Administered by:

BlueCross BlueShield of New Mexico

UNM Hospitals

Account #: 111003

HMO Blue Group

A Guide To Your Group HMO Blue Care Health Care Plan – Standard Network Option

111003 (August 1, 2017)

CUSTOMER ASSISTANCE

Customer Service: Medical/Surgical Claims and Prescription Drugs—The 24/7 Nurseline can help when you have a **health** problem or concern. The 24/7 Nurseline is staffed by registered nurses who are available 24 hours a day, 7 days a week.

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

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

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

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

Send all **drug plan claims t**o the pharmacy benefit manager at:

Prime Therapeutics
P.O. Box 14624
Lexington, KY 40512-4624

Preauthorizations: Medical/Surgical Services and Prescription Drugs—For 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

Mental Health and Chemical Dependency—For inquiries or preauthorizations related to mental health or chemical dependency services, call the Behavioral Health Unit (BHU):

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

Send claims* to:

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

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

www.bcbsnm.com

When you locate the web site address above, click on the triangle (or drop-down menu) under the question, *Are you a member of one of our largest groups?* (located in the middle of the page). Choose UNM Hospitals from the drop-down list and you will be connected to the UNMH homepage of the BCBSNM web site. For questions about using the web site, or if you have problems access information, call a Customer Service Advocate.

***Exceptions to Claim Submission Procedures**—Claims for health care services received from providers that do not contract **directly** with BCBSNM, should be sent to the Blue Cross and Blue Shield Plan in the state where services were received. **Note: Do not submit drug plan claims to BCBSNM.** See *Section 8: 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

To All Eligible Employees
UNM Hospitals

Welcome to the PPO health care benefit plan for eligible employees of **UNM Hospitals (UNMH)** and their eligible family members. Blue Cross and Blue Shield of New Mexico (BCBSNM), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, and an Independent Licensee of the Blue Cross and Blue Shield Association is pleased to serve as the Claims Administrator for the **UNMH** self-funded health care benefit plan.

This benefit booklet contains a summary description of the health care benefits (referred to as the Plan) that UNMH provides to all eligible employees and their eligible family members who meet the criteria described in *Section 2*. You may visit any licensed health care provider of your choice under the UNMH managed health care plan and receive the benefits for covered services.

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

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

UNMH reserves the right to increase, decrease, or discontinue any or all provisions under this UNMH managed health care plan. Any modifications to the Plan will apply to all covered persons, who are covered under this Plan at the time of such change.

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

Sincerely,

UNM Hospitals

Revision History: offcycle change effective 8/2017 with all applicable updates

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-423-1630 or visit www.bcbsnm.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-423-1630 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Standard Network: $600 Individual / $1,200 Family Out-of-Network: $1,800 Individual / $3,600 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care, Standard Network office visits and prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Standard Network: $5,000 Individual / $10,000 Family Out-of-Network: $10,000 per Individual Prescription drug expense limit: $1,500 Individual / $3,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balanced-billed charges, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsnm.com or call 1-800-423-1630 for a list of Preferred providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Standard Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit; deductible does not apply	40% coinsurance	None
	Specialist visit	$45 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care/screening/immunization	No Charge; deductible does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	$1,000 annual out-of-pocket limit. Preauthorization is required.
	Imaging (CT/PET scans, MRIs)	$200 copay CT/PET $250 copay MRI	40% coinsurance	CT/PT scans and MRIs require preauthorization.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsnm.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Standard Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **Prescription drug coverage** is available at www.bcbsnm.com.	Preferred generic drugs	$8 copay Retail $16 copay Mail; deductible does not apply	Not Covered	Prescription drug out-of-pocket limit: $1,500 Individual / $3,000 Family Retail prescriptions are limited up to a 30-day supply or 120 units, whichever is less. Mail-order prescriptions are limited to a 90-day supply or 360 units, whichever is less. Specialty drugs are not available through mail-order. May require preauthorization.
	Non-preferred generic drugs	$20 copay Retail $40 copay Mail; deductible does not apply	Not Covered	
	Preferred brand drugs	$45 copay Retail $90 copay Mail; deductible does not apply	Not Covered	
	Non-preferred brand drugs	$75 copay Retail $150 copay Mail; deductible does not apply	Not Covered	
	Preferred specialty drugs	$150 copay Retail; deductible does not apply	Not Covered	
	Non-preferred specialty drugs	$300 copay Retail; deductible does not apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$350 copay	40% coinsurance	None
	Physician/surgeon fees	$35/$45 copay/visit; deductible does not apply	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$300 copay/ER visit	$300 copay/ER visit	ER copay waived if admitted.
	Emergency medical transportation	$75 copay Ground $125 copay Air	$75 copay Ground $125 copay Air	None
	Urgent care	$75 copay UNM $100 copay Non UNM	40% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsnm.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Standard Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/admit	40% coinsurance	Includes inpatient rehabilitation; all inpatient services require preauthorization.
	Physician/surgeon fees	No Charge	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/visit; deductible does not apply	40% coinsurance	Includes office, home, outpatient, and IOP services; inpatient and partial hospitalization.
	Inpatient services	$500 copay/admit	40% coinsurance	IOP, inpatient, and partial hospitalization require preauthorization.
If you are pregnant	Office visits	$35/$45 copay/visit; deductible does not apply	40% coinsurance	Copay charged for initial visit only. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	$35/$45 copay/visit; deductible does not apply	40% coinsurance	
	Childbirth/delivery facility services	$500 copay/admit	40% coinsurance	Requires preauthorization.
If you need help recovering or have other special health needs	Home health care	$35 copay/visit	40% coinsurance	Limited to 100 visits per year. Requires preauthorization.
	Rehabilitation services	$45 copay/visit	40% coinsurance	Includes physical, occupational, and speech therapies (office/outpatient). Limited to 35 visits per year.
	Habilitation services	$45 copay/visit	40% coinsurance	
	Skilled nursing care	No Charge	40% coinsurance	Limited to 60 days per lifetime. Requires preauthorization.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	No Charge	40% coinsurance	Requires preauthorization. Respite care: allow up to 7 days.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsnm.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Standard Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	If vision coverage purchased, see your vision plan information.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	If dental coverage purchased, see your dental plan information.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery (unless medically necessary; preauthorization required)
- Cosmetic surgery
- Dental care (Adult, routine dental)
- Hearing aids
- Long term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (unless you are diabetic)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (max 20 visits/year)
- Chiropractic care
- Infertility treatment (including drugs and injections; lifetime max. of 12 attempts per employee/spouse)
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-423-1630, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsnm.com.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of New Mexico (BCBSNM) Appeals Unit at 1-800-205-9926 or visit www.bcbsnm.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the New Mexico Superintendent of Insurance toll-free at 1-855-427-5674 or www.osi.state.nm.us.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-423-1630.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-423-1630.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-423-1630.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-423-1630.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$600
Specialist *copayments*	$45
Hospital (facility) *copayments*	$500
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$600
Copayments	$800
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,960**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$600
Specialist *copayments coinsurance*	$45
Hospital (facility) *copayments*	$500
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost sharing	
Deductibles	$600
Copayments	$1,400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,360**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$600
Specialist *copayments coinsurance*	$45
Hospital (facility) *copayments*	$500
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,000**

In this example, Mia would pay:

Cost sharing	
Deductibles	$300
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

The plan would be responsible for the other costs of these EXAMPLE covered services.

BlueCross BlueShield of New Mexico

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.
To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員, 或沒有會員卡, 請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il servizio clienti al numero riportato sul lato posteriore della tua tessera di socio. Se non sei socio o non possiedi una tessera, puoi chiamare il numero 855-710-6984.
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、メンバーカードの裏のカスタマーサービス番号までお電話ください。メンバーでない場合またはカードをお持ちでない場合は 855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídílkidgo, ts'ídá bee ná ahóóti'i' t'áá níik'e níká a'doolwoł. Ata' halne'í bich'į' hadeesdzih nínízingo éí kwe'é da'íníishgi áká anídaalwo'ígíí bich'į' hodíílnih, bee nééhózinii bine'dęę' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo koji' hodíílnih 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با خدمات مشتری به شماره ای که در پشت کارت عضویت شما درج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 855-710-6984 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
ไทย Thai	หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่ามโดยติดต่อฝ่ายบริการลูกค้าที่หมายเลขตามที่ระบุด้านหลังบัตรสมาชิก หากไม่ใช่สมาชิกหรือไม่มีบัตร กรุณาติดต่อที่หมายเลข 855-710-6984
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35th Floor	Fax:	855-661-6960
Chicago, Illinois 60601	Email:	CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Washington, DC 20201	Complaint Forms:	http://www.hhs.gov/ocr/office/file/index.html

TABLE OF CONTENTS

SECTION 1: HOW TO USE THIS BENEFIT BOOKLET

This benefit booklet describes the medical/surgical, prescription drug, and mental health/chemical dependency coverage available to members of this health care plan and the Plan's benefit limitations and exclusions, in addition to providing information about how to enroll and add eligible family members to coverage, what happens when Plan coverage terminates, how to file a claim or an appeal, and what to do if you have other health care coverage. Please read this booklet carefully.

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

DEFINITIONS

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

SUMMARY OF BENEFITS AND COVERAGE (SBC)

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

IDENTIFICATION (ID) CARD

You will receive a BCBSNM identification (ID) card. The ID card contains your "group" number and your identification number (including an alpha prefix) and tells providers that you are entitled to benefits under this health care plan with BCBSNM. The ID card provides the information needed when you require health care services, including mental health/chemical dependency services and prescription drugs, or when contacting a Customer Service Advocate.

Carry it with you. Have your ID card handy when you call for an appointment and show it to the receptionist when you sign in for an appointment. (If you are covered by Medicare, have both your Medicare ID card and your UNMH Plan ID card handy when you call.) The card will show the most common copayments under the Plan (such as for office visits, emergency room services, and your drug plan copayments.) Do not let anyone who is not named in your coverage use your card to receive benefits. If you need an additional card or need to replace a lost card, contact a BCBSNM Customer Service Advocate.

PROVIDER NETWORK DIRECTORY

In order to receive maximum benefits under the UNMH health plan, you need to use providers who are considered preferred providers, or In-Network. You may choose to receive services outside the designated network and receive reduced benefits for most covered services (some benefits are not available unless the service is received from an In-Network provider).

The provider network directory is available through the BCBSNM website at www.bcbsnm.com. It lists all providers in the preferred provider network and participating pharmacies.

Since it is your responsibility to determine if a provider is a UNMH preferred provider network or not, BCBSNM has made every effort to assist you with finding a preferred provider. The entire provider network is available through the Internet or you can request a paper copy of the preferred provider directory from a Customer Service Advocate; it will be mailed to you free of charge. There are also toll-free phone numbers to call if you are out of the country and need covered services. The provider network directory lists all providers in the Standard Network and participating pharmacies. **Note:** Although provider directories are current as of the date shown at the bottom of each page, they can change without notice. To verify a provider's status or if you have any questions about the directory, contact a Customer Service Advocate or visit the BCBSNM website.

Always use a preferred provider to make sure you receive the highest level of benefits. If you are receiving services from a nonpreferred provider or from a preferred provider that contracts with a BCBS Plan outside New Mexico, you must ensure that your receive preauthorization for certain services (see Section 4 for a list of services needing preauthorization). The phone number to call is also on your BCBSNM Plan ID card.

DRUG PLAN BENEFITS

BCBSNM has contracted with a separate pharmacy benefit manager to administer your outpatient drug plan benefits, Prime Therapeutics. In addition to your benefit booklet, you will be sent important information about your drug plan benefits. For information specific to your drug plan coverage, see "Prescription Drugs and Other Items" in *Section 5: Covered Services*.

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.

IN-NETWORK BENEFIT ONLY

Some services are eligible for benefits **only** when received from preferred providers. Refer to your *Summary of Benefits* for specific details.

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 Standard Time. See *Section 4: Preauthorizations* for details. **Note:** Call Customer Service if you need preauthorization assistance after 5 P.M.

Emergency/Maternity Admission Notification

To receive full benefits for emergency hospital admissions, you (or your provider) should notify BCBSNM **within 48 hours** of admission, or as soon as reasonably possible following admission. Call BCBSNM's Health Services department, Monday through Friday, 8 A.M. to 5 P.M., Mountain Standard Time. Also, if you have a routine delivery and stay in the hospital **more than 48 hours**, or if you have a C-section delivery and stay in the hospital **more than 96 hours**, you must call BCBSNM for preauthorization 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.

PREAUTHORIZATION OF BEHAVIORAL HEALTH CARE

All inpatient and specified outpatient mental health and chemical dependency services must be preauthorized by the Behavioral Health Unit (BHU) at the phone number below (also listed on the back of your ID card). For services requiring preauthorization, you or your physician should call the BHU before you schedule treatment. The BHU will coordinate covered services with an In-Network provider near you. **If you do not call and receive preauthorization before receiving nonemergency services, benefits for services may be denied**. Call 7 days a week, 24 hours a day:

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

PREAUTHORIZATION AND COMPLAINT/APPEAL PROCEDURES

In addition to the summary of complaint and appeal procedures presented in this booklet, you should have a special notice that provides all of the details of the BCBSNM complaint and appeals procedures, including independent external review and other actions that may be available under your health plan. If you do not have the special notice, please call a Customer Service Advocate.

HEALTH AND WELLNESS MAINTENANCE AND IMPROVEMENT PROGRAMS

BCBSNM and your employer have the right to offer programs for the purposes of medical management programs, quality improvement programs, and health behavior wellness, maintenance or improvement over and above the standard benefits provided by this plan. These programs may allow for a reward, a contribution, a disincentive, a differential in premiums or a differential in medical, prescription drug or equipment, copayment, coinsurance, deductibles or costs, or a combination of incentives and/or disincentives for participating in any program offered or administered by BCBSNM or any retailer, provider, or manufacturer chosen by BCBSNM to administer such program. Discounted programs for various health behavior wellness or insurance-related items and services may also be available from time to time. For details of current discounts or other programs available, please contact a customer services representative by calling the phone number on the back of your ID card. Such programs may be discontinued with or without notice. Contact your employer for additional information regarding any value based programs offered by your employer.

For individuals in wellness programs who are unable to participate in these incentives or disincentives due to an adverse health factor shall not be penalized based upon an adverse status and unless otherwise permitted by law. Blue Cross Blue Shield will allow a reasonable alternative to any individual for whom it is unreasonably difficult, due to a medical condition, to satisfy otherwise applicable wellness program standards.

Contact Blue Cross Blue Shield for additional information regarding any value based programs offered by Blue Cross Blue Shield.

IDENTITY THEFT PROTECTION SERVICES

As a member, BCBSNM makes available at no additional cost to you, identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by BCBSNM's designated outside vendor and acceptance or declination of these services is optional to members. Members who wish to accept such identity theft protection services will need to individually enroll in the program online at www.bcbsnm.com or telephonically by calling the toll free telephone number on your identification card. Services may automatically end when the person is no longer an eligible member. Services may change or be discontinued at any time with or without notice and BCBSNM does not have guarantee that a particular vendor or service will be any given time. The services are provided as a convenience and are not considered covered benefits under this benefit program.

Contact Blue Cross Blue Shield for additional information regarding any value based programs offered by Blue Cross Blue Shield.

CUSTOMER SERVICE

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

Customer Service representatives can help with the following:

- answer questions about your benefits
- assist with preauthorization requests
- check on a claim's status
- order a replacement ID card, provider directory, benefit booklet, or forms

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

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

Website: www.bcbsnm.com

Behavioral Health Customer Service

When you have questions about your behavioral health benefits, call the BCBSNM Behavioral Health Unit (BHU) for assistance.

Toll-free: 1-888-898-0070

Deaf and Speech Disabled Assistance

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

Translation Assistance

If you need help communicating with BCBSNM, BCBSNM offers Spanish bilingual interpreters for members who call Customer Service. If you need multi-lingual services, call the Customer Service phone number on the back of your ID card.

After Hours Help

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

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

24/7 Nurseline

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

Toll-free: 1-800-973-6329

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

Special Beginnings®

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

Toll-free: 1-888-421-7781

BLUE ACCESS FOR MEMBERS SM

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

If you need help accessing the BAM site, call:

BAM Help Desk (toll-free): 1-888-706-0583
Help Desk Hours: Monday through Friday 6 A.M. – 9 P.M., Mountain Standard Time
Saturday 6 A.M. – 2:30 P.M. Mountain Standard Time.

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

HEALTH CARE FRAUD INFORMATION

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

- Be wary of offers to waive copayments, deductibles, or coinsurance. These costs are passed on to you eventually.
- Be wary of mobile health testing labs. Ask what your health care insurance will be charged for the tests.
- Review the bills from your providers and the *Explanation of Benefits* (EOB) you receive from BCBSNM. Verify that services for all charges were received. If there are any discrepancies, call a BCBSNM Customer Service Advocate.
- Be very cautious about giving information about your health care insurance over the phone.

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

SECTION 2: ENROLLMENT AND TERMINATION INFORMATION

WHO IS ELIGIBLE

All active employees and their eligible family members members meeting the eligibility criteria specified by UNM Hospitals are eligible for coverage under either network. To find out eligibility criteria specified by UNMH, contact the UNMH Benefits Department.

NON-BENEFIT EMPLOYEES - ENROLLMENT FOLLOWING BENEFIT MEASUREMENT PERIOD

Employees who were determined to be part-time or full-time during the monthly look-back measurement period as applicable to the work position and their eligible Dependents may enroll in the Plan the first day of the first full calendar month of the applicable stability period that follows the benefit measurement period. To the extent previously satisfied, the employment Waiting Period will be considered satisfied.

Unless otherwise specified in the Administrative Services Agreement, all active employees who have completed the employee probationary period and who are regularly working the minimum number of hours specified in the Administrative Services Agreement and their eligible family members are eligible for coverage. (No such probationary period may exceed 90 days unless permitted by applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations. If BCBSNM records show that your group has a probationary period that exceeds the time period permitted by applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations, then BCBSNM reserves the right to begin your coverage on a date that BCBSNM believes is within the required period. Regardless of whether BCBSNM exercises that right, your group is responsible for your probationary period. If you have questions about your probationary period or the number of hours you must work per week or to learn of any other eligibility criteria specified by your group, contact your benefits administrator.)

BCBSNM may request proof that a valid employer-employee relationship exists, if applicable, and/or that the applicant meets the eligibility requirements stated in the Administrative Services Agreement and the member's application.

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

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

ELIGIBLE FAMILY MEMBERS

Covered family member, covered spouse, covered child - An eligible spouse or eligible child (as defined below) who has applied for and been granted coverage under the subscriber's policy based on his/her family relationship to the subscriber.

Eligible family members - Family members of the subscriber, limited to the following persons:

- the subscriber's legal **spouse, or domestic partner**
- the subscriber's eligible **child** through the end of the month in which the child reaches **age 26** (Once a covered child reaches age 26, the child is automatically removed from coverage and rates adjusted accordingly - unless the child is an eligible family member under this Plan due to a disability as described below.)

- the subscriber's **unmarried** child age 26 or older who was enrolled as the subscriber's covered child in this health plan at the time of reaching the age limit, and who is medically certified as **disabled,** chiefly dependent upon the subscriber for support and maintenance, and incapable of self-sustaining employment by reason of his/her disability. Such condition must be certified by a physician and BCBSNM. Also, a child may continue to be eligible for coverage age 26 or older only if the condition began before or during the month in which the child would lose coverage due to his/her age. BCBSNM must receive written notice of the disabling condition within 31 days of the child's attainment of the limiting age and subsequently, as may be required by BCBSNM, but not more frequently than annually after the two-year period following the Child's attainment of the limiting age of 26.

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

- natural or legally adopted child of the subscriber
- child placed in the subscriber's home for purposes of adoption (including a child for whom the subscriber is a party in a suit in which the adoption of the child by the subscriber is being sought)
- stepchild of the subscriber (or otherwise eligible child of a domestic partner, if domestic partners are covered under your benefit plan)
- child for whom the subscriber must provide coverage because of a court order or administrative order pursuant to state law

A child meeting the criteria above is an "eligible child" whether or not the subscriber is the custodial or noncustodial parent, and whether or not the eligible child is claimed on income tax, employed, married, attending school or residing in the subscriber's home, **except** that once the subscriber is no longer a legal guardian of a child or there is no longer a court order to provide coverage to a child, the child must be eligible as a natural child, legally adopted child, or stepchild of the subscriber in order to retain eligibility as a family member under this health plan.

If your family member is residing outside the service area, he/she may be eligible to enroll in a Guest Membership. Enrolling in an affiliated HMO Plan would make your family member eligible for In-Network benefits other than emergency and urgent care. See "Guest Membership", later in this section for details.

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

Information for Noncustodial Parents

When a child is covered by the Plan through the child's noncustodial parent, then **UNMH** will:

- provide such information to the custodial parent as may be necessary for the child to obtain benefits through the Plan;
- permit the custodial parent or the provider (with the custodial parent's approval) to submit claims for covered services with the approval of the noncustodial parent; 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.

Family Members Who Are Not Eligible

A subscriber's spouse or child is not an eligible family member while:

- on active duty in the armed forces of any country (unless eligible for continued coverage for a limited period of time under federal law); or
- covered under this Plan as a subscriber or family member of another subscriber of this or any other UNMH sponsored health plan.

MEDICARE-ELIGIBLE MEMBERS

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

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

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

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

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

If Medicare is Primary

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

APPLYING FOR COVERAGE

An eligible person can apply for coverage, including for his/her eligible family members, by submitting an enrollment/change form to **UNMH within 31 days** after becoming eligible according to the terms of the Administrative Services Agreement**. Note: UNMH** cannot use genetic information or require genetic testing in order to determine or to limit or deny coverage.

Employee Contributions – UNM Hospitals is solely responsible for determining payroll deductions and for collecting employee contributions for coverage. Please contact the UNMH Benefits Department for information about contributions required.

Waiving Coverage – If you (the employee) decline to enroll in this group health plan when initially eligible to do so, you must sign a "Wavier of Coverage" form and submit it to the UNMH Benefits Department within 31 days of becoming eligible for coverage under this Plan. It is very important that you indicate the reason for declining coverage. If you decline coverage due to having other health care coverage and later involuntarily lose the other coverage, you may be eligible to enroll in Plan coverage as a special enrollee. If you later lose the other coverage and wish to enroll in this 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 wishes to enroll in this Plan as a result, you will need to submit proof that the family member had the required creditable coverage.

WHEN COVERAGE BEGINS

UNMH will determine your effective date of coverage according to the provisions of the Administrative Services Agreement. Contact the UNMH Benefits Department to determine your effective date of coverage.

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

CHANGES TO COVERAGE

After initial enrollment, you may need to add eligible family members to, or remove them from your coverage, update your address, or switch from Individual to Family coverage, or vice versa.

Your ability to change coverage types (e.g., from Family to Individual coverage, etc.) will depend on the rules and regulations set forth by UNMH. Please contact UNMH Benefits Department to find out when you can change your coverage type or remove a person from your coverage.

ADDING A FAMILY MEMBER TO COVERAGE

A subscriber may apply for coverage of an eligible family member (such as a new spouse or a newborn child) **within 31 days** of acquiring the newly eligible family member the subscriber must:

- contact UNMH Benefits Department;
- complete and submit all necessary enrollment/change forms and provide legal documentation of proof of dependency to the UNMH Benefits Department, and
- pay any additional premium or other employee contribution for coverage, which may mean changing, for example, from Individual to Family coverage.

If the subscriber does not submit a completed and signed enrollment/change form to the UNMH Benefits Department (or the COBRA administrator), along with necessary documentation within 31 days of acquiring a new family member, the family member may not be added to coverage until the next annual open enrollment (except as specified under the "Special Enrollment for Active Employees and Their Family members," later in this section).

Adding a Spouse or a Domestic Partner

If a subscriber adds coverage for a spouse **within 31 days** of marriage, the effective date of the new eligible family member's coverage will be no later than the first of the month following the date your group received the completed and signed enrollment/change application form. If the subscriber does not submit a completed and signed enrollment/change application form to UNMH Benefits Department (or to the COBRA administrator), along with necessary documentation and, if required, change from Individual (or Employee + Child(ren) coverage, if applicable) to Family coverage **within 31 days** of marriage, the spouse may not be added to coverage except as a late applicant (or as specified under "Special Enrollment" later in this section). You may also have the option of applying for a Two-Person (Employee + Spouse) coverage type. Ask the UNMH Benefits Department which coverage types are available to you. For example, if you are applying for coverage for a new spouse and his/her eligible child(ren), you will have to change to Family coverage. See "Adding an Eligible Child," below.

If the enrollment/change form is received before the first of the month following the date of marriage, the spouse's effective date will be the first of the month following the marriage date. If the form is received within 31 days, but after the first of the month following marriage, the spouse will not be covered until the first of the month following the receipt date. If order to obtain coverage for your spouse on the earliest possible date, you must submit the enrollment/change form to the UNMH Benefits Department before the date you are getting married. Documentation may be submitted after the marriage date.

Adding a domestic partner - To add a new domestic partner, you must first provide the UNMH Benefits Department with the required form and documentation that established the domestic partnership according to the criteria, policies, and procedures of UNM Hospitals. (Contact the UNMH Benefits Department for details on establishing a domestic partnership through UNM Hospitals.) Once the partnership has been established by UNMH Benefits Department, you must submit a completed and signed enrollment/change form to the UNMH Benefits Department, along with a copy of any other required documentation, **within 31 days** of establishing the partnership. Domestic partners do not become effective until all documentation is approved by UNMH Benefits Department staff and you have been advised of the approval. If you do **not** submit the completed and signed enrollment/change form requesting that the domestic partner be added to your coverage within 31 days, the domestic partner will be considered a late applicant. You may not add coverage for late applicant until the next annual open enrollment period.

Adding an Eligible Child

If you do not submit an application for an eligible child or add additional coverage, if required, within the time frames below, the child will be considered a **late applicant**, except as specified under "Special Enrollment."

Newborn Children

You must add coverage by submitting a signed and completed enrollment/change form to the UNMH Benefits Department within 31 days of birth in order for any newborn charges, routine or otherwise, to be covered beyond the first 48 hours of birth (or 96 hours in the case of C–secton).

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

Adopted Children

A child placed in the subscriber's home for the purposes of adoption may be added to coverage as soon as the child is placed in the home. However, application for coverage can be made as late as **31 days** following legal adoption without being considered late. (Although a child over the age of 18 is not eligible for adoption, an adopted child is covered as any other child, subject to the same eligible child age limitations and restrictions.) **Note:** An adopted child 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., 63 or more days).

Legal Guardianship

Application for coverage must be made for a child for whom the subscriber or the subscriber's spouse becomes the legal guardian **within 31 days** of the court or administrative order granting guardianship. If not specified in the court order, the child's effective date of coverage will be the date the order has been filed as public record with the State, or the effective date of Family coverage, whichever is later.

Stepchild

Application for coverage must be made for a stepchild **within 31 days** of the marriage to the stepchild's biological parent.

Court Ordered Coverage for Children

When an employee or employer is required by a court or administrative order to provide coverage for an eligible child, the eligible child may be enrolled in the subscriber's Family coverage, or Employee/Children coverage, if available and will **not** be considered a late applicant. (If the subscriber has Individual or Two-Person coverage, he/she may be required to pay additional premium in order for the eligible child to be added.) If not specified in the court or administrative order, the eligible child's effective date of coverage will be the date the order has been filed as public record with the State or the effective date of Family coverage, or Employee/Children coverage, if available, whichever is later. UNMH Benefits Department must receive a copy of the court or administrative order.

LATE APPLICANT

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

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

If you acquire a new family member, you must complete an enrollment/change form and deliver it to UNMH Benefits department within 31 days of the new family member's birth, adoption, or marriage or the new family member will be considered a late applicant (unless the family member is eligible for a special enrollment). Application for coverage form late applicants will be accepted only during UNMH's open enrollment period, except as described under the "Special Enrollment for Active Employees and Their Family Members" in this section.

Application for coverage from late applicants will be accepted only during your group's annual open enrollment period, except as described under the "Special Enrollment for Active Employees and Their Eligible Family Members" and "Switch Enrollment and Changes in Plan" provisions of this Section 2.

OPEN ENROLLMENT

Open enrollment is the period prior to the group's anniversary date during which the following actions may be taken:

- any eligible, active employees may enroll themselves and their eligible family member as members under this Plan,
- employees may drop eligible and ineligible family members.

There is no penalty, benefit reduction for enrolling during open enrollment. Ask the UNMH Benefits Department when your open enrollment period is held.

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

SPECIAL ENROLLMENT FOR ACTIVE EMPLOYEES AND THEIR COVERED FAMILY MEMBERS

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

Note: There are no special enrollments for persons applying for any continuation coverage if offered under your Plan. You must enroll in these coverages timely.

Qualifying Events

The four instances of special enrollment are:

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, may apply for coverage for himself/herself and eligible family members. (The eligible family members need not have been covered under the prior benefit plan when the UNMH employee has been granted a special enrollment under this provision.) Currently enrolled employees may also add eligible family members to coverage under this provision if the eligible family member had prior creditable coverage that was involuntarily lost. (See definition of "involuntary loss of coverage" in *Section 10: Definitions.")*

If a completed and signed enrollment/change form is received by the UMNH Benefits Department **within 31 days** of losing the other coverage, 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 UNMH Benefits Department 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 UNMH Benefits Department.

If the employee lost prior coverage, special enrollment is available to the current employee and any eligible family members of the employee (including spouse). If an eligible family member of the current employee lost prior coverage, special enrollment is available for the affected eligible family member and the employee (not other eligible family members). The choice to quit paying premiums, for example, because the subscriber or one family member under the other carrier's benefit plan reaches a lifetime benefit maximum in **not** an example of involuntary loss of coverage for the entire family. However, in the case of one eligible family member losing prior coverage, although all family members may not be eligible for a "special" enrollment, eligible family members may be enrolled at the same time as the special enrollee, subject to late applicant provisions. Also, in order to be eligible for a special enrollment due to loss of prior coverage, the declining person must have completed a waiver of coverage statement when first eligible to enroll, and the reason stated for declining coverage must have been due to having other coverage. If an employee requests a special enrollment for self only, eligible family member(s) only, or both, BCBSNM requires proof of loss of coverage or proof of the date of the event.

Change in Family Status

An employee who acquires a new eligible family member due to marriage, birth, adoption, or placement for adoption may apply for a special enrollment in this Plan for himself/herself **and other family members** who are eligible for coverage under this Plan. Application for special enrollment of the employee and his/her eligible family members will **not** be considered late if submitted **within 31 days** of the marriage, birth, adoption, or placement of the eligible child in the subscriber's home. If submitted more than 31 days following the change in family status, special enrollment is not available.

- **Newborn or Adopted Child:** For a change in family status due to birth of an eligible newborn or adoption of a child, coverage begins on the date of birth or adoption (or, if earlier, on the date of placement in the subscriber's home).
- **Marriage:** The effective date of coverage for all persons granted a special enrollment due to marriage will be the same as the new spouse's effective date of coverage as described under "Adding An Eligible Family Member to Coverage."

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

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

Loss of Medicaid/SCHIP Eligibility

If an eligible employee or his/her eligible family member is not currently enrolled in the Plan and loses eligibility under Medicaid or under a state child health plan (SCHIP), the person losing such coverage may enroll in the Plan without being considered a late applicant. To be eligible for special enrollment, the person must apply for coverage under the group health plan no later than **60 days** after the date of termination of Medicaid or SCHIP coverage. (In order for an eligible family member to be eligible for special enrollment, the employee must be covered under the employer group health plan. If the employee is not enrolled in the Plan when the eligible family member becomes eligible for assistance, the employee must enroll into the Plan at the same time as the eligible family member.) Documentation from the state – supporting the fact that the person had Medicaid/SCHIP coverage that was lost involuntarily – may be submitted at a later date with the UNMH Benefits Department'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 UNMH Benefits Department.

If the employee lost Medicaid/SCHIP coverage, special enrollment is available to the current employee and any eligible family members of the employee (including spouse). If an eligible family member of the current employee lost Medicaid/SCHIP coverage, special enrollment is available for the affected eligible family member and the employee (not other eligible family members).

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 UNMH Benefits Department-sponsored coverage. This includes premium assistance for continuation coverage under federal or state law. Therefore, if an eligible employee or an eligible family member is not enrolled in the Plan and later becomes eligible for group health plan premium assistance under Medicaid or under SCHIP, the eligible person may enroll in the Plan without being considered a late applicant. To be eligible for special enrollment, the affected person must apply for coverage through the UNMH Benefits Department no later than **60 days** after becoming eligible for premium assistance. (In order for a family member to be eligible for special enrollment, the employee must be covered under the UNMH Benefits Department's health plan. If the employee is not enrolled in the Plan when the eligible family member becomes eligible for assistance, the employee must enroll in to the Plan at the same time as the eligible family member.)

Documentation from the state – supporting the fact that the person is eligible for premium assistance from Medicaid or SCHIP – may be submitted at a later date with the UNMH Benefits Department'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 UNMH Benefits Department.

The current employee who is eligible but not enrolled for coverage under the terms of the group health plan (or a dependent 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.

Applying for Special Enrollment

Application for special enrollment must be made **within the time period specified for each of the qualifying events above** in order to qualify you and/or your eligible family member(s) for a special enrollment right (switch enrollment may be available to members who are offered more than one Plan option). Please contact your benefits administrator for details about special enrollment privileges that apply to you and your eligible family members.

Waiving Coverage

If an employee declines to enroll in this group health plan when initially eligible to do so, the employee must sign a waiver of coverage statement and submit it to the UNMH Benefits Department. **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 eligible family members may be eligible to enroll in the employer's group plan as "special enrollees." An employee waiver of coverage statement, indicating that coverage is being declined due to having coverage, must be submitted to the UNMH Benefits Department **within 31 days** of becoming eligible for coverage under the employer's health care Plan. If you later lose the other coverage and wish to enroll in the Plan as a result, you will also need to submit proof that you had the required creditable coverage.

If you do not enroll an eligible family member when he/she is initially eligible, you do not need to sign a waiver of coverage statement. However, if the affected family member later loses the other coverage and requests a special enrollment, you *will* need to submit proof that the family member had the required creditable coverage.

If the person declining coverage later requests a special enrollment, but no such proof of loss or prior coverage is provided, or if the reason for declining coverage is *not* due to having other coverage, he/she will be ineligible for special enrollment. If the person chooses to enroll anyway, the person will be considered a late applicant.

Coverage Effective Date

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

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

RE-ENROLLMENT

If a previously covered employee and/or eligible family member wishes to re-enroll in this Plan following a voluntary terminating of coverage he/she will usually be considered a late applicant and may not enroll until the next annual enrollment period. See "Special Enrollment for Active Employees and Their Family Members" in this section, for exceptions. If you are returning from a leave of absence under the Family and Medical Leave Act (FMLA) or under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERA), you have 31 days to re-apply for coverage or you will be considered a late applicant.

If coverage is voluntarily discontinued or is discontinued due to nonpayment of premium by a COBRA subscriber for self and/or for any covered family member, the terminated member may not re-enroll at any time.

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

NOTIFICATION OF ELIGIBILITY AND ADDRESS CHANGES

The subscriber must notify **UNMH Benefits Department within 31 days** following any changes that may affect his/her or a family member's eligibility, including a change to a covered family member's name or address, by indicating such changes on an enrollment/change form and submitting it to **UNMH.** (Members covered under federal continuation must submit enrollment/change forms directly to the COBRA administrator.)

Employees and Their Eligible Family Members

Employees covered under the group Plan are responsible for completing and submitting signed enrollment/change forms to UNMH Benefits Department.

COBRA Continuation Policy Members

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

COVERAGE TERMINATION

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

- The employee **terminates employment** or **otherwise loses eligibility** according to the terms of the Administrative Services Agreement. If the group or subscriber fails to notify BCBSNM **within 30 days** to remove an ineligible person from coverage, BCBSNM may recover any payment made on the ineligible person's behalf.
- The last day of the benefit measurement period during which the covered Employee did not average the required weekly minimum hours of service established by the Employer. (See the section entitled COBRA Continuation Coverage).
- The **employee retires**.
- 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 subscriber and to the group or, in the case of continuation coverage, to the subscriber.)

- When the member chooses to discontinue coverage during a **leave of absence** for more than 31 days or as provided by law. (You must contact the UNMH Benefits Department in order to ensure that coverage is terminated according to your wishes. During a leave of absence covered by the Family and Medical leave Act (FMLA), coverage will continue as provided by law. Contact the UNMH Benefits Department for information. If you allow your coverage to lapse due to nonpayment of premium, you have 31 days in which to notify UNMH Benefits Department that you intend to re-enroll. Coverage will be reinstated according to UNMH guidelines and rules and a new enrollment/change form may be required.)
- When the member chooses to discontinue coverage upon entering the **armed forces** for **more than 31 days** or as provided by law. (See "Leave of Absence or Military Service.") You must contact the UNMH Benefits Department in order to ensure that coverage is terminated according to your wishes. (During a leave of absence covered by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), coverage will continue as provided by law. Contact the UNMH Benefits Department for information. If you allow your coverage to lapse due to nonpayment of premium, you have 31 days in which to notify the UNMH Benefits Department that you intend to re-enroll. Coverage will be reinstated according to UNMH 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 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 eligible family members, **UNMH** may terminate the coverage of the subscriber and his/her eligible family members retroactively to the date of initial enrollment. The subscriber is liable for any benefit payments made as a result of such improper actions.
- When the subscriber **dies**. (Surviving eligible family members remain covered through the last-paid billing period.)
- If this Plan is primary over **Medicare** due to federal laws and regulations, when the Medicare-eligible member *chooses* Medicare as his/her primary coverage. (See "Medicare-Eligible Members" for information on coverage options for members who are entitled to Medicare.)
- When the member acts in a **disruptive** manner that prevents the orderly business operation of any network provider or dishonestly attempts to gain a financial or material advantage.
- When **group coverage is discontinued** for the entire group or for the employee's enrollment classification.
- When the subscriber moves to a primary residence or place of employment **outside the geographic area** serviced by BCBSNM. (See "Guest Membership," later in this section, if you are moving temporarily for 90-180 days or "How to Continue Coverage," later in this section if the move is permanent or longer than 180 days.)

Additional Family Member Termination Reasons

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

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

If a family member is being removed from coverage because of losing his/her eligibility under the Plan (for reasons other than reaching the eligible child age limit), the enrollment/change form must be received by UNMH Benefits Department **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. **If you do not advise the UNMH Benefits Department within 31 days to remove an ineligible person from your coverage, no premium adjustment will be made and no claims will be**

covered for the ineligible person. BCBSNM and the providers of care may recover benefits erroneously paid on behalf of the removed member.

If the employee does not submit a signed enrollment/change form to the UNMH Benefits Department within 31 days of a family member's loss of eligibility under the Plan, there will be no payroll deduction changes until the next open enrollment; however, benefits will not be available for the ineligible person.

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

Voluntary Termination of Coverage

To remove a family member from coverage before loss of eligibility or to voluntarily terminate his/her own coverage, the subscriber must submit a completed enrollment/change form to the UNMH Benefits department during open enrollment. Voluntary termination is not allowed under your Plan outside the annual open enrollment period. Voluntarily terminated members may re-enroll under the Plan only as late applicants (except as provided under "Special Enrollment"). Also, these members are **not** eligible for any extension of benefits or federal continuation coverage. Voluntarily terminated members are not eligible for any federal continuation coverage.

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

Termination of Continuation Coverage

See "How to Continue Coverage" for more information.

Leave of Absence for Military Service

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

HOW TO CONTINUE COVERAGE

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

Note: If you are enrolled under a Guest Membership with another Blue Cross and Blue Shield HMO Plan, you may not apply for continuation coverage with the out-of-state Plan, but must contact BCBSNM. To prevent any temporary loss of Guest Membership during the change to continuation coverage, you should call BCBSNM as soon as possible after learning of your loss of eligibility under the Plan.

Continuation Coverage

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

You are not eligible to enroll for continuation coverage if:

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

Refer to *Appendix A: Continuation Coverage Rights under COBRA* or contact your benefits administrator for details about enrolling in continuation coverage.

Continuation Benefits

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

Federal Continuation (COBRA)

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

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

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

- the first of the month when you become entitled to Medicare
- when the employer discontinues offering this Plan to employees (If this Plan is replaced by another health care plan, continuation coverage will also be replaced by the new Plan.)
- when you become covered under another group health care plan

Premium Payments

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

USERRA Continuation Coverage

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

GUEST MEMBERSHIP

Subscribers who are temporarily working or residing out of state for at least 90 days may be eligible for Guest membership for up to 180 days of membership in one of the many participating Blue Cross and Blue Shield HMOs. Also, eligible family members residing in another state for at least 90 days may also enroll for coverage in the out-of-state, host HMO Plan for as long as this group plan is administered by the BCBSNM HMO, or until the family member is no longer eligible (e.g., reaches the age limit or subscriber terminates coverage). Under either option, the local HMO provides all of the services and access available through their Plan. For more information, call the BCBSNM Customer Service Department.

Note: A member covered under another HMO's Guest Membership is subject to the eligibility criteria of this health Plan; however, such members will receive a benefit booklet and summary from the host HMO Plan. The benefits, benefit limits, and exclusions of this benefit booklet will not apply to guest members of another HMO Plan. Also, guest members of another Plan cannot enroll in state or federal continuation coverage options directly through the other Plan. In such cases, the member should contact BCBSNM as soon as possible after learning that his/her coverage will cease in order to minimize any possibility of temporarily losing a Guest Membership during the transfer of coverage.

ELIGIBILITY AND PREMIUM QUESTIONS

UNMH determines the eligibility of all members covered under the Plan. UNMH is also responsible for all administrative policies regarding payroll deductions and/or collection of contributions for coverage from members covered under the Plan. If you need assistance in enrolling, changing an address, terminating coverage, or changing coverage, or if you have any questions regarding eligibility in the Plan or your contributions for group coverage, contact:

UNM Hospitals
Attention: Benefits Department
933 Bradbury Drive SE, Suite 3002
Albuquerque, NM 87106
Telephone: 505-272-2325

COBRA Continuation Coverage

Members covered under a federal continuation plan due to COBRA should direct questions and send premiums to the COBRA Administrator.

Premium Increases/Decreases

When an employee experiences a change in status (including but not limited to: marriage, divorce, birth, adoptions, change in employment status, loss of prior coverage, person no longer meeting eligibility rules), the employee has 31 days from the date of the status change to contact the UNMH Benefits Department to make coverage changes. The completed and signed enrollment/change form must be received by the UNMH Benefits Department within 31 days following the status change. Premium changes will be effective the first day of the month following the change in status, except in the case of a newborn or the placement of child(ren) through adoption. (The addition of a child through birth or placement will result in a full premium being charged for the pay period in which the event occurred.)

In order to timely remove a family member from coverage and have payroll deductions adjusted accordingly, if applicable, the completed and signed enrollment/change form must be received by the UNMH Benefits Department within 31 days following the family member's loss of eligibility.

SECTION 3: HOW YOUR PLAN WORKS

OVERVIEW OF THE UNMH HEALTH PLAN

The UNM Hospitals Managed Care health plan is designed to help you stay health and to treat you when you are not. The plan is unique in several ways:

- You do not need to select a primary care physician (PCP) to coordinate your health care, but are encourage to visit your PCP before seeking specialist care. You pay a lower copayment for the office visits of a PCP.
- You have wellness benefits that encourage you to take care of yourself.
- The Standard or LoboCare Network (referred to as the *Standard Network*) is available to all members of the Plan and provides you with the convenience of fixed-dollar copayments for most services when you use *Standard Network* providers.
- When you use In-Network providers, you don't have to worry about the paperwork – the provider will file claims for you. Usually, you simply pay your copayment (or applicable member share) at the time of the visit.
- Members may choose to receive covered services from any provider outside their network (Out-of-Network services) and still receive benefits, subject to an annual deductible and coinsurance. Note: Some services are not covered unless received from In-Network providers. Check you *Summary of Benefits*.

Provider Network Overview – Under the Standard Network, you have two levels of coverage – *Standard Network* and Out-of-Network. Any provider that is not in the *Standard Network* is considered Out-of-Network. To receive the *Standard Network* level of coverage, covered services must be received from a provider in the *Standard Network*.

The Out-of-Network level of coverage allows you to access health care without visiting providers within your authorized network. You will have to pay an annual deductible and a percentage of covered charges for services from an Out-of-Network providers. (In some cases, such as for emergency care, Out-of-Network provider services may be eligible for a higher level of coverage, see "Network Exceptions" later in this section.)

IN-NETWORK PROVIDER SERVICES

You will pay a fixed-dollar copayment for most covered services from In-Network providers.

In order to make the most of your health plan benefits, it is important that you:

- understand the difference between a PCP (see "Your Primary Care Provider" in this section) and an In-Network specialist (see "In-Network Specialists and Hospitals" later in this section);

Under the Standard Network, you must choose a provider from the Standard Network in order to receive In-Network benefits for nonemergency care.

YOUR PRIMARY CARE PROVIDER (PCP)

You do not need to choose a primary care provider (PCP) at the time of enrollment. However, when you visit a provider that is a PCP, you will pay a lower copayment for office visits than if you visit an In-Network specialist (see further information in this section). NOTE: Certain mental health and chemical dependency services and OB/GYN services are also subject to the lower office visit copayments. See your *Summary of Benefits*.

Visiting your PCP – To avoid possible delays when scheduling an appointment, please follow these steps:

- For routine appointments or sudden illnesses call your PCP's office and identify yourself as a member of an HMO (or managed care) health plan administered by BCBSNM. You will be given instructions to follow.
- To receive office care after your PCP's normal business hours or on weekends and holidays, you should call your PCP (or the physician who is on call for your PCP) and request instructions.

Upon arriving for an appointment, show your Plan ID card to the provider's receptionist.

Cancelling an Appointment – If you need to cancel an appointment, notify your PCP as soon as possible, but at least 12 hours before the scheduled appointment. You may be charged a fee for a missed appointment. This Plan will not pay for such a charge. If you are going to be late for an appointment, please notify your PCP, who may ask you to reschedule.

IN–NETWORK SPECIALISTS AND HOSPITALS

If you need care that is not available from your PCP, your PCP may recommend that you visit another, more appropriate In–Network specialist or facility. You do not need a referral from your PCP before seeking care from any In–Network facility, specialist, or other health care provider. Under the *Standard Network* you have the freedom of going directly to the Network provider of your choice. NOTE: Certain mental health and chemical dependency services and OB/GYN services are also subject to the lower office visit copayments. See your *Summary of Benefits*.

Keep Your PCP Informed – Although you do not need a PCP referral before arranging to receive covered services from another In–Network provider, you should consult with your PCP, if possible. Your PCP knows you and your medical history and may be able to suggest a course of treatment or a particular specialist that is more appropriate than one you may be considering. Also, many specialists and facilities will not take patients that have not been referred to them by a physician.

Preauthorization Needed for Some Services – Your PCP should also be aware of the types of services that require preauthorization and be familiar with the kind of medical information BCBSNM needs in such cases. While you may call BCBSNM for preauthorization (before you incur costs that may not be covered), you may be told in most cases that your PCP or other provider must call BCBSNM to obtain the preauthorization for you. If this is the case, please call your PCP or other In–Network provider and discuss your preauthorization request with them. Your provider is not obligated to request preauthorization on your behalf if he/she does not agree that services you are requesting are appropriate or medically necessary.

Nonemergency Hospital Admissions – this Plan will cover a medically necessary inpatient stay for a covered service if you are admitted to an In–Network facility by your PCP or by an In–Network specialist. To be covered, you must obtain preauthorization from BCBSNM before being admitted. See *Section 4* for more information.

Out–of–Country Services – This Plan does not cover services received outside the United States at the In–Network benefit level, unless there is an emergency. See *Section 8* for more information about filing claims for out–of–country services.

Emergency and Urgent Care – You do not preauthorization before seeking emergency care from any hospital or ambulance. Such services will be covered at the Standard Network level of coverage, although you should inform your PCP of Out–of–Network services as soon as possible in order to ensure that benefits are paid correctly.

For urgent care, you must get BCBSNM authorization within 48 hours of receiving services outside New Mexico (or from other Out–of–Network providers in New Mexico). If you do not call your PCP within this time period or if your PCP does not agree that you require urgent care and does not approve the preauthorization request to BCBSNM, covered services will be paid a the Out–of–Network level of coverage.

OUT–OF–NETWORK PROVIDER SERVICES

If you visit an Out–of–Network provider for nonemergency care, you will receive Out–of–Network benefits for covered services in most cases. (Some benefits are not available unless services are received from an In–Network provider, see your *Summary of Benefits*.)

When you go outside the network, your choice of provider will determine if you will have to pay the difference between the covered charge and the billed charge for a covered service, in addition to the annual Out–of–Network deductible and coinsurance:

BCBS–Participating Providers – when obtaining services outside your authorized network, you can take advantage of the non–HMO participating provider contracts that BCBSNM has with providers throughout New Mexico and along the borders of neighboring states – and the participating agreements that other BCBS Plans have with providers throughout the world An Out–of–Network provider that participates as a non–HMO provider with a BCBS Plan will accept the covered charge for covered services as payment in full and will bill you only for deductible and coinsurance, and for noncovered services. These BCBS participating providers will write off the

difference between the billed charge and the covered charge, reducing your out-of-pocket expenses. These providers will also file claims on your behalf to the appropriate BCBS Plan based on where services were received.

Nonparticipating Provider Services – You can always choose to visit an Out-of-Network provider that is not in the BCBS participating network, but you will have to pay the difference between the covered charge and the provider's billed charge. These nonparticipating providers are also not obligated to file claims on your behalf. NOTE: The difference between a provider's billed charge and the covered charge can be considerable – and is not applied to any deductible or out-of-pocket limit under the Plan. You will be entirely responsible for payment of this difference.

Before seeking services, you need to be aware of preauthorization requirements which are described in *Section 4* of this booklet.

Important – If you choose to see a physician for nonemergency care, whether In-Network or Out-of-Network, and find that you have received services needing preauthorization – and you did not get the authorization – benefits for the services may be denied. In such cases, you may be responsible for the entire cost of the service – even if you were not aware of the preauthorization requirements.

PROVIDER DIRECTORY AND ONLINE PROVIDER FINDER®

When you need medical care, there are a variety of ways you can choose a Primary Preferred Provider (PPP) or other In-Network provider in your area. You can also access mental health providers (including those specializing in chemical dependency) and participating pharmacies. **Note:** Only those providers listed under Family Practice, General Practice, Internal Medicine, Gynecology, Obstetrics/Gynecology and Pediatrics are considered Primary Preferred Providers (PPPs). See "Cost-Sharing Features," later in this section for details.

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

Note: Providers who are listed in the directory as having a participating contract are **not** preferred providers (unless they are also listed as having a preferred provider contract). You must use providers in the **In-Network provider network** in order to obtain the highest level of benefit under this Plan for nonemergency care. However, if you live in or travel to a state that does not offer In-Network provider contracts, you can receive the "In-Network provider" benefit level by visiting participating providers in that state. **If you are in an emergency situation, call 911 if necessary or go directly to the nearest emergency room.**

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

Web-Based BCBSNM Provider Finder

To find an In-Network provider in New Mexico or along the border of neighboring states, please visit the *Provider Finder* section of the BCBSNM website for a list of network providers:

www.bcbsnm.com

If you use the web address above, click on the drop-down menu next to "-Choose One-" under the question, "Are you a member of one of our largest groups?" (located towards the middle of the page). "Choose UNM Hospitals" from the drop-down list and you will be connected to the UNMH home page of the BCBSNM web site. Select the provider directory link for the *Standard Network*.

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

Paper Provider Network Directory

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

Finding a Pharmacy

To find a participating pharmacy, visit the Prime Therapeutics website at:

www.MyPrime.com

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

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 LIMITS

There is no general 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

In-Network services are subject to a deductible. You will pay only a fixed-dollar amount copayment for covered charges at the time of the services are received (some services are paid at a percentage of the covered charge). Covered Out-of-Network services are subject to an annual calendar year deductible plus a percentage of covered charges or coinsurance. All medical/surgical services are subject to an annual out-of-pocket limit, after which no more copayments or coinsurance, as applicable, will be due for the rest of the calendar year. This section describes each of those cost-sharing features. Refer to your *Summary of Benefits* for details.

YOUR DEDUCTIBLE

There is an annual deductible to meet for the *Standard Network* benefit levels. Your deductible amounts are indicated on your Summary of Benefits. Once a member's deductible payments for In-Network and Out-of-Network services reaches the individual deductible amount during a calendar year, this plan will begin paying it share of that member's covered In-Network and Out-of-Network charges, at the percentage indicated, for the remainder of the calendar year. Under individual coverage, each covered person must meet his/her own individual deducible each year.

Family Deductible - If you have family coverage, each person enrolled in the family contract meets the In-Network and Out-of-Network deductibles for a calendar year when the total deducible amount for all covered family members reaches two times the individual deductible amount. (The deductible amounts for two or more covered family members are combined to satisfy the family deductible. However, once a member meets the individual deductible, that member's deductible is satisfied for the year, and no more charges incurred by that member can be used to satisfy the family deductible.)

What Is Not Subject to the Deductible

Services covered under "Prescription Drugs and Other Items," services covered at 100% due to the Affordable Care act, or any services listed on the Summary of Benefits as "deductible waived", inpatient physician charges as well as some outpatient therapy such as: Chemotherapy, Radiation, and Inhalation Therapy, subject to a fixed-dollar copayment, and certain transplant services are not subject to a deductible. Refer to your Summary of Benefits for details.

Admissions Spanning Two Calendar Years

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

Timely Filing Reminder

Out-of-Network benefits ae payable only after BCBSNM's record show that the deductible has been satisfied. Providers that contract 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 providers, you must file them **within 180 days** 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.

COPAYMENTS

Copayments for specific services are listed on your Summary of Benefits. Under the In-Network level of coverage, you pay a lower copayment for office visits of PCPs than you do for office visits of specialist. (Some specialist services are also subject to the lower copayment).

You must make copayments directly to providers at the time of service. You are always responsible for paying a provider's full charges for noncovered services and for services received without a necessary authorization.

OB/GYN and Gynecology-Only Specialist Office Services - The lower PCP copayment also applied to office services of a provider in your chosen network with a specialty of obstetrics/gynecology or gynecology only, regardless of whether that provider has signed a PCP contract with BCBSNM.

Mental Health and Chemical Dependency Services and Office Services - The lower PCP copayment also applied to office services of a provider in your chosen network who is providing mental health or chemical dependency therapy to you, even though that provider does not have a PCP contract with BCBSNM.

Prescription Drug copayments and Other Charges - When you purchase covered prescription drugs and other items through the drug plan, your responsibility may be either a fixed-dollar amount or a percentage of the covered charge. (You may also have to pay the difference between the cost of a brand-name drug and its generic equivalent.) In either case, drug plan copayments are **not** subject to the deductible. See "Prescription Drugs and Other Items" for more information about the drug plan.

COINSURANCE

For some covered services, you must pay a percentage of covered charges (coinsurance). After your share has been calculated, this Plan pays the rest of the covered charge, up to maximum benefit limits, if any. You pay a lower percentage of covered charges when you visit an In-Network provider.

Out-of-Network providers may charge you the difference between the billed charge for a covered service and the covered charge allowed by BCBSNM – in addition to your coinsurance and deductible amount.

Remember: The covered charge may be less than the billed charge for a covered service. In-Network providers may not bill you more than the covered charge. **Note:** If you receive covered services from an "unsolicited" provider, as defined in this section, you will be responsible for amounts over the covered charge.

OUT-OF-POCKET LIMIT

The out-of-pocket limit is the maximum amount of deductible, coinsurance, and copayments that you pay for most covered services in a calendar year. There are separate out-of-pocket limits for In-Network providers and Out-of-Network providers. After the out-of-pocket limit is reached, this Plan pays 100 percent of most of your In-Network provider or Out-of-Network provider covered charges for the rest of the calendar year, not to exceed any benefit limits.

The out-of-pocket amounts for In-Network provider services are **not** applied to the Out-of-Network provider out-of-pocket limit. In addition, the out-of-pocket amounts for Out-of-Network provider services are not applied to the In-Network provider out-of-pocket limit.

The higher Out-of-Network limit must be met using coinsurance amounts paid for covered Out-of-Network services. Once the Out-of-Network limit is met, this Plan pays 100 percent of the member's covered charges for Out-of-Network services.

Under the family coverage, the family In-Network out-of-pocket limit is two times the individual amount. Out-of-Network out-of-pocket limit must be met by each covered person until his/her individual out-of-pocket limit is satisfied. In-Network and Out-of-Network out-of-pocket limits do not cross apply. Once the family out-of-pocket limits are met, this Plan pays 100 percent of the family's covered charges.

Annual Outpatient Diagnostic Testing Limits - For In-Network outpatient diagnostic testing such as laboratory tests, x-rays, EKGs, and ultrasounds, you pay a percentage of covered charges, up to the maximum annual out-of-pocket limit indicated on your Summary of Benefits. Once this out-of-pocket limit reached by a member, this Plan pays 100 percent of that member's covered In-Network outpatient diagnostic testing for the rest of the calendar year. (there is no family limit under this provision. The amount applied to the In-Network outpatient diagnostic testing limit is applied to the general out-of-pocket limit as well.

This provision does not include Positron Emission Testing (PET), computerized tomography (CT scans), magnetic resonance imaging (MRI or MRA), infertility related testing, or dental related x-rays and other testing (even if accident related or related to dental surgery).

Prescription Drug Out-of-Pocket Limit - There is a separate out-of-pocket limit for prescription drugs. Once this out-of-pocket limit is reached by a member, this Plan pays 100% of that member's covered prescription drug charges for the rest of the calendar year. Under the family coverage, the family In-Network out-of-pocket limit is two times the individual amount. Once the family out-of-pocket limits are met, this Plan pays 100 percent of the family's covered charges.

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:

- amounts in excess of covered charges (including amounts in excess of annual or lifetime benefit limits, if applicable)
- noncovered expenses (including services in excess of annual or lifetime day/visit limits)
- drug plan copayments (There is a separate Out-of-Pocket Limit for Prescription drugs)

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

Remember: If you receive services from an Out-of-Network provider, you may be responsible for paying the provider any amounts over the covered charge, even if your out-of-pocket limit is met. The difference between the provider's billed charge and the covered charge can be considerable.

CHANGES TO THE COST-SHARING AMOUNTS

Copayments, coinsurance percentage amounts, deductibles, and out-of-pocket limits may change during a calendar year. If changes are made, the change applies only to services received after the change goes into effect (for inpatient services, benefits are determined based on the date you are admitted to the facility). You will be notified if changes are made to this Plan.

If your group increases the deductible or out-of-pocket limit amounts during a calendar year, the new amounts must be met during the same calendar year. For example, if you have met your deductible and your group changes to a higher deductible, you will not receive benefit payments for services received after the change went into effect until the increased deductible is met.

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

BENEFIT LEVEL EXCEPTIONS

In some cases, you will be able to receive services outside your authorized network and receive a higher level of coverage than would otherwise normally be available. However, this Plan does not cover services received outside the United States at the In-Network benefit level under any of the following provisions as indicated on the *Summary of Benefits*, except as listed below.

Emergency Care

If you visit an Out-of-Network provider for emergency care services, the In-Network provider deductible and coinsurance is applied only to the initial treatment, which includes emergency room services and, if you are hospitalized **within 48 hours** of an emergency, the related inpatient hospitalization is paid at the Standard Network benefit level. (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 the Out-of-Network provider benefit for the services of an Out-of-Network provider, even if an In-Network 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.)

Urgent Care

If you are traveling outside the service area, you will receive *Standard Network* benefits for urgent care services received from an Out-of-Network provider if you obtain BCBSNM authorization for such services within 48 hours of visiting the Out-of-Network provider.

If you do not receive authorization for any nonemergency services from an Out-of-Network provider you will receive Out-of-Network benefits only for covered services. (See "Emergency and Urgent Care" in *Section 5: Covered Services* for more information.)

Transition of Care

This provision applies to both Continuity of Care and Transition of Care. If your health care Provider leaves the BCBSNM Provider network (for reasons other than medical competence or professional behavior) or if you are a new Member and your Provider is not in the Provider network when you enroll, BCBSNM may authorize you to continue an ongoing course of treatment with the Provider for a transitional period of time of not less than 30 days. (If necessary and ordered by the treating Provider, BCBSNM may also authorize transitional care from other out-of-network Providers.) An ongoing course of treatment will include, but is not limited to: (1) Treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; (2) Treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, radiation therapy or post-operative visits; (3) The second or third trimester of pregnancy, through the postpartum period; or (4) An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes. The period will be sufficient to permit coordinated transition planning consistent with your condition and needs. Special provisions may apply if the required transitional period exceeds 30 days. Call the BCBSNM Customer Service department for details.

Members who extend coverage under an extension of benefits due to disability 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 at the in-network level (if any) in such instances of extended coverage.

Unsolicited Providers

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

Ancillary Provider

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 In-Network 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 In-Network 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 an Out-of-Network surgeon provides your care or you are admitted to a nonpreferred hospital or other treatment facility, you will be responsible for amounts over the covered charge for any services received from Out-of-Network providers during the admission or procedure.

Note: Except as described above, the In-Network provider benefit level will not apply to nonemergency services when received from an Out-of-Network provider.

Service Availability

In some cases, you will be able to receive services outside the Standard Network and receive a higher level of coverage than would otherwise normally be available. In order for the services to be approved at the higher level of coverage, the services must not be available in the Standard Network. Additionally the services must be medically necessary and preauthorized. Services will not be approved based on provider preference.

IF YOU HAVE MEDICARE

Note: This section applies to you only if you are primary under Medicare and Plan benefits are going to be coordinated with Medicare as a result. If you are not sure if Medicare is primary or secondary, please call the Social Security office for more information.

If you have Medicare as your **primary coverage,** the Plan usually pays benefits only after Medicare has paid its portion of your covered health care services. Medicare is called the "primary" coverage or carrier and pays its benefits first. The **UNMH** Medical Program is "secondary" coverage.

You may not elect to change your **UNMH** Plