Individuals With Diabetes

We provide 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 Durable Medical Equipment (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
We cover 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, Durable Medical Equipment (DME), Insulin, and Supplies
We cover 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

We require the use of approved DME brands that are purchased at in-network pharmacy, preferred vendor or preferred Durable Medical Equipment supplier.

We 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 (FDA). 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 Care 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 Plan 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
- 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, Copayment 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 Care 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 Care 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 Care Benefits plan in a timely manner, and when needed, you can:

- Contact us at the toll-free telephone number on the back of your ID 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
- 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 days. If we fail to reimburse you in a timely manner, we will pay an interest rate of 18% per year on the amount due.

If you are not satisfied with our resolution you can file a complaint with the Office of 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 (MH/SUD) 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 New Mexico 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 therapy (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 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 you and your MH/SUD Provider.
- 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.

Benefit Level Exceptions

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

Emergency Care

If you visit a Nonpreferred Provider for Emergency Care services, the Preferred Provider benefit is applied only to the initial treatment, which includes emergency room services and, if you are hospitalized within 48 hours of an emergency, the related inpatient hospitalization. (Emergency services are typically provided, but not limited to emergency rooms, trauma centers, or ambulances.) Non-emergency Behavioral Health services provided in an emergency room will be paid the same as Emergency Care services.

NOTE: All Members have access to emergent and Urgent Care triage services 24 hours a day, 7 days a week.

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

Transition of Care

This provision applies to both Continuity of Care and Transition of Care. If your health care Provider leaves the BCBSNM Provider network (for reasons other than medical competence or professional behavior) or if you are a new Member and your Provider is not in the Provider network when you enroll, BCBSNM may authorize you to continue an ongoing course of treatment with the Provider for a transitional period of time of not less than 30 days. (If necessary and ordered by the treating Provider, BCBSNM may also authorize transitional care from other out-of-network Providers.) An ongoing course of treatment will include, but is not limited to:

- Treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted
- Treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the Covered Person is currently receiving, such as Chemotherapy, Radiation Therapy or post-operative visits
- The second or third trimester of pregnancy, through the postpartum period
- 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 BCBSNM Customer Service 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 Authorizations for services of an out-of-network Provider. Services of an out-of-network Provider are not covered at the In-Network level (if any) in such instances of extended coverage.

Unsolicited Providers

In some states, the local BCBS Plan does not offer Preferred Provider contracts to certain types of Providers (e.g., Home Health Care Agencies, Chiropractors, Ambulance Providers). These Provider types are referred to as unsolicited Providers. Unsolicited Providers vary from state to state. If you receive Covered Services from an unsolicited Provider outside New Mexico, you will receive the Preferred Provider benefit level for those services. However, the unsolicited Provider may still bill you for amounts that are in excess of Covered Charges. You will be responsible for these amounts, in addition to your Deductible(s) and Coinsurance.

Ancillary Provider

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

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

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

SECTION 4: UTILIZATION MANAGEMENT

Utilization Management may be referred to as Medical Necessity reviews, utilization review (UR), or medical management reviews. A Medical Necessity review for a procedure/service, inpatient Admission and length of stay is based on BCBSNM Medical Policy and/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. However, some services may require a Prior Authorization before the start of services, while other services will be subject to a Post-Service Medical Necessity review. If requested, services normally subject to a Post-Service Medical Necessity review may be reviewed for Medical Necessity prior to the service through a recommended clinical review as defined below.

Refer to the definition in **Section 10: Definitions, Medically Necessary/Medical Necessity** 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 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.

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 ID 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 and Substance Use Disorder condition, illness, injury or disease.

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** section of this Benefit Booklet.

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 calendar 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 are Prior Authorized. Your 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 and the status of Prior Authorization requests (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 Prior Authorized, you may appeal the decision as explained in **Section 8: Claims Payments and Appeals**.

Prior Authorization Responsibility

BCBSNM Preferred Provider (Participating Provider, In-Network Provider) Prior Authorization

Your Preferred Provider is responsible for obtaining Prior Authorization, in those circumstances where authorizations may be required. If Prior Authorization is not obtained 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.

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

NOTE: Providers that contract with other Blue Cross and Blue Shield Plans are not familiar with the Prior Authorization requirements of BCBSNM. Unless a Provider contracts directly with BCBSNM as a Preferred Provider, the Provider is not responsible for being aware of this plan's Prior Authorization requirements, except as described in the section **BlueCard® Program** in the **General Provisions** section of this Benefit Booklet.

Nonpreferred Providers Or Providers Outside New Mexico

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

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 telephone numbers on the back of your ID Card. The call should be made between 8:00 A.M. and 5:00 P.M. MT on business days and 8:00 A.M. and 11:00 A.M. MT on Saturdays, Sundays and legal holidays. After working hours or on weekends, please call the toll-free telephone number on the back of your ID 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**.**

In-network benefits will be available if you use a Preferred Provider or Preferred Specialty Care Provider. If you elect to use out-of-network Providers for services and supplies available in-network, out-of-network benefits will be paid.

However, if care is not reasonably available from Preferred Providers as defined by applicable law, and BCBSNM prior authorizes your visit to an out-of-network Provider to be covered at the in-network benefit level prior to the visit, in-network benefits will be paid; otherwise, out-of-network benefits will be paid.

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 the **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 (C-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 toll-free telephone number on the back of your ID Card.

For Behavioral Health Outpatient Service review please see the **Contacting Behavioral Health** section below.

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/Substance Use Disorder (MH/SUD) services:			
Process:	**Type of Service:**	**Phone/Fax:**	**Send to:**
Request Prior Authorization	Medical/Surgical	Phone: 1-800-325-8334 Fax: 866-589-8523	BCBSNM P.O. Box 660058 Dallas, TX 75266-0058
	MH/SUD	Phone: 1-888-898-0070 Fax: 877-361-7659	BCBSNM BH Unit P.O. Box 660058 Dallas, TX 75266-0058
Customer Service inquiry	Medical/Surgical	Phone: 1-800-432-0750	BCBSNM P.O. Box 660058 Dallas, TX 75266-0058
	MH/SUD	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
	MH/SUD		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
	MH/SUD	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; MH/SUD	Phone: 1-833-415-0566	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 we pay for Inpatient Services, but they do not deny your right to be admitted to any Facility and to choose your services.

Other Prior Authorizations

In addition to Prior Authorization review for all non-emergency Inpatient Services, Prior Authorization is required for certain other services listed below. Most Prior Authorizations may be requested over the telephone. If a written request is needed, have your Provider call a Health Services representative for instructions for filing a written request for Prior Authorization. An out-of-network Provider, or an out-of-state Network Provider may call on your behalf, but it is your responsibility to ensure that BCBSNM is called. Preferred Providers that contract directly with BCBSNM are responsible for requesting all necessary Prior Authorizations for you. (See **Inpatient Prior Authorization** for further information regarding inpatient Prior Authorization requirements.)

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

No Prior Authorization Received:	Claim Disposition: Preferred	Claim Disposition: Nonpreferred
Service is Medically Necessary	Claim is paid based on Member's benefit plan	Claim is paid based on Member's benefit plan
Service is not Medically Necessary	Claim is denied	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 concerns. There are two different procedures depending upon the type of issue involved, pre-service or post-service. This is a summary of the procedures that apply to Prior Authorization requests (pre-service Claims). For appeals involving post-service Claims payments or denials, see **Section 8: Claims Payment and Appeals**.

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

If you have an inquiry or a concern about any Prior Authorization request, call your Customer Service Advocate at the toll-free telephone number on the back of your ID Card 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 in this Benefit Booklet.

Upon completion of the inpatient or emergency Admission review, BCBSNM will send a letter to you, your Physician, Behavioral Health practitioner and/or 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 **Claims Payments and Appeals** section of this Benefit Booklet.

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

Recommended Clinical Review

A recommended clinical review is a voluntary Medical Necessity review. BCBSNM will review the request to determine if it meets approved BCBSNM medical policy and/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 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 toll-free telephone number on the back of your ID Card.

Recommended clinical 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. Please coordinate with your Provider to submit a request for a recommended clinical review.

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 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 telephone number on the back of your ID 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 P.M., 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 Reviews

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 affected for a variety of reasons. For example, the Member may have become ineligible as of the date of service or the Member's benefits may have changed as of the date of service. 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**.

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. Providers should submit appropriate documentation at the time of a Post-Service Medical Necessity Review request. A Post-Service Medical Necessity Review may be performed when a Prior Authorization was not obtained prior to services being rendered.

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, limitations, and exclusions of this Benefit Booklet. Post-Service Medical Necessity Reviews do not guarantee payment of benefits by BCBSNM, for instance a Member may become ineligible as of the date of service or the Member's benefits may have changed as of the date of service.

Request for Additional Information

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

SECTION 5: COVERED SERVICES

This section describes the services and supplies covered by this Group Health Care Plan, subject to the limitations and exclusions in **Section 3: How Your Plan Works** and **Section 6: General Limitations and Exclusions**. All payments are based on Covered Charges as determined by BCBSNM. Services of a Noncontracting Provider are covered only in an emergency or if Prior Authorization is given 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.

NOTE: 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 non-participating. 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 Customer Service at the toll-free telephone number on the back of your ID Card.

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

Medically Necessary Services

A service or supply is Medically Necessary when it is provided to diagnose or treat a covered medical condition, is a service or supply that is covered under this plan, and is determined by BCBSNM's medical director (in consultation with your Provider) 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 all of the conditions of Medically Necessary as defined above in order to be covered.

NOTE: Because a health care Provider prescribes, orders, recommends, or approves a service does not make it Medically Necessary or make it a Covered Service, even if it is not specifically listed as an exclusion. BCBSNM will determine Medical Necessity based on the criteria above.

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, which 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 not Medically Necessary will be denied.

Ambulance Services

We cover Ambulance Services when a Member requires emergency Health Care Services under circumstances that would lead a reasonable/prudent layperson acting in good faith to believe that transportation in any other vehicle would result in jeopardy to your physical or Mental Health.

Services must be provided by a licensed Ambulance Service, in a vehicle that is equipped and staffed with life-sustaining equipment and personnel. We will cover services for transportation within New Mexico, to the nearest in-network facility where emergency Health Care Services and treatment can be rendered, or to an out-of-network facility if an in-network facility is not reasonably accessible or able to provide required care.

We will also cover services for transportation outside of New Mexico, to the nearest appropriate facility where emergency Health Care Services and treatment can be rendered.

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 you required emergency Health Care Services, including consideration of your presenting symptoms
- 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, high-risk situation, this plan also covers Medically Necessary ambulance transportation to a Health Care Facility with appropriate Facilities, or from one Hospital to another.

Inter-facility transfer Ambulance Services transporting between hospitals, skilled nursing facilities, or diagnostic facilities are covered, if Medically Necessary.

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 PPO's established procedures for obtaining Emergency Care

Air Ambulance

Ground ambulance is usually the approved method of transportation. We cover air ambulance when Medically Necessary.

We will not pay more for air Ambulance Services than we would have paid for ground Ambulance Services over the same distance unless your medical condition renders the utilization of such ground Ambulance Services medically inappropriate.

Exclusions

We do 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

Autism Spectrum Disorders

We cover the diagnosis, Habilitative 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. Any treatment plan to treat Autism Spectrum Disorder shall include the diagnosis, the proposed treatment by types, the frequency and duration of treatment, the anticipated outcomes stated as goals, the frequency with which the treatment plan will be updated, and the signature of the treating Provider.

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. Examples include therapy for a child who is not walking or talking at the expected age and includes therapy to enhance the ability of a child to function with a Congenital, Genetic or Early Acquired disorder. There services may include Physical Therapy, 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 Benefit Booklet. 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** listed in this Benefit Booklet except where explicitly mentioned as being an exception. This benefit is subject to the other general provisions of the plan, including but not limited to coordination of benefits, Participating Provider agreements, restrictions on Health Care Services, including review of Medical Necessity, case management, and other managed care provisions.

