Your Health Care Benefit Program

# City of Albuquerque

## and Participating Entities

**A Guide to Your Exclusive Provider Option (EPO)**

**Health Care Plan**

Underwritten by:

BlueCross BlueShield of New Mexico

*Experience. Wellness. Everywhere.*℠

NM81452 (07/10)

# CUSTOMER ASSISTANCE

**For Medical/Surgical Claims or Eligibility and Claim Questions**—The 24/7 Nurseline can help when you have a **health** problem or concern. The 24/7 Nurseline is staffed by registered nurses who are available 24 hours a day, 7 days a week.

**24/7 Nurseline toll-free telephone number:** 1-800-973-6329

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

**Street address:** 4373 Alexander Blvd. NE
**Toll-free telephone number:** 1-800-432-0750

Send all **written inquiries/preauthorization requests** and submit **medical/surgical claims*** to:

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

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

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

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**Mental Health and Chemical Dependency**—For inquiries or preauthorizations related to mental health or chemical dependency services, call the BCBSNM behavioral health services administrator:

**24 hours/day, 7 days/week: 1-800-583-6372 or 1-505-816-6790**

**Send claims* to:**
Claims, Mesa Mental Health
P.O. Box 92165
Albuquerque, New Mexico 87199-2165

**All other correspondence:**
Mesa Mental Health
P.O. Box 90607
Albuquerque, New Mexico 87199-0607

**Web Site**—For provider network information, BCBSNM Drug List, claim forms, and other information, or to e-mail your question to BCBSNM, visit the BCBSNM Web site at:

**www.bcbsnm.com**

***Exceptions to Claim Submission Procedures**—Claims for health care services received from providers that do not contract **directly** with BCBSNM (or Mesa Mental Health), should be sent to the Blue Cross and Blue Shield Plan in the state where services were received. **Note: Do not submit drug plan claims to BCBSNM. The name and address of the pharmacy benefit manager is in a separate brochure.** See *Section 8: Claim Payments and Appeals* for details on submitting claims.

**Be sure to read this benefit booklet carefully and refer to the *Summary of Benefits*.**

A message from

## BLUE CROSS AND BLUE SHIELD OF NEW MEXICO

This health care benefit 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 benefit plan. Please read your entire benefit booklet very carefully. We hope that most of the questions you have about your coverage will be answered.

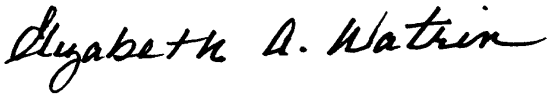
We refer to our company as ''BCBSNM'' in this benefit booklet, and we refer to the company or association that you work for as the ''group.'' *Section 10: Definitions* will explain the meaning of many of the terms used in this benefit booklet. Whenever the term ''you'' or ''your'' is used, we also mean all eligible family members who are covered under this benefit plan.

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 ID card, or as listed in *Customer Assistance*. 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,



Elizabeth A. Watrin
President
Blue Cross and Blue Shield of New Mexico

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# SECTION 1: HOW TO USE THIS BENEFIT BOOKLET

This section of the benefit booklet describes some important features you should know about your coverage.

## 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

Throughout this benefit booklet, you are asked to refer to a separately issued *Summary of Benefits* that shows specific member cost-sharing amounts and coverage limitations of your benefit plan. If you do not have a *Summary of Benefits*, please contact a BCBSNM Customer Service representative (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 benefit 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 benefit program with BCBSNM.

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

## PROVIDER NETWORK DIRECTORY

The provider network directory is available through the BCBSNM Web site at www.bcbsnm.com. It lists all providers in the BCBSNM preferred provider (PPO) network, including mental health/chemical dependency providers and participating pharmacies. It also provides links to the listings of preferred providers in other states. (If you want a paper copy of a directory, you may request one from Customer Service. It will be mailed to you free of charge.) **Note:** Although provider directories are current as of the date shown at the bottom of each page, they can change without notice. To verify a provider's status or if you have any questions about the directory, contact a Customer Service representative or visit the BCBSNM Web site.

## DRUG PLAN BENEFITS

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

## BLUECARD® BROCHURE

As a member of a PPO health plan administered by BCBSNM, you take your health plan benefits with you – across the country and around the world. The BlueCard Program gives you access to preferred providers almost everywhere you travel or live. Almost 90 percent of physicians in the United States contract with Blue Cross and Blue Shield (BCBS) Plans. You and your dependents can receive the Preferred Provider level of benefits – even when traveling or living outside New Mexico – by using health care providers that contract as preferred providers with their local BCBS Plan. You should have received a brochure describing this program in more detail. It's a valuable addition to your health care plan coverage. Instructions for locating a preferred provider outside New Mexico are in the brochure or can be found on the BCBSNM Web site at www.bcbsnm.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.

## ADMISSION REVIEW OR OTHER PREAUTHORIZATION REQUIRED

To receive full benefits for some nonemergency admissions and certain medical/surgical services, you or your provider must call the BCBSNM Health Services department **before** you receive treatment. Call Monday through Friday, 8 a.m. to 5 p.m., Mountain Time. See *Section 4: Admission Review and Other Preauthorizations* for details. **Note:** Call Customer Service if you need preauthorization assistance after 5 p.m.

To receive full benefits for emergency or maternity–related hospital admissions, you (or your provider) must notify BCBSNM **within 48 hours** of admission. Call BCBSNM's Health Services department, Monday through Friday, 8 a.m. to 5 p.m., Mountain Time. Also, if you have a routine delivery and stay in the hospital **more than 48 hours**, or if you have a C-section delivery and stay in the hospital **more than 96 hours**, you must call BCBSNM for admission approval before you are discharged.

### Written Request Required

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

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

Please ask your health care provider to submit your request early enough to ensure that there is time to process the request before the date you are planning to receive services.

## CALL MESA MENTAL HEALTH FOR PREAUTHORIZATION

For all inpatient and outpatient mental health and chemical dependency services, you or your physician must call the BCBSNM behavioral health services administrator, Mesa Mental Health, **before** you schedule treatment. Mesa Mental Health will coordinate covered services with a preferred provider near you. If you do not call before receiving nonemergency services, benefits for covered services may be reduced or denied. Call 7 days a week, 24 hours a day. See *Section 4: Admission Review and Other Preauthorizations* for details.

## BLUEEXTRAS [SM]

Certain local and national retailers, outlets and businesses offer BCBSNM health plan members an opportunity to save money on services that are not covered under this benefit plan. These discount offers and other services are not part of your medical/surgical health care benefits described in this benefit booklet, and the entities making the offers and the providers of the services may not be affiliated or associated with BCBSNM or your group health care plan. However, from time to time, BCBSNM will be announcing such offers by sending manufacturer or retail discount coupons to member households, inserting information in the member newsletters, or mailing descriptions of various programs being offered to our members by businesses such as health clubs, pharmacies, vision care providers, hearing aid retailers, dentists, etc. These mailings may contain coupons or offers that enable you, at your discretion, to purchase the described product or enroll in a certain program at a discount or at no charge. The retailer, provider, or manufacturer may pay for and/or provide the content for this information. The discounts and services available to members may change at any time and BCBSNM does not guarantee that a particular discount or service will be available at any given time. For details of current discounts available, please contact a Customer Service representative by calling the phone number on the back of your ID card.

## OTHER MEMBER SERVICES

To help members track claim payments, make health care choices, and reduce health care costs, BCBSNM maintains a flexible array of online programs and tools for health care plan members. The online "Blue Access for Members" (BAM) tool provides convenient and secure access to claim information and account management features and to various cost comparison tools. While online, members can also access a wide range of health and wellness programs and tools, including a health risk assessment and personalized health updates, and a program in which members can earn merchandise and gift cards for making healthy lifestyle choices and for participating in various activities. To access these online programs, go to www.bcbsnm.com, log into Blue Access for Members and create a user ID and

password for instant and secure access. If you need help accessing the site, call the Blue Access Help Desk toll-free at 1-888-706-0583, Monday through Friday 7 A.M. to 9 P.M., Mountain Time, or Saturday 6 A.M. to 2:30 P.M. Mountain Time. **Note:** Depending on your group's coverage, you may not have access to all online features. Check with your benefits administrator or call Customer Service at the number on the back of your ID card. BCBSNM assesses the usefulness of various programs regularly, using data about program usage and member feedback to make changes to online tools as needed. Therefore, available programs and program 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 Web site 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 representative.
- Be very cautious about giving information about your health care insurance over the phone.

If you suspect fraud, contact the BCBSNM Fraud Hotline at 1-888-841-7998.

## CUSTOMER ASSISTANCE

For your convenience, the toll−free customer service number for BCBSNM is printed at the bottom of every page in this booklet. Refer to *Customer Assistance* on the inside cover of this booklet for important phone numbers, Web site, and mailing address information. If you need language services, call the Customer Service phone number on the back of your ID card.

# SECTION 2: ENROLLMENT AND TERMINATION INFORMATION

## WHO IS ELIGIBLE

***Member –*** Each enrollee (the subscriber and any eligible dependent) who is enrolled for coverage and entitled to receive benefits under this benefit plan in accordance with the terms of the Group Master Contract. Throughout this booklet, "you" and "your" refer to each member.

***Subscriber –*** The person whose employment or other status, except for family dependency, is the basis for enrollment eligibility, or in the case of a direct–pay contract, the person in whose name the contract is issued. "Subscriber" may also encompass other persons in a nonemployee relationship with the employer, group, or business if specified in the Group Master Contract.

Unless otherwise specified in the Group Master Contract, all active employees who have completed the employee probationary period and are regularly working the minimum number of hours specified in the Group Master Contract and their eligible dependents are eligible for coverage. To find out the number of hours you must work per week and to learn of any other eligibility criteria specified by your group, contact your employer's Benefits Office. In order to obtain coverage for yourself and any eligible family members, you must complete your enrollment within 31 days of your hire date. If you do not enroll within 31 days, you may not enroll until the next annual open enrollment period, except as specified under "Special Enrollment."

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

See "Re-Enrollment" in this section for important information if you or a dependent were previously enrolled in a health care plan administered by BCBSNM.

## ELIGIBLE DEPENDENTS

***Eligible dependents –*** Family members of the subscriber, limited to the following persons:

- the subscribers legal **spouse**
- the subscriber's **domestic partner** (NOTE: Not all governing bodies of the entities have approved allowing an employee's domestic partner and hi/her children to be eligible for insurance coverage. Check with your employer's Benefits Office for more information.)
- the subscriber's **child** until the day the child becomes age **26** (At that time, the child is automatically removed from coverage as a dependent.)
- the subscriber's child age **26** or older who was enrolled as a dependent at the time of reaching the age limit, and who is medically certified as **disabled** and chiefly dependent upon the subscriber for support and maintenance (Such condition must be certified by a physician and BCBSNM. Also, a child may continue to be eligible for coverage beyond the dependent age limit only if the condition began before or during the month in which the child would lose coverage due to his/her age. BCBSNM must receive written notice of the disabling condition before the end of the month during which the child's coverage would otherwise end.)

***Child –*** A child is considered to be a specific age on the first day of the month following his/her birthday, and includes an unmarried:

- a natural or legally adopted child of the subscriber, whether or not the subscriber is the custodial or noncustodial parent, and whether or not the child is claimed on income tax or residing in the subscriber's home
- child under age 18 placed in the subscriber's home for purposes of adoption
- stepchild of the subscriber (or otherwise eligible child of a domestic partner, if domestic partners are covered under your employer's plan)
- child for whom the subscriber is the legal guardian
- child for whom the subscriber must provide coverage because of a court order pursuant to state law

***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 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; and
- has signed jointly with you, a notarized affidavit which can be made available to BCBSNM upon request.

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

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

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

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

The federal government does not recognize domestic partners as qualified dependents 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 city for the domestic partner and his/her covered children. Employees wanting to change benefit elections involving a domestic partner must adhere to the same rules regarding qualifying events.

Within 31 days of hire, you must submit all required forms to your employer's Benefits Office. Once you have made an election during your initial enrollment period of 31 days from your hire date, 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 a dependent under this coverage. Unless listed as an eligible dependent above, no other family member, relative, or person is eligible for coverage as a dependent. 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." NOTE: A child who is also an eligible employee under this benefit plan may not be covered as both a dependent child and as an employee under this benefit plan. If the child continues to be eligible as a dependent child under an employee's contract, the child must choose to either remain on the parent's contract as a dependent child or choose to switch to his/her own employee contact under the City of Albuquerque EPO Plan.

### Information for Noncustodial Parents

When a child is covered by the health care plan through the child's noncustodial parent, then BCBSNM will:

- provide such information to the custodial parent as may be necessary for the child to obtain benefits through the benefit plan;

- permit the custodial parent or the provider (with the custodial parent's approval) to submit claims for covered services with the approval of the noncustodial parent; and
- make payments on claims submitted in accordance with the above provision directly to the custodial parent, the provider, or the state Medicaid agency, as applicable.

## MEDICARE-ELIGIBLE MEMBERS

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

**If Medicare is Secondary –** If an employee qualifies under the provisions of federal law for the working aged (TEFRA), then the working employee age 65 or older and/or his/her eligible spouse age 65 or older may continue this health care plan coverage as primary over Medicare until the eligible employee retires. There are also other instances in which you may retain regular group coverage when entitled to Medicare. Refer to the *Medicare Handbook* or contact the Social Security Administration for more information and eligibility guidelines that apply to you.

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

**If Medicare is Primary –** If federal law does not require that this group coverage be primary over Medicare, and the employer offers coverage that is secondary to Medicare, members age 65 and older must change to the employer plan coverage that is secondary to Medicare. If offered through your employer, this coverage is available through BCBSNM. If you do not have both Parts of Medicare, or if you are under age 65, you must retain regular plan coverage until you obtain both Parts of Medicare or until the beginning of the month in which you reach 65. If the employer does not offer coverage secondary to Medicare, see "How to Continue Coverage." later in this section for more continued coverage options.

Refer to a Medicare Handbook or contact the Social Security Administration for more information and eligibility guidelines that apply to you. Members of any age with both Parts of Medicare may also choose to apply for an individual Medicare Supplement Policy, which may require a health statement and/or a pre–existing conditions waiting period. (The options available to members under age 65 and eligible for Medicare may differ from those available to members age 65 and older.)

## APPLYING FOR COVERAGE

An eligible person can apply for coverage, including for his/her eligible dependents, by submitting an enrollment/change form to the employer **within 31 days** after becoming eligible for benefit plan coverage. If you do not enroll within 31 days, you may not enroll until the next annual open enrollment period, except as specified under "Special Enrollment." **Note:** BCBSNM cannot use genetic information or require genetic testing in order to determine if a condition is pre–existing or to limit or deny coverage.

### Waiving Coverage

If an employee declines to enroll in this group health plan when initially eligible to do so, the employee must sign a *Waiver of Coverage* form 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 his/her dependents may be eligible to enroll in the employer's group plan as "special enrollees." An employee *Waivers of Coverage* form, 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 health care benefit plan. If you later lose the other coverage and wish to enroll in the benefit 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 he/she is initially eligible, you do not need to sign a *Waiver of Coverage.* 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, he/she will be ineligible for special enrollment. If the person chooses to enroll anyway, the person will be considered a late applicant.

## WHEN COVERAGE BEGINS

BCBSNM will determine your effective date of coverage according to the provisions of the Group Master Contract. Contact your employer to determine your effective date of coverage. Participation is not automatic; you must complete, sign, and submit an application for benefit plan participation in order to obtain coverage under this benefit plan.

**This benefit plan does not cover** any service received before your effective date of coverage (which, for eligible dependents, may be later than the subscriber's effective date). Also, if your prior coverage has an extension of benefits provision, this benefit plan 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 dependents 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 the City of Albuquerque and on whether or not you are paying employee contributions for coverage on a pre–tax basis. Please contact your employer to find out when you can change your coverage type or remove a person from your coverage.

## ADDING A DEPENDENT TO COVERAGE

You may apply for coverage of a dependent such as a spouse or an eligible child. **Within 31 days** of acquiring the new dependent, or before adding a spouse or child to coverage, you 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 to your employer, and
- pay any additional premium or other employee contribution for coverage, which may mean changing, for example, from Individual to Family coverage.

If you do not submit a completed and signed enrollment/change form to the employer (or to the COBRA administrator, if applicable), along with necessary documentation and, if required, change from Individual to Family coverage **within 31 days** of acquiring a new dependent, the child or spouse will be considered a late applicant under the "Late Applicant Provision" (except as specified under "Special Enrollment").

### Adding a Spouse or Domestic Partner

An employee may also enroll an eligible spouse who has not been covered under the benefit plan or a newly acquired spouse. In order to prevent delays in claims payments, you must complete an enrollment/change form, providing the spouse's name, age, relationship, and other information as required by the benefit plan – along with legal documentation of proof of dependency (such as marriage certificate).

If you add coverage for a spouse **within 31 days** of marriage, the effective date of the new dependent's coverage will be no later than the first of the month following the date your employer received the completed and signed enrollment/change application form. If you do not submit a completed and signed enrollment/change application form to add a spouse **within 31 days** of marriage, the spouse will be considered a late applicant , except as specified under "Special Enrollment."

**Domestic partners and their eligible children may be added to existing coverage only during the annual open enrollment period.**

### Adding a Dependent Child

If you do not submit an application for a dependent 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 is in effect, a newborn, natural child is covered from birth. (You should, however, submit an application to add the newborn as a dependent as soon as possible after birth.) If Family coverage is not in effect, you must change to Family coverage **within 31** days of the birth in order for newborn care to be covered beyond day 31. **Note:** A newborn who is not enrolled within 31 days of birth 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 his/her birth and has had prior creditable coverage since that date with no significant lapse (i.e., 95 or more days).

**Note:** If the parent of the newborn is a dependent child of the subscriber (i.e., the newborn is the subscriber's grandchild), benefits are **not** available for the newborn.

### Adopted Children

A child under age 18 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 dependent age limitations and restrictions.) **Note:** An adopted 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 plan or other creditable coverage within 30 days of his/her adoption or placement for adoption and has had prior creditable coverage since that date with no significant lapse (i.e., 95 or more days).

### Legal Guardianship

Application for coverage must be made for a child for whom you or your spouse becomes the legal guardian **within 31 days** of the court or administrative order granting guardianship. If not specified in the court order, the dependent'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, whichever is later.

### Court Ordered Dependent Coverage

When an employee or employer is required by a court or administrative order to provide coverage for an eligible dependent child, the dependent may be enrolled in the employee's Family coverage and will **not** be considered a late applicant. (If you have Individual coverage, you may be required to pay additional premium in order for the dependent to be added.) If not specified in the court or administrative order, the dependent'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, whichever is later. The employer must receive a copy of the court or administrative order. Also, see "Information For Non−Custodial Parents," earlier in this section and "Claims Payment Provisions" in *Section 8* for information about qualified medical child support orders.

## ADDRESS AND ELIGIBILITY CHANGES

You, as the subscriber, are responsible for notifying the appropriate party **within 31 days** following any changes that may affect your or a dependent's eligibility, by indicating such changes on an enrollment/change form and submitting it to the employer. This includes any address or name change, any change that may affect your or a dependent's eligibility, including a change to a covered family member's name or address. You are also responsible for requesting changes to your coverage type by submitting signed and completed enrollment/change forms to the appropriate party. You can obtain this form at BCBSNM's Web site at www.bcbsnm.com, from your Benefits Office, or by calling the BCBSNM Customer Service department. The party that must be advised depends on whether you are covered as an active employee or under a COBRA continuation policy:

### Employees and Their Dependents

Employees covered under the group benefit plan are responsible for completing and submitting signed enrollment/change forms to your employer. Only then can your employer properly adjust payroll deductions or billing and advise BCBSNM of the change in coverage.

### COBRA Continuation Policy Members

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

## OPEN ENROLLMENT

An annual open enrollment period will be held for at least three weeks (usually during May). During the open enrollment period, any eligible employee and his/her eligible dependents may enroll in the health care plan for which the employee is eligible. Members may also choose to change to a different health plan if eligible to do so. **Benefit changes elected during open enrollment are effective on July 1 (or on June 30 for coverage terminations).**

**Note:** Open enrollment is **not** available to terminated members who initially declined continued coverage under a COBRA or conversion contract. If an applicant does not enroll in these coverages timely, he/she may **not** enroll at a later date.

## LATE APPLICANT PROVISION

***Late applicant*** **–** Unless eligible for a "special enrollment," applications from the following enrollees will be considered late:

- unless enrolling during the annual open enrollment period, anyone not enrolled **within 31 days** of becoming eligible for coverage under this group health care plan (e.g., a newborn child added to coverage more than 31 days after birth, a child added more than 31 days after legal adoption, or a new spouse or stepchild added more than 31 days after marriage)
- anyone who voluntarily terminates his/her coverage and applies for reinstatement of such coverage at a later date (except as provided under the USERRA of 1994)

**Late applicants may not enroll until the next annual open enrollment period.**

### COBRA–Eligible Members

**Late applications are not accepted from terminating members applying for coverage under COBRA.** (There are federal regulations regarding the amount of time that a terminating plan member has to apply for COBRA coverage when first eligible. See "How to Continue Coverage" for more information.)

## SWITCH ENROLLMENT AND CHANGES IN PLAN

Your benefit plan choice can only be changed outside open enrollment if you, as an active employee or dependent of an active employee, are eligible for a special enrollment. (See "Special Enrollment" for details.)

### During Open Enrollment Period

During the annual open enrollment period, the subscriber and his/her eligible dependents 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 he/she is eligible. The effective date of the change made during open enrollment will be July 1.

### Outside the Open Enrollment Period

If you or your dependent must change to another health care plan being offered by the City of Albuquerque because of a change in the subscriber's residency (i.e., moving outside an HMO service area) or family status (i.e., a special enrollment qualifying event), an enrollment/change form must be submitted to the City of Albuquerque as soon as possible (or, for continuation members, to 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

You have a limited amount of time during which you may request a special enrollment. If you do not request a special enrollment within the time frames described under "Qualifying Events," you will be considered a late applicant.

**Note:** There are no "special enrollments" for persons applying for any continuation, conversion, or extension of benefits due to disability. You must enroll in such coverage timely.

## Applying for Special Enrollment

Application for special enrollment must be made **within the time period specified for each of the qualifying events** in order to qualify you and/or your dependent(s) for a special enrollment right. Please contact your employer for details about special enrollment privileges that apply to you and your eligible family members.

## Waiver of Coverage

If an employee or other eligible dependent declines to enroll in this group health care plan when initially eligible to do so, the employee must sign a *Waiver of Coverage* form for the declining person and submit it to the employer. **It is very important that the employee indicate the reason for declining coverage.** If the eligible person declined coverage due to having other health care coverage and later involuntarily loses the other coverage, he/she may be eligible to enroll in the employer group plan as a "special enrollee." Waivers of coverage, indicating that coverage is being declined due to having other coverage, must be submitted to the employer **within 31 days** of becoming eligible for coverage under this employer's health care plan. (If the person declining coverage later requests a special enrollment, but no such written explanation was provided to the employer, or if the reason for declining coverage was not due to having other coverage, the person will not be eligible for special enrollment. If the person chooses to enroll anyway, he/she 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.

## Qualifying Events

There are four instances ("qualifying events") in which an eligible person can obtain a "special enrollment" right (see definition in *Section 10: Definitions)* and enroll in this group plan more than 31 days after becoming eligible without being considered a late applicant. 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,** you will be considered a late applicant.

### 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 himself/herself and eligible dependents. (The dependents 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 dependents to coverage under this provision if the dependent had prior creditable coverage that was involuntarily lost or had reached lifetime benefit maximum under the other carrier's benefit plan. (See definition of "involuntary loss of coverage" in *Section 10: Definitions.")*

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 dependent that he/she 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 dependents of the employee (including spouse). If a dependent of the current employee lost prior coverage, special enrollment is available for the affected dependent and the employee (not other**

**dependents).** 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 dependent losing prior coverage, although all family members may not be eligible for a "special" enrollment, eligible dependents 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* form 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, dependent(s) only, or both, BCBSNM requires proof of loss of coverage or proof of the date of the event.

### Change in Family Status

An employee who acquires a new eligible dependent due to marriage, birth, adoption, or placement for adoption may apply for a special enrollment in this benefit plan for himself/herself **and other family members** who are eligible for coverage under this benefit plan. Application for special enrollment of the employee and his/her dependents will **not** be considered late if submitted **within 31 days** of the marriage, birth, adoption, or placement of the dependent 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 A Dependent to Coverage."

**This right to special enrollment upon a change in family status applies to the employee and to all eligible dependents.**

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.

### Loss of Medicaid/SCHIP Eligibility

If an eligible employee or his/her eligible dependent is not currently enrolled in the benefit plan and loses eligibility under Medicaid or under a state child health plan (SCHIP), the person losing such coverage may enroll in the benefit plan without being considered a late applicant. To be eligible for special enrollment, the person must apply for coverage under the group health plan no later than **60 days** after the date of termination of Medicaid or SCHIP coverage. (In order for a dependent to be eligible for special enrollment, the employee must be covered under the employer group health plan. If the employee is not enrolled in the benefit plan when the dependent becomes eligible for assistance, the employee must enroll into the benefit plan at the same time as the eligible dependent.) 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 dependents of the employee (including spouse). If a dependent of the current employee lost Medicaid/SCHIP coverage, special enrollment is available for the affected dependent and the employee (not other dependents).**

### Medicaid/SCHIP Group Health Plan Premium Assistance Eligibility

A state may offer premium subsidies through Medicaid or a state child health plan (SCHIP) to low–income children and their families for qualified employer–sponsored coverage. This includes premium assistance for continuation coverage under federal or state law. Therefore, if an eligible employee or an eligible dependent is not enrolled in the benefit plan and later becomes eligible for group health plan premium assistance under Medicaid or under SCHIP, the eligible person may enroll in the benefit 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 dependent 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 benefit plan when the dependent becomes eligible for assistance, the employee must enroll in to the benefit plan at the same time as the eligible dependent.)

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

If a completed and signed enrollment/change form is **not** received within the time periods set forth in this section, the employee and /or his /her dependents will be considered late applicants and no special enrollment right will be available.

## COVERAGE TERMINATION

BCBSNM will not cancel your coverage for nonpayment of copayments 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 or termination of the Group Master Contract, we must provide you written notice at least 30 calendar days in advance. The notice must be in writing and dated, state the reason for the cancellation and the date on which it becomes effective, provide you a list of circumstances under which your coverage cannot be cancelled, and provide you information about appealing your termination to the superintendent of insurance in New Mexico. You will not receive a notice of cancellation if there is no renewal provision in your contract.

If the employer fails to submit premium payments to BCBSNM on a timely basis, coverage will terminate for all affected members as of the end of the last–paid–billing period. The affected members and the employer will **not** be notified of such a termination.

If a member's coverage is cancelled (for reasons other than fraud or deception) and the subscriber has paid premium in advance on behalf of the affected member, BCBSNM will return to the subscriber, within 30 days, the appropriate pro rata portion of the premium, less any amounts due to BCBSNM.

Unless stated otherwise, if you do not elect or do not qualify for continuation coverage (see "How to Continue Coverage"), coverage ends at the end of the pay period in which eligibility ends due to one of the situations below (unless otherwise indicated):

- The employee **terminates employment** or **otherwise loses eligibility** according to the terms of the Group Master 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. If the employee retires, coverage ends at the end of the month during which the employee retired.
- 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 received and paid for during the 30-day grace period will be billed both to the employee and to the group or, in the case of continuation coverage, to the subscriber.)
- When the member chooses to discontinue coverage due to a **leave of absence** or upon entering the **armed forces** for **more than 30 days** or as provided by law. You must contact the employer in order to ensure that coverage is terminated according to your wishes. During a leave of absence covered by the Family Medical Leave Act (FMLA) or the Uniformed Services Employment and Re–employment Rights Act of 1994 (USERRA), coverage will continue as provided by law. Contact the employer for information. If you allow your coverage to lapse due to nonpayment of premium, you have **31 day**s in which to notify the employer that you intend to re–enroll. Coverage will be reinstated according to benefit plan guidelines and rules and a new enrollment/change form may be required.)

- When the **member materially fails to abide by the rules,** policies, or procedures of this benefit 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 his/her dependents, BCBSNM may terminate the coverage of the subscriber and his/her dependents 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 dependents remain covered through the last-paid billing period.)
- If this benefit plan is primary over **Medicare** due to federal laws and regulations, when the Medicare-eligible member *chooses* Medicare Part A or B as his/her primary coverage. (See "Medicare-Eligible Members" for information on coverage options for members who are entitled to Medicare.)
- At the *beginning* of the month when the member becomes **age 65** (excepting any laws to the contrary that apply to certain large group employer health plans). See "How to Continue Coverage" for more information regarding continued coverage options in these cases.
- 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 days' advance written notice**.

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

### Additional Dependent Termination Reasons

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

- At the end of the **last-paid billing period** for dependent coverage.
- At the end of the pay period when a child **no longer qualifies as a dependent** under the benefit plan (e.g., a child is removed from placement in the home, marries; in the case of a dependent reaching the dependent age limit, coverage continues until the end of the month). unless the child is medically certified as handicapped).
- At the end of the pay period following the date of a final **divorce** decree or **legal separation** for a spouse.
- At the end of the pay period when the subscriber gives a minimum **30 days' advance notice** in writing to end coverage for a dependent(s), according to the rules of your benefit plan as established by the City of Albuquerque.
- At the end of the pay period following the **dissolution of a domestic partnership.**

If a dependent is being removed from coverage because of losing his/her eligibility under the benefit plan (including when a child reaches the dependent child age limit), the enrollment/change form must be received by BCBSNM **within 31 days** following the effective date of the change. In these cases, the member will be removed from coverage as of the end of the month following the change in his/her 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 dependent from coverage before loss of eligibility or to voluntarily terminate his/her own coverage, the subscriber must submit a completed enrollment/change form to his/her employer's Benefits Office. If voluntary termination is allowed under your benefit plan outside the annual open enrollment period, coverage will end the next first of the month billing period following receipt of the enrollment/change form. Voluntarily terminated members may re-enroll under the benefit 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.

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

### Termination of Continuation Coverage or Extension of Benefits

See "How to Continue Coverage" for more information.

### Leave of Absence or Military Service

Coverage will end for a subscriber and his/her eligible dependents 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 Master 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. The affected members and the employer will **not** be notified of such terminations. (If the employer fails to submit premium payments to BCBSNM, it is the employer's responsibility to advise members of BCBSNM benefit plan termination.)

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

- changes in federal and state law; or
- changes to coverage classifications (for example, to a new age category or geographic location, or from a single dependent coverage to a two dependent coverage type); or
- after giving the employer and/or subscriber **60 days'** written notice.

### Premium Refunds

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

- the enrollment/change form is not received **within 31 days** of the change in eligibility status; or
- any claims or capitation amounts have been paid on behalf of the terminated member during the period for which premiums have been paid.

### Cancellation Appeals

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 New Mexico Superintendent of Insurance.

## RE-ENROLLMENT

If a previously covered employee and/or dependent is re-enrolled in this group benefit plan, he/she will usually be considered a late applicant. See "Late Applicant Provision" and "Special Enrollment" for exceptions and details.

Any individual whose previous BCBSNM contract was terminated for good cause is not eligible to re-enroll in this benefit 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 benefit plan is re-established.)

## HOW TO CONTINUE COVERAGE

If you lose coverage under this benefit 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.

### Extension of Benefits

If you are totally disabled (see definition in *Section 10: Definitions)* on the date your group's BCBSNM coverage terminates, your health care coverage may be continued (for only the disabling condition) for **up to 12 consecutive months** after the group terminates coverage with BCBSNM.

An extension of benefits is available if you:

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

If coverage is continued under this provision, benefits for the disabling condition are paid subject to all applicable limitations, exclusions, and maximums that applied at the time the group's coverage terminated. To claim an extension of benefits, you must notify BCBSNM **within 31 days** of the group's coverage termination date and provide evidence of your total disability.

### Continuation Coverage

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

You are not eligible to enroll for continuation coverage if:

- the employer stops offering this coverage to its employees, *or*
- you do not elect continuation coverage in a timely fashion.

### 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 benefit plan's 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 dependent 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 dependent who was removed from coverage by the subscriber while the dependent 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 benefit plan to employees (If this benefit plan is replaced by another health care plan, continuation coverage will also be replaced by the new benefit plan.) **Exception:** If your group declares bankruptcy and you are covered under this benefit plan as a retiree, you and your dependents may be eligible for continued coverage.
- when you become covered under another group health care plan (However, if that health plan includes a pre–existing conditions limitation, continuation coverage will not end until that limitation has been satisfied or until another event occurs which would make you ineligible for continued coverage.)
- when the continuation period expires (If this employer's benefit 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.")

### USERRA Continuation Coverage

Employees and their covered dependents 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).

### Direct-Pay Premium Payments

Subscribers under federal COBRA continuation coverage must pay premiums to the COBRA administrator. Contact your employer's Benefit Office for an application for coverage and details.

Premiums for coverage may change on your group's renewal date or on any date that the benefit 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.

## CONVERSION TO INDIVIDUAL COVERAGE

Involuntarily terminating members may change to individual (direct-pay) conversion coverage if this employer group health plan is still in effect and coverage is lost due to one of the following circumstances:

- termination of employment
- a member no longer meets the eligibility requirements of the Group Master Contract
- the period of continuation coverage expires
- a dependent loses coverage for one of the following reasons:
  - — divorce or legal separation from the subscriber
  - — disqualification of the member under the definition of a dependent
  - — death of the subscriber
  - — an employee becomes primary under Medicare — leaving dependents without coverage

The subscriber and any eligible dependents *who were covered* at the time that group coverage was lost are eligible to apply for conversion coverage without a health statement.

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

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

- when group coverage under this benefit plan was discontinued for the entire group or the employee's enrollment classification
- when you reside outside of or move out of New Mexico (Call BCBSNM for details on transferring coverage to the Blue Cross Blue Shield Plan in the state where you are living.)

If you are entitled to Medicare, your conversion coverage option is limited to a Medicare Supplement Plan administered by BCBSNM. Depending upon your age and the benefit plan you select, a health statement may be required and a pre–existing conditions limitation may apply. (The options for members under age 65 are limited.) Call a Customer Service representative for the enrollment options available to you.

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

# SECTION 3: HOW YOUR PLAN WORKS

## BENEFIT CHOICES

This health care plan provides benefits under agreement with an exclusive network of Preferred Providers. When you need nonemergency health care that is covered under the benefit plan, **you must choose a provider from the Blue Cross and Blue Shield "Preferred Provider Organization (PPO)" network in order to receive benefits.**

***At A Glance***

| Preferred Provider Services |
|---|
| •You must use preferred providers except in an emergency and specified situations described on the next page. |
| •You pay a fixed-dollar amount (copayment) for a covered service. |
| •You have an annual out-of-pocket limit (includes copayments and coinsurance). |
| •The preferred provider is responsible for filing claims for you directly to the local Blue Cross and Blue Shield Plan. |
| •The preferred provider will not bill you for amounts above the covered charge, which may be less than the billed charge. The "covered charge" is the amount that BCBSNM determines is fair and reasonable allowance for a particular covered service. After your share of a covered charge (e.g., coinsurance, copayment, and/or penalty amount) has been calculated, BCBSNM pays the remaining amount of the covered charge, up to maximum benefit limits, if any. |
| •Preferred providers that contract **directly** with BCBSNM are responsible for requesting all necessary preauthorizations and admission review for you. (Providers that contract with another BCBS Plan may call for approval on your behalf, but you will be responsible for making sure that approval is obtained when required. If you do not obtain preauthorization, benefits may be reduced or denied.) |

## PREFERRED PROVIDERS VERSUS NONPREFERRED PROVIDERS

***Preferred Providers*** are health care professionals and facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, or another BCBS Plan as "preferred" or "PPO" providers. These providers have agreed to provide health care for **EPO** plan members and accept the benefit plan's payment for a covered service plus the member's share of the covered charge (i.e., coinsurance, copayment and/or penalty amount, 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 "Filing Claims" in *Section 8: Claim Payments and Appeals* for more information.) **Unless listed as an exception under "Exceptions for Nonpreferred Providers," services of nonpreferred providers are not covered.**

When you receive treatment or schedule a surgery or admission, ask each of your providers if he/she is a preferred provider. (A physician's or other provider's contract may be separate from the facility's contract.)

When you receive nonemergency medical care, covered services must be received from a provider that has contracted with BCBSNM and/or his/her local Blue Cross and Blue Shield Plan as a preferred provider.

Unless listed under "Exceptions for Nonpreferred Providers," benefits are not available for nonemergency services received from a nonpreferred provider – even if a preferred provider is not available in your area to perform the services.

## SELECTING A PROVIDER

When you need medical care in New Mexico (or along the border of neighboring states), visit the BCBSNM Web site at www.bcbsnm.com or use the *BCBSNM Preferred Provider Network Directory* to choose a preferred provider. The directory also lists mental health providers (including those specializing in chemical dependency) and participating pharmacies.

To verify a provider's current status, request a current directory, request a paper copy of a directory (free of charge), or if you have any questions about the directory, contact a BCBSNM Customer Service representative or visit the BCBSNM Web site at www.bcbsnm.com.

### Outside New Mexico

For a list of contracting providers outside New Mexico, call the BlueCard Doctor and Hospital Information Line at 1-800-810-BLUE (2583) or visit the BCBSNM Web site at www.bcbsnm.com which provides links to the listings of preferred providers in other states. You can also connect to the national provider location system at www.bcbsnm.com. (If you need emergency care, call 911 if necessary or go directly to the nearest emergency room.)

When you call, a BlueCard representative will give you the name and telephone number of a local provider who will be able to call BCBSNM Customer Service for eligibility information and will submit a claim for the services provided to the local Blue Cross and Blue Shield (BCBS) Plan. Preferred providers in other states are also eligible for the Preferred Provider level of benefits.

Out-of-state providers that contract with their local BCBS Plan also accept covered charges as payment in full. **Note:** Providers who have a "participating-only" contract are **not** preferred providers and you will not receive benefits when receiving services from participating-only providers. You must use **preferred providers** in order to obtain the higher benefit (unless listed under "Exceptions for Nonpreferred Providers" below).

### Exceptions for Nonpreferred Providers

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

#### Emergency Care

If you visit a nonpreferred provider for emergency care services, you will receive benefits for the initial treatment, which includes emergency room services and, if you are hospitalized **within 48 hours** of an emergency, the related inpatient hospitalization. (Office/urgent care facility services are not considered "emergency care" for purposes of this provision.)

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

#### Ancillary Providers

Once you have obtained preauthorization 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 any services received from nonpreferred providers during the admission or procedure.

#### Unsolicited Providers

In some states, the local BCBS Plan does not offer preferred provider contracts to certain types of providers (e.g., home health care agencies, chiropractors, ambulance providers). These provider types are referred to as "unsolicited providers." The types of providers that are unsolicited varies from state to state. If you receive covered services from an "unsolicited provider" outside New Mexico, you will receive benefits for those services. **However, the unsolicited provider may still bill you for amounts that are in excess of covered charges. You will be responsible for these amounts, in addition to your coinsurance or copayment.**

**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 90 days. (If necessary and ordered by the treating provider, BCBSNM may also authorize transitional care from other out−of−network providers.) The period will be sufficient to permit coordinated transition planning consistent with your condition and needs. Special provisions may apply if the required transitional period exceeds 90 days. If you have entered the third trimester of pregnancy at the effective date of enrollment, the transitional period shall include post−partum care directly related to the delivery. Call the BCBSNM Customer Service department for details.

Members who extend coverage under an extension of benefits due to disability after the group contract is terminated are not eligible to receive preauthorization for services of an out−of−network provider. Services of an out−of−network provider are **not** covered in such instances of extended coverage.

**These are the only instances in which the services of a nonpreferred provider will be covered.**

**Note:** For follow-up care (which is no longer considered emergency care) and for all other nonemergency care, you will receive **no** benefit for the services of a nonpreferred provider, even if a preferred provider is not available to perform the service, except as specified above. (See "Emergency and Urgent Care" in *Section 5: Covered Services* for more information.)

## CALENDAR YEAR

A calendar year is a period of one year which begins on January 1 and ends on December 31 of the same year. The initial calendar year is from a member's effective date of coverage through December 31 of the same year, which may be less than 12 months.

## BENEFIT LIMITATION

There is no lifetime maximum benefit under this plan. However, certain services have separate benefit limits per admission or per calendar year. (See the *Summary of Benefits* for details.)

Benefits are determined based upon the coverage in effect on the day a service is received, an item is purchased, or a health care expense is incurred. For inpatient services, benefits are based upon the coverage in effect on the date of admission, except that if you are an inpatient at the time your coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date.

## COST-SHARING FEATURES

For some services, you will pay only a fixed−dollar amount copayment for covered charges. In other cases, you will have to pay a percentage of the covered charge (preferred providers will not bill you for amounts in excess of the covered charge). When you receive a number of services during a single visit or procedure, you may have to pay both a copayment and a percentage of the covered charges that are not included in the copayment.

## DEDUCTIBLE

There are no deductibles to meet with this benefit plan.

## COPAYMENTS

Copayments are the fixed−dollar amount of a covered charge that you pay for certain certain services as specified on the separately issued *Summary of Benefits*.

**Office Visit Copayment**

When you receive **office services** from a preferred provider, you pay only a fixed-dollar amount (or copayment), for his/her covered **office visit charge**. The copayments for 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 coinsurance requirements and/or to an additional copayment as listed on the *Summary of Benefits.*

### Prescription Drug Plan Copayment

When you purchase covered prescription drugs and other items through the separately issued *Drug Plan Rider*, your responsibility may be either a fixed-dollar amount or a percentage of the covered charge. In either case, drug plan copayments are **not** subject to the out-of-pocket limit provisions. 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 as "coinsurance." After your share has been calculated, this benefit plan pays the rest of the covered charge, up to maximum benefit limits, if any.

## OUT-OF-POCKET LIMIT

The out-of-pocket limit is the maximum amount of coinsurance and copayments that you pay for most covered services in a calendar year. After the out-of-pocket limit is reached, this benefit plan pays 100 percent of most of your covered charges for the rest of the calendar year, not to exceed any benefit limits.

#### Individual Limits

Once your coinsurance and copayment amounts reach the individual amount indicated on the *Summary of Benefits,* this benefit plan pays 100 percent of most of your covered charges for the rest of the calendar year.

#### Family Limits

An entire family meets the out-of-pocket limit during a calendar year when the total coinsurance and copayment amounts 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.)

### What is Not Included in the Out-of-Pocket Limits

The following amounts are **not** applied to the out-of-pocket limits and are **not** eligible for 100 percent payment under this provision:

- penalty amounts
- amounts in excess of covered charges (including amounts in excess of annual or lifetime benefit limits)
- noncovered expenses (including services in excess of annual or lifetime day/visit limits)
- *Drug Plan Rider* copayments

*See the Summary of Benefits for your copayments, coinsurance percentages, and out-of-pocket limit amounts.*

## CHANGES TO THE COST-SHARING AMOUNTS

Coinsurance percentage amounts, copayments, and out-of-pocket limits may change during a calendar year. If changes are made, the change applies only to services received after the change goes into effect. You will be notified if changes are made to this benefit plan.

If your group increases the out-of-pocket limit amounts during a calendar year, the new amounts must be met during the same calendar year.

If your group decreases the out-of-pocket limit amounts, you will not receive a refund for amounts applied to the higher out-of-pocket limit.

## TIMELY FILING REMINDER

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 a nonparticipating provider (see "Exceptions for Nonpreferred Providers," earlier in this section), 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: Claim Payments and Appeals* for details.

## SECTION 4: ADMISSION REVIEW AND OTHER PREAUTHORIZATIONS

You or your provider must obtain authorization from BCBSNM *before* you are admitted as an inpatient (admission review approval) or receive certain types of services (other preauthorizations).

In order to receive benefits:

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

These approval requirements will provide you with assurance that you are being treated in the most efficient and appropriate health care setting and can help manage the rising costs of health care. **Please note:**

Preauthorization determines only the medical necessity of a specific service and/or an admission and an allowable length of stay. **Preauthorization does not guarantee your eligibility for coverage, that benefit payment will be made, or that you will receive benefits.** Eligibility and benefits are based on the date you receive the services. Services not listed as covered, excluded services, services received after your termination date under this benefit plan, and services that are not medically necessary will be denied.

Even when this benefit plan is not your primary coverage, these approval procedures must be followed. **Failure to do so may result in a reduction or in a denial of benefits.**

Most preauthorization requests will be evaluated and you and/or the provider notified of BCBSNM's decision **within 15 days** of receiving the request (**within 72 hours** for urgent care requests). If requested services are not approved, the notice will include: 1) the reasons for denial; 2) a reference to the health care plan provisions on which the denial is based; and 3) an explanation of how you may appeal the decision if you do not agree with the denial (see "If Your Preauthorization Request is Denied" later in this section).

Retroactive approvals will not be given and you may be responsible for the charges if preauthorization is not obtained **before** the service is received.

### BCBSNM PREFERRED PROVIDERS

If the attending physician is a preferred provider that contracts **directly** with BCBSNM, obtaining preauthorization is not your responsibility — it is the provider's. Preferred providers contracting with BCBSNM must obtain **preauthorization** from BCBSNM (or from Mesa Mental Health, when applicable) in the following circumstances:

- when recommending any nonemergency admission, readmission, or transfer
- when a covered newborn stays in the hospital longer than the mother
- before providing or recommending a service listed under "Other Preauthorizations," later in this section

**Note:** Providers that contract with other Blue Cross and Blue Shield Plans are not familiar with the preauthorization requirements of BCBSNM. Unless a provider contracts directly with BCBSNM as a preferred provider, the provider is not responsible for being aware of this benefit plan's admission review and other preauthorization requirements.

### NONPREFERRED PROVIDERS OR PROVIDERS OUTSIDE NEW MEXICO

If any provider outside New Mexico (except for those contracting as preferred providers directly with BCBSNM) or any nonpreferred provider recommends an admission or a service that requires preauthorization, the provider is **not** obligated to obtain the preauthorization for you. In such cases, it is **your** responsibility to ensure that approval is obtained. **Remember:** Nonpreferred providers are covered only for emergency care and in those specific circumstances described in *Section 3: How Your Plan Works.*

If approval is not obtained **before** services are received, **you will incur a penalty for a covered admission or, for some services, be entirely responsible for the charges.** The provider may call on your behalf, but it is **your responsibility** to ensure that BCBSNM (or Mesa Mental Health, when applicable) is called.

## ADMISSION REVIEW APPROVAL

Admission review is required for most admissions **before** you are admitted to the:

- hospital
- skilled nursing facility
- physical rehabilitation facility
- other treatment facility

If you do not obtain admission approval within the time limits indicated in the table below, benefits for covered facility services will be **reduced or denied** as explained under "Penalty for Not Obtaining Approval."

| Type of inpatient admission, readmission, or transfer: | When to obtain admission review approval: |
|---|---|
| **Nonemergency** | **Before** the patient is admitted. |
| **Emergency, nonmaternity** | **Within 48 hours** of the admission. If the patient's condition makes it impossible to call within 48 hours, call as soon as possible. |
| **Maternity–related** (including eligible newborns when the mother is not covered) | **Before the mother's maternity due date**, soon after pregnancy is confirmed. You are responsible for making sure that BCBSNM is notified within 48 hours of the admission for a routine delivery or within 96 hours of a C–section delivery (or as soon as possible). |
| **Extended stay, newborn** (an eligible newborn stays in the hospital longer than the mother) | **Before the newborn's mother is discharged.** |

### How the Approval Procedure Works

When you or your provider call, BCBSNM's Health Services representative will ask for information about your medical condition, the proposed treatment plan, and the estimated length of stay. The Health Services representative will evaluate the information and notify the attending physician and the facility (usually at the time of the call) if benefits for the proposed hospitalization are approved. If the admission is not approved, you may appeal the decision as explained later in this section.

### Penalty for Not Obtaining Approval

If you or your provider **do not call,** or if you call and **do not receive approval** for inpatient benefits, but you choose to be hospitalized anyway, **no** benefits may be paid or partial payment may be made, as indicated in the table below:

| If, based on a review of the claim: | Then: |
|---|---|
| The admission was **not for a covered service**. | Benefits for the facility and all related services will be **denied.*** |
| The admission was for an item listed under **"Other Preauthorizations,"** (e.g., high–dose chemotherapy). | Benefits for the facility and all related services will be **denied.*** |
| The admission was for any other covered service but hospitalization was **not medically necessary**. | Benefits will be **denied** for **room, board,** and **other charges** that are not medically necessary.* |
| The admission was for a **medically necessary covered service.** | Benefits for the facility's covered services will be **reduced by $400.*** |

*The admission review penalty of **$**400 and charges for noncovered and denied services are **not applied** to any out-of-pocket limit. You are responsible for paying this amount.

Admission review requirements may affect the amounts that this benefit plan pays for inpatient services, but they do not deny your right to be admitted to any facility and to choose your services.

## OTHER PREAUTHORIZATIONS

In addition to admission review for all inpatient services, preauthorization is required for certain other services. Most preauthorizations may be requested over the telephone. If a *written* request is needed and you call, a Health Services representative will give you instructions for filing a written request for preauthorization.

If preauthorization is not obtained, **benefits will be denied** for the following services and all related services:

- **air ambulance** services (unless during a medical emergency)
- **alcohol** or **drug abuse** services (Preauthorization is obtained from Mesa Mental Health.)
- **autism spectrum disorders for children**
- **cardiac** or **pulmonary rehabilitation**
- **chemotherapy** (high-dose)
- **dental-related services** in a hospital or other facility (the procedure may not be covered even if benefits for the hospitalization are approved as medically necessary; see *Section 5: Covered Services)*; **oral/maxillofacial** surgery procedures; treatment of **accidental injuries to teeth** (except initial treatment); **orthognathic surgery;** and treatment of **orthognathism**
- **diabetic supplies**; **insulin pumps**; and **diabetic equipment** costing $500 (or more)
- **diagnostics** including **PET scans; cardiac CT scans; sleep studies; genetic testing or counseling; infertility testing**
- **dialysis** (home)
- **durable medical equipment,** medical supplies and prosthetic devices costing **$500** (or more) or requiring **long-term rental; orthopedic appliances, orthotics;** and **surgically implanted prosthetics,** regardless of total cost
- **enteral nutritional products, special medical foods,** and **certain drugs** covered under the *Drug Plan Rider;* prescription **refills** before the supply should have been exhausted
- **home health care**
- **home infusion therapy** (HIT)
- **hospice care**
- **infertility-related services** (Only limited services are covered.)
- **injections** for growth hormone, Avonex, Copaxone
- **inpatient hospital/treatment facility admissions** including hospital care, rehabilitation facilities, inpatient hospice, and skilled nursing facilities (SNFs)
- **out–of–network/nonparticipating providers** for non–emergent services including urgent care, specialist services, hospitals, and other facilities
- **private room charges**
- **psychiatric intake evaluations** and **medication checks; electroshock therapy; psychological testing; psychotherapy**
- **rehabilitative services** (outpatient/office physical, occupational, and speech therapy
- **smoking/tobacco use cessation** drug therapy (See your *Drug Plan Rider*.)
- certain **surgical procedures,** including, but not limited to **cochlear implants, reconstructive surgical services, mastectomy services,** and **bariatric (obesity) surgery**
- **transplant procedures** including, but not limited to **heart, lung, heart–lung, liver, pancreas–kidney,** and **pretransplant evaluations**

The services listed above may not be approved for payment (for example, due to being experimental, investigational, unproven, or not medically necessary). It is strongly recommended that you request preauthorization for high-cost services in order to reduce the likelihood of benefits being denied *after* charges are incurred. The complete list of services requiring preauthorization is subject to review and change by BCBSNM. BCBSNM-contracted providers

have a list of all procedures and services, including individual surgical procedures and injectable drugs, that require preauthorization. If you need a copy of this list, call a Customer Service representative.

### If You Are Not Satisfied

If you are not satisfied with the results of the decision made by BCBSNM, see *Section 8: Claim Payment and Appeals.*

## ADVANCE BENEFIT INFORMATION

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

## UTILIZATION REVIEW/QUALITY MANAGEMENT

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

# SECTION 5: COVERED SERVICES

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

## MEDICALLY NECESSARY SERVICES

A service or supply is medically necessary when it is provided to diagnose or treat a covered medical condition, is a service or supply that is covered under this benefit plan and is determined by BCBSNM's medical director to meet all of the following conditions:

- it is medical in nature;
- it is recommended by the treating physician;
- it is the most appropriate supply or level of service, taking into consideration:
  - potential benefits;
  - potential harms;
  - cost, when choosing between alternatives that are equally effective; and
  - cost effectiveness, when compared to the alternative services or supplies;
- it is known to be effective in improving health outcomes as determined by credible scientific evidence published in the peer-reviewed medical literature (for established services or supplies, professional standards and expert opinion may also be taken into account); and
- it is not for the convenience of the member, the treating physician, the hospital or any other health care provider.

All services must be eligible for benefits as described in this section, not listed as an exclusion and must 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.)

## AMBULANCE SERVICES

This benefit plan covers ambulance services in an emergency (e.g., cardiac arrest, stroke). When you cannot be safely transported by any other means in a nonemergency situation, this benefit plan also covers medically necessary ambulance transportation to a hospital with appropriate facilities, or from one hospital to another.

### Air Ambulance

Ground ambulance is usually the approved method of transportation. This benefit plan covers air ambulance only when terrain, distance, or your physical condition requires the use of air ambulance services or for high-risk maternity and newborn transport to tertiary care facilities. To be covered, nonemergency air ambulance services require **preauthorization** from BCBSNM.

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

**Exclusions**

This benefit plan does **not** cover:

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

## ACUPUNCTURE/CHIROPRACTIC SERVICES

This benefit plan covers acupuncture when administered by a licensed provider acting within the scope of licensure and chiropractic services administered by a chiropractor acting within the scope of his/her licensure and according to the standards of chiropractic medicine in New Mexico (or the state in which services are rendered). Services must be necessary for the treatment of an illness or injury. Benefits for acupuncture (which includes acupuncture used as an anesthetic) and for chiropractic services (which includes physical therapy, spinal manipulation, x−rays, office visits, and other covered services performed by a chiropractor), are limited as specified on your *Summary of Benefits.*

This benefit plan does **not** cover:

- herbs or homeopathic preparations
- services of a massage therapist or rolfing
- any therapeutic exercise equipment prescribed for home use
- maintenance therapy or care or long−term therapy

## AUTISM SPECTRUM DISORDERS

For a member **19 years old or younger** (or, if enrolled in high school, 22 years old or younger), this benefit plan covers the habilitative and rehabilitative treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy, and applied behavioral analysis (ABA) when provided by an in−network provider. Providers must be credentialed to provide such therapy. **Note:** ABA services are not indicated for children over the age of seven.

Treatment must be prescribed by the member's treating physician in accordance with a treatment plan. The treatment plan must be **preauthorized** by BCBSNM; if services are received but were not approved as part of the treatment plan, benefits for covered services will be denied. Once maximum functionality has been reached and no additional improvement is expected, no therapies are covered unless required to maintain that member's current functionality (that is, in the absence of additional treatment, the patient would suffer a setback). **No benefits are available for any treatments not shown to be habilitative or rehabilitative.**

Benefits for all services for the treatment of autism spectrum disorder are limited for each eligible BCBSNM−insured person to **$36,000** per calendar year and to **$200,000** in total lifetime benefits. Once the annual maximum is reached, no more benefits for autism therapy are provided until the next year. Once a lifetime maximum is reached, no more benefits for autism therapy are provided for that BCBSNM member.

Changing from one plan to another under the same group, reinstating prior BCBSNM coverage, changing employers, changing policyholder or subscriber, or moving from individual coverage to group coverage or vice versa does **not** reinstate autism benefits once an annual or lifetime maximum is reached for a particular insured member. All amounts payable under this provision are tracked at the member level regardless of the policy number under which charges accrued. For example, if a member is covered under two BCBSNM policies, the maximum annual benefit and the maximum lifetime benefit is not doubled for that member. Regardless of the number of policies under which the member is covered, benefits will not exceed the *per member* annual and lifetime maximum benefits mandated by law.

Services are subject to usual member cost−sharing features such as coinsurance, copayments and out−of−pocket limits − based on place of treatment and type of service. All services are subject to the *General Limitations and Exclusions* of the member's plan except where explicitly mentioned as being an exception. For example, certain autism spectrum disorder services mandated by law are not excepted from exclusions such as "Pre−Existing Conditions" exclusions.

Regardless of the type of therapy received, claims for services related to autism spectrum disorder should be mailed to BCBSNM − **not** to the behavioral health services administrator.

**Exclusions**

This benefit plan does **not** cover:

- any experimental, long−term, or maintenance treatments not required under state law
- any treatment or therapy from an out−of−network provider
- medically unnecessary or nonhabilitative services under any circumstance

- applied behavioral analysis (ABA) for children over the age of seven
- any services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children 3 to 22 years old who have autism spectrum disorder
- services that have not been preauthorized by BCBSNM
- respite services or care
- Sensory Integration Therapy (SIT) or Auditory Integration Therapy (AIT)
- music therapy, vision therapy, or touch or massage therapy
- floor time
- facilitated communication
- elimination diets; nutritional supplements; intravenous immune globulin infusion; secretin infusion
- chelation therapy
- hippotherapy, animal therapy, or art therapy

## DENTAL-RELATED/TMJ SERVICES AND ORAL SURGERY

The following services are the only dental-related services and oral surgery procedures covered under this benefit plan. When alternative procedures or devices are available, benefits are based upon the least costly, medically appropriate procedure or device available.

### Dental and Facial Accidents

Benefits for covered services for the treatment of accidental injuries to the jaw, mouth, face or sound natural teeth are generally subject to the same limitations, exclusions and member cost-sharing provisions that would apply to similar services when not dental-related (e.g., x-rays, medical supplies, surgical services).

To be covered, *initial* treatment for the accidental injury must be sought **within 72 hours** of the accident. Any services required after the initial treatment must receive **preauthorization,** requested **in writing,** from BCBSNM and be received **within 12 months** of the date of accident in order to be covered. (For treatment of TMJ or CMJ injuries, see "TMJ/CMJ Services.")

### Facility Charges and General Anesthesia for Dental-Related Services

This benefit plan covers inpatient or outpatient hospital expenses (including ambulatory surgical centers) and hospital and physician charges for the administration of general anesthesia for noncovered, medically necessary dental-related services if the patient requires hospitalization for one of the following reasons:

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

All hospital covered services for dental procedures must be **preauthorized** by BCBSNM. **Note:** Unless listed as a covered service in this section, the dentist's services for the procedure will not be covered.

### Oral Surgery

This benefit plan covers the following oral surgical procedures only:

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

### TMJ/CMJ Services

This benefit plan covers standard diagnostic, therapeutic, surgical and nonsurgical treatments of temporomandibular joint (TMJ) and craniomandibular joint (CMJ) disorders or accidental injuries. Treatment may include orthodontic appliances and treatment, crowns, bridges, or dentures **only if** required because of an accidental injury to sound natural teeth involving the TMJ or CMJ.

### Exclusions

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

- surgeon's or dentist's charges for noncovered dental services
- hospitalization or general anesthesia for the patient's or provider's convenience
- any service related to a dental procedure that is not medically necessary or that is excluded under this benefit 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, services related to pre–existing conditions, work-related injuries, etc.)
- nonstandard services (diagnostic, therapeutic, or surgical)
- removal of tori, exostoses, or impacted teeth
- dental-related services that may be related to, or required as the result of, a medical condition or procedure (e.g., chemotherapy or radiation therapy)
- procedures involving orthodontic care, the teeth, dental implants, periodontal disease, 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"
- artificial devices and/or bone grafts for denture wear

## DIABETIC SERVICES

Diabetic persons are entitled to the same benefits for medically necessary covered services as are other members under the health care plan. For special coverage details, such as for insulin, glucose monitors and educational services, refer to the applicable provisions as noted below. **Note:** This benefit plan will also cover items not specifically listed as covered when new and improved equipment, appliances and prescription drugs for the treatment and management of diabetes are approved by the U.S. Food and Drug Administration.

*For insulin and over-the-counter diabetic supplies, see your separately issued Drug Plan Rider.*

*For durable medical equipment, see "Supplies, Equipment and Prosthetics."*

*For educational services and diabetes management services, see "Physician Visits/Medical Care."*

## EMERGENCY CARE AND URGENT CARE

### Emergency Care

This benefit plan covers medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to his/her health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part, or disfigurement. (In addition, initial treatment must be sought **within 48 hours** of the accident or onset of symptoms and services must be received in an emergency room, trauma center, or ambulance to qualify as an emergency.)

*For accidental injury to the mouth, jaw, teeth, or TMJ, see "Dental-Related/TMJ Services and Oral Surgery."*

**Use of an emergency center for nonemergency 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 nonemergency.**

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

If you visit a nonpreferred provider for emergency care, the preferred provider benefit is applied only to the initial treatment, which includes emergency room services and, if you are hospitalized **within 48 hours** of an emergency, the related inpatient hospitalization. Once you are discharged, covered follow-up care from a nonpreferred provider is **not covered**. (Services received in an office or urgent care facility are not considered emergency care for purposes of this provision.)

For all follow-up care (which is no longer considered emergency care) and for all other nonemergency care, you will need to select a preferred provider to receive benefits for covered services.

#### 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.

### Member Copayments

If you are directly admitted as an inpatient, the copayment for emergency room services is waived. The inpatient hospital benefit will apply in such cases.

### Urgent Care

This benefit plan covers urgent care services which means medically necessary medical or surgical procedures, treatments, or services received for an unforeseen condition that is *not* life-threatening. The condition does, however, require prompt medical attention to prevent a serious deterioration in your health (e.g., high fever, cuts requiring stitches).

Care received in an urgent care facility is covered as any other type of service, subject to the copayment listed on your *Summary of Benefits.* If services are received in an emergency room or other trauma center, the condition must meet the definition of an "emergency" in order to be covered.

## HEARING AIDS/RELATED SERVICES FOR CHILDREN UNDER AGE 21

This benefit plan covers the cost of hearing aids, the fitting and dispensing fees for hearing aids and ear molds, up to a maximum amount of **$2,200 per hearing impaired ear every 36 months** for members under 21 years old. This 36-month benefit period begins on the date the first covered hearing aid-related service is received and payable under this provision and ends 36 months later. The next benefit period for the impaired ear begins 36 months after the first

hearing aid-related service (e.g., fitting cost, ear mold, etc.) OR on the date the next hearing aid-related service for that ear, whichever length of time is greater.

Benefits for hearing aid-related services payable under this provision are not subject to the coinsurance or copayment amount. Benefits for hearing aid-related services will be provided at **100 percent** of the covered charges. (Other covered services, such as hearing examinations and audiometric testing related to a hearing aid need for members under 21 years old are subject to the, coinsurance and copayment 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 age 21 and older.**

## HOME HEALTH CARE/HOME I.V. SERVICES

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

### Conditions and Limitations of Coverage

If you are homebound (unable to receive medical care on an outpatient basis), this benefit plan covers home health care services and home I.V. services for up to the number of visits specified in the *Summary of Benefits.* Services must be provided under the direction of a physician and nursing management must be through a home health care agency approved by BCBSNM. A *visit* is one period of home health service of up to four hours.

### Preauthorization Required

Before you receive home health care services or home I.V. therapy, you, your physician or home health care agency must obtain **preauthorization** from BCBSNM. **This benefit plan does not cover home health care services or home I.V. services without preauthorization.**

### Covered Services

This benefit plan covers the following services, subject to the limitations and conditions above, when provided by an approved home health care agency during a covered visit in your home:

- skilled nursing care provided on an intermittent basis by a registered nurse or licensed practical nurse
- physical, occupational, or respiratory therapy provided by licensed or certified physical, occupational or respiratory therapists
- speech therapy provided by a speech pathologist or an American Speech and Hearing Association certified therapist
- intravenous medications and other prescription drugs ordinarily not available through a retail pharmacy if **preauthorization** is received from BCBSNM (If drugs are not provided by the home health care agency, see your separately issued *Drug Plan Rider.*)
- laboratory services that would have been covered during an inpatient admission
- parenteral and enteral nutritional products that can only be legally dispensed by the written prescription of a physician and are labeled as such on the packages (If *not* provided by the home health care agency or if products do not require a prescription, see your separately issued *Drug Plan Rider.*)
- medical supplies
- skilled services by a qualified aide to do such things as change dressings and check blood pressure, pulse, and temperature

### Exclusions

This benefit plan does **not** cover:

- care provided primarily for your or your family's convenience
- homemaking services or care that consists mostly of bathing, feeding, exercising, preparing meals for, moving, giving medications to, or acting as a sitter for the patient (See the "Custodial Care" exclusion in *Section 6: General Limitations and Exclusions*.)

- services provided by a nurse who ordinarily resides in your home or is a member of your immediate family
- nonprescription enteral nutritional products (See your separately issued *Drug Plan Rider* for details about possible benefits for these products.)

## HOSPICE CARE SERVICES

### Conditions and Limitations

This benefit plan covers inpatient and home hospice services for a terminally ill member received during a hospice benefit period when provided by a hospice program approved by BCBSNM.

If you need an extension of the hospice benefit period, the hospice agency must provide a new treatment plan and the attending physician must recertify your condition to BCBSNM. **No more than two hospice benefit periods** will be approved. **Note:** An extension of the hospice benefit period does **not** increase the total amount of benefits payable under this provision.

### Preauthorization Required

Before you receive hospice care, you, your attending physician, or the hospice agency must request **preauthorization** from BCBSNM. **Hospice care services are not covered without preauthorization.**

### Covered Services

This benefit plan covers the following services, subject to the conditions and limitations above, under the hospice care benefit:

- visits from hospice physicians
- skilled nursing care by a registered nurse or licensed practical nurse
- physical and occupational therapy by licensed or certified physical or occupational therapists
- speech therapy provided by an American Speech and Hearing Association certified therapist
- medical supplies (If supplies are *not* provided by the hospice agency, see "Supplies, Equipment and Prosthetics.")
- drugs and medications for the terminally ill patient (If drugs are *not* provided by the hospice agency, see your separately issued *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 his/her family deal with a specified medical condition.)
- services of a home health aide under the supervision of a registered nurse and in conjunction with skilled nursing care
- nutritional guidance and support, such as intravenous feeding and hyperalimentation
- respite care for a period **not to exceed five continuous days** for **every 60 days** of hospice care and **no more than two respite care periods** during each hospice benefit period (*Respite care* provides a brief break from total care-giving by the family.)

### Exclusions

This benefit plan does **not** cover:

- food, housing, or delivered meals
- medical transportation
- homemaker and housekeeping services
- comfort items
- private duty nursing

- pastoral, spiritual or bereavement counseling
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this benefit plan
- care or services received after the member's coverage terminates

The following services are **not** hospice care benefits but may be covered elsewhere under this benefit plan: acute inpatient hospital care for curative services, durable medical equipment, physician visits unrelated to hospice care and, ambulance services.

## HOSPITAL/OTHER FACILITY SERVICES

### Blood Services

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

### Inpatient Services

#### Admission Review Required

If hospitalization is recommended by a nonpreferred provider or you are outside New Mexico, **you are responsible** for obtaining admission approval. If you do not follow the admission review procedures, benefits for covered facility services will be **reduced** or **denied** as explained in *Section 4: Admission Review and Other Preauthorizations.*

#### Covered Services

For acute inpatient medical or surgical care received during a covered hospital admission, this benefit plan covers semiprivate room or special care unit (e.g., ICU, CCU) expenses and other medically necessary services provided by the facility. (If you have a private room for any reason other than isolation, covered room expenses are limited to the average semiprivate room rate, whether or not a semiprivate room is available. BCBSNM must give **preauthorization** for medically necessary private room charges to be covered.)

#### Medical Detoxification

This benefit plan also covers medically necessary services related to medical detoxification from the effects of alcohol or drug abuse. Detoxification is the treatment in an acute care facility for withdrawal from the physiological effects of alcohol or drug abuse, which usually takes about **three days** in an acute care facility. Benefits for detoxification services are the same as for any other acute medical/surgical condition. See "Psychotherapy (Mental Health and Chemical Dependency)" for information about benefits for chemical dependency rehabilitation.

### Exclusions

This benefit plan does **not** cover:

- private room expenses, unless your medical condition requires isolation for protection from exposure to bacteria or diseases (e.g., severe burns or conditions that require isolation according to public health laws)
- admissions related to noncovered services or procedures (See "Dental-Related/TMJ Services and Oral surgery" for an exception.)
- extended care facility admissions or admissions to similar institutions
- admissions for rehabilitative treatment, such as oxygen therapy (For physical rehabilitation benefits, see "Rehabilitation and Other Therapy.")

### Outpatient or Observation Services

Coverage for outpatient or observation services and related physician or other professional provider services for the treatment of illness or accidental injury depends on the type of service received (for example, see "Lab, X-Ray, Other Diagnostic Services" or "Emergency and Urgent Care").

## LAB, X-RAY, OTHER DIAGNOSTIC SERVICES

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

This benefit plan covers diagnostic services, including but not limited to, preadmission testing, that are related to an illness or accidental injury. Covered services include:

- psychological testing with **preauthorization** from Mesa Mental Health
- x-ray and radiology services, ultrasound and imaging studies
- laboratory and pathology tests
- EKG, EEG and other electronic diagnostic medical procedures
- genetic testing, with **preauthorization** from BCBSNM (Tests such as amniocentesis or ultrasound to determine the gender of an unborn child are not covered; see "Maternity/Reproductive Services and Newborn Care.")
- infertility-related testing, with **preauthorization** from BCBSNM (See "Maternity/Reproductive Services and Newborn Care.")
- PET (Positron Emission Tomography) scans and cardiac CT scans with **preauthorization** from BCBSNM
- sleep disorder studies with **preauthorization** (If services must be performed on an inpatient basis, admission approval is required.)
- audiometric (hearing) and vision tests for the diagnosis and/or treatment of an accidental injury or an illness

**Note:** All services, including those for which preauthorization is required, must meet the standards of medical necessity criteria established by BCBSNM and will not be covered if excluded for any reason under this benefit plan. Some services requiring preauthorization will not be approved for payment.

## MATERNITY/REPRODUCTIVE SERVICES AND NEWBORN CARE

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

### Family Planning and Infertility-Related Services

*For oral contraceptive coverage and contraceptive devices purchased from a pharmacy, see your Drug Plan Rider.*

#### Family Planning

Covered family planning services include FDA-approved devices and other procedures such as:

- injection of Depo-Provera for birth control purposes
- diaphragm, including fitting
- IUDs or cervical caps, including fitting, insertion, and removal
- surgical sterilization procedures such as vasectomies and tubal ligations

#### Infertility-Related Services

This benefit plan covers the following infertility-related treatments when **preauthorization** is received from BCBSNM (**Note:** the following procedures only *secondarily* treat infertility):

- surgical treatments such as opening an obstructed fallopian tube, epididymis, or vas 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.

Infertility *testing,* when **preauthorization** is received from BCBSNM, 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 benefit plan will cover lab tests to monitor hormone levels following the hormone replacement treatment listed as covered above. However, daily ultrasounds to monitor ova maturation are **not** covered since the testing is being used to monitor a noncovered infertility treatment.

## Exclusions

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

- contraceptive devices that do require a prescription, including over-the-counter contraceptive products such as condoms and spermicide
- sterilization reversal for males or females
- infertility treatments and related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization
- Gamete Intrafallopian Transfer (GIFT)
- Zygote Intrafallopian Transfer (ZIFT)
- cost of donor sperm
- artificial conception or insemination; fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such as in-vivo or in-vitro (test tube) fertilization, and embryo transfer; drugs for induced ovulation; or other artificial methods of conception

## Maternity Services

If you are pregnant, you should call BCBSNM before your maternity due date, soon after your pregnancy is confirmed. You are responsible for making sure that BCBSNM is notified **within 48 hours** of admission for a routine delivery or **within 96 hours** for a C-section delivery (or as soon as possible). If not notified within this time period, benefits for covered facility services will be reduced by **$400**. See *Section 4: Admission Review and Other Preauthorizations.*

A covered dependent daughter also has coverage for maternity services. However, if the parent of the newborn is a dependent child of the subscriber (i.e., the newborn is the subscriber's grandchild), benefits are **not** available for the newborn.

### Covered Services

Covered maternity services include:

- hospital or other facility charges for semiprivate room and ancillary services, including the use of labor, delivery, and recovery rooms (This benefit plan covers all medically necessary hospitalization, including at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a C-section delivery.)
- 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 his/her local BCBS Plan and is credentialed to provide the service. The office visit during which a pregnancy is confirmed is subject to the member cost-sharing provisions that apply to any other office visit.)
- pregnancy-related diagnostic tests, including genetic testing or counseling if **preauthorized** by BCBSNM (Services must be sought due to a family history of a gender-linked genetic disorder or to diagnose a possible congenital defect caused by a present, external factor that increases risk, such as advanced maternal age or alcohol abuse. For example, tests such as amniocentesis or ultrasound to determine the gender of an unborn child are **not** covered.)
- necessary anesthesia services by a provider qualified to perform such services, including acupuncture used as an anesthetic during a covered surgical procedure and administered by a physician, a licensed doctor of oriental medicine, or other practitioner as required by law
- when necessary to protect the life of the infant or mother, coverage for transportation, including air transport, for the medically high-risk pregnant woman with an impending delivery of a potentially

viable infant to the nearest available tertiary care facility for newly born infants (See "Ambulance Services" for details.)

- services of a physician who actively assists the operating surgeon in performing a covered surgical procedure when the procedure requires an assistant
- elective, spontaneous, or therapeutic termination of pregnancy prior to full term

### Newborn Care

Covered services for initial routine newborn care include:

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

For children who are covered from their date of birth, benefits include coverage of injury or sickness, including covered services related to the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities as required by New Mexico state law. **Note:** If the parent of the newborn is a dependent child of the subscriber (i.e., the newborn is the subscriber's grandchild), services for the newborn are **not** covered.

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

#### Extended Stay Newborn Care

A newborn who is enrolled for coverage within the time limits specified in *Section 2: Enrollment and Termination Information* is also covered if he/she stays in the hospital longer than the mother.

If you are in a nonpreferred facility, you must ensure that BCBSNM is called **before** the mother is discharged from the hospital. If you do not, benefits for the newborn's covered facility services will be reduced by $400. The baby's services will be subject to a separate coinsurance and out-of-pocket limit.

## PHYSICIAN VISITS/MEDICAL CARE

Benefits for services received in a physician's office are based on the type of service received while in the office. This section describes benefits for therapeutic injections, allergy care and testing, and other nonsurgical, nonroutine medical visits to a health care provider for evaluating your condition and planning a course of treatment. See specific topics referenced in this section for more information regarding a particular type of service (e.g., "Preventive Care Services," "Transplant Services," etc.).

### Office Visits and Consultations

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

### Allergy Care

This benefit plan covers direct skin (percutaneous and intradermal) and patch allergy tests, radioallergosorbent testing (RAST), allergy serum, and appropriate FDA-approved allergy injections administered in a provider's office or in a facility.

### Diabetes Self-Management Education

This benefit plan covers diabetes self-management training if you have diabetes or an elevated blood glucose due to pregnancy. Training must be prescribed by a health care provider and given by a certified, registered or licensed health care professional with recent education in diabetes management. Covered services are limited to:

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

See your separately issued *Drug Plan Rider* for benefits for insulin and oral agents to control blood glucose levels, needles, syringes, and test strips; see "Supplies, Equipment and Prosthetics" for other covered supplies and equipment required due to diabetes.

### Genetic Inborn Errors of Metabolism

This benefit plan covers medically necessary expenses related to the diagnosis, monitoring and control of genetic inborn errors of metabolism as defined in *Section 10: Definitions.* Covered services include medical assessment, including clinical services, biochemical analysis, medical supplies, prescription drugs (see your *Drug Plan Rider*), corrective lenses for conditions related to the genetic inborn error of metabolism, nutritional management and **preauthorized** special medical foods (as defined and described in your *Drug Plan Rider*). 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 benefit 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" and corrective lenses under "Supplies, Equipment and Prosthetics").

To be covered, the member must be receiving medical treatment provided by licensed health care professionals, including physicians, dieticians and nutritionists, who have specific training in managing patients diagnosed with genetic inborn errors of metabolism.

### Injections and Injectable Drugs

This benefit plan covers most FDA-approved therapeutic injections administered in a provider's office. However, this benefit plan covers some injectable drugs only when **preauthorization** is received from BCBSNM. Your BCBSNM-contracted provider has a list of those injectable drugs that require preauthorization. If you need a copy of the list, contact a BCBSNM Health Services representative. (When you request preauthorization, you may be directed to purchase the self-injectable medication through your *Drug Plan Rider.*)

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

### Mental Health Evaluation Services

This benefit plan covers medication checks and intake evaluations for mental disorders and alcohol and drug abuse when **preauthorized** by Mesa Mental Health. See "Psychotherapy (Mental Health and Chemical Dependency)" for psychotherapy and other therapeutic service benefits.

### Inpatient Medical Visits

With the exception of dental-related services (see "Dental-Related/TMJ Services and Oral Surgery"), this benefit plan covers the following services when received on a covered inpatient hospital day:

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

## PREVENTIVE CARE SERVICES

This benefit plan covers the following routine physical examinations and associated testing in accordance with national medical standards, the state of New Mexico, the American Academy of Pediatrics and the U.S. Preventive Services Task Force:

- routine physical, breast, and pelvic examinations
- routine adult and pediatric immunizations
- low-dose mammogram screenings, (e.g., one baseline mammogram to persons age 40 through 41, one mammogram biennially to persons age 40–49 and one mammogram annually to persons age 50 and over), papilloma virus screening, and cytologic screening (a Pap test or liquid–based cervical cytopathology)
- human papillomavirus vaccine (HPV) for members ages 9 – 26 years old
- blood hemoglobin, blood pressure and blood glucose level tests
- colorectal screening tests
- blood cholesterol or fractionated cholesterol level including a low-density lipoprotein (LDL) and a high-density lipoprotein (HDL) level; stool examination for the presence of blood; colonoscopy; and glaucoma eye tests
- well-child care, including well–baby and well–child screening for diagnosing the presence of autism spectrum disorder (not limited by the $36,000 annual or $200,000 lifetime maximum benefit for autism spectrum disorders; see "Autism Spectrum Disorders" for additional covered services.)
- vision and hearing screenings in order to detect the need for additional vision or hearing testing for members through age 17 when received as part of a routine physical examination (A screening does *not* include an eye examination, refraction or other test to determine the amount and kind of correction needed.)
- health education and counseling services if recommended by your physician, including an annual consultation to discuss lifestyle behaviors that promote health and well-being

The services listed above 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.

### Exclusions

This benefit plan does **not** cover:

- employment physicals, insurance examinations, or examinations at the request of a third party (the requesting party may be responsible for payment); premarital examinations; sports or camp physicals; any other nonpreventive physical examination
- immunizations or medications required for international travel
- hepatitis B immunizations when required due to possible exposure during the member's work
- routine eye examinations; eye refractions; visual screening for members over age 17 ; or any related service or supply
- routine hearing examinations; hearing aids; hearing screening for members over age 17 ; or any related service or supply, unless otherwise specified in this section (See "Hearing Aids/Related Services for Children Under Age 21.")

## PSYCHOTHERAPY (MENTAL HEALTH AND CHEMICAL DEPENDENCY)

**Note:** You do not receive a separate mental health/chemical dependency ID card; use your BCBSNM ID card to receive all medical/surgical and mental health/chemical dependency services covered under this benefit plan.

### Medical Necessity

In order to be covered, treatment must be medically necessary and not experimental, investigational or unproven. Therapy must be:

- required for the treatment of a distinct mental disorder as defined by the latest version of the *Diagnostic and Statistical Manual* published by the American Psychiatric Association; and
- reasonably expected to result in significant and sustained improvement in your condition and daily functioning; and
- consistent with your symptoms, functional impairments and diagnoses and in keeping with generally accepted national and local standards of care; and
- provided to you at the least restrictive level of care.

### Covered Services/Providers

Covered services include solution-focused evaluative and therapeutic mental health services (including individual and group psychotherapy) received in a psychiatric hospital or an alcohol abuse treatment program that complies with alcohol and drug abuse program standards developed by the state of New Mexico, and services rendered by psychiatrists, licensed psychologists, and other providers as defined in *Section 10: Definitions*. See your BCBSNM Provider Directory for a list of contracting providers or check the BCBSNM Web site at **www.bcbsnm.com** or the Mesa Mental Health Web site at **www.mesamentalhealth.com**.

### Preauthorization Required

All psychotherapy must be **preauthorized** by Mesa Mental Health. See *Section 4: Admission Review and Other Preauthorizations* for details.

This benefit plan also covers electroshock therapy when **preauthorization** is received from Mesa Mental Health.

### Benefits

Benefits for inpatient and outpatient mental disorders and drug or alcohol abuse services are as specified on the *Summary of Benefits.*

### Exclusions

This benefit plan does **not** cover:

- care that has not been **preauthorized** by Mesa Mental Health
- 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, day treatment, or behavior modification services
- long-term therapy or therapy for the treatment of chronic mental disorders or incurable conditions for which treatment produces minimal or temporary change of relief – except that medication management for chronic conditions is covered (Chronic conditions are conditions such as, but not limited to, autism, Down's Syndrome and developmental delays. See "Early Developmental Delay and Disability" in *Section 8: Claims Payments and Appeals* for reimbursement of certain services provided to eligible children by the Department of Health.)
- maintenance therapy or care provided after you have reached your rehabilitative potential (See the "Long–Term or Maintenance Therapy" exclusion in the *General Limitations and Exclusions* section.)
- biofeedback, hypnotherapy, or behavior modification services
- religious or marital counseling
- custodial care (See the "Custodial Care" exclusion in *Section 6: General Limitations and Exclusions*.)
- any care that is patient-elected and is not considered medically necessary
- care that is mandated by court order or as a legal alternative, and lacks clinical necessity as diagnosed by a licensed provider; services rendered as a condition of parole or probation

- special education, school testing and evaluations, counseling, therapy or care for learning deficiencies or educational and developmental disorders; behavioral problems unless associated with manifest mental disorders or other disturbances (See "Early Developmental Delay and Disability" in *Section 8: Claim Payments and Appeals* for reimbursement of certain services provided to eligible children by the Department of Health.)
- 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
- care in excess of the annual or lifetime maximum benefits specified in the *Summary of Benefits,* if any

## REHABILITATION AND OTHER THERAPY

*When billed by a facility during a covered admission, therapy is covered in the same manner as the other ancillary services (see "Hospital/Other Facility Services").*

### Acupuncture/Chiropractic Services

This benefit plan covers acupuncture when administered by a licensed provider acting within the scope of licensure and chiropractic services administered by a chiropractor acting within the scope of his/her licensure and according to the standards of chiropractic medicine in New Mexico (or the state in which the services were rendered). Services must be necessary for the treatment of an illness or injury. Benefits for acupuncture (which includes acupuncture used as an anesthetic) and for chiropractic services (which includes physical therapy, spinal manipulation, x−rays, office visits, and other covered services performed by the chiropractor), are limited as specified on your *Summary of Benefits.*

This benefit plan does **not** cover:

- herbs or homeopathic preparations
- services of a massage therapist or rolfing
- any therapeutic exercise equipment prescribed for home use
- maintenance therapy or care or long−term therapy

### Cardiac and Pulmonary Rehabilitation

This benefit plan covers outpatient cardiac rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services. **Preauthorization** must be obtained from BCBSNM or benefits will be denied.

### Chemotherapy and Radiation Therapy

This benefit plan covers the treatment of malignant disease by standard chemotherapy and treatment of disease by radiation therapy. **High-dose chemotherapy treatments must receive preauthorization from BCBSNM in order to be covered.**

#### Cancer Clinical Trials

If you are a participant in an approved cancer clinical trial that is being conducted in New Mexico, you may receive coverage for certain routine patient care costs incurred in the trial. Trials designed to test toxicity or disease pathophysiology are not included. Trials must have a therapeutic intent and be provided as part of a study being conducted in a cancer clinical trial in New Mexico. The persons conducting the trial must provide BCBSNM with notice of when the member enters and leaves a qualified cancer clinical trial and must accept BCBSNM's covered charges as payment in full.

The routine patient care costs that are covered must be the same services or treatments that would be covered if you were receiving standard cancer treatment. Benefits also include FDA-approved prescription drugs that are not paid for by the manufacturer, distributor or supplier of the drug. (Member cost-sharing provisions described under your separately issued *Drug Plan Rider* will apply to these benefits.)

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

## Dialysis

This benefit plan covers the following services when received from a dialysis provider, or when **preauthorization** is received from BCBSNM, in your home:

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

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

### Preauthorization Required

To be covered, all inpatient, outpatient, office and home-based short-term rehabilitation treatments, including skilled nursing facility and physical rehabilitation facility admissions, must receive **preauthorization** from BCBSNM. Short-term rehabilitation required due to reinjury or aggravation of an injury is also covered but must receive a separate **preauthorization** from BCBSNM, even if therapy was authorized for the original injury.

### Covered Services

This benefit plan covers the following short-term rehabilitation services when rendered for the medically necessary treatment of accidental injury or illness:

- occupational therapy performed by a licensed occupational therapist
- physical therapy performed by a physician, licensed physical therapist, or other professional provider licensed as a physical therapist (such as a doctor of oriental medicine)
- speech therapy, including audio diagnostic testing, performed by a properly accredited speech therapist for the treatment of communication impairment or swallowing disorders caused by disease, trauma, congenital anomaly, or a previous treatment or therapy
- inpatient physical rehabilitation and skilled nursing facility services

### Benefit Limits

Benefits for all inpatient, outpatient, office, and home-based services combined are limited as specified in the *Summary of Benefits.* **Note:** Long–term therapy, maintenance therapy, and therapy for chronic conditions are **not** covered. This benefit plan covers short–term rehabilitation only.

### Conditions of Coverage

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

- Services must be **preauthorized** by BCBSNM.
- There is a documented condition or delay in recovery that can be expected to measurably improve with therapy within two months of beginning active therapy. This period may be extended upon recommendation of the referring preferred physician, in consultation with BCBSNM.
- Improvement would not normally be expected to occur without intervention.

### Exclusions

This benefit plan does **not** cover:

- maintenance therapy or care provided after you have reached your rehabilitative potential except as required under New Mexico State law (Even if you have not reached your rehabilitative potential, this benefit plan does not cover services that exceed maximum benefit limits, if any. See “Autism Spectrum

Disorders" in this *Covered Services* section and the "Long-Term and Maintenance Therapy" exclusion in *Section 6: General Limitations and Exclusions.*)

- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay, except as required by law and described in this *Covered Services* section under "Autism Spectrum Disorders" (See "Early Developmental Delay and Disability" in *Section 8: Claim Payments and Appeals* for reimbursement of certain services provided to eligible children by the Department of Health.)
- diagnostic, therapeutic, rehabilitative or health maintenance services provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered provider
- therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights)
- private room expenses
- speech therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic; other speech services that can be carried out by the patient, the family or caregiver/teacher
- long-term therapies even if you have not yet used or exhausted maximum benefits, if any (See the "Long-Term and Maintenance Therapy" exclusion in *Section 6 General Limitations and Exclusions.*)
- herbs, homeopathic preparations, or nutritional supplements
- services of a massage therapist, or rolfing
- any therapeutic exercise equipment prescribed for home use

## SMOKING/TOBACCO USE CESSATION

This benefit plan covers smoking and tobacco use cessation treatment, limited to the following diagnostic and counseling services and drug therapy that has been preauthorized by BCBSNM (subject to member cost-sharing provisions applicable to the type of service received, such as prescription drugs, counseling, etc.):

- diagnostic services to identify tobacco use, use-related conditions, and dependence
- two 90-day courses of **preauthorized** treatment with FDA-approved prescription drugs to assist you with quitting tobacco use or smoking (See your separately issued *Drug Plan Rider* for benefit details.)
- a choice of cessation counseling of up to 90 minutes total provider contact time or two multi-session group programs per benefit period (Covered counseling is restricted to programs that meet minimum requirements established by the NM Public Regulation Commission; see *Section 10: Definitions* for minimum cessation counseling requirements.)

Starting any course of prescription drug therapy or cessation counseling constitutes one entire course of drug therapy or cessation counseling – even if you discontinue or fail to complete the course. For example, if you purchase a one-month supply of a prescription drug for smoking cessation and do not continue the drug beyond one month, you will have used up one entire 90-day course of treatment with the 30-day supply.

To locate a provider that is approved to provide cessation counseling sessions, you may call BCBSNM Customer Service or ask your personal physician about obtaining a prescription for smoking cessation drugs.

### Exclusions

This benefit plan does **not** cover the following services:

- drug therapy that has not received preauthorization
- acupuncture, biofeedback or hypnotherapy for smoking/tobacco use cessation
- over-the-counter tobacco cessation products, including but not limited to items such as nicotine patches or nicotine gum (See your separately issued *Drug Plan Rider* for copayments and other limitations that apply to prescription drugs.)

## SUPPLIES, EQUIPMENT AND PROSTHETICS

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

*For diabetic supplies such as needles, syringes, and test strips, see your separately issued Drug Plan Rider.*

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

If you have a question about durable medical equipment, medical supplies, prosthetics or appliances not listed, please call the BCBSNM Health Services Department.

**Preauthorization** from BCBSNM is required for:

- **specific items** listed in this section
- **long-term rental** of an item
- when total charges for an item equal **$500** or more *(Total charges* means either the total purchase price of the item or total rental charges for the estimated period of use.)

### Diabetic Supplies and Equipment

Under this provision, this benefit plan covers the following supplies and equipment for diabetic members and individuals with elevated glucose levels due to pregnancy (supplies are not to exceed a **30-day supply** purchased during any 30-day period):

- injection aids, including those adaptable to meet the needs of the legally blind
- insulin pumps if **preauthorization** is received from BCBSNM, and insulin pump supplies
- blood glucose monitors, including those for the legally blind
- medically necessary podiatric appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics that have been **preauthorized** by BCBSNM, custom molded inserts, replacement inserts, preventive devices, and shoe modifications

**Reminder:** Preauthorization is required for items costing **over $500** or requiring long-term rental. For additional diabetic supply coverage, (e.g., insulin needle and syringes, autolet, test strips for glucose monitors, glucagon emergency kits) see your *Drug Plan Rider.*

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

### Durable Medical Equipment and Appliances

This benefit plan covers the following items (**preauthorization is required for items costing over $500 or requiring long-term rental):**

- orthopedic appliances (**preauthorization** is required, regardless of total cost)
- replacement of items only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- oxygen and oxygen equipment, wheelchairs, hospital beds, crutches, and other medically necessary durable medical equipment
- lens implants for aphakic patients (those with no lens in the eye) and soft lenses or sclera shells (white supporting tissue of eyeball)

- either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) when needed to replace lenses absent at birth or lost through cataract or other intraocular surgery or ocular injury, to treat conditions related to genetic inborn errors of metabolism, or prescribed by a physician as the only treatment available for keratoconus (Duplicate glasses/lenses are not covered. Replacement is covered only if a physician or optometrist recommends a change in prescription due to a change in your medical condition.)
- cardiac pacemakers
- the rental of (or at the option of BCBSNM, the purchase of) durable medical equipment (including repairs to such purchased items), when prescribed by a covered health care provider and required for therapeutic use

### Medical Supplies

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

- colostomy bags, catheters
- gastrostomy tubes
- hollister supplies
- tracheostomy kits, masks
- lamb's wool or sheepskin pads
- ace bandages, elastic supports when billed by a physician or other provider during a covered office visit
- slings
- support hose prescribed by a physician for treatment of varicose veins (**six** pair per calendar year )

### Orthotics and Prosthetic Devices

When medically necessary and ordered by a provider, this benefit plan covers the following items:

- surgically implanted prosthetics or devices, including penile implants required as a result of illness or accidental injury, if **preauthorization** for such items is received from BCBSNM
- 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 items only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- breast prosthetics when required as the result of a mastectomy and mastectomy bras, which are limited to **four bras** per calendar year )
- functional orthotics only for patients having a locomotive problem or gait difficulty resulting from mechanical problems of the foot, ankle or leg (A functional orthotic is used to control the function of the joints and is covered only when **preauthorized by BCBSNM** and prescribed by a physician or podiatrist.)

When alternative prosthetic devices are available, the allowance for a prosthesis will be based upon the least costly item.

### Exclusions

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

- air conditioners, biofeedback equipment, humidifiers, purifiers, self-help devices or whirlpools
- items that are primarily nonmedical in nature such as Jacuzzi units, hot tubs, exercise equipment, heating pads, hot water bottles, or diapers
- nonstandard or deluxe equipment, such as motor-driven wheelchairs, chairlifts or beds; external prosthetics that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing

- repairs to items that you do not own
- comfort items such as bedboards, beds or mattresses of any kind, bathtub lifts, overbed tables, or telephone arms
- repair costs that exceed the rental price of another unit for the estimated period of need, or repair or rental costs that exceed the purchase price of a new unit
- dental appliances (See "Dental-Related/TMJ Services and Oral Surgery" for exceptions.)
- accommodative orthotics (deal with structural abnormalities of the foot, accommodate such abnormalities, and provide comfort, but do not alter function)
- orthopedic shoes, unless joined to braces (Diabetic members may be eligible to receive benefits for these items. Call BCBSNM Health Services for details.)
- equipment or supplies not ordered by a health care provider, including items used for comfort, convenience, or personal hygiene
- duplicate items; repairs to duplicate items; or the replacement of items because of loss, theft, or destruction
- stethoscopes or blood pressure monitors
- voice synthesizers or other communication devices
- eyeglasses or contact lenses or the costs related to prescribing or fitting of glasses or contact lenses, unless listed as covered; sunglasses, special tints, or other extra features for eyeglasses or contact lenses
- hearing aids or ear molds, fitting of hearing aids or ear molds, or related services or supplies, unless otherwise specified in *Section 5: Covered Services* (For surgically implanted devices for the profoundly hearing impaired, see "Surgery and Related Services.")
- syringes or needles for self-administering drugs (Coverage for insulin needles and syringes and other diabetic supplies not listed as covered in this section is described under your separately issued *Drug Plan Rider*).
- items that can be purchased over-the-counter, including but not limited to dressings for bed sores and burns, gauze, and bandages
- contraceptive devices that do not require a prescription, including over-the-counter contraceptive products such as condoms and spermicide (See "Maternity/Reproductive Services and Newborn Care: Family Planning" for devices requiring a prescription.)
- items not listed as covered

## SURGERY AND RELATED SERVICES

*For accidental injuries to the jaws, mouth, or teeth, oral surgery, or treatment of TMJ disorders or injuries, see "Dental-Related/TMJ Services and Oral Surgery."*

*See "Maternity/Reproductive Services and Newborn Care" for deliveries, C-sections, surgical sterilizations and limited infertility-related treatments or "Transplant Services," if applicable.*

**You are responsible for obtaining admission review and/or other preauthorization when necessary (see *Section 4: Admission Review and Other Preauthorization*).**

### Surgeon's Services

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

#### Cochlear Implants

This benefit plan covers cochlear implantation of a hearing device (such as an electromagnetic bone conductor) to facilitate communication for the profoundly hearing impaired, including training to use the device. You must submit a **written request for preauthorization** to BCBSNM before treatment begins. This benefit plan does **not** cover cochlear implant services without preauthorization.

### Mastectomy Services

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

This benefit plan also covers cosmetic breast surgery, when **preauthorized** by BCBSNM and received **within 12 months** of a mastectomy for breast cancer (unless a later surgical procedure is approved as medically appropriate by BCBSNM). Coverage is limited to:

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

This benefit plan does **not** cover subsequent procedures to correct unsatisfactory cosmetic results attained during the initial breast/nipple surgery or tattooing or breast surgery that has not received preauthorization from BCBSNM.

## Obesity Surgery

This benefit plan covers medical and surgical services for the treatment or control of morbid obesity as defined below and if the services are demonstrated, through existing peer–reviewed, evidence–based, scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the morbid obesity. (*Morbid obesity* is defined as having a Body Mass Index (BMI) of 40 or greater without co–morbidities, or a BMI of 35–39 with co–morbidities.) Surgery and any related nutritional counseling must be **preauthorized** by BCBSNM. The following items are specifically excluded:

- medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or morbid obesity; and
- weight loss programs or treatments, whether or not they are prescribed or recommended by a physician or are under medical supervision.

### Reconstructive Surgery

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

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

You or your physician must obtain **preauthorization, requested in writing,** from BCBSNM **before** the reconstructive service is provided. If the procedure (including any reconstructive service listed under "Dental-Related/TMJ Services and Oral Surgery") has not received preauthorization, **the surgery and all related charges will be denied.** Cosmetic procedures and procedures that are not medically necessary, including all services related to such procedures, will also be **denied.**

### Exclusions

This benefit plan does **not** cover:

- cosmetic or plastic surgery or procedures, such as breast augmentation, rhinoplasty, and surgical alteration of the eye that does not materially improve the physiological function of an organ or body part (unless covered under "Mastectomy Services")
- procedures to correct cosmetically unsatisfactory surgical results or surgically induced scars

- refractive keratoplasty, including radial keratotomy, or any procedure to correct visual refractive defect
- unless required as part of medically necessary diabetic disease management, trimming of corns, calluses, toenails or bunions (except surgical treatment such as capsular or bone surgery)
- sex change operations or complications arising from transsexual surgery
- subsequent surgical procedures needed because you did not comply with prescribed medical treatment or because of a complication from a previous noncovered procedure (such as a noncovered organ transplant, sex change operation or previous cosmetic surgery)
- any reconstructive procedure, orthognathic surgery, cochlear implant, breast reduction, orthotripsy, or cosmetic breast surgery that has not received preauthorization from BCBSNM
- the insertion of artificial organs, or services related to transplants not specifically listed as covered under "Transplant Services"
- standby services unless the procedure is identified by BCBSNM as requiring the services of an assistant surgeon and the standby physician actually assists

### Anesthesia Services

This benefit plan covers necessary anesthesia services, including acupuncture used as an anesthetic, when administered during a covered surgical procedure by a physician, certified registered nurse anesthetist (CRNA), a licensed doctor of oriental medicine (for acupuncture) or other practitioner as required by law.

#### Exclusions

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

### Assistant Surgeon Services

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

#### Exclusions

This benefit plan does **not** cover:

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

## TRANSPLANT SERVICES

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

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

### Effect of Medicare Eligibility on Coverage

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

### Organ Procurement or Donor Expenses

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

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

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

### Bone Marrow, Cornea or Kidney

This benefit plan covers the following transplant procedures if **preauthorization** is received from BCBSNM:

- bone marrow transplant for a member with aplastic anemia, leukemia, severe combined immunodeficiency disease (SCID), or Wiskott-Aldrich syndrome, and other conditions determined by BCBSNM to be medically necessary and not experimental, investigational, or unproven
- cornea transplant
- kidney transplant

#### Cost–Sharing Provisions

Covered services related to the above transplants are subject to the usual cost-sharing features and benefit limits of this benefit plan (e.g., coinsurance, copayments and out-of-pocket limits; and annual home health care maximums).

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

This benefit plan also covers transplant-related services for a **heart, heart-lung, liver, lung or pancreas-kidney** transplant. Services must be **preauthorized** in order to be covered. Also, all other limitations, requirements, and exclusions of this "Transplant Services" provision apply to these transplant-related services. In addition, the following provisions apply to the above–listed transplants for **one year** following the date of the actual transplant or retransplant. After one year, usual benefits apply and the services must be covered under other provisions of the benefit plan in order to be considered for benefit payment.

#### 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.

#### 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. Also, a standard per diem benefit **($125)** will be allocated for food and lodging expenses for the transplant recipient and one additional adult traveling with you (the transplant recipient). If the transplant recipient is a dependent child under the age of 18, benefits for travel and per diem expenses for **two adults** to accompany the child are available.

Travel expenses and standard per diem allowances are limited to a total combined lifetime maximum benefit of **$10,000** per transplant. Your case manager may approve travel and per diem food and 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 retransplant date.

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

**Cost–Sharing Features**

Covered services under this "Heart, Heart–Lung, Liver, Lung, Pancreas–Kidney" provision are subject to copayments based on the place of treatment and type of service. There is no deductible to meet. If you need a retransplant, these cost–sharing provisions renew starting from the date of the retransplant procedure.

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

## Transplant Exclusions

This benefit plan does **not** cover:

- any transplant or organ-combination transplant not listed as covered
- implantation of artificial organs or devices (mechanical heart); nonhuman organ transplants
- care for complications of noncovered transplants or follow-up care related to such transplants
- services related to a transplant that did not receive preauthorization from BCBSNM
- services related to a transplant performed in a facility not contracted directly or indirectly with BCBSNM to provide the required transplant (except cornea, kidney, or bone marrow)
- expenses incurred by a member of this plan for the donation of an organ to another person
- drugs that are self-administered or for use while at home (These services may be covered under your separately issued *Drug Plan Rider.*)
- donor expenses after the donor has been discharged from the transplant facility
- lodging, food, beverage, or meal expenses in excess of the per diem allowance, if available
- 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 bone marrow, cornea, or kidney transplant
- 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.*

**This benefit plan does not cover any service or supply not specifically listed as a covered service in this benefit booklet. If a service is not covered, then all services performed in conjunction with it are not covered.**

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

### — Before Effective Date of Coverage

**This benefit plan does not cover** any service received, item purchased, prescription filled, or health care expense incurred before your effective date of coverage. If you are an inpatient when coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date.

### — Biofeedback

**This benefit plan does not cover** services related to biofeedback.

### — Blood Services

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

### — Complications of Noncovered Services

**This benefit plan does not cover** any services, treatments, or procedures required as the result of complications of a noncovered service, treatment, or procedure (e.g., due to a noncovered sex change operation, cometic surgery, transplant, or experimental procedure).

### — Convalescent Care or Rest Cures

**This benefit plan does not cover** convalescent care or rest cures.

### — Cosmetic Services

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

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

**Exception:** Cosmetic breast/nipple surgery required due to a mastectomy that occurred less than **12 months** before the planned cosmetic procedure may be covered. However, **preauthorization, requested in writing,** must be obtained from BCBSNM for such services. Also, preauthorized reconstructive surgery, which may have a coincidental cosmetic effect, may be covered when required as the result of accidental injury, illness, or congenital defect. See "Surgery and Related Services" in *Section 5: Covered Services* for details.

### — Custodial Care

**This benefit plan does not cover** custodial care or care in a place that is primarily your residence when you do not require skilled nursing care. **This benefit plan does not cover** services to assist in activities of daily living

(such as sitter's or homemaker's services), or services not requiring the continuous attention of skilled medical or paramedical personnel, regardless of where they are furnished or by whom they were recommended.

### — Dental-Related/TMJ Services and Oral Surgery

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

### — Domiciliary Care

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

### — Duplicate (Double) Coverage

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

### — Duplicate Testing

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

### — Experimental, Investigational, or Unproven Services

**This benefit plan does not cover** any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical practice* (as defined) or those considered experimental, investigational, or unproven, unless for acupuncture rendered by a licensed doctor of oriental medicine or unless specifically listed as covered under "Autism Spectrum Disorders" or under "Cancer Clinical Trials" in *Section 5: Covered Services* and mandated by law. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted when services were administered, the service is experimental and will not be covered. To be considered experimental, investigational, or unproven, one or more of the following conditions must be met:

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

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

*Reliable evidence* means only published reports and articles in authoritative peer-reviewed medical and scientific literature; the written protocol or protocols used by the treating facility, or the protocol(s) of another facility studying substantially the same medical treatment, procedure, device, or drug; or the written informed consent used by the treating facility or by another facility studying substantially the same medical treatment, procedure,

device, or drug. *Experimental or investigational* does not mean cancer chemotherapy or other types of therapies that are the subjects of ongoing phase IV clinical trials.

The service must be medically necessary and not excluded by any other contract exclusion.

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

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

### — Food or Lodging Expenses

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

### — Genetic Testing or Counseling

**This benefit plan does not cover** genetic counseling or testing, unless the testing has received **preauthorization** from BCBSNM. See "Maternity/Reproductive Services and Newborn Care" in *Section 5: Covered Services* for details. **This benefit plan does not cover** tests such as amniocentesis or ultrasound to determine the gender of an unborn child.

### — Hair Loss Treatments

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

### — Hearing Examinations, Procedures and Aids

**This benefit plan does not cover** audiometric (hearing) tests **unless** 1) required for the diagnosis and/or treatment of an accidental injury or an illness, or 2) covered as a preventive *screening* service for children through age 21 or, 3) covered as part of the hearing aid benefit for members under age 21 and described under "Supplies, Equipment, and Prosthetics" in *Section 5: Covered Services.* (A screening does *not* include a hearing test to determine the amount and kind of correction needed.) **This benefit plan does not cover** hearing aids or ear molds, fitting of hearing aids or ear molds, or any related service or supply for **members age 21 and older.** For **members under age 21**, see "Supplies, Equipment, and Prosthetics" in *Section 5.* (For surgically implanted devices, see "Hearing Aids/Related Services for Children Under Age 21" and "Surgery and Related Services" in *Section 5: Covered Services.*)

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

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

### — Hypnotherapy

**This benefit plan does not cover** hypnosis or services related to hypnosis, whether for medical or anesthetic purposes.

### — Infertility Services/Artificial Conception

**This benefit plan does not cover** services related to, but not limited to, procedures such as: artificial conception or insemination, fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such

as in-vivo or in-vitro ("test tube") fertilization, Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), embryo transfer, drugs for induced ovulation, or other artificial methods of conception. **This benefit plan does not cover** the cost of donor sperm, costs associated with the collection, preparation, or storage of sperm for artificial insemination, or donor fees.

**This benefit plan does not cover** infertility testing, treatments, or related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization. **This benefit plan does not cover** reversal of a prior sterilization procedure. (Certain treatments of medical conditions that sometimes result in restored fertility may be covered; see "Maternity/Reproductive Services and Newborn Care" in *Section 5: Covered Services*.)

### — Late Claim Filing

**This benefit plan does not cover** services of a nonparticipating provider if the claim for such services is received by BCBSNM **more than 12 months** after the date of service. (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.) See "Filing Claims" in *Section 8: Claim Payments and Appeals* for details.

### — Learning Deficiencies/Behavioral Problems

**This benefit plan does not cover** special education, counseling, therapy, diagnostic testing, treatment, or any other service for learning deficiencies or chronic behavioral problems, whether or not associated with a manifest mental disorder, retardation, or other disturbance. (See "Autism Spectrum Disorders" in *Section 5: Covered Services* for details about mandated coverage for children with these diagnoses. See *Section 8: Claim Payments and Appeals* for reimbursement of certain services provided to eligible children by the Department of Health.)

### — Limited Services/Covered Charges

**This benefit plan does not cover** amounts in excess of covered charges or services that exceed any maximum benefit limits listed in this benefit booklet, or any amendments, riders, addenda, or endorsements.

### — Local Anesthesia

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

### — Long-Term and Maintenance Therapy

**This benefit plan does not cover** long-term therapy, even if medically necessary and even if any applicable benefit maximum has not yet been reached. (Therapies are considered long-term if measurable improvement is not possible **within two months** of beginning active therapy.) **Note:** This exclusion does **not** apply to benefits for medication or medication management or to certain services required to be covered under New Mexico state law for children with autism spectrum disorders.

**This benefit plan does not cover** maintenance therapy or care or any treatment that does not significantly improve your function or productivity, or care provided after you have reached your rehabilitative potential (unless therapy is covered during an approved hospice benefit period). In a dispute about whether your rehabilitative potential has been reached, you are responsible for furnishing documentation from your physician supporting his/her opinion. **Note:** Even if your rehabilitative potential has not yet been reached, **this benefit plan does not cover** services that exceed maximum benefit limits.

### — Medical Policy Determinations

Any technologies, procedures, or services for which medical policies have been developed by BCBSNM are either limited or excluded as defined in the medical policy. (See "Medical Policy" in *Section 10: Definitions).* **Exception:** The fact that this benefit plan covers certain services that are excluded under BCBSNM medical policy 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 policy. Only covered

acupuncture and those services mandated by state law will be excepted from this BCBSNM standard medical policy exclusion.

### — Medically Unnecessary Services

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

BCBSNM determines whether a service or supply is medically necessary and whether it is covered. Because a provider prescribes, orders, recommends, or approves a service or supply does *not* make it medically necessary or make it a covered service, even if it is not specifically listed as an exclusion. (BCBSNM determines medical necessity based on the criteria given in *Section 5: Covered Services*.)

### — No Legal Payment Obligation

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

- charges made only because benefits are available under this benefit 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, Medicaid, or certain services that are reimbursed to the Department of Health according to the "Early Developmental Delay and Disability" provision in *Section 8: Claim Payments and Appeals.*

### — Noncovered Providers of Service

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

- member of your immediate family or a person normally residing in your home
- physician, other person, supplier, or facility (including staff members) that are not specifically listed as covered in this benefit booklet, such as a:
  - — health spa or health fitness center (whether or not services are provided by a licensed or registered provider)
  - — school infirmary
  - — halfway house
  - — massage therapist
  - — private sanitarium
  - — extended care facility or similar institution
  - — residential treatment center (A residential treatment center is a facility where the primary services are the provision of room and board and constant supervision or a structured daily routine for a person who is impaired but whose condition does not require acute care hospitalization.)
  - — dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group

## — Nonmedical Expenses

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

- adoption or surrogate expenses
- educational programs such as behavior modification and arthritis classes (Some diabetic services and other educational programs may be covered; see "Physician Visits/Medical Care" and "Preventive Services" in *Section 5: Covered Services* for details.)
- vocational or training services and supplies
- mailing and/or shipping and handling
- missed appointments; "get-acquainted" visits without physical assessment or medical care; telephone consultations; provision of medical information to perform admission review or other preauthorizations; 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
- personal comfort services, including homemaker and housekeeping services, except in association with respite care covered during a hospice admission
- immunizations or medications required for international travel
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; phone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- physicals or screening examinations and immunizations given primarily for insurance, licensing, employment, camp, weight reduction programs, medical research programs, sports, or for any nonpreventive purpose
- hepatitis B immunizations when required due to possible exposure during the 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
- psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education

## — Nonpreferred Provider Services

**This benefit plan does not cover** nonemergency services provided by a nonpreferred provider unless **preauthorization** for such services is received from BCBSNM. You will be financially responsible for the services of a nonpreferred provider if you did not receive, in advance, a valid approval from BCBSNM. **Note:** When preauthorization is requested, BCBSNM may require that you travel to another city to receive services from a preferred provider.

Except in emergencies, BCBSNM will generally NOT authorize services of a nonpreferred provider if the services could be obtained from a preferred provider. Authorizations (preauthorizations) for such services are given only under very special circumstances related to **medical necessity** and **lack of provider availability in the BCBSNM preferred provider network.** BCBSNM will NOT approve an authorization request based on non–medical issues such as whether or not you or your doctor prefer the out–of–network provider or find the provider more convenient. Regardless of medical necessity or non–medical issues, nonpreferred providers' services are NOT covered under this benefit plan, except during an emergency, if you do not first obtain preauthorization.

### — Nonprescription Drugs

**This benefit plan does not cover** nonprescription or over-the-counter drugs, medications, ointments, or creams, including herbal or homeopathic preparations, or prescription drugs that have over-the-counter equivalents, except for those products specifically listed as covered in your separately issued *Drug Plan Rider.* This exclusion includes nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum.

### — Nutritional Supplements

**This benefit plan does not cover** vitamins, dietary/nutritional supplements, special foods, formulas, mother's milk, or diets, unless prescribed by a physician. Such supplements require a prescription to be covered under the "Home Health Care/Home I.V. Services" in *Section 5: Covered Services.* This benefit plan covers other nutritional products only under specific conditions set forth under your *Drug Plan Rider.*

### — Post-Termination Services

**This benefit plan does not cover** any service received or item or drug purchased after your coverage is terminated, even if: 1) preauthorization for such service, item, or drug was received from BCBSNM, or 2) the service, item, or drug was needed because of an event that occurred while you were covered. If you are an inpatient when coverage ends, benefits for the admission will be available only for those covered services received before your termination date.

### — Pre–Existing Conditions

For members who are subject to this provision, **this benefit plan does not cover** any pre–existing conditions for up to **six months** following the member's initial enrollment eligibility date. A late applicant accepted for coverage is not covered for pre–existing conditions for up to **18 months** following his/her effective date of coverage. (See "Pre–Existing Conditions Limitation" in *Section 2: Enrollment and Termination Information*.)

### — Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products and Special Medical Foods

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

### — Preauthorization Not Obtained When Required

**This benefit plan does not cover** certain services if you do not obtain preauthorization from BCBSNM before those services are received. See *Section 4: Admission Review and Other Preauthorizations.*

### — Private Duty Nursing Services

**This benefit plan does not cover** private duty nursing services.

### — Private Room Expenses

**This benefit plan does not cover** private room expenses, unless your medical condition requires isolation for protection from exposure to bacteria or diseases (e.g., severe burns and conditions that require isolation according to public health laws). Private room charges must be **preauthorized** by BCBSNM to be covered.

### — Sex-Change Operations and Services

**This benefit plan does not cover** services related to sex-change operations, reversals of such procedures or complications arising from transsexual surgery.

### — Sexual Dysfunction Treatment

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

## — Supplies, Equipment and Prosthetics

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

## — Surgery and Related Services

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

## — Therapy and Counseling Services

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

- recreational, sleep, crystal, primal scream, sex, and Z therapies
- self-help, stress management, weight-loss, and codependency programs
- smoking/tobacco use cessation counseling programs that do not meet the standards set by the NM Public Regulation Commission
- 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, religious, marital, or bereavement counseling
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this benefit plan
- therapy for chronic conditions such as, but not limited to, cerebral palsy or developmental delay, except as required by law and described in *Section 5* under "Autism Spectrum Disorders" (See "Early Developmental Delay and Disability" in *Section 8: Claim Payments and Appeals* for coverage of certain services provided to eligible children by the Department of Health.)
- any therapeutic exercise equipment for home use (e.g., treadmill, weights)

## — Thermography

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

## — TMJ/CMJ Services

**This benefit plan does not cover** nonstandard diagnostic, therapeutic, or surgical TMJ/CMJ treatments. **This benefit plan does not cover** orthodontic appliances and treatment, crowns, bridges, or dentures for TMJ/CMJ treatments unless required as the result of an accidental injury to the TMJ/CMJ.

## — Transplant Services

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

## — Travel or Transportation

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

### — Veteran's Administration Facility

**This benefit plan does not cover** services or supplies furnished by a Veterans Administration facility for a service-connected disability or while a member is in active military service.

### — Vision Services

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

### — War-Related Conditions

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

### — Work-Related Conditions

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

- occupational disease laws
- employer's liability
- municipal, state, or federal law (except Medicaid)
- Workers' Compensation Act

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

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

- You fail to file a claim within the filing period allowed by the applicable law.
- You obtain care not authorized by Workers' Compensation insurance.
- Your employer fails to carry the required Workers' Compensation insurance. (The employer may be liable for an employee's work-related illness or injury expenses.)
- You fail to comply with any other provisions of the law.

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

# SECTION 7: COORDINATION OF BENEFITS (COB) AND REIMBURSEMENT

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

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

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

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

**The following rules determine which coverage pays first:**

**No COB Provision** — If the other valid coverage does not include a COB provision, that coverage pays first.

**Medicare** — If the other valid coverage is Medicare and Medicare is not secondary according to federal law, Medicare pays first.

**Subscriber/Dependent** — If a member is covered as the subscriber under one coverage and as a dependent under another, the subscriber's coverage pays first. **Exception:** If Medicare is secondary to the plan of an *active* worker covering the Medicare beneficiary as a dependent, then that plan determines its benefits first, then Medicare, and last, the plan covering the Medicare beneficiary as the subscriber.

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.

**Dependent Child** — For a dependent child whose parents are not separated or divorced, the coverage of the parent whose birthday falls earlier in the calendar year pays first. If the other valid coverage does not follow this rule, the father's coverage pays first.

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

- *Court-Decreed Obligations.* Regardless of which parent has custody, if a court decree specifies which parent is financially responsible for the child's health care expenses, the coverage of that parent pays first.
- *Custodial/Noncustodial.* The plan of the custodial parent pays first. The plan of the spouse of the custodial parent pays second. The plan of the noncustodial parent pays last.
- *Joint Custody.* If the parents share joint custody, and the court decree does not state which parent is responsible for the health care expenses of the child, the plans follow the rules that apply to children whose parents are not separated or divorced.

**Active/Inactive Employee** — If a member is covered as an active employee under one coverage and as an inactive employee under another, the coverage through active employment pays first. (Even if a member is covered as a dependent 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 benefit 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 benefit 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 dependents 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 dependents.
- BCBSNM is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits BCBSNM provided for that sickness or injury.

BCBSNM shall have the right to first reimbursement out of all funds you, your covered dependents 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

## FILING CLAIMS

You must submit claims **within 12 months** after the date services or supplies were received. **A claim submitted more than 12 months after the service was received will not be accepted under any circumstance.** If a claim is returned for further information, resubmit it **within 45 days.**

## 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 admission review and preauthorization requirements or benefits may be reduced or denied as explained in *Section 4: Admission Review and Other Preauthorizations.* Covered services are the same services listed as covered in *Section 5: Covered Services* and all services are subject to the limitations and exclusions listed throughout this booklet.

## IF YOU HAVE OTHER VALID COVERAGE

When you have other valid coverage that is "primary" over this benefit plan, you need to file your claim with the other carrier first. (See *Section 7: Coordination of Benefits (COB)and Reimbursement.*) After your other coverage (including health care insurance, dental or vision plan, Medicare, automobile, or other liability insurance, Workers' Compensation, etc.) pays its benefits, a copy of their payment explanation form must be attached to the claim sent to BCBSNM or to the local BCBS Plan, as instructed under "Where to Send Claim Forms" later in this section.

If the other valid coverage pays benefits to you (or your family member) directly, give your provider a copy of the payment explanation so that he/she can include it with the claim sent to BCBSNM or to the local BCBS Plan. (If a nonparticipating provider does not file claims for you, attach a copy of the payment explanation to the claim that you send to BCBSNM or to the local BCBS Plan, as applicable.)

## PARTICIPATING AND PREFERRED PROVIDERS

Your "preferred" provider may have two agreements with the local BCBS Plan — a preferred provider contract and another participating provider contract. Some providers have **only** the participating provider contract and are **not** considered preferred providers and their services are **not** covered except during an emergency or unless listed as an "exception" in *Section 3: How Your Plan Works*. However, all participating and preferred providers file claims with their local BCBS Plan and payment is made directly to them. Be sure that these providers know you have health care coverage administered by BCBSNM. Do **not** file claims for these services yourself.

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

## PROVIDERS 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 or a participating provider agreement. If your nonparticipating provider does not file a claim for you for emergency care, submit a separate claim form for each family member as the services are received. Attach itemized bills and, if applicable, your other valid coverage's payment explanation, to a *Member Claim Form.* (Forms can be printed from the BCBSNM Web site at www.bcbsnm.com or requested from a Customer Service representative.) 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.)

## 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)

**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 representative. If your itemized bills include services previously filed, identify clearly the new charges that you are submitting. (See "Where to Send Claim Forms" below, for special instructions regarding out-of-country claims.)

## WHERE TO SEND CLAIM FORMS

If your nonparticipating provider does not file a claim for you, you (not the provider) are responsible for filing the claim.

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

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

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

### Mental Health/Chemical Dependency Claims

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

**Mesa Mental Health**
**P.O. Box 92165**
**Albuquerque, New Mexico 87199-2165**

### 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 representative or on the BCBSNM Web site at www.bcbsnm.com.

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

For covered inpatient hospital services received outside the United States (including Puerto Rico, Jamaica, and the U.S. Virgin Islands) and Canada, show your benefit 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.

The BlueCard Worldwide *International Claim Form* is to be used to submit institutional and professional claims for benefits for covered 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.

Since the claim cannot be returned, please be sure to keep photocopies of all bills and supporting documentation for your personal records. The member should submit an *International Claim Form* (available at www.bcbs.com), attach itemized bills, and mail to BlueCard Worldwide at the address below. BlueCard Worldwide 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:

**BlueCard Worldwide Service Center**
**P.O. Box 72017**
**Richmond, VA 23255–2017 USA**

## CLAIMS PAYMENT PROVISIONS

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

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

### If A Claim Is Denied

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

### 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, coinsurance, any penalty amounts, 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.

### Overpayments

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

### Medicaid

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

### Early Development Delay and Disability

For covered dependent children **under age four** who are also eligible for services under the Department of Health's (DOH) "Family, Infant and Toddler" (FIT) program, as defined in 7.30.8, NMAC, your BCBSNM benefit 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 benefit 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 benefit plan. Claims for services payable to the DOH under this provision will be honored only if submitted to BCBSNM by the DOH.

### 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.

### 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, coinsurance, any penalty amounts, 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.

### Provider Payment Example

The examples on the following page demonstrate your liability for services from a preferred provider versus a nonpreferred provider (e.g., unsolicited providers). Both examples are for a plan that pays 80 percent of covered charges with the remaining 20 percent of covered charges paid by the member.

## BLUECARD PROGRAM

Other Blue Cross and Blue Shield Plans outside of New Mexico ("Host Blue") may have contracts with certain providers in their service areas. Under BlueCard, when you receive covered services outside of New Mexico from a Host Blue contracting provider that does not have a contract with BCBSNM, the amount you pay for covered services is calculated on the lower of:

- the billed charges for your covered services, or
- the negotiated price that the Host Blue passes on to BCBSNM.

Here's an example of how this calculation could work. Suppose you receive covered services for an illness while you are on vacation outside of New Mexico. You show your ID card to the provider to let him or her know that you are covered by BCBSNM. The provider has negotiated with the Host Blue a price of $80, even though the provider's standard charge for this service is $100. In this example, the provider bills the Host Blue $100. The Host Blue, in turn, forwards the claim to BCBSNM and indicates that the negotiated price for the covered service is $80. BCBSNM would then base the amount you must pay for the service — the amount applied to your deductible, if any, and your coinsurance — on the $80 negotiated price, not the $100 billed charge. So, for example, if your coinsurance is 20 percent, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a covered service.

**Please Note:** The coinsurance in the previous example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Look at the *Summary of Benefits* for your payment responsibilities under this benefit plan.

Often, this "negotiated price" is a **simple discount** that reflects the actual price the Host Blue pays. Sometimes, it is an **estimated price** that takes into account special arrangements the Host Blue has with an individual provider or a group of providers. Such arrangements may include settlements, withholds, non-claims transactions, and/or other types of variable payments. The "negotiated price" may also be an **average price** based on a discount that results in expected average savings (after taking into account the same special arrangements used to obtain an estimated price). Average prices tend to vary more from actual prices than estimated prices.

Negotiated prices may be adjusted from time to time to correct for over– or underestimation of past prices. However, the amount used by BCBSNM to calculate your share of the billed amount is considered a final price.

Laws in a small number of states may require the Host Blue to 1) use another method for, or 2) add a surcharge to your liability calculation. If any state laws mandate other liability calculation methods, including a surcharge, BCBSNM would calculate your liability for any covered services according to the applicable state law in effect when you received care.

## APPEALS PROCESS

### Grievances (Complaints)

If you have an inquiry or a concern about any prior authorization request, claims payment, claims that have been denied or only partially paid, the quality of care your receive, the cancellation of your coverage, or any other review decisions made by BCBSNM, call a BCBSNM Customer Service representative for assistance. Many complaints or problems can be handled informally by calling, writing, or e–mailing BCBSNM Customer Service. If you are not satisfied with the initial response, you can request internal review as described below.

If you make an oral grievance, a BCBSNM Customer Service representative will assist you. The Managed Health Care Bureau of the New Mexico Insurance Division is also available to assist you with the grievances, questions, or complaints. Call

**1–888–427–5772 or (505) 827–3928**

You may designate a representative to act for you in the internal review. Your designation of a representative must be in writing in order to protect against disclosure of information about you except to your authorized representative. You, your guardian or representative, or a provider acting on your behalf can contact a BCBSNM Customer Service representative in person, by letter, by e–mail, or by telephone if you have an inquiry or complaint about a prior authorization request, a claim payment or denial, or any other issue. If you make an inquiry or complaint or file a grievance under the following procedures, you will not be subject to retaliatory action by BCBSNM. **Note:** This is a summary of procedures. You may request a more detailed written explanation of these procedures by calling BCBSNM Customer Service.

### Grievance Procedures

If you are not satisfied with the initial decision made by BCBSNM, you can request internal review. Within **180 days** after you receive notice of a BCBSNM decision (payment, denial, or partial denial) on a claim or a prior authorization request, call or write BCBSNM Customer Service and explain your reasons for disagreeing with the decision. If you do not submit the request for internal review within the 180–day period, you waive your right to

internal review, unless you can satisfy BCBSNM that matters beyond your control prevented you from timely filing the request. You may also ask to see relevant documents and you may submit written issues, comments and additional medical information as part of the internal review.

### Adverse Determination Grievance

This is a summary of the grievance procedure that applies to "adverse determinations" made by BCBSNM regarding a request for a health care service. An "adverse determination" means a decision made either pre−service or post−service by BCBSNM that a health care service requested by a provider or member has been reviewed and, based upon the information available, does not meet the requirements for coverage or medical necessity and the requested health care service is either denied, reduced, or terminated.

If your request for health care service has been denied in whole or in part, you may request internal review of the adverse determination. The internal review will be either "expedited" or "standard."

If required by the medical exigencies of the request, BCBSNM will conduct an "Expedited Review" and will render a decision as soon as practicable, but not later than **72 hours** from receipt of the request.

If not medically exigent, BCBSNM will conduct a "Standard Review." If the request for internal review is made **before** you receive the health care service ("pre−service request for review"), the **entire** internal review process shall be completed within **20 working days** of receipt of the request for internal review. If the request for internal review is made **after** you receive the health care service ("post−service request for review"), the **entire** internal review shall be completed within **40 working days** of the request for internal review. BCBSNM may extend the review period **10 working days** in pre−service cases and **20 working days** in post−service cases.

If BCBSNM upholds the adverse determination, BCBSNM will notify you of that decision by telephone (if available) and by mail. You will be informed of the next internal level of appeal at that time and will be asked whether you want to pursue an "internal panel review" (second level of appeal) of the decision. If you elect to pursue internal panel review, BCBSNM will notify you of the date, time, and location that the panel will convene and will make arrangements for you to participate by phone or in person, if necessary. BCBSNM will not unreasonably deny your request for a postponement. The internal panel decision will be provided to you by telephone, if available, and in writing within the time frames set forth by the applicable regulations, subject to any extensions or postponements.

### Administrative Grievance

This is a summary of the grievance procedure followed by BCBSNM for any oral or written complaint about any aspect of the benefit plan other than a request for health care service including, without limitation:

- administrative practices of BCBSNM that affect the availability, delivery or quality of health care services;
- claims payment, handling, or reimbursement for health care services, and
- termination of coverage.

If you are dissatisfied with a decision, action, or inaction of BCBSNM, you have the right to request an initial internal review of the administrative grievance orally or in writing. A BCBSNM representative will complete the internal review and mail a written decision to you within **15 working days** of receipt of the administrative grievance. The decision will be binding unless you request reconsideration of the internal review within **20 working days** of your receipt of the initial decision.

Upon receipt of your request for reconsideration of the internal review, BCBSNM will appoint a reconsideration committee to schedule and hold a hearing. Arrangements will be made for you to participate in the hearing in person or by telephone. The hearing shall be held within **15 working days** after the receipt of your request for reconsideration and the decision of committee will be provided to you in writing within **7 working days** after the hearing. BCBSNM will not unreasonably deny your request for a postponement.

## BCBSNM Contacts

For more information, contact:

**BCBSNM Appeals Unit**
**P.O. Box 27630**
**Albuquerque, NM 87125–9815**

**Telephone (toll–free): (800) 205–9926**
**e–mail: See Web site at www.bcbsnm.com**
**Fax: (505) 816–3837**

## EXTERNAL APPEALS

If you are still not satisfied after having completed the BCBSNM inquiry, appeals, and grievance procedures, you have the option of taking one or more of the following steps. (You may not take legal action to recover benefits under this benefit plan until 60 days after BCBSNM has received the claim or prior authorization request in question. Also, you may not take any legal action after three years from the date that the claim in question. Also, you may not take any legal action after three years from the date that the claim in question must be filed with BCBSNM.)

### Review by the NM Superintendent of Insurance

If you are dissatisfied with the BCBSNM internal review of your grievance or appeal decision, you have the right to request an external review by the New Mexico Superintendent of Insurance by filing a written request **within 20 working days** of receipt of the written decision from BCBSNM. You may file your request by:

- Mail to the Superintendent of Insurance, Attention: Managed Health Care Bureau –External Review Request, New Mexico Public Regulation Commission, P.O. Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico, 87504–1269;
- Fax to Managed Health Care Bureau–External Review Request at (505) 827–4734;
- E–mail to mhcb.grievance@state.nm.us (subject: “External Review Request”);
- Online by using a Division of Insurance Complaint Form at http://www.nmprc.state.nm.us; or
- If required by medical exigencies of the case, by telephone at 1–888–427–5772 or (505) 827–3928.

You will need to provide a copy of the BCBSNM decision; a fully executed release form authorizing the Superintendent to obtain any necessary medical records from BCBSNM or other health care provider; and any other supporting documentation. You may contact the Managed Health Care Bureau to assist you in this process by calling toll–free at 1–888–427–5772.

### ERISA Appeals Procedures

For plans subject to the Employee Retirement Income Security Act of 1974 (ERISA), BCBSNM’s time frames for responding to your request for review may be different than those described on the previous page. As stated on the previous page, you have **180 days** from receiving a notice of adverse benefit determination to submit an appeal. Under the “Expedited Review” process for pre–service urgent care claims, BCBSNM will respond as soon as possible, but also no later than 72 hours after receiving your initial inquiry. However, under the “Standard Review” process, BCBSNM will respond to adverse determinations within the following time frames:

- **30 calendar days** after receiving your initial request for internal review of a **pre–service** claim; and
- **60 calendar days** after receiving your initial request for internal review of a **post–service** claim.

If you go on to request a second internal panel review, BCBSNM must respond to pre–service requests within another 15 calendar days and to post–service requests within another 30 calendar days of receiving the request for the internal panel review.

These time frames may be extended in accordance with ERISA. If you are not satisfied after completing the ERISA Appeal Procedure, you may have the right to bring a civil action under ERISA section 502(a). See below as to right to file a legal action if you are in an ERISA plan, and right to demand arbitration if you are in a non–ERISA plan.

### External Appeal for ERISA Plans

This benefit plan provided by your group may be part of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). The "External Appeal for ERISA Plans" right is applicable to all group plans except governmental plans, church plans, and plans maintained outside the United States primarily for the benefit of persons substantially all of whom are nonresident aliens. Therefore, if this benefit plan is governed by ERISA and you are still not satisfied after having completed the reconsideration or appeal process administered by BCBSNM, you may have a right to bring a civil action under ERISA section 502(a).

### Arbitration for Non-ERISA Plans

The "Arbitration for Non-ERISA Plans" provision applies to all governmental plans, church plans, and plans maintained outside the United States primarily for the benefit of persons substantially all of whom are nonresident aliens. If a dispute about coverage, benefits or handling of claims or preauthorization requests continues after the member has followed and exhausted the reconsideration or appeal process administered by BCBSNM, the issue or claim shall be submitted to arbitration upon agreement by the member. The rules for arbitration shall be the "Commercial Arbitration Rules" developed by the American Arbitration Association. You may obtain a copy of these rules from a Customer Service representative. The rules are also available from the American Arbitration Association's Web site (www.adr.org). The use of arbitration does not limit your ability to seek other means by which to resolve disputes, but is an avenue available to you.

## CATASTROPHIC EVENTS

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

# SECTION 9: GENERAL PROVISIONS

## APPLICATION STATEMENT

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

## AVAILABILITY OF PROVIDER SERVICES

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

## 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 30 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.

## 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.

## 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.

## DISCLOSURE AND RELEASE OF INFORMATION

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

## ENTIRE CONTRACT

This benefit booklet (and any amendments, riders, endorsements, and the *Summary of Benefits*), your group enrollment/change application, and your identification (ID) card shall constitute the entire contract. All statements, in the absence of fraud, made by any applicant shall be deemed representations and not warranties. No such statements shall void coverage or reduce benefits unless contained in a written application for coverage.

## EXECUTION OF PAPERS

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

## HOLD–HARMLESS

The contracts between BCBSNM and its preferred providers include a "hold harmless" clause which provides that a PPO plan member (or EPO plan member) cannot be liable to the provider for monies owed by BCBSNM for health care plan services covered under the EPO health plan.

## INDEPENDENT CONTRACTORS

The relationship between BCBSNM and its network providers is that of independent contractors; physicians and other providers are not agents or employees of BCBSNM, and BCBSNM and its employees are not employees or agents of any network provider. BCBSNM will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any network provider. The

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

## MEMBER RIGHTS

All members have these rights:

- The right to available and accessible services, when medically necessary as determined by your primary care or treating physician in consultation with BCBSNM, 24 hours per day, 7 days a week or urgent or emergency care services, and for other health services as defined by your benefit booklet.
- The right to be treated with courtesy and consideration, and with respect for your dignity and your need for privacy.
- The right to have their privacy respected, including the privacy of medical and financial records maintained by BCBSNM and its health care providers as required by law.
- The right to be provided with information concerning BCBSNM's policies and procedures regarding products, services, providers, and appeals procedures and other information about the company and the benefits provided.
- The right to choose a preferred provider within the limits of the covered benefits and plan network, including the right to refuse care of specific practitioners.
- The right to all the rights afforded by law, rule, or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language you understand.
- The right to receive from your physician(s) or provider, in terms that you understand, an explanation of your complete medical condition, recommended treatment, risk(s) of treatment, expected results and reasonable medical alternatives, irrespective of BCBSNM's position on treatment options. If you are not capable of understanding the information, the explanation shall be provided to your next of kin, guardian, agent or surrogate, if able, and documented in your medical record.
- The right to prompt notification of termination or changes in benefits, services or provider network.
- The right to file a complaint or appeal with BCBSNM or with the New Mexico Superintendent of Insurance and to receive an answer to those complaints within a reasonable time.
- The right to request information about any financial arrangements or provisions between BCBSNM and its preferred providers that may restrict referral or treatment options or limit the services offered to members.
- The right to adequate access to qualified health professionals near your work or home within the BCBSNM service area (the state of New Mexico).
- The right to affordable health care, with limits on out–of–pocket expenses, including the right to seek care from a nonpreferred provider, and an explanation of your financial responsibility when services are provided by a nonpreferred provider, or provided without required preauthorization.
- The right to detailed information about coverage, maximum benefits, and exclusions of specific conditions, ailments or disorders, including restricted prescription benefits, and all requirements that you must follow for preauthorization and utilization review.
- The right to make recommendations regarding BCBSNM's member rights and responsibilities policies.
- The right to complete explanation of why care is denied, an opportunity to appeal the decision to BCBSNM's internal review, the right to a secondary appeal, and the right to request the assistance of the Superintendent of Insurance.

## MEMBER RESPONSIBILITIES

As a member enrolled in a managed health care plan administered by BCBSNM, you have these responsibilities:

- The responsibility to supply information (to the extent possible) that BCBSNM and its preferred practitioners and providers need in order to provide care.

- The responsibility to follow plans and instructions for care that you have agreed on with your treating provider or practitioners.
- The responsibility to understand your health problems and participate in developing mutually agreed–upon treatment goals with your treating provider or practitioner to the degree possible.

## MEMBERSHIP RECORDS

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

## RESEARCH FEES

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

## SENDING NOTICES

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

## SECTION 10: DEFINITIONS

It is important for you to understand the meaning of the following terms as many determine 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 by controlling and regulating the flow and balance of energy and functioning of the person to restore health.

**Admission** — The period of time between the dates when a patient enters a facility as an inpatient and is discharged as an inpatient. (If you are an inpatient at the time your coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date.)

**Adverse determination** — A decision made either pre–service or post–service by BCBSNM that a health care service requested by a provider or member has been reviewed and, based upon the information available, does not meet the requirements for coverage or medical necessity and the requested health care service is either denied, reduced, or terminated.

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

**Alcohol abuse treatment facility, alcohol abuse treatment program** — An appropriately licensed provider of medical detoxification and rehabilitation treatment for alcohol abuse.

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

**Ambulatory surgical facility** — An appropriately licensed provider, with an organized staff of physicians, that meets all of the following criteria:

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis; *and*
- provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility; *and*
- does not provide inpatient accommodations; *and*
- is not a facility used primarily as an office or clinic for the private practice of a physician or other provider.

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

**Applied behavioral analysis (ABA)** — Services that include behavior modification training programs that are based on the theory that behavior is learned through interaction between an individual and the environment. The goal of behavior management is to reinforce and increase desirable, functional behaviors while reducing undesirable, "maladaptive" behaviors. Services would not apply to children over the age of seven.

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

**Benefit booklet** — This document or evidence of coverage, which explains the benefits, limitations, exclusions, terms, and conditions of your health coverage.

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

**Brand-name drug** — A drug that is available from only one source or when available from multiple sources is protected with a patent.

**Calendar year** — A calendar year is a period of one year that begins on January 1 and ends on December 31 of the same year. The initial calendar year benefit period is from a member's effective date of coverage and ends on December 31, which may be less than 12 months.

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

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

**Certified nurse-midwife** — A person who is licensed by the Board of Nursing as a registered nurse and who is licensed by the New Mexico Department of Health (or appropriate state regulatory body) as a certified nurse-midwife.

**Certified nurse practitioner** — A registered nurse whose qualifications are endorsed by the Board of Nursing for expanded practice as a certified nurse practitioner and whose name and pertinent information is entered on the list of certified nurse practitioners maintained by the Board of Nursing.

**Cessation counseling** — As applied to the "Smoking/Tobacco Use Cessation" benefit described in *Section 5: Covered Services*, cessation counseling means a program, including individual, group, or proactive telephone quit line, that:

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

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

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

**Child** — See definition of "Dependent."

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

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

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

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

**Coinsurance** — A percentage of covered charges that you are required to pay for a covered service. For covered services that are subject to coinsurance, you pay the percentage (indicated on the *Summary of Benefits*) of BCBSNM's covered charge after the deductible (if any) has been met.

**Copayment** — A fixed-dollar amount that you are required to pay towards some covered services.

**Cosmetic** — See the "Cosmetic Services" exclusion in *Section 6: General Limitations and Exclusions.*

**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 BCBSNM determines is a fair and reasonable allowance for a particular covered service. After your share of a covered charge (e.g., coinsurance, and/or penalty amount) 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.** Also see "Claims Payment Provision" in *Section 8: Claim Payments and Appeals*.

**Covered services** — Those services and other items for which benefits are available under the terms of the benefit program 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.

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

**Dentist, oral surgeon** — A doctor of dental surgery (D.D.S.) or doctor of medical dentistry (D.M.D.) who is licensed to practice prevention, diagnosis, and treatment of diseases, accidental injuries and malformation of the teeth, jaws, and mouth.

**Diagnostic services** — Procedures such as laboratory and pathology tests, x-ray services, EKGs, and EEGs that do **not** require the use of an operating or recovery room and that are ordered by a provider to determine a condition or disease.

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

**Doctor of oriental medicine** — A person who is a doctor of oriental medicine (D.O.M.) licensed by the appropriate governmental agency to practice acupuncture and oriental medicine.

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

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

**Effective date of coverage** — 12:01 a.m. of the date on which a member's coverage begins.

**Emergency, emergency care** — Medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to his/her health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part, or disfigurement. (In addition, initial treatment must be sought **within 48 hours** of the accident or onset of symptoms and services must be received in an emergency room, trauma center, or ambulance to qualify as an emergency.)

**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. The employer determines the length of the probationary period.

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

**Experimental, investigational, or unproven** — See the "Experimental, Investigational, or Unproven Services" exclusion in *Section 6: General Limitations and Exclusions*.

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

**Generic drug** — The chemical equivalent of a brand-name drug. According to the U.S. Food and Drug Administration (FDA) regulations, brand-name drugs and generic drugs must meet the same standards for safety, purity, strength, and quality. A generic drug is usually available from multiple sources and is not protected by a patent.

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

**Good cause** — Failure of the subscriber to pay the premiums or other applicable charges for coverage; a material failure to abide by the rules, policies, or procedures of this benefit plan; or fraud or material misrepresentation affecting coverage.

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

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

**Group health care plan** — An employee 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 dependents (as defined under the terms of the benefit plan).

**Group Master Application** — The application for coverage completed by the employer (or association representative).

**Group Master Contract** — A contract for health care services which by its terms limits eligibility to members of a specified group. The Group Master Contract includes the Group Master Application and may include coverage for dependents.

**Habilitative treatment** — Treatment programs that are necessary to: 1) develop, 2) maintain, and 3) restore to the maximum extent practicable the functioning of an individual. All three conditions must be met in order to be considered habilitative.

**Home health care agency** — An appropriately licensed provider that both:

- brings skilled nursing care and other services on an intermittent, visiting basis into your home in accordance with the licensing regulations for home health care agencies in New Mexico or in the state where the services are provided; *and*
- is responsible for supervising the delivery of these services under a plan prescribed and approved in writing by the attending physician.

**Home health care services** — Covered services, as listed under "Home Health Care/Home I.V. Services" in *Section 5: Covered Services,* that are provided in the home according to a treatment plan by a certified home health care agency under active physician and nursing management. Registered nurses must coordinate the services on behalf of the home health care agency and the patient's physician.

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

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

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

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

- diagnosis and treatment of illness, injury, deformity, abnormality, or pregnancy
- clinical laboratory, diagnostic x-ray, and definitive medical treatment provided by an organized medical staff within the institution
- treatment facilities for emergency care and surgical services either within the institution or through a contractual arrangement with another licensed hospital (These contracted services must be documented by a well-defined plan and related to community needs.)

A hospital is not, other than incidentally, a skilled nursing facility, nursing home, custodial care home, health resort, spa, or sanatorium; is not a place for rest, the aging, or the treatment of mental illness, alcoholism, drug abuse, or pulmonary tuberculosis; ordinarily does not provide hospice or rehabilitation care; and is not a residential treatment center.

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

**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 his/her effective date of coverage.

**Inpatient services** — Care provided while you are confined as an inpatient in a hospital or treatment center for at least 24 hours. Inpatient care includes partial hospitalization (a nonresidential program that includes from 3 to 12 hours of continuous psychiatric care in a treatment facility). 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.

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

**Involuntary loss of coverage** — As applied to special enrollment provisions, loss of other coverage due to legal separation, divorce, death, moving out of an HMO area, termination of employment, reduction in hours, or termination of employer contributions (even if the affected member continues such coverage by paying the amount previously paid by the employer). A loss of coverage may also occur if your employer ceased offering coverage to the particular class of workers or similarly situated individuals to which you belonged, or terminated your benefit package option and no substitute benefit plan was offered. If you were covered under a state or federal continuation policy due to prior employment, involuntary loss of coverage includes exhaustion of the maximum continuation time period. Involuntary loss of coverage does not include a loss of coverage due your failure to pay premiums on a timely basis or termination of coverage for good cause.

**Late applicant** — Unless eligible for a special enrollment, applications from the following enrollees will be considered late:

- anyone not enrolled **within 31 days** of becoming eligible for coverage under this benefit plan (e.g., a newborn child added to coverage more than 31 days after birth when Family coverage (or Employee/Children), if available) is not already in effect, a child added more than 31 days after legal adoption, a new spouse or stepchild added more than 31 days after marriage)
- anyone enrolling on the group's initial BCBSNM enrollment date who was not covered under the group's prior plan (but who was eligible for such coverage)
- anyone eligible but not enrolled during the group's initial enrollment
- anyone who voluntarily terminates his/her coverage and applies for reinstatement of such coverage at a later date (except as provided under the USERRA of 1994)

**Licensed midwife** — A person who practices lay midwifery and is registered as a licensed midwife by the New Mexico Department of Health (or appropriate state regulatory body).

**Licensed practical nurse (L.P.N.)** — A nurse who has graduated from a formal practical nursing education program and is licensed by appropriate state authority.

**Maintenance medications** — Prescription drugs taken regularly to treat a chronic health condition, such as high blood pressure or diabetes.

**Maternity** — Any condition that is related to pregnancy. Maternity care includes prenatal and postnatal care and care for the complications of pregnancy, such as ectopic pregnancy, spontaneous abortion (miscarriage), elective abortion,

or C-section. See "Maternity/Reproductive Services and Newborn Care" in *Section 5: Covered Services* for more information.

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

**Medical detoxification** — Treatment in an acute care facility for withdrawal from the physiological effects of alcoholism or drug abuse. (Detoxification usually takes about three days in an acute care facility.)

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

**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** — See "Medically Necessary Services" in *Section 5: Covered Services.*

**Medicare** — The program of health care for the aged, end-stage renal disease (ESRD) patients, and disabled persons established by Title XVIII of the Social Security Act of 1965, as amended.

**Member** — An enrollee (the subscriber or any eligible dependent) who is enrolled for coverage and entitled to receive benefits under this benefit plan in accordance with the terms of the Group Master Contract. Throughout this benefit booklet, the terms "you" and "your" refer to each member.

**Mental disorder** — A clinically significant behavioral or psychological syndrome or condition that causes distress and disability and for which improvement can be expected with relatively short-term treatment. Mental disorder does not include developmental disabilities, autism spectrum disorders, drug or alcohol abuse, or learning disabilities.

**Nonparticipating provider** — An appropriately licensed health care provider that has not contracted directly or indirectly, for the service being provided, with BCBSNM.

**Nonpreferred provider** — Providers that have not contracted with BCBSNM, either directly or indirectly, to be part of the "preferred" or "PPO" provider network. (These providers may have participating provider agreements, but are **not** considered preferred providers. See the definition of "Participating provider," for more information.)

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

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

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

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

**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 benefit plan.

**Other providers** — Clinical psychologists and the following masters-degreed psychotherapists (an independently **licensed** professional provider with either an M.A. or M.S. degree in psychology or counseling): licensed independent social workers (L.I.S.W.); licensed professional clinical mental health counselors (L.P.C.C.); masters-level registered nurse certified in psychiatric counseling (R.N.C.S.); licensed marriage and family therapist (L.M.F.T.). For chemical dependency services, a provider also includes a licensed alcohol and drug abuse counselor (L.A.D.A.C.).

**Out-of-pocket limit** — The maximum amount of coinsurance that you pay for most covered services in a calendar year. After an out-of-pocket limit is reached, this benefit plan pays 100 percent of most of your covered charges for the rest of that calendar year, not to exceed any benefit limits.

**Outpatient services** — Medical/surgical services received in the outpatient department of a hospital, observation room, emergency room, ambulatory surgical facility, freestanding dialysis facility, or other covered outpatient treatment facility. Outpatient medical services include those hospital services that can reasonably be provided on an ambulatory basis and those preventive, medically necessary, diagnostic and treatment procedures prescribed by your attending physician. Such services may be provided at a hospital, a physician's office, any other appropriate licensed facility, or at any other appropriate facility if the professional delivering the services is licensed to practice, is certified and is practicing under authority of the health care insurer, a medical group, an independent practice association, or other authority authorized by applicable New Mexico law.

**Participating pharmacy** — See definition of "Provider."

**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. Your "preferred" provider may have two agreements with the local BCBS Plan — a preferred provider contract and another "participating" provider contract. Providers that have only the participating provider contract are **not** considered preferred providers. See definition of "Provider."

**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** — See definition of "Provider."

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

**Practitioner of the healing arts** — See definition of "Provider."

**Pre–existing conditions** — A physical or mental condition for which medical advice, medication, diagnosis, care or treatment was recommended for or received by an applicant **within a six-month period** before his/her initial enrollment eligibility date. Pregnancy and pregnancy-related diagnoses are **not** considered pre–existing conditions.

**Preferred provider** — See definition of "Provider."

**Pregnancy-related services** — See definition of "Maternity," earlier in the section.

**Prescription drugs, medicines and devices** — Those that are taken at the discretion 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 "Experimental, Investigational, or Unproven Service" in *Section 6: General Limitations and Exclusions*.)

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

**Preauthorization** — A requirement that you or your provider must obtain authorization from BCBSNM *before* you are admitted as an inpatient (admission review approval) and before you receive certain types of services (other preauthorizations).

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

**Provider** — A duly licensed hospital, physician, or other practitioner of the healing arts authorized to furnish health care services within the scope of licensure.

**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 home health care agency, a diagnostic laboratory or imaging center, and a rehabilitation or other therapeutic health setting.

**Physician:** A practitioner of the healing arts who is also 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.

**Practitioner of the healing arts:** Any physician, professional provider or other person holding a license or certificate provided for in Chapter 61, Article 4, 5, 6 or 14A NMSA 1978 authorizing the licensee to offer or undertake to diagnose, treat, or operate on or prescribe for any human pain, injury, disease, deformity, or physical or mental condition.

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:

**Preferred (PPO) Provider:** Practitioners of the healing arts and facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, another BCBS Plan, or the national BCBS transplant network as "preferred" or "PPO" providers. These providers belong to the Preferred Provider Network.

**Transplant provider:** These providers have contracted with BCBSNM through the Blue Cross and Blue Shield Association to provide transplant services covered under this health plan. They belong to the national BCBS transplant network.

**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 benefit 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 pharmacy drugs to members; these pharmacies are called "Specialty Pharmacy Providers" and some drugs must be dispensed by these specially contracted pharmacy providers in order to be covered.

A network provider agrees to provide health care services to members with an expectation of receiving payment (other than copayments or coinsurance) 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 benefit plan's payment (provided in accordance with the provisions of the contract) plus the member's share (coinsurance, 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.

**Psychiatric hospital** — A psychiatric facility licensed as an acute care facility or a psychiatric unit in a medical facility that is licensed as an acute care facility. Services are provided by or under the supervision of an organized staff of physicians. Continuous 24-hour nursing services are provided under the supervision of a registered nurse.

**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, telocobalt, and radioactive isotope treatment for malignant diseases and other medical conditions.

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

**Registered 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.

**Rehabilitation hospital** — An appropriately licensed facility that provides rehabilitation care services on an inpatient basis. Rehabilitation care services consist of the combined use of a multidisciplinary team of physical, occupational, speech, and respiratory therapists, medical social workers, and rehabilitation nurses to enable patients disabled by illness or accidental injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

**Residential treatment center** — See the "Noncovered Providers of Service" exclusion in *Section 6: General Limitations and Exclusions.*

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

**Routine newborn care** — Care of a child immediately following his/her birth that includes:

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

**Routine patient care cost** — For purposes of the cancer clinical trial benefit described under "Rehabilitation and Other Therapy" in *Section 5: Covered Services,* a "routine patient care cost" means a medical service or treatment that is covered under a health plan that would be covered if you were receiving standard cancer treatment, or an FDA-approved drug provided to you during a cancer clinical trial, but only to the extent that the drug is not paid for by the manufacturer, distributor, or supplier of the drug. (**Note:** For a covered cancer clinical trial, it is not necessary for the FDA to approve the drug for use in treating your particular condition.) A routine patient care cost does **not** include the cost of any investigational drug, device or procedure, the cost of a non-health care service that you must receive as a result of your participation in the cancer clinical trial, costs for managing the research, costs that would not be covered or that would not be rendered if non-investigational treatments were provided, or costs paid or not charged for by the trial providers.

**Service area** — The BCBSNM EPO benefit plan's service area is the geographic area where BCBSNM is licensed to conduct managed health care plan 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 alcoholism or drug abuse rehabilitation, which are also subject to separate limitations and exclusions.)

**Skilled nursing care** — Care that can be provided only by someone with at least the qualifications of a licensed practical nurse (L.P.N.) or registered nurse (R.N.).

**Skilled nursing facility** — A facility or part of a facility that:

- is licensed in accordance with state or local law; *and*
- is a Medicare-participating facility; *and*
- is primarily engaged in providing skilled nursing care to inpatients under the supervision of a duly licensed physician; *and*

- provides continuous 24-hour nursing service by or under the supervision of a registered nurse; *and*
- does **not** include any facility that is primarily a rest home, a facility for the care of the aged, or for treatment of drug abuse, mental disorder, tuberculosis, or for intermediate, custodial, or educational care.

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

**Special care unit** — A designated unit that has concentrated facilities, equipment, and supportive services to provide an intensive level of care for critically ill patients. Examples of special care units are intensive care unit (ICU), cardiac care unit (CCU), subintensive care unit, and isolation room.

**Special enrollment** — When an otherwise eligible employee or dependent did not enroll in the benefit plan when initially eligible, there are certain instances (or "qualifying events") during which the employee and his/her eligible dependents, if any, may enroll in the benefit 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 and/or without increasing the pre–existing conditions waiting period, if any, under your benefit plan.

**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.

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

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

**Subscriber** — The individual whose employment or other status, except for family dependency, is the basis for enrollment eligibility, or in the case of a direct-pay contract, the person in whose name the contract is issued. The term "subscriber" may also encompass other persons in a nonemployee relationship with the employer, group, or business if specified in the Group Master Contract (e.g., COBRA members).

**Summary of Benefits** — The separately issued schedule that defines your coinsurance requirements, out–of–pocket limit, and annual or lifetime benefits, and provides an overview of covered services.

**Surgical services** — Any of a variety of technical procedures for treatment or diagnosis of anatomical disease or accidental injury including, but not limited to: cutting; microsurgery (use of scopes); laser procedures; grafting, suturing, castings; treatment of fractures and dislocations; electrical, chemical, or medical destruction of tissue; endoscopic examinations; anesthetic epidural procedures; other invasive procedures. Benefits for surgical services also include usual and related local anesthesia, necessary assistant surgeon expenses, and pre- and post-operative care, including recasting.

**Temporomandibular joint (TMJ) syndrome** — A condition that may include painful temporomandibular joints, tenderness in the muscles that move the jaw, clicking of joints, and limitation of jaw movement.

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

**Tertiary care facility** — A hospital unit that provides complete perinatal care (occurring in the period shortly before and after birth) and intensive care of intrapartum (occurring during childbirth or delivery) and perinatal high-risk

patients. This hospital unit also has responsibilities for coordination of transport, communication and data analysis systems for the geographic area served.

**Totally disabled** — A member (subscriber or dependent) 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.

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

**Transplant-related services** — Any hospitalizations and medical or surgical services related to a covered transplant or retransplant and any subsequent hospitalizations and medical or surgical services related to a covered transplant or retransplant, and received within one year of the transplant or retransplant while the member is covered.

**Unit** — A "unit," for purposes of defining benefit limits for short–term rehabilitation and psychotherapy for mental disorders, is equivalent to one inpatient hospital day, one outpatient therapy visit, or one office– or home–based therapy visit (when not part of an approved home health or hospice admission, which are subject to separate benefit limitations and exclusions). When applied to the psychotherapy benefit for mental disorders, a "unit" also includes one one partial hospitalization day or one intensive outpatient therapy visit.

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

**Waiting period** — The length of time during which benefits will not be available for pre–existing conditions.

# APPENDIX A: CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

This notice generally explains:

- COBRA continuation coverage;
- when it may become available to you and your family if your group is subject to the provisions of COBRA; and
- what you need to do to protect your right to receive it.

This notice gives only a summary of COBRA continuation coverage rights. For more information about the rights and obligations under the benefit plan and under federal law, contact the benefit plan administrator or see *Section 2: Enrollment and Termination Information* of this benefit booklet.

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

## COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of health care plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the health care plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the benefit 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 benefit plan.

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

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

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

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

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

- the parent-employee dies;
- the parent-employee's hours of employment are reduced;
- the parent-employee's employment ends for any reason other than his or her gross misconduct;

- The parent-employee becomes enrolled in Medicare (Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the benefit plan as a "dependent child".

If the benefit 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 benefit plan, the retiree is a qualified beneficiary with respect to the bankruptcy. The retiree's spouse, surviving spouse and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the benefit plan.

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

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

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

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child losing eligibility for coverage as a dependent child), you must notify the benefit plan administrator. The benefit plan requires you to notify the benefit 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 benefit 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 benefit plan coverage would otherwise have been lost.

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

- The death of the employee;
- The enrollment of the employee in Medicare (Part A, Part B or both);
- Your divorce or legal separation; or
- A dependent child losing eligibility as a dependent child.

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

### Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the benefit 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 benefit 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 benefit plan administrator is notified of the Social Security Administration's determination **within 60 days** of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

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

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, **up to a maximum of 36 months**. This extension is available to the spouse and dependent 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 a dependent child when that child stops being eligible under the benefit plan as a dependent child.

In all of these cases, you must make sure that the benefit 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 benefit plan administrator or the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

In order to protect your family's rights, you should keep the benefit 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 benefit plan administrator.

## BENEFIT 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 City Of Albuquerque and Blue Cross and Blue Shield of New Mexico (BCBSNM) includes the following documents:

- this benefit booklet and any amendments, riders, or endorsements;
- the enrollment/change form(s) for the subscriber and his/her dependents;
- the members' identification cards; and
- the *Summary of Benefits*

In addition, City Of Albuquerque has important documents that are part of the legal agreement:

- the Group Master Application; and
- the Group Master Contract between BCBSNM and City Of Albuquerque.

The above documents constitute the entire legal agreement between BCBSNM and City Of Albuquerque. 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 30 days before the changes become effective.

# BlueCross BlueShield of New Mexico

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