Regardless of the type of therapy received, Claims for services related to Autism Spectrum Disorder should be 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
We do not cover:

- Any Experimental, long-term, or maintenance treatments not covered under state law. You may contact Customer Service at the toll-free telephone number on the back of your ID 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
- 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) or Auditory Integration Therapy (AIT)
- Music therapy, vision therapy, touch or massage therapy
- Floor time

- Facilitated communication
- Elimination diets; nutritional supplements; intravenous immune globulin infusion; secretin infusion
- Chelation therapy
- Hippotherapy, animal therapy, or art therapy

Dental-Related Services And Oral Surgery

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

Dental and Facial Accidents

Benefits for Covered Services for the treatment of Accidental Injuries to the jaw, mouth, face, Sound Natural Teeth, or surrounding tissue 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 accident 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 and any services required after the initial treatment must be associated with the initial accident in order to be covered. (For treatment of TMJ or CMJ injuries, see **TMJ/CMJ Services**, later in this section.)

Facility Fees and General Anesthesia for Dental-Related Services

We cover 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 with or without additional adjunctive techniques and modalities cannot be expected to produce a successful or superior result
- 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, anxious, or uncommunicative with dental needs that 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. See **Section 4: Utilization Management** for more information about Prior Authorization requirements.

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

Oral Surgery

We cover the following oral surgical procedures only:

- Medically Necessary orthognathic surgery
- External or intraoral cutting and draining of cellulitis (not including treatment of dental-related abscesses)
- Incision of accessory sinuses, salivary glands or ducts

- Lingual frenectomy
- Removal or biopsy of tumors or cysts of the jaws, cheeks, lips, tongue, roof or floor of mouth when pathological examination is required
- Medically Necessary oral Surgery to treat infections or abscesses of the teeth that involve 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

We cover Medically Necessary diagnostic, therapeutic, surgical and nonsurgical treatments of Temporomandibular Joint (TMJ) and Craniomandibular Joint (CMJ) disorders or Accidental Injuries. These services are subject to the same conditions and limitations as applied to treatment of any other joint in the body. Treatment may include orthodontic Appliances and treatment, crowns, bridges, or dentures only if required because of an Accidental Injury to Sound Natural Teeth involving the Temporomandibular or Craniomandibular Joint.

Exclusions

We do 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, exostoses, or impacted teeth
- 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 corresponding **Dental Care Rider** for more details regarding your dental coverage.

Diabetic Services

Diabetic persons are entitled to the same benefits for Medically Necessary Covered Services as are other Members under the Group 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

Emergency Care

We cover 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. (Emergency services are typically provided, but not limited to emergency rooms, trauma centers, or ambulance.) 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 Behavioral Health Services provided in an emergency room will be paid the same as Emergency Care services.

NOTE: All Members have access to emergent and Urgent Care triage services 24 hours a day, 7 days a week when those services are needed immediately to prevent jeopardy to the Member's health.

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

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

If you visit a Nonpreferred Provider for Emergency Care, the Preferred Provider benefit is applied only to the initial treatment, which includes emergency room services and, if you are hospitalized within 48 hours of an emergency, the related inpatient hospitalization. Once you are discharged, covered non-emergent follow-up care from a Nonpreferred Provider is paid at the Nonpreferred Provider benefit level. (Emergency services are typically provided but not limited to emergency rooms, trauma centers, or ambulances.) Non-emergency Behavioral Health Services provided in an emergency room will be paid the same as Emergency Care services.

We cover Emergency Care for trauma services and all other emergency services until the Member is medically stable, does not require critical care, and can be safely transferred to an in-network facility if required.

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

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

Follow-Up Care
For all non-emergent follow-up care (which is no longer considered Emergency Care) and for all other non-Emergency Care, you will receive the Nonpreferred Provider benefit for the Covered Services of a Nonpreferred Provider.

Urgent Care
We cover Urgent Care services, which means Medically Necessary medical or surgical procedures, treatments, or services received for an unforeseen condition that is not life-threatening. The condition does, however, require prompt medical attention to prevent a serious deterioration in your health (e.g., high fever, cuts requiring stitches).

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

Genetic Inborn Errors of Metabolism (IEM)

We cover Medically Necessary expenses related to the diagnosis, monitoring, and control of Genetic Inborn Errors of Metabolism as defined in **Section 10: Definitions**. 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 IEM.

Covered Services

- Nutritional and medical assessment
- Clinical services
- Biochemical analysis
- Medical Supplies
- Prescription drugs/Medications (see your **Drug Plan Rider**),
- Corrective lenses for conditions related to IEM
- Nutritional management
- Special Medical Foods (as defined and described in your **Drug Plan Rider**).
- One pair of standard (non-tinted) eyeglasses (or contact lenses if medically necessary) when related to IEM (This includes the eye refraction examination, lenses and standard frames.)

Exclusions

- Food substitutes for lactose intolerance or other carbohydrate intolerances, including soy foods or elemental formulas or other over the counter (OTC) digestive aids are not covered
- Ordinary foodstuffs that might be part of an exclusionary diet
- Food substitutes that do not qualify as special medical foods for the treatment of IEM
- Special medical foods that are not Medically Necessary
- Dietary supplements and items for conditions including, but not limited to, diabetes mellitus, hypertension, hyperlipidemia, obesity, Autism Spectrum Disorder, celiac disease and allergies to food products

In order to be covered, services cannot be excluded under any other provision of this Benefit Booklet and are paid according to the provisions of the plan that apply to that particular type of service (e.g., Special Medical Foods are covered under your **Drug Plan Rider**, medical assessments under **Physician Visits/Medical Care.**

Hearing Aids/Related Services For Children Up To Age 21

We cover 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 provided by an audiologist, or Provider for Members up to 21 years old.

Benefits for hearing aid-related services payable under this provision are not subject to any Deductible or Coinsurance amount.

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

Home Health Care/Home Intravenous (I.V.) Services

Conditions and Limitations of Coverage

If you are homebound due to physical illness (unable to receive medical care on an outpatient basis), we cover 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. A *visit* is one period of home health service of up to four hours. Home Health Care has a maximum of 100 visits per year.

Prior Authorization Required

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

Covered Services

We cover 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
- Medical equipment, prescription drugs and medications, laboratory services and supplies deemed Medically Necessary by a Provider for the provision of health services in the home, except Durable Medical Equipment, will be covered 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 (If drugs are not provided by the Home Health Care Agency, see your **Drug Plan Rider**.)
- 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 **Drug Plan Rider**.)
- Skilled services by a qualified aide to do such things as change dressings and check blood pressure, pulse, and temperature

Cost-Sharing

Your Copayment, 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, 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, Coinsurance or Deductible based on the type of Provider, service, or supply.

Exclusions

We do 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

We cover inpatient and home Hospice services for a Terminally Ill Patient 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. (See **Section 10: Definitions, Hospice Benefit Period**, for more information.)

Covered Services

We cover the following services, subject to the conditions and limitations under the Hospice Care benefit:

- Visits from Hospice Physicians
- Skilled Nursing Care by a Registered Nurse or Licensed Practical Nurse
- Physical and Occupational Therapy by licensed or certified Physical or Occupational Therapists
- Speech Therapy provided by an American Speech and Hearing Association certified therapist
- Medical Supplies (If supplies are *not* provided by the Hospice agency, see **Supplies, Equipment and Prosthetics**, later in this section.)
- Drugs and medications for the Terminally Ill Patient (If drugs are *not* provided by the Hospice agency, see your **Drug Plan Rider**.)
- 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
- 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 caregiving by the family.)

Cost-Sharing

Your Copayment, 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, Coinsurance, or Deductible based on the type of Provider, service or supply.

Exclusions

We do not cover:

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

Where there is not a certified Hospice program available, regular Home Health Care Services benefits will apply.

Hospital/Other Facility Services

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).

Covered Services
For acute inpatient medical or surgical care received during a covered Hospital Admission, we cover room and board and other Medically Necessary services provided by the Facility.

Blood Services
We cover the processing, transporting, handling, and administration of blood and blood components. We cover directed donor or autologous blood storage fees only when the blood is used during a scheduled surgical procedure. We do not cover blood replaced through donor credit.

Medical Detoxification
We cover 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)**, later in this section, for information about benefits for Substance Use Disorder rehabilitation. See **Section 4: Utilization Management**, for more information about Prior Authorization requirements.

Exclusions
We do 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 (for example, see **Lab, X-Ray, Other Diagnostic Services**, later in this section or **Emergency Care and Urgent Care**, earlier in this section).

Lab, X-Ray, Other Diagnostic Services
For invasive diagnostic procedures such as biopsies and endoscopies or any procedure that requires the use of an operating or recovery room, see **Surgery and Related Services**, later in this section.

We cover Diagnostic Services, including but not limited to, pre-Admission testing, which are related to an illness or Accidental Injury. Covered Services include:
- X-ray and radiology services, ultrasound, and imaging studies
- Laboratory and pathology tests
- EKG, EEG, and other electronic diagnostic medical procedures
- Genetic testing (Tests such as amniocentesis or ultrasound to determine the gender of an unborn child are not covered; see **Maternity/Reproductive Services and Newborn Care**, below.)
- Infertility-related testing (See **Maternity/Reproductive Services and Newborn Care**, below.)
- PET (Positron Emission Tomography) scans, cardiac CT scans
- MRIs
- Psychological or neuropsychological testing with Prior Authorization from BCBSNM
- Audiometric (hearing) and vision tests for the diagnosis and/or treatment of an Accidental Injury or and illness

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

Coronary Artery Calcification Tests
Early detection test for cardiovascular disease (CVD). 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

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, after your Deductible has been met.

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. Some services requiring Prior Authorization will not be approved for payment.

Maternity, Reproductive Services, And Newborn Care

Like benefits for other conditions, Member cost-sharing amounts for pregnancy, family planning, infertility, and Routine 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 a Provider in the Preferred or Participating Provider network. When these services are received from an out-of-network Provider, if your plan has out-of-network benefits for non-emergency services, the usual out-of-network Deductible, Coinsurance, and out-of-pocket amounts will apply.

- Clinical contraceptive services such as consultations, examinations, procedures (including for immediate (pre-discharge) postpartum 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
- Female surgical sterilization procedures (other than hysterectomy), including tubal ligations

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

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

Covered contraceptive drugs and devices are available by contacting Customer Service at the toll-free telephone number on the back of your ID Card or posted on the BCBSNM website:

www.bcbsnm.com/docs/rx-drugs/nm/contraceptive-list-nm.pdf

Infertility-Related Services
We cover the diagnosis and the following Medically Necessary infertility-related treatments (**NOTE:** The following procedures only secondarily treat infertility):

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

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

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

Exclusions
In addition to services not listed as covered above, we do not cover:

- Sterilization reversal (Sterilization reversal may be performed for the treatment of a medical condition brought on by the sterilization.)
- 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
- Other artificial methods of conception

Pregnancy-Related/Maternity Services
If you are pregnant, you should call BCBSNM before your maternity due date, soon after your pregnancy is confirmed. BCBSNM must be notified as soon as possible if the birthing parent's stay is greater than 48 hours for a routine delivery or greater than 96 hours for a C-section delivery.

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

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

Covered Services

Covered Pregnancy-Related/Maternity Services include:

- Hospital or other Facility Fees for room and board and ancillary services, including the use of labor, delivery, and recovery rooms (We cover all Medically Necessary hospitalization, including at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a C-section delivery. **NOTE:** Newborns who are not eligible for coverage under this plan will not be covered beyond the 48 or 96 hours required under federal law.)

- Routine or complicated delivery, including prenatal and postnatal medical care of an Obstetrician, Certified Nurse Midwife or Licensed Midwife. (Expenses for prenatal and postnatal care are included in the total Covered Charge for the actual delivery or completion of pregnancy.) **NOTE:** Home births are not covered unless the Provider has a Preferred 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. (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 in accordance with existing 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 individual 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

- Elective, spontaneous, or therapeutic abortion prior to full term

Special Beginnings®

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

1-888-421-7781

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).

Newborn Care
If you have Family Coverage on the date a new Eligible Child is born, the initial newborn care for the child is covered. If you do not have coverage for your newborn on the date of birth, you must add coverage within 31 days of birth in order for any newborn charges, routine or otherwise, to be covered beyond the first 48 hours of birth (or 96 hours in the case of a C-section).

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

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, including Provider visits and incubators
- 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 newborn's services will be subject to a separate Copayment and Out-of-Pocket Limit.

Breastfeeding Support and Services
We cover counseling and support services rendered by a lactation consultant such as a Certified Nurse Practitioner, Certified Nurse Midwife or midwife, not subject to Coinsurance, Deductible, Copayment, or benefit maximums when received from a Provider in the Preferred or Participating Provider network (if your plan has out-of-network benefits for non-emergency services, out-of-network services are subject to the usual out-of-network Deductible, Coinsurance, and out-of-pocket amount).

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., later in this section).

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

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

Allergy Care
We cover Medically Necessary direct skin (percutaneous and intradermal) and patch allergy tests, radioallergosorbent testing (RAST), allergy serum, and appropriate FDA-approved allergy injections administered in a Provider's office or in a Facility.

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.

Injections and Injectable Drugs
We cover most FDA-approved therapeutic injections administered in a Provider's office. However, we cover 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 BCBSNM Customer Service. (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 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. Call a BCBSNM Customer Service Advocate if you have any questions about this policy.

Inpatient Medical Visits
With the exception of Dental-Related Services, we cover the following services when received on a covered inpatient Hospital stay:

- Visits for a condition requiring only medical care, unless related to Hospice Care
- Consultations (including second opinions) and, if surgery is performed, inpatient visits by a Provider who is not the surgeon and who provides medical care not related to the surgery (For the surgeon's services, see **Surgery and Related Services** or **Transplant Services**, later in this section.)
- Medical care requiring two or more Physicians at the same time because of multiple illnesses
- Initial Routine Newborn Care for a newborn added to coverage within the time limits specified in **Section 2: Enrollment and Termination Information** (See **Maternity/Reproductive Services and Newborn Care**, earlier in this section, for details and for extended stay benefits.)

Mental Health Evaluation Services
We cover medication checks and intake evaluations for Mental Health, Alcohol, and Drug Abuse. See **Psychotherapy (Mental Health and Substance Use Disorder)**, later in this section, for psychotherapy and other therapeutic service benefits.

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.

We cover 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. Out-of-network services are subject to the usual out-of-network Deductible, Coinsurance, and Out-of-Pocket Limit.

- 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 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, and 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 ID Card.

Preventive drugs (including both prescription and over-the-counter products) that meet the preventive recommendations outlined above 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, Coinsurance, Deductible, or dollar maximum when obtained from a Participating Pharmacy. Drugs on the ACA No-Cost Preventive Drug List that are obtained from a nonparticipating Pharmacy may be subject to Copayment, Coinsurance, Deductible, or dollar maximums, if applicable.

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

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

The list below is subject to change. A current list is available to you and your Physician on the USPSTF website at: www.uspreventiveservicestaskforce.org/Page/Name/recommendations, or you can contact Customer Service at 1-800-432-0750.

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

- Abdominal aortic aneurysm screening for men ages 65 to 75 who have ever smoked
- Clinicians offer or refer adults with a Body Mass Index (BMI) of 30 or higher to intensive, multicomponent behavioral interventions
- Unhealthy alcohol and drug use screening and counseling
- Blood pressure screening
- Colorectal cancer screening for adults age 45 and over
- Depression screening
- Physical activity counseling for adults who are overweight or obese and have additional cardiovascular disease (CVD) 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,

- 1 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 cancer 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, including 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 Care 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

HDHP-HSA Preventive Drug Program
In addition, to the preventive care services listed above, if you are covered under a HDHP-HSA plan, your benefits include coverage for certain outpatient prescription drugs, when prescribed by a Physician that are covered under the HDHP-HSA Preventive Drug Program. A list of the specific drugs included in the HDHP-HSA Preventive Drug Program, is available to you and your Physician by accessing the BCBSNM Website at: www.bcbsnm.com or you can contact Customer Service at the toll-free number on your ID Card. For covered drugs please refer to the specific Drug List for your plan.

Benefits for outpatient prescription drugs covered under the HDHP-HSA Preventive Drug Program will be provided at 100% of the Covered Charge and will not be subject to any Deductible, Coinsurance, and/or Copayment when obtained from a Preferred Participating Pharmacy or a Participating Pharmacy when prescribed for preventive purposes.

Benefits for outpatient prescription drugs covered under the HDHP-HSA Preventive Drug Program will be subject to nonparticipating pharmacy cost-sharing when obtained from a nonparticipating Pharmacy.

These drugs could also at times be prescribed for treatment purposes. If your Physician has prescribed a listed drug for treatment purposes (and not preventive purposes) then it will be subject to any applicable Deductible, Coinsurance, and/or Copayment.

NOTE: For more information on drugs covered under your outpatient prescription drug benefit refer to the **Drug Plan Rider**.

Exclusions
We do 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 persons 40-49, and one mammogram annually for persons 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.

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, Mental Health or Substance Use Disorder 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.*

HDHP-HSA - Behavioral Health Services

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, which 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.

NOTE: If covered Mental Health or Substance Use Disorder services are found to be Medically Necessary and a Prior Authorization is granted, it will not be rescinded or modified after your Provider renders services, except in cases of fraud or violation of the Provider's 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 through Prior Authorization by the Behavioral Health Unit (BHU) 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 Works**.

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 Disorder 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
We cover Residential Treatment Centers. 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 Health 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.

Exclusions
We do 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, wilderness, summer camp, or ranch programs
- Maintenance therapy or care provided after you have reached your rehabilitative potential
- Biofeedback, hypnotherapy, 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 purpose of providing Custodial Care service, convalescent care, rest cures, or domiciliary care to the patient
- Services or supplies received during an inpatient stay when the stay is solely related to behavior, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and Mental 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 Disorders or other disturbances
- Non-national standard therapies, including those that are Experimental as determined by the Mental Health professional practice
- The cost of any damages to a treatment Facility

Rehabilitation And Other Therapy

When billed by a Facility during a covered Admission, therapy is covered in the same manner as the other ancillary services (See **Hospital/Other Facility Services**, earlier in this section).

Acupuncture and Chiropractic Services
We cover Acupuncture, acupressure, osteopathic, 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. Benefits for Acupuncture and for Chiropractic Services are specified in the **Summary of Benefits**.

NOTE: If your Provider charges for other services in addition to Acupuncture or Chiropractic Services, 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. It is recommended that Acupuncture be part of a coordinated plan of care approved by your Provider.

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.

The Provider of Chiropractic Services must determine in advance that chiropractic treatment can be expected to result in significant improvement of the condition within a period of 2 months. Treatment is limited to means of manual manipulation. Subluxation must be documented by chiropractic examination and documented in the chiropractic record.

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 for primary care visits.

Cardiac and Pulmonary Rehabilitation
We cover outpatient Cardiac Rehabilitation programs provided within six months of a cardiac incident and outpatient Pulmonary Rehabilitation services.

Chemotherapy and Radiation Therapy
We cover the treatment of malignant disease by standard Chemotherapy and treatment of disease by or 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 or 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 treatment for cancer or other life-threatening diseases. 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 in your **Drug Plan Rider** will apply to these benefits.) If benefits for services provided in the trial are denied, you may contact the Superintendent of Insurance for an expedited appeal.

Benefits for Routine Patient Care Costs for Participation in Approved Clinical Trials
Benefits for eligible expenses for Routine Patient Care Costs are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is recognized under state and/or federal law.

Benefits are not available under this section for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial. If benefits for services provided in the trial are denied, you may contact the Superintendent of Insurance for an expedited appeal.

BCBSNM holds no responsibility for out-of-network costs unless standard treatment out-of-network is covered. In no event will BCBSNM be responsible for out-of-network costs for any trials undertaken for the purposes of or reoccurrence of cancer or other life-threatening illness.

Routine Patient Care Costs are covered for Members in an Approved Clinical Trial if:

- You encounter life-threatening diseases or conditions during the course of treatment
- The clinical trial is undertaken for the purposes of the prevention of the or the prevention of reoccurrence, early detection, or treatment of cancer or other life threatening medical treatment for which no equally or more effective standard treatment exists
- The clinical trial is not designed exclusively to test toxicity or disease pathophysiology and it has a therapeutic intent

- The clinical trial is being provided in New Mexico as a part of a scientific study of a new therapy or intervention
- There is no non-investigational treatment equivalent to the clinical trial
- There is a reasonable expectation shown in clinical or pre-clinical data that the clinical trial will be at least efficacious as any non-investigational alternative
- There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial will be at least effective as any other medical treatment

The personnel providing the clinical trial or conducting the study must provide the trial or study within their scope of practice, experience, and training, and must be capable of providing the clinical trial based on experience, training, and volume of patients treated to maintain their expertise. The personnel must agree to accept reimbursement as payment in full from BCBSNM at the rates established by the Plan, not exceeding the level of reimbursement applicable to similar services administered by Providers within BCBSNM's network with written notification to BCBSNM when a patient enters or leaves the clinical trial.

Exclusions

- Pursuant to the patient informed consent document, no third party (including BCBSNM) is liable for damages associated with the treatment provided during a phase of a clinical trial.
- Costs of the clinical trial that are customarily paid for by the government, biochemical, pharmaceutical or medical device industry sources
- The cost of a non-FDA approved investigational drug, device, or procedure
- The cost of a non-health care service the patient is required to receive as a result of participation in the clinical trial
- Costs associated with managing the research that is associated with the clinical trial
- Costs that would not be covered if non-investigational treatments were provided
- Costs of tests that are necessary for the research of the clinical trial
- Costs paid for or not charged by the clinical trial Providers

Dialysis

We cover the following services when received from a Dialysis Provider:

- Home hemodialysis when Prior Authorized by BCBSNM
- Dialysis when Prior Authorized 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 to the number of visits that a Member may receive within each Plan Year.

Routine Foot Care

We cover 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
All inpatient Short-Term Rehabilitation treatments, including Skilled Nursing Facility and physical rehabilitation Facility Admissions, are subject to Prior Authorization from BCBSNM. See **Section 4: Utilization Management** for more information about Prior Authorization requirements. Skilled Nursing Care has a 30 day per year combined maximum with inpatient rehabilitation.

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
We cover the following Short-Term Rehabilitation services when rendered for the Medically Necessary treatment of Accidental Injury or illness:

- Occupational Therapy performed by a licensed Occupational Therapist or other eligible Professional Provider acting within the scope of their license
- Physical Therapy performed by a Physician, licensed Physical Therapist, or other eligible 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 room and board 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, Coinsurance, or Deductible based on the type of Provider, place of treatment, or type of service.

Benefit Limits
Benefits are limited, if applicable, as specified in the **Summary of Benefits**.

NOTE: Long-term therapy, maintenance therapy, and therapy for chronic conditions are not covered. We cover Short-Term Rehabilitation only.

Exclusions
We do not cover:

- Long-term maintenance therapy or care provided after you have reached your rehabilitative potential and/or significant improvement is unlikely to occur except as required under New Mexico State law (Even if you have not reached your rehabilitative potential, we do not cover services that exceed maximum benefit limits, if any.)

- Therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy, muscular dystrophy, or developmental delay, except as required by law and described earlier in this 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)
- Speech Therapy for dysfunctions that self-correct over time; Speech Therapy for stuttering, speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic; other speech services that can be carried out by the patient, the family, or caregiver/teacher
- Herbs, homeopathic preparations, or nutritional supplements
- Services of a massage therapist or rolfing
- 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

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 department.

Breast Pumps

We cover 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 In-Network Provider. If your plan has out-of-network benefits for non-emergency services, out-of-network services are subject to the usual out-of-network Coinsurance, Deductible, and out-of-pocket expense limit. Electric breast pumps are limited to 1 per benefit period.

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 (DME) and Appliances

We cover the following items:

- Orthopedic Appliances
- Replacement of items only when required because of wear (and the item cannot be repaired) or when Medically Necessary due to 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

We cover the rental (or at the option of BCBSNM, the purchase of) DME (including repairs to or replacement of such purchased items), when prescribed by a covered health care Provider and required for therapeutic use.

Medical Supplies
We cover the following Medical Supplies, not to exceed a 30-day supply purchased during any 30-day period, unless otherwise indicated:

- Colostomy bags, catheters
- Gastrostomy tubes
- Hollister supplies
- Tracheostomy kits, masks
- Lamb's wool or sheepskin pads
- Ace bandages, elastic supports when billed by a Physician or other Provider during a covered office visit
- Slings
- Support hose prescribed by a Physician for treatment of varicose veins (six pairs per Plan Year)

Orthotics and Prosthetic Devices
We cover the following items when Medically Necessary and ordered by a Provider:

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

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

Exclusions
We do 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 bath/shower equipment, Jacuzzi units, hot tubs, exercise equipment, heating pads, hot water bottles, or diapers
- Nonstandard or deluxe equipment, such as motor-driven wheelchairs, chairlifts, or beds
- Repairs to items that you do not own
- Comfort items such as bed boards, beds or mattresses of any kind, bathtub lifts, overbed tables, or telephone arms

- Repair or rental costs that exceeds the purchase price of a new unit
- Dental Appliances (See **Dental-Related Services and Oral Surgery**, earlier in this section, for exceptions.)
- 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, or treatment of tissue damage in any location with platelet rich plasma
- 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/speech 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
- Eye refractive procedures including keratotomy, laser procedures, and other techniques; Visual training, and eye movement therapy
- Hearing aids or ear molds, fitting of hearing aids or ear molds, or related services or supplies for persons 21 and older or, if under age 21, in excess of the maximum benefit described in this section (For surgically implanted devices for the profoundly hearing impaired, see **Surgery and Related Services**, below.)
- Syringes or needles for self-administering drugs (Coverage for insulin needles and syringes and other diabetic supplies not listed as covered in this section is described in your **Drug Plan Rider**.)
- Select medications may be excluded from the medical benefit when a self-administered formulation of the product is available.
- 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

We provide 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 Care Benefits and are not subject to separate financial requirements or utilization restrictions. Examples of prosthetic devices include but are not limited to breast prostheses when required, artificial limbs, prosthetic eye, penile prosthesis, joint replacements, heart pacemakers, tracheostomy tubes and cochlear implants.

Coverage includes:

- Clinical care
- All supplies, materials, and devices determined by the Physician to be Medically Necessary and most appropriate to maximize upper and lower limb function, maintain activities of daily living or essential job-related activities, and meet the medical needs for physical activities such but not limited to running, biking, swimming, strength training
- All services, including design, fabrication, and repair
- Replacement of a device, any part of such devices, without regard to useful lifetime restrictions, if an ordering health care Provider determines that a replacement device, or a replacement part is necessary because of any of the following:
    - o A change in your physiological condition

    - An irreparable change in the condition of the device or in a part of the device
    - The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60% 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 devices and custom orthotics will not be provided when required 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.

Anesthesia Services

We cover Medically 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**, earlier in this section, for information about Acupuncture benefits.)

Exclusions

We do 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

We do 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

Bariatric Surgery

We cover the surgical treatment of morbid obesity (bariatric surgery) only if it is Medically Necessary as defined in this Benefit Booklet.

Bariatric surgery is covered for patients with a Body Mass Index (BMI) of 35 kg/m2 or greater who are at high risk for increased morbidity due to specific obesity related co-morbid medical conditions, and if a Member meets these criteria and all other requirements of this plan.

Cochlear Implants

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

Mastectomy Services
We cover 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).

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

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

We do not cover subsequent procedures to correct unsatisfactory cosmetic results attained during the initial breast/nipple surgery or tattooing, or breast surgery.

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. We cover Reconstructive Surgery when required to correct a functional disorder caused by:

- An Accidental Injury
- A disease process or its treatment (For breast surgery following a mastectomy, see **Mastectomy Services**, above.)
- A functional congenital defect (any condition, present from birth, which 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
We do 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**, above)
- 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)
- Obesity treatment
- The insertion of artificial organs, or services related to Transplants not specifically listed as covered under **Transplant Services**, below
- Standby services unless the procedure is identified by BCBSNM as requiring the services of an assistant surgeon and the standby Physician actually assists

Transplant Services

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

If you are approved as a Transplant recipient candidate, you must ensure that Prior Authorization for the actual Transplant is also received. None of the benefits described here are available unless you have this Prior

Authorization. See **Section 4: Utilization Management** for more information about Prior Authorization requirements.

Anatomical Gift Nondiscrimination
BCBSNM will not deny, reduce, limit covered benefits, or deny enrollment or renewal 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 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.

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

- Cornea Transplant
- Kidney Transplant
- Bone marrow Transplant for a Member with:
  - Aplastic anemia
  - Leukemia
  - Severe combined immunodeficiency disease (SCID)
  - Wiskott-Aldrich syndrome
  - Other conditions determined by BCBSNM to be Medically Necessary and not Experimental, Investigational, or Unproven

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

Heart, Heart-Lung, Liver, Lung, Pancreas-Kidney
We cover 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.

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.

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

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

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
    - Wilm’s Tumor
    - Myelodysplastic syndrome
    - Myelofibrosis

- Sickle cell disease
- Thalassemia major

Transplant Exclusions

We do 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)
- Non-human organ Transplants, except for porcine (pig) heart valve
- 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)
- Care for complications of non-covered Transplants or follow-up care related to such Transplants
- Expenses incurred by a Member of this plan for the donation of an organ to a non-Member or when the procedure is not a covered service
- Drugs that are self-administered or for use while at home unless specifically covered under this plan
- Donor expenses after the donor has been discharged from the Transplant Facility
- Lodging expenses in excess of the per diem allowance, if available, and food, beverage, or meal expenses
- Travel or per diem expenses:
  - Incurred more than five days before or more than one year following the date of transplantation
  - If the recipient's case manager indicates that travel is not Medically Necessary
  - Related to a kidney Transplant (unless services are not reasonably available within your community without travel)

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.

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

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

Associated Services

If a service is not covered, we 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

We do 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

We do not cover services related to biofeedback, except for treatment for Raynaud's disease and urinary or fecal incontinence.

Blood Services

We do not cover directed donor or autologous blood storage fees when the blood is used during a nonscheduled surgical procedure. We do not cover blood replaced through donor credit.

Cannabis

We do 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

We do 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: We do 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 is unrelated to the noncovered service.

Convalescent Care or Rest Cures

We do 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. We do not cover Cosmetic surgery, services, or procedures for psychiatric or psychological reasons, or to change family characteristics or conditions caused by aging. We do not cover services related to or required as a result of a Cosmetic service, procedure, surgery, or subsequent procedures to correct unsatisfactory Cosmetic results attained during an initial surgery.

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

Exception: Breast/nipple surgery performed as reconstructive procedures following a covered mastectomy may be covered. 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
We do 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 nonprofessional 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 **Section 5: Covered Services, Dental-Related Services and Oral Surgery**, for additional exclusions.

Domiciliary Care
We do 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
We do 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, we 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
We do not cover duplicative diagnostic testing or overreads of laboratory, pathology, or radiology tests.

Experimental, Investigational, or Unproven Services
We do not cover any treatment, procedure, Facility, equipment, drug, device, or supply (including emerging technologies, services, procedures, and service paradigms) 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 **Section 5: Covered Services, Autism**

Spectrum Disorders or Cancer Clinical Trials and mandated by law. You may contact Customer Service at the number on the back of your ID Card for more information about what Experimental/Investigational Services or Supplies may be excluded. 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 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
- 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

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

NOTE: Prescription Drugs that are approved by the FDA through the accelerated approval program may be considered Experimental/Investigational and may not be covered.

Food or Lodging Expenses

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

Genetic Testing or Counseling

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

Hair Loss Treatments
We do 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
We do not cover audiometric (hearing) tests unless:

- Required for the diagnosis and/or treatment of an Accidental Injury or an illness
- Covered as a preventive screening service
- Covered as part of the hearing aid benefit for Members up to age 21 and described in **Section 5: Covered Services, Hearing Aids/Related Services for Children Up to Age 21** (A screening does not include a hearing test to determine the amount and kind of correction needed.)

We do not cover hearing aids or ear molds, fitting of hearing aids or ear molds, or any related service or supply for Members aged 21 and older. For Members up to age 21, see **Section 5: Covered Services, Hearing Aids/Related Services for Children Up to Age 21**. For surgically implanted devices, see **Section 5: Covered Services, Surgery and Related Services**.

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

Hypnotherapy
We do not cover hypnosis or services related to hypnosis, whether for medical or anesthetic purposes.

Infertility Services/Artificial Conception
We do 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.

We do not cover the cost of donor sperm, costs associated with the collection, preparation, or storage of sperm for artificial insemination, or donor fees. We do not cover infertility testing, treatments, or related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization.

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

Late Claim Filing
We do not cover services of a Nonparticipating Provider if the Claim for such services is received by BCBSNM more than 12 months after the date of service. (Preferred Providers contracting directly with BCBSNM and Providers that have a Participating Provider agreement with BCBSNM will file Claims for you and must submit them within a specified period of time, usually 180 days.) If a Claim is returned for further information, resubmit it within 45 days.

Learning Deficiencies/Behavioral Problems
We do not cover special education, counseling, therapy, diagnostic testing, treatment, or any other service for learning deficiencies or chronic behavioral problems, whether or not associated with a manifest Mental Health, Intellectual Disability, or other disturbance. See **Section 5: Covered Services, Autism Spectrum Disorders**, for details about mandated coverage for children with these diagnoses. See **Section 8: Claims Payments and Appeals** for reimbursement of certain services provided to Eligible Children by the Department of Health.

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

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

We do 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 we cover 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 those services mandated by state law will be excepted from this BCBSNM standard Medical Necessity guidelines exclusion.

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

Medically Unnecessary Services
We do 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 **Section 5: Covered Services, Preventive Services or Autism Spectrum Disorders**).

A Provider in consultation with BCBSNM, 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
We do 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 provision in **Section 8: Claims Payments and Appeals, Early Developmental Delay and Disability**.

Noncovered Providers of Service

We do 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

Nonmedical Expenses

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

- Adoption or surrogate expenses
- Educational programs such as behavior modification and arthritis classes (Some diabetic services and other educational programs may be covered, see **Section 5: Covered Services, Physician Visits/Medical Care and Preventive Services**, for details.)
- Vocational or training services and supplies
- Mailing, electronic mailing (e-mail), and/or shipping and handling
- Missed appointments; get-acquainted visits without physical assessment or medical care; provision of medical information to perform Admission review or other Prior Authorizations; filling out of Claim forms; copies of medical records; interest expenses
- Modifications to home, vehicle, or workplace to accommodate medical conditions; voice synthesizers; other communication devices
- Membership at spas, health clubs, or other such facilities
- Personal convenience items such as air conditioners, humidifiers, exercise equipment, or personal services such as haircuts, shampoos, guest meals, and television rentals, Internet services
- Personal comfort services, including homemaker and housekeeping services, except in association with respite care covered during a Hospice Admission
- Immunizations or medications required for international travel
- Moving expenses or other personal expenses (e.g., laundry or dry-cleaning expenses; phone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- Physicals or screening examinations and immunizations given primarily for insurance, licensing, employment, camp, weight reduction programs, medical research programs, sports, or for any 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

Nonpreferred Provider Services
We do not cover Transplants when received from a Nonpreferred Provider.

Nonprescription Drugs
We do 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 **Drug Plan Rider**.

Nutritional Supplements
We do not cover vitamins, dietary/nutritional supplements, special foods, formulas, birthing parent's milk, or diets, unless prescribed by a Physician. Such supplements require a prescription to be covered in **Section 5: Covered Services, Home Health Care/Home Intravenous (I.V.) Services**. We cover other nutritional products only under specific conditions set forth in your **Drug Plan Rider**.

Post-Termination Services
We do 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, Insulin, Diabetic Supplies, Enteral Nutritional Products and Special Medical Foods
In addition to services excluded by the other general limitations and exclusions listed throughout this section, see **Section 5: Covered Services, Prescription Drugs and Other Items**, for additional exclusions.

You should have received a **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
We do not cover private duty nursing services.

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

Sexual Dysfunction Treatment
We do not cover services related to the treatment of sexual dysfunction**.**

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

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

Testing
We do 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
- Urine for measurement of collagen cross links
- Cervicovaginal fluid for amniotic fluid protein
- Allergen specific IgG measurement

Therapy and Counseling Services
We do not cover therapies and counseling programs other than the therapies listed as covered in this Benefit Booklet. In addition to treatments excluded by the other general limitations and exclusions listed throughout this section*, see* **Section 5: Covered Services, Rehabilitation and Other Therapy** for additional exclusions. We do 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**
- 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 federal law and described in **Section 5: Covered Services, Autism Spectrum Disorders**. See **Section 8: Claims 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)
- Speech Therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic, except as required by law and described in **Section 5: Covered Services, Autism Spectrum Disorders**; other speech services that can be carried out by the patient, the family, or caregiver/teacher

Thermography
We do not cover thermography (a technique that photographically represents the surface temperatures of the body).

Transplant Services
Please see **Section 5: Covered Services, Transplant 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, we do not cover any other Transplants (or organ-combination Transplants) or services related to any other Transplants.

Travel or Transportation
We do not cover travel expenses, even if travel is necessary to receive Covered Services unless such services are eligible for coverage in **Section 5: Covered Services, Transplant Services or Ambulance Services**.

Veteran's Administration Facility
We do 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
We do not cover Viscosupplementation (intra-articular hyaluronic acid injection).

Vision Services
We do 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). We do 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 in **Section 5: Covered Services, Supplies, Equipment and Prosthetics**. We do not cover sunglasses, special tints, or other extra features for eyeglasses or contact lenses.

War-Related Conditions
We do not cover any service required as the result of any act of war or related to an illness or Accidental Injury sustained during combat or active military service.

Weight Management
We do not cover weight-loss or other weight-management programs, dietary control, or medical obesity treatment, other than counseling programs as required under federal law.

Work-Related Conditions
We do 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.)

We do 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 exclusion in **Section 6: General Limitations and Exclusions, Work-Related Conditions**.

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% 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, which provide payments for medical services and are considered Other Valid Coverage for purposes of coordinating benefits under this plan.)

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

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

The following rules determine which coverage pays first:

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 timely information is not provided.

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

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

Reimbursement

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

- 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.

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

SECTION 8: CLAIMS PAYMENTS AND APPEALS

Important Note About Filing Claims

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

If the Other Valid Coverage pays benefits to you (or your family member) directly, give your Provider a copy of the explanation of benefits 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 explanation of benefits to the Claim that you send to BCBSNM or to the local BCBS plan, as applicable.)

Participating And Preferred Providers

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

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

Provider Network

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

Nonparticipating Providers

A Nonparticipating Provider is one that has neither a Preferred nor a Participating Provider agreement. If your Nonparticipating Provider does not file a Claim for you, submit a separate Claim form for each family member as the services are received. Attach itemized bills and, if applicable, your Other Valid Coverage's payment explanation, to a Member Claim Form. (Forms can be printed from the BCBSNM website at: formfinder.hcsc.net/formfinder/search-display.do?portal=pub_mem&state=NM 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-(833)-415-0566
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: Participating and Preferred Providers will file Claims for you; these procedures are used only when you must file your own Claim.

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

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

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

Mental Health and Substance Use Disorder Claims

Claims for covered Mental Health and Substance Use Disorder services received in New Mexico should be submitted to:

Blue Cross and Blue Shield of New Mexico
Attn: 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. If not included in your enrollment materials, you can obtain the name and address of the pharmacy benefit manager and the necessary Claim forms from a Customer service advocate or on the BCBSNM website at: 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, Canada, U.S. Virgin Islands, Jamaica, or Puerto Rico

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

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

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 **Grievance Procedures**, later in this section.) You also have 180 days in which to appeal a decision.

Covered Charge

Provider payments are based upon Preferred Provider and Participating Provider agreements and Covered Charges as determined by BCBSNM. For services received outside of New Mexico, Covered Charges may be based on the local plan practice (e.g., for out-of-state Providers that contract with their local Blue Cross and Blue Shield Plan, the Covered Charge may be based upon the amount negotiated by the other plan with its own Contracted Providers). You are responsible for paying Copayments, Deductibles, Coinsurance, and noncovered expenses. For Covered Services received in foreign countries, BCBSNM will use the exchange rate in effect on the date of service in order to determine billed charges.

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

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

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 Facility Claims

- 100% of the base Medicare Allowable for Physician, other Professional Provider Claims, and other ancillary Providers of covered Health Care Services and supplies

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

- Services for which a Medicare Allowable cannot be determined based on the information submitted on the Claim (in such cases, the Covered Charge is 50% of the billed charge)
- Home health Claims (the Covered Charge is 50% of the billed charge)
- Services administered and priced by any subcontractor of BCBSNM or by the Blue Cross and Blue Shield Association
- Claims paid by Medicare as primary coverage and submitted to your health plan for secondary payment
- New Mexico ground ambulance Claims (for which the state's Office of Superintendent of Insurance sets fares)
- Covered Claims priced by a non-New Mexico BCBS Plan through BlueCard® using local pricing methods
- The categories of Claims for Covered Services from Noncontracted Providers discussed in more detail below

Benefits for Emergency Care

If you receive treatment from a Nonparticipating Provider for Emergency Care, BCBSNM will review and process payment consistent with the In-Network benefit for the Covered Services provided. Non-emergency Behavioral Health Services provided in an emergency room will be paid the same as Emergency Care services. As for air ambulance Emergency Care, you may be responsible for charges from the Nonparticipating Provider above any amount that BCBSNM pays that corresponds to the in-network benefit level.

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

- Covered Services required during an emergency and received in an air ambulance
- For PPO health plans, services from Noncontracted Providers that satisfy at least one of the two conditions below and, as a result, are eligible for the Preferred Provider benefit level of coverage:
    - Covered Services from Noncontracted Providers within the United States that are classified as unsolicited as explained earlier in **Section 3: How Your Plan Works** and as determined by the Member's host plan while outside the Service Area of BCBSNM
    - Prior Authorized 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 60th 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.

Provider Payment Example

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

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

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

Example 2. Nonpreferred Provider Claim Payment (plan pays 80%; Deductible is met):

Provider's billed charge	$10,000
Covered Charges (maximum amount that can be considered for benefit payment)	$8,000
BCBSNM payment to Provider (80% of $8,000)	$6,400
Member Coinsurance (20% of $8,000) applied to the Out-of-Pocket Limit	$1,600
Amount over the Covered Charges - The amount over the Covered Charges is considered non-covered under the terms of your SBC and cannot be applied towards your our of network Out-of-Pocket Limit. Please see your SBC for a list of eligible cost shares that apply to your out of network Out-of-Pocket Limit.	$2,000
Total amount due from Member (Coinsurance only):	$3,600

Example 3. In-Network Hospital (plan Pays 90%) out-of-network Hospital (plan Pays 70%):

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

Inter-Plan Arrangements

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

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

You always have the choice to receive services from Contracted or Noncontracted Providers in New Mexico or outside New Mexico, but the difference in the amount you pay may be substantial. When services are received by you outside the state of New Mexico from either Contracted or 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 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 Contracted Providers Outside of New Mexico

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

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

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

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

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

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

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

In some cases, BCBSNM may, but is not required to, in its sole and discretion, negotiate a payment with a noncontracting health care Provider on an exception basis.

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

Services Received from a Noncontracted Provider Outside of New Mexico

If services are provided by a Noncontracted Provider, the Provider may, but is not required to, submit Claims on your behalf. A Noncontracted Provider has not negotiated its payments/rates with either the Host Blue or BCBSNM. If the 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.

You will be subject to balance billing when you receive non-emergency services from a Noncontracted Provider. This amount may be significant. Balance billing means that the Noncontracted Provider may require you to pay any amount that the Provider bills that exceeds the sum of what BCBSNM pays toward the Covered Charge and your Member Share of the Covered Charge.

Member Liability Calculation

In General

Under Inter-Plan Arrangements, when services are received outside the state of New Mexico from a Noncontracted Provider, the Covered Charge will be determined by the Host Blue servicing area or by applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations, and will be passed on to BCBSNM. BCBSNM will use the Host Blue's Covered Charge as its Covered Charge so that your Claim can be processed timely. BCBSNM's Covered Charge will be an amount up to but not in excess of the Covered Charge the Host Blue has passed on to BCBSNM. In addition to being responsible to pay your Member Share, you may be subject to balance billing by the Noncontracted Provider who provided services to you. Before you receive services from a Noncontracted Provider, you should ask for a written breakdown of all amounts that you will have to pay, including Member share and balance billing amounts, for the services you receive. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

Exceptions

In certain situations, BCBSNM may use other payment bases, to determine the amount BCBSNM will pay for services rendered by Noncontracted health care Providers, such as:

- Billed charges for Covered Services
- The payment we would make if the Health Care Services had been obtained within our Service Area
- A special negotiated payment, as permitted under the Inter-Plan Arrangements:
    - 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
    - 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 to determine the amount BCBSNM will pay for services rendered by Noncontracted health care Providers. In these situations, the Member may be responsible for the difference between the amount that the Noncontracted Provider bills and the payment BCBSNM will make for the Covered Services as set forth in this paragraph.

Inter-Plan Arrangements: Federal/State Taxes/Surcharges/Fees
Federal or state laws or regulations may impose a surcharge, tax, or other fee. If applicable, BCBSNM will include any such surcharge, tax or other fee as part of the Claim charge passed on to you.

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

Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter BlueCard® Service Area), you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core is unlike the BlueCard® Program available in the BlueCard® Service Area in certain ways.

For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient, and Professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard® Service Area, you will typically have to pay the Providers and submit the Claims yourself to obtain reimbursement for these services.

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

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

Emergency Care Services
We cover only limited Health Care Services received outside of the United States. As used in this section, out-of-area Covered Services include emergency services and Urgent Care obtained outside of the United States. Non-emergent follow-up care following an emergency is also available provided the services are approved through Prior Authorization by BCBSNM. Any other services will not be eligible for benefits unless approved through Prior Authorization by BCBSNM.

Inpatient Services
In most cases, if you contact the service center for assistance, Hospitals will not require you to pay for covered Inpatient Services, except for your cost-share amounts (Deductibles, Coinsurance, etc.). In such cases, the Hospital will submit 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. You must contact BCBSNM to obtain Prior Authorization for non-emergency Inpatient Services.

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

Submitting a Blue Cross Blue Shield Global Core Claim

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

Member Data Share

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

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

Summary Of Health Insurance Grievance Procedures

Unless otherwise specified below:

- Any reference to 1-5 days means only working days and excludes weekends and holidays
- Any reference to 6 days or more means calendar days, including weekends and holidays

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

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

or from OSI by calling:
1-505-827-3811
or toll free at 1-833-415-0566

What types of decisions can be reviewed?

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

1. **Adverse determination:** You may request a review if your insurer has denied Prior Authorization (certification) for a proposed procedure, has denied full or partial payment for a procedure you have already received, or is denying or reducing further payment for an ongoing procedure that you are already receiving and that has been previously covered. (The insurer must notify you before terminating or reducing coverage for an ongoing course of treatment and must continue to cover the treatment during the appeal process.) This type of denial may also include a refusal to cover a service for which benefits might otherwise be provided because the service is determined to be Experimental, Investigational, or

not Medically Necessary or appropriate. It may also include a denial by the insurer of a participant's or beneficiary's eligibility to participate in a plan. These types of denials are collectively called Adverse Determinations.

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

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 we handle an administrative matter, you will receive a detailed written description of the grievance procedures from us as well as forms and detailed instructions for requesting a review. We provide representatives who have been trained to assist you with the process of requesting a review.

Always contact us first about filing an appeal or grievance and specifically ask for assistance filing an appeal or grievance.

If we are non-responsive or if you have further questions about your rights, you may contact the New Mexico Office of Superintendent of Insurance Managed Health Care Bureau consumer assistance team at:

Office of Superintendent of Insurance – MHCB
PO Box 1689
Santa Fe, NM 87504-1689
1-505-827-4601 or toll free at 1-855-427-5674
Fax #: 1-505-827-4253, Attn: MHCB

1120 Paseo de Peralta, Fourth Floor
Santa Fe, NM 87501
E-mail: mhcb.grievance@osi.nm.gov

Review Of An Adverse Determination

How does Prior Authorization for a Health Care Service work?

When your insurer receives a request to Prior Authorize (certify) payment for a Health Care Service or a request to reimburse your health care 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 Care Benefits plan (policy). For example, if your policy excludes payment for equine therapy, then your insurer will not agree to pay for services even if you have a clear need for them.

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

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

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

How long does initial certification take?

Standard decision: The insurer must make an initial decision within 5 working days. However, the insurer may extend the review period for a maximum of 10 calendar days if it:

- Can demonstrate reasonable cause beyond its control for the delay
- Can demonstrate that the delay will not result in increased medical risk to you
- Provides a written progress report and explanation for the delay to you and your Provider within the original 5 working day review period

What if I need services in a hurry?

Urgent Care situation: An Urgent Care situation is a situation in which a decision from the insurer is needed quickly because:

- 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 condition, believes that delay would subject you to severe pain that cannot be adequately managed without the requested care or treatment
- The medical demands of your case require an expedited decision

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

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

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

IMPORTANT: If you are facing an emergency, you should seek medical care immediately and then notify your insurer as soon as possible. The insurer will guide 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 1 working day after the decision, unless an urgent matter requires a quicker notice. If the insurer denies certification, the insurer must notify you and the Provider within 24 hours after the decision.

If my initial request is denied, how can I appeal this decision?
If your initial request for services is denied or you are dissatisfied with the way your insurer handles an administrative matter, you will receive a detailed written description of the grievance procedures from your insurer as well as forms and detailed instructions for requesting a review.

You may submit the request for review either orally or in writing, depending on the terms of your policy.

We provide 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: 1-888-898-0010
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 1-833-415-0566
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.

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

How much time do I have to decide whether to request a review?
You must notify the insurer that you wish to request in internal review within 180 days after the date you are notified that the initial request has been denied.

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

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

Standard review: Your insurer must complete both the medical director's review and (if you then request it) the insurer's internal panel review within 30 days after receipt of your pre-service request for review or within 60 days if you have already received the service. 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.

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

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.

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 may 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 24 hours after the panel decision or sooner if Medically Necessary. 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 a 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 the date of the panel to decide whether you want to have the request reviewed by an IRO.

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

The IRO will report the final decision to you, your Provider, your insurer, and to OSI. Your insurer must comply with the decision of the IRO. If the IRO finds that the requested services should be provided, then the insurer must 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 within 20 days of the IRO decision, 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 30 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 three (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 for a review of an administrative decision.

Can I appeal the decision from the internal reviewer?

Yes. You have 20 days to request that the insurer from 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 5 days prior to the committee meeting so that you may provide information, and/or attend the hearing in person or by telephone.

If you are unable to prepare for the committee hearing within the time set by the insurer, you may request that the committee hearing be postponed for up to 30 days. The reconsideration committee will mail its decision to you within 7 days after the hearing.

How can I request an external review?

If you are dissatisfied with the reconsideration committee's decision, you may ask the Superintendent to review the matter within 20 days after you receive the written decision from the insurer. You may submit the request to OSI using forms that are provided by your insurer. Forms are also available on the OSI website located at www.osi.state.nm.us. You may also call OSI to request the forms at 1-505-827-3811 or toll free at 1-833-415-0566.

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.

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

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

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

SECTION 9: GENERAL PROVISIONS

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 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. Members can call customer service at 1-800-432-0750 to learn more about the Consumer Advisory Board.

Disabled Children Continued Coverage

BCBSNM, which provides 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. The disabled dependent form can be located at www.bcbsnm.com/docs/forms/group/nm/grp-disabled-dependent-form-nm.pdf.

Disclaimer Of Liability

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

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

Disclosure And Release Of Information

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

Entire Contract

This Benefit Booklet (and any amendments, riders, endorsements, and the **Summary of Benefits**), your Group enrollment/change application (Group Administration Document, Benefit Program Application, Benefit Program Application – Amendment, and Application and Enrollment Form), and your 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.

Continuity of Care

If you are under the care of a Participating Provider as defined in this Benefit Booklet who stops participating in the plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), you may be able to continue coverage for that Provider's Covered Services at the Participating Provider benefit level if one of the following conditions is met:

- You are undergoing a course of treatment for a serious and complex condition
- You are undergoing institutional or inpatient care

- You are scheduled to undergo nonelective surgery from the Provider (Including receipt of postoperative care from such Provider with respect to such surgery)
- You are pregnant or undergoing a course of treatment for your pregnancy
- You are determined to be terminally ill

A serious and complex condition is one that:

- For an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if you are currently receiving Chemotherapy, Radiation therapy, or post-operative visits for a serious acute disease or condition)
- For a chronic illness or condition, is life-threatening, degenerative, disabling or potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date the plan notifies you of the Provider's termination, or any longer period provided by state law. If you are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for benefits under this provision, as explained in the Benefit Booklet.

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.

Air Ambulance Services means, for purposes of this section only, medical transport by helicopter or airplane for patients.

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:

- Placing the health of the individual, or with respect to a pregnant person, the unborn child in serious jeopardy
- Constituting a serious impairment to bodily functions
- 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 facility 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 section only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

Recognized Amount means, for purposes of this section 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, we 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.

Your plan includes Air Ambulance Services as a Covered Service. If 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, Optometrist, Psychologist, Podiatrist, Physician Assistant, Certified Nurse 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 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, 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 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.

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 and Responsibilities

All Members have the following rights and responsibilities:

- 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, for urgent or Emergency Care services, and for other Health Care Services as defined in this Benefit Booklet
- To be provided with information concerning our policies and procedures regarding products, services, providers, appeals procedures and other information about the benefits provided
- To choose a primary care Provider within the limits of the covered benefits, plan network, including the right to refuse care of specific Health Care Professionals
- To receive from your Physician or Provider, in terms that you understand, an explanation of your complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, irrespective of our position on treatment options. If you're not capable of understanding the information, the explanation shall be provided to your next of kin, guardian, agent or surrogate, if available, and documented in your medical record
- 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
- To prompt notification of termination or changes in benefits, services or Provider network
- To file a complaint or appeal with us or the Office of Superintendent of Insurance and to receive an answer to those complaints in accordance with existing law
- To privacy of medical and financial records maintained by us and our health care providers, in accordance with existing law
- To know upon request of any financial arrangements or provisions between us and our providers which may restrict referral or treatment options or limit the services offered to you
- To adequate access to qualified health professionals for the treatment of covered benefits near where you live or work within our service area
- To affordable health care, with limits on out-of-pocket expenses, including the right to seek care from a non-participating provider, and an explanation of your financial responsibility when services are provided by a non-participating provider, or provided without required Prior Authorization
- To an example of the financial responsibility if you go out-of-network; inclusion of the entire "billing examples" provided by the Office of Superintendent of Insurance available on their website
- To detailed information about coverage, maximum benefits, and exclusions of specific conditions, ailments or disorders, including restricted prescription benefits, and all requirements that you must follow for Prior Authorization and utilization review
- To a complete explanation of why care is denied, an opportunity to appeal the decision to our internal review, the right to a secondary appeal, and the right to request the Superintendent's assistance
- 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

Membership Records

We 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
- 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 or 1-855-4ASK-OSI (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 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 and 1-855-4ASK-OSI (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 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 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 Benefit Booklet are personal to the Member. Neither these benefits nor health care plan payments may be transferred or given to any person, corporation, or entity. Any attempted transfer will be void. Use of benefits by anyone other than a Member will be considered fraud or material misrepresentation in the use of services or facilities, which may result in cancellation of coverage for the Member and appropriate legal action by BCBSNM.

SECTION 10: DEFINITIONS

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

Accidental Injury

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

Acupuncture

The use of needles inserted into the human body for the prevention, cure, or correction of any disease, illness, injury, pain, or other condition as determined appropriate by your Provider.

Adjustment Factor

The percentage by which the Medicare Allowable amount is multiplied in order to arrive at the Noncontracting Allowable Amount. (See definition of Covered Charge.) 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 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 ground or air Ambulance 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 (FDA)
- 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 Disorders* 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 **Summary of Benefits**, which explains the benefits, limitations, exclusions, terms, and conditions of your health coverage.

Benefit Program Application (BPA)

The application for coverage completed by the Group and made a part of the Group Contract.

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. For details, see **Section 1: How To Use This Benefit Booklet**.

BlueCard®

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

BlueCard® Access

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

Blue Cross and Blue Shield of New Mexico (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

A person who is licensed by the Board of Nursing as a Registered Nurse and who is licensed by the New Mexico Department of Health (or appropriate state regulatory body) as a Certified Nurse Midwife providing services in preparation for or in connection with the delivery of a newborn.

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 benefit described in **Section 5: Covered Services, Preventive Services, Smoking/Tobacco Use Cessation,** 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.

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

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

Coinsurance

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

Contracted Provider

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

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 Group Health Care 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. For information about pricing of Noncontracted Provider Claims, see **Section 8: Claims Payments and Appeals**.

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, which 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 Person or Enrollee

A Subscriber, policyholder, or Subscriber's enrolled dependent or dependents, or other individual participating in this health benefits plan.

Covered Services

Those services and other items for which benefits are available under the terms of the benefit plan of an eligible plan Member.

Creditable Coverage

Health care coverage through an employment-based Group Health Care Plan; health insurance coverage; Part A or B of Title 18 of the Social Security Act (Medicare); Title 19 of the Social Security Act (Medicaid) except coverage consisting solely of benefits pursuant to section 1928 of that title; 10 USCA Chapter 55 (military benefits); a medical care program of the Indian Health Service or of an Indian nation, tribe, or pueblo; the NM Medical Insurance Pool (NMMIP) Act, or similar state sponsored health insurance pool; a health plan offered pursuant to 5 USCA Chapter 89; a public health plan as defined in federal regulations, whether foreign or domestic; any coverage provided by a governmental entity, whether or not insured, a State Children's Health Insurance Program; or a health benefit plan offered pursuant to section 5(e) of the federal Peace Corps Act.

Custodial Care Services

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

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

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

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

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. Your drug plan may or may not use a Drug List. See your **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 Medically Necessary standard equipment for the treatment of an illness or Accidental Injury 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 Child

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

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

Eligible Family Members

Family members of the Subscriber, limited to the following:

- 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 Subscriber's Domestic Partner 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 spouse or Subscriber's Domestic Partner aged 26 or older who was enrolled as the Subscriber's covered child in this Group Health Care 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 age 26 or older 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 disabled dependent form may be located at www.bcbsnm.com/docs/forms/group/nm/grp-disabled-dependent-form-nm.pdf
- 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 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).

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

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

- The improvement must be attainable outside the Investigational settings

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

Facility Fees
Facility fees are the portion of a health care treatment bill that covers all the costs of delivering patient care, except for those that are billed by physicians and other professionals.

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 (IEM)
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, which 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 exhibit, 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 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 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 Group Health Care Benefits plan, a physical or Behavioral Health Service.

High-Deductible Health Plan (HDHP)

A health insurance plan with a high minimum Deductible for medical expenses. A Deductible is the portion of an insurance Claim that the insured pays out of pocket. Once an individual has paid that portion of a Claim, the insurance company will cover the other portion, as specified in the contract. An HDHP usually has a higher annual Deductible than a typical health plan, and its minimum Deductible varies by year. A High Deductible Plan (HDHP) can be combined with a health savings account (HSA).

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, provided such order is renewed at least every sixty (60) days

Home Health Care Services

Covered Services, as listed in **Section 5: Covered Services, Home Health Care/Home Intravenous (I.V.) Services**, that are provided in the home according to a treatment plan by a certified Home Health Care Agency under active Physician and nursing management. Registered Nurses must coordinate the services on behalf of the Home Health Care Agency and the patient's Physician.

Hospice

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

Hospice Benefit Period

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

Hospice Care

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

Hospital

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

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

Host Blue

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

Identification Card (ID Card)

The card BCBSNM issues to the Subscriber that identifies the cardholder as a plan Member.

Infusion Suite

An alternative to Hospital and clinic-based infusion settings where specialty medications can be infused.

Initial Enrollment Eligibility Date

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

Inpatient Services

Care provided while you are confined as an inpatient in a Hospital or treatment center for at least 24 hours. Inpatient Hospital Services include, but are not limited to, semi-private room accommodations, general nursing care, meals, and special diets or parenteral nutrition when Medically Necessary, Physician and surgeon services, use of all Hospital facilities when use of such facilities is determined to be Medically Necessary by your treating Physician, pharmaceuticals and other medications, anesthesia and oxygen services, special duty nursing when Medically Necessary, Radiation Therapy, inhalation therapy, and administration of whole blood and blood components when Medically Necessary.

Intensive Outpatient Program (IOP)

Distinct levels or phases of treatment that are provided by a certified/licensed 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.

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.

Late Applicant

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

- Anyone not enrolled within 31 days of becoming eligible for coverage under this health care plan (e.g., a child added more than 31 days after legal adoption, a new spouse or stepchild added more than 31 days after marriage)
- Anyone enrolling on the Group's initial BCBSNM enrollment date who was not covered under the Group's prior plan (but who was eligible for such coverage)
- Anyone eligible but not enrolled during the Group's initial enrollment
- Anyone who voluntarily terminates 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 in preparation for or in connection with the delivery of a newborn and is registered as a Licensed Midwife by the New Mexico Department of Health (or appropriate state regulatory body).

Licensed Practical Nurse (L.P.N.)

A nurse who has graduated from a formal practical nursing education program and is licensed by appropriate state authority.

Managed Health Care Plan

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

Maternity/Pregnancy-Related

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

Medicaid

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

Medical Detoxification

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

Medical Supplies

Expendable items (except prescription drugs) ordered by a Physician or other Professional Provider, that are required for the treatment of an illness or Accidental Injury.

Medically Necessary, Medical Necessity

Health Care Services determined by a Provider, in consultation with 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, Mental Health or Substance Use Disorder condition, illness, injury or disease.

Medicare

Means Title 18 of the Social Security Amendments of 1965, Health Insurance for Aged and Disabled, as then constituted or later amended.

Member

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 subjected to limited days, visits, or dollar limits, as long as they are Medically Necessary and have been Prior Authorized. Mental Health that respond to and require long-term treatment with medications and/or therapeutic treatment including schizophrenia, bi-polar disorder, and chronic depression are also covered.

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

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.

Obstetrician-Gynecologist (OB-GYN)
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 (O.D.)
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 Preferred Provider or for Nonpreferred 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 most of your Preferred or Nonpreferred 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 is performed in an Ambulatory Surgical Facility or the outpatient department of a Hospital, but not including a procedure performed in an office or clinic. Outpatient Surgery includes any procedure that requires the use of an Ambulatory Surgical Facility or an outpatient Hospital operating or recovery room.

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

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

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

Physician Assistant
A 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 (also known as a benefit period) is a period of one year that 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
A Health Care Professional as defined in Paragraph (2) of Subsection B of Section 59A-22-32 NMSA 1978.

Preferred Provider
See definition of Provider, below.

Pregnancy-Related Services
See definition of Maternity/Pregnancy-Related, earlier in this section.

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

Prior Authorization
A voluntary or mandatory pre-service determination, including a recommended clinical review, that a health insurer makes regarding your eligibility for Health Care Services, based on Medical Necessity, the appropriateness of the 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 or Prosthetic Device
An externally attached or surgically implanted artificial substitute for an absent body part; for example, an artificial eye or limb.

Provider
A licensed Health Care Professional, Hospital or other Facility authorized to furnish Health Care Services. A Provider may belong to one or more networks, but if you want to visit a Network Provider, you must choose the Provider from the appropriate network:

PPP (Primary Preferred Provider): A Preferred Provider in one of the following medical specialties only: Family Practice; General Practice; Internal Medicine; Obstetrics/Gynecology; Gynecology; Oriental Medicine; or Pediatrics. In the event that you have a chronic medical condition of sufficient severity to require primary coordination of care by a specialist, a PPO Specialist may provide primary coordination of care provided that the specialist is otherwise credentialed by BCBSNM and participating in the Preferred Provider. PPPs do not include Physicians specializing in any other fields such as Obstetrics only, Geriatrics, Pediatric Surgery or Pediatric Allergy.

Preferred Provider: A Provider who has contracted with BCBSNM as a Preferred Provider but does not practice one of the Primary Preferred Provider medical specialties.

Nonpreferred Provider: Providers that have not contracted with BCBSNM, either directly or indirectly (for example, through another BCBS Plan). These Providers may have participating-only Provider agreements but are not considered Preferred Providers and are not eligible for Preferred Provider coverage under your health plan, unless listed as an exception under **Exceptions for Nonpreferred Providers**.

PPO Specialist: A Practitioner of the Healing Arts who is in the Preferred Provider Network -but does not belong to one of the specialties defined above as being for a Primary Preferred Provider (or PPP). A specialist does not include Hospitals or other treatment facilities, Urgent Care facilities, pharmacies, equipment suppliers, Ambulance companies, or similar ancillary health care Providers.

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

pharmacies are called specialty pharmacy Providers and some drugs must be dispensed by these specialty pharmacy Providers in order to be covered.

Network Provider: A Contracted Provider that agrees to provide Health Care Services to Members with an expectation of receiving payment (other than Coinsurance or Deductible) directly or indirectly from BCBSNM (or other entity with whom the Provider has contracted). A Network Provider agrees to bill BCBSNM (or other contracting entity) directly and to accept this plan's payment (provided in accordance with the provisions of the contract) plus the Member's share (Coinsurance, Deductibles, Copayments, etc.) as payment in full for Covered Services. BCBSNM (or other contracting entity) will pay the Network Provider directly. BCBSNM (or other contracting entity) may add, change, or terminate specific Network Providers at its discretion or recommend a specific Provider for specialized care as Medical Necessity warrants**.**

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

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

Psychologist

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

Pulmonary Rehabilitation

An individualized, supervised physical conditioning program. Occupational Therapists teach you how to pace yourself, conserve energy, and simplify tasks. Respiratory Therapists train you in bronchial hygiene, proper use of inhalers, and proper breathing.

Radiation Therapy

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

Reconstructive Surgery

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

Registered Lay Midwife

Any person who practices lay midwifery in preparation for or in connection with the delivery of a newborn 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 identified at the initial visit 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, wilderness programs, supervised living, group homes, boarding houses, or other facilities that provide primarily a supportive/custodial environment and/or primary address long-term social needs, even if counseling is provided in such facilities. To qualify as a Residential Treatment Center, patients must be medically monitored with 24-hour medical professional availability and on-site nursing care and supervision for at least one shift a day with on call availability for other shifts.

Respiratory Therapist

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

Routine Newborn Care

Care of a child immediately following their birth that includes:

- Routine Hospital nursery services, including alpha-fetoprotein IV screening
- Routine medical care in the Hospital after delivery, including Provider visits and incubators
- 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 benefits 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
- Items and services that are not provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

Routine Screening Colonoscopy/Mammogram

Tests to screen for occult colorectal and/or breast cancer in persons who, at the time of testing, are not known to have active cancer of the colon or breast, respectively. (If there is a history of colon or breast cancer, for the purposes of the Preventive Services benefit, a cancer is no longer active if there has been no treatment for it and no evidence of recurrence for the previous three years.) Routine screening tests are performed at defined intervals based on recommendations of national organizations as summarized in the BCBSNM Preventive Care Guidelines. Routine screening tests do not include tests (sometimes called surveillance testing) intended to monitor the current status or progression of a cancer that is already diagnosed.

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

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

Service Area

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

Short-Term Rehabilitation

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

Skilled Nursing Care

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

Skilled Nursing Facility

A Facility or part of a Facility that:

- Is licensed in accordance with state or local law
- 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 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.

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 Group Health Care 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 abuse, which includes Alcohol or Drug Abuse) may also be defined by significant risk of severe withdrawal symptoms if the use of alcohol, drugs, or other substance is discontinued.

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 that defines your Coinsurance, Deductibles and/or Copayments, Out-of-Pocket Limits, and annual or lifetime benefits (if applicable) and provides an overview of Covered Services. It is referred to as the **Summary of Benefits** throughout this Benefit Booklet.

Supplemental Breast Examination

A Medically Necessary and clinically appropriate examination of the breast using breast magnetic resonance imaging or breast ultrasound that is used to screen for breast cancer when there is no abnormality seen or suspected and based on personal or family medical history or additional factors that may increase the risk of breast cancer.

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

Use of telecommunications and information technology to provide clinical health care from a distance. Telemedicine allows Health Care Professionals to evaluate, diagnose and treat patients in remote locations using telecommunications and information technology in real time or asynchronously, including the use of interactive simultaneous audio and video or store-and-forward technology, or remote patient monitoring and telecommunications in order to deliver Health Care Services to a site where the patient is located, along with the use of electronic media and health information. Telemedicine allows patients in remote locations to access medical expertise without travel.

Temporomandibular Joint (TMJ) Syndrome

A condition that may include painful temporomandibular joints, tenderness in the muscles that move the jaw, clicking of joints, and limitation of jaw movement.

Terminally Ill Patient

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

Tertiary Care Facility

A Hospital unit that provides complete perinatal care 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.

Totally Disabled

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

Transplant

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

Transplant-Related Services

Any hospitalizations and medical or Surgical Services related to a covered Transplant or re-implantation and any subsequent hospitalizations and medical or Surgical Services related to a covered Transplant or re-implantation and received within one year of the Transplant or re-implantation.

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

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** in this Benefit Booklet.

The plan administrator of the plan is named by the employer or by the Group Health Care 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 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/Domestic Partner of an employee, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events happens:

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

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/Domestic Partner, surviving spouse/Domestic Partner 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/Domestic Partner 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:

1. **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.

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

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

In all of these cases, you must make sure that the 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 Website 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.

Acceptance of coverage under this Benefit Booklet constitutes acceptance of its terms, conditions, limitations, and exclusions. Members are bound by all of the terms of this Benefit Booklet.

The legal agreement between your employer (or association) and Blue Cross and Blue Shield of New Mexico (BCBSNM) includes the following documents:

- This Benefit Booklet and any amendments, riders, or endorsements
- The enrollment/change form(s) for the Subscriber and their dependents
- The Members' ID Cards
- The **Summary of Benefits**

In addition, your employer (or association) has important documents that are part of the legal agreement:

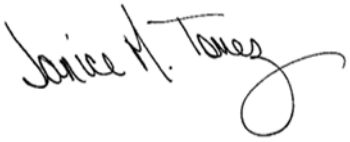
- The Benefit Program Application from the employer
- The Group Contract between BCBSNM and the employer or association

The above documents constitute the entire legal agreement between BCBSNM and the employer. No change or modification to the agreement will be valid unless it is in writing and signed by an officer of BCBSNM. No agent or employee of BCBSNM has authority to change this Benefit Booklet or waive any of its provisions. You will be notified of any changes to this Benefit Booklet at least 60 days before the changes become effective.

6 Tier Coinsurance
Drug Plan Rider
for Large Group PPO Coverages

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.

Coinsurance The percentage 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 after you have met your or your family's Deductible 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:

www.bcbsnm.com/nm/documents/rx-drugs/drug-lists/performance-full-nm-2026.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. You should know that not all drugs identified as a generic by the drug product database, manufacturer, Pharmacy, are considered generic for coverage purposes or similar. Generic Drugs are identified within the Drug List which is available on the BCBSNM website at:

www.bcbsnm.com/nm/documents/rx-drugs/drug-lists/performance-full-nm-2026.pdf

You may also contact a customer service advocate for more information.

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

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

Multi-Category Split Fill Program
If this is your first time using select medications in certain drug classes (e.g., medications for cancer, multiple sclerosis, lung disorders etc.) or if you have not filled one of these medications within 120 days, you may be eligible for a partial fill (14-15-day supply) of the medication for up to the first 3 months of therapy. This is to help see how the medication is working for you. Your Copayments 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/prescription-drugs/pharmacies/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:

www.bcbsnm.com/nm/documents/rx-drugs/drug-lists/performance-full-nm-2026.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:

www.bcbsnm.com/nm/documents/rx-drugs/drug-lists/performance-full-nm-2026.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:

www.bcbsnm.com/nm/documents/rx-drugs/drug-lists/performance-full-nm-2026.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.

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:

www.bcbsnm.com/nm/documents/rx-drugs/drug-lists/performance-full-nm-2026.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:

www.bcbsnm.com/nm/documents/rx-drugs/drug-lists/performance-full-nm-2026.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:

www.bcbsnm.com/nm/documents/rx-drugs/drug-lists/performance-full-nm-2026.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**.)

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 Inborn 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 Coinsurance** section of this rider.

Specialty Drug List

A list of the names of Specialty Drugs which must be purchased through BCBSNM's specialty Pharmacy provider. The Specialty Drug List is subject to periodic review and change by BCBSNM. If you need a list of specialty Pharmacy drugs, request it from a customer service advocate or visit the BCBSNM website at:

www.bcbsnm.com/nm/documents/rx-drugs/drug-lists/performance-full-nm-2026.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 is 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 or
- 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 be made available to you. By calling the customer service toll-free number on your identification card or accessing the BCBSNM website at:

www.bcbsnm.com/nm/documents/rx-drugs/drug-lists/performance-full-nm-2026.pdf

You will be able to determine the Drug List that applies to you and whether a particular drug is on the Drug List.

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

Covered Medications and Other Items

In order to receive maximum benefits, the following drugs, supplies, and other products must be obtained from a Preferred Participating Pharmacy or a Participating Pharmacy under the Preferred Network or Specialty Pharmacy drug programs or 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/provider_finder/important_info_rx.html

- 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 Coinsurance 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
  - Vareniline

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 through the website or by calling customer service at 1-800-432-0750. Your physician can request the necessary prior authorization.

NOTE: Prior Authorization requirements do not apply to covered prescription drugs for the treatment of a

substance use disorder, an auto-immune disorder, or cancer, or a Rare Disease when determined to be Medically Necessary, except when a biosimilar, interchangeable biologic, or a generic version is available. Standard medical necessity determinations will be made by a health care professional from the same or similar practice specialty that typically manages the medical condition, within seven (7) days, and emergency medical necessity determinations will be made within twenty-four (24) hours if a delay in treatment could: (1) seriously jeopardize your life or overall health; (2) affect your ability to regain maximum function; or (3) subject you to severe and intolerable pain.

Step Therapy

The step therapy program 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 step therapy exception request for coverage of the targeted drug. For additional information, please refer to the **Exceptions Process** section below.

NOTE: Continued coverage of prescription drug, that is the subject of a step therapy exception request, will be provided for no less than the duration of the therapeutic effect of that 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 by contacting customer service at 1-800-432-0750 or on our website at:

www.bcbsnm.com/prescription-drugs/pharmacies/programs

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 a 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 consistent with how intravenously administered anticancer drugs are covered under the medical benefit. 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. 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/docs/rx-drugs/nm/contraceptive-list-nm.pdf

This list is also available by contacting customer service at the toll-free number on your ID card.

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 items 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/provider_finder/important_info_rx.html

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 Coinsurance 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.

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 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.

In such cases, you will be responsible for 50% of the covered charge (i.e., the BCBSNM-contracted rate) applicable had you purchased these covered items at a Participating Pharmacy, plus the tiered Copayment amount corresponding to these covered items under your particular drug plan. However, no Coinsurance will apply to orally administered anticancer medications when received from a Participating Pharmacy. Drug plan benefits will be paid for the difference between the foregoing amounts that are your responsibility and any remaining covered charges up to the amount originally billed for these covered items by the out-of-network retail Pharmacy 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 or call the customer service toll-free number on your identification card.

In order to receive maximum benefits for Specialty Drugs, you must obtain the Specialty Drugs from a preferred Specialty Pharmacy Provider. When you obtain Specialty Drugs from a preferred Specialty Pharmacy Provider, benefits will be provided according to the payment provisions indicated in this Benefit Highlights of this Certificate.

Except as provided elsewhere in this rider for orally administered anticancer medications for members covered under a PPO medical plan or as otherwise required under applicable law or regulation. 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:

www.bcbsnm.com/nm/documents/rx-drugs/drug-lists/performance-full-nm-2026.pdf

Your cost for Specialty Drugs is indicated under the **Member Coinsurance** section below and you will be responsible for the Deductible, any Coinsurance, any pricing differences when applicable, noncovered 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 Coinsurance** section below and you will be responsible for the Deductible, Coinsurance, 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 Coinsurance

For covered Prescription Drugs, insulin, diabetic supplies, and nutritional products, you pay the applicable tiered Coinsurance (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 Deductible amounts (if applicable), and Coinsurance percentages. Any additional Coinsurance amounts due for certain covered items are noted in this rider.

Each calendar year, the Copayment percentage amounts are applied to you or your family's applicable annual Prescription Drug out-of-pocket limit in combination with your medical and behavioral health benefits plan for that calendar year. Any pricing differences between the cost of Brand-Name Drugs and their generic equivalents that you pay under this drug plan portion of your health care benefits plan are not applied to you or your family's applicable annual Prescription Drug out-of-pocket limit in combination with your medical and behavioral health for that calendar year under the medical portion of your health care benefits plan (see your **SBC**). After you have met this Prescription Drug out-of-pocket limit for Participating or Preferred Participating Pharmacies 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 Prescription Drug 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 Coinsurance 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 Coinsurance Drug Plan and how it works). When you need a prescription order filled, you should use a Preferred Participating or Pharmacy or a Participating Pharmacy. Each prescription or refill is subject to the Coinsurance shown on the **SBC**. Any Deductible shown in the **SBC** will also apply.

When you go to a Preferred Participating Pharmacy or a Participating Pharmacy, you must pay any Coinsurance Deductible (if any), 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 contact customer service at the toll-free number on your ID card or access the website at:

www.bcbsnm.com/rx-drugs/pharmacy/find-a-pharmacy

In-Network

Pharmacy claims apply to in-network Deductible (if applicable) and Coinsurance amounts paid at an in-network Pharmacy would only apply to your in-network out-of-pocket limit.

Out-Of-Network

Pharmacy claims from an out-of-network Pharmacy apply to out-of-network Deductible (if applicable) and Coinsurance 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 Generic Drugs (Preferred) and may contain some Brand-Name Drugs
- Tier 2 includes mostly Generic Drugs (Nonpreferred) and may contain some Brand-Name Drugs
- Tier 3 includes mostly Brand-Name Drugs (Preferred) and may contain some Generic Drugs
- Tier 4 includes mostly Brand-Name Drugs (Nonpreferred) and may contain some Generic Drugs
- Tier 5 includes mostly Specialty Drugs (Preferred) and may contain some Generic Drugs
- Tier 6 includes mostly Specialty Drugs (Nonpreferred) 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 Coinsurance 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, Participating Pharmacy or a BCBSNM designated specialty Pharmacy provider, or BCBSNM designated mail order service vendor in order to be covered under your drug plan.

For example, if the health benefits plan you chose features this option:0%/0%/0%/0%/0%/0%		
Six-Tier Plan, after Medical Deductible is met	Tier	Coinsurance 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]	Coinsurance of 0% of Covered Charge
	Tier 2[1]	Coinsurance of 0% of Covered Charge
	Tier 3[1,2]	Coinsurance of 0% of Covered Charge
	Tier 4[1,2]	Coinsurance of 0% of Covered Charge
Nonpreferred Participating Pharmacy Retail Pharmacy One Coinsurance amount up to a 30-day supply	Tier 1[1]	Coinsurance of 0% of Covered Charge
	Tier 2[1]	Coinsurance of 0% of Covered Charge
	Tier 3[1,2]	Coinsurance of 0% of Covered Charge
	Tier 4[1,2]	Coinsurance of 0% of Covered Charge
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]	Coinsurance of 0% of Covered Charge
	Tier 6[1,2]	Coinsurance of 0% of Covered Charge
[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 Coinsurance, 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.bcbsnm.com/nm/documents/rx-drugs/drug-lists/performance-full-nm-2026.pdf(For a list of Pharmacies that are contracted with BCBSNM to provide this service, go to the BCBSNM website at www.bcbsnm.com/provider_finder/important_info_rx.html.		No Coinsurance
Certain Prescription Drugs for treatment of mental illness, behavioral health, and substance use disorders from Participating Pharmacies Please see your Drug List at: www.bcbsnm.com/prescription-drugs/pharmacies/programs, for more information.		No Coinsurance
Mail Order Service (available for Tiers 1, 2, 3 or 4 only; Specialty Drugs are not covered through Mail Order Service) Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.		3 times the Coinsurance for Tier 1, 2, 3 or 4 drugs
Nonprescription Enteral Nutritional Products and Special Medical Foods (Coinsurance requires Prior Authorization; brand-name or generic)		Coinsurance of 50% of Covered Charges
For Members covered under a PPO Medical plan: For those Prescription Drug services and supplies from an out-of-network Retail or Specialty Pharmacy eligible for coverage.		Coinsurance of 50% of Covered Charges plus Coinsurance percentage of remaining Covered Charges

Under this drug plan, drugs are available at tiered Coinsurance levels. The benefits you receive and the amount you pay will differ depending upon the type of drugs, or diabetic supplies, or insulin and insulin syringes**,** or nutritional products obtained and whether they are obtained from a Preferred Participating Pharmacy, Participating Pharmacy, Nonparticipating Pharmacy, 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. Deductible applies.

When the Coinsurance amount for an item purchased under the drug plan is greater than the covered charge for the supply being purchased from a Participating Pharmacy, you pay the least of

- Your Coinsurance
- 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 Coinsurance amount 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	Coinsurance Requirements
Nonprescription Nutritional Products	30-day supply during any 30-day period	Coinsurance of 50% of covered charges (includes prescriptions for Enteral Nutritional Products and Special Medical Foods as described under **Covered Drugs and Other Items**)
Retail Pharmacy, and Specialty Pharmacy Provider	During each one-month period, a 30-day supply	Coinsurance for a 30-day supply.
Preferred Participating Retail Pharmacy Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.	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.	Coinsurance for Coinsurance for a 90-day supply.
Mail Order Service (Tiers 1, 2, 3, and 4 only) Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.	During each three-month period, up to a 90-day supply	Coinsurance for a 90-day supply.

Dispensing Limits

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

Drug Plan Exclusions

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

- Drugs/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
- Nonprescription and over-the-counter drugs unless required by New Mexico state law, or specifically listed as covered, including herbal or homeopathic preparations, and nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum, or prescription drugs that have over-the-counter equivalents
- Drugs or other items for the treatment of sexual or erectile dysfunction devices
- Devices, technology, and durable medical equipment of any type (even though such devices may require

a prescription order) such as, but not limited to, therapeutic devices, artificial appliances, digital health technologies and/or applications, or similar devices (except disposable hypodermic needles and syringes for self-administered injections)

- Medications or preparations used for cosmetic purposes (such as preparations to promote hair growth or medicated cosmetics)
- Tretinoin (sold under such Brand-Names as Retin-A) 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; weight reduction drugs; food or diet supplements and medication prescribed for body building or similar purposes
- Ordinary foodstuffs that might be part of an exclusionary diet; any product that does not have and/or require a physician's prescription; food items purchased at a health food, vitamin or similar store; foods purchased on the internet
- Drugs determined to have inferior efficacy or significant safety issues
- Covered drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under Workers' Compensation law
- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of an identification card
- Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under the medical portion of health care benefits plan, or for which benefits have been exhausted
- Any Prescription Drug for which the FDA has determined its use to be contraindicated for the treatment of the particular condition for which the drug has been prescribed
- 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 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)
- 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
- Nonparticipating Pharmacy provider or other provider unless eligible for benefits in an Emergency situation (as defined in your Benefit Booklet) or for Members covered under PPO medical plans, as listed under Preferred Pharmacy Network, and purchased from a nonparticipating retail Pharmacy for replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced
- 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. 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. 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?

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 directly receive any portion of any such discounts. The calculation of your cost sharing obligation for covered prescription drugs will be credited for the full value of any such discounts at the point of sale. The drug fees and/or discounts that BCBSNM has negotiated with Prime Therapeutics LLC (Prime) through the Pharmacy Benefit Management (PBM) Agreement will be used to calculate your share of the cost of Prescription Drugs passed through to you for both retail and mail/Specialty

Drugs. 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.

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 paid weighted claim basis. Funding levers means a mechanism through which BCBSNM funds the fees (net fee, ancillary fees and special project fees) owed to the PBM. Funding levers always include manufacturer administrative fees, mail order utilization, Participating Pharmacy transaction fees, and, if elected by BCBSNM, may include rebates and retail spread. BCBSNM's net fee owed to Prime for core services will be offset by the funding levers. BCBSNM pays Prime the net fee for core services, ancillary fees and special project fees, offset by all applicable funding levers as agreed upon under the terms of its agreement with Prime.

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 Benefit Managers

BCBSNM hereby informs you that it owns a significant portion of the equity of Prime and that BCBSNM has entered into one or more agreements with Prime or other entities (collectively referred to as Pharmacy Benefit Managers, or PBMs), for the provision of, and payment for, Prescription Drug benefits to all persons entitled to Prescription Drug benefits under individual certificates, group health insurance policies and contracts to which BCBSNM is a party, including this contract. PBMs have agreements with pharmaceutical manufacturers to receive rebates for using their products. In addition, Prime's mail order Pharmacy and other PBM services operate through the same entity, Prime Therapeutics LLC. Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of BCBSNM but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufacturers to cover the administrative costs of processing late payments). BCBSNM may receive such rebates from Prime. You are not entitled to receive any portion of any such rebates as they are calculated into the pricing of the product.

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.

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.

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

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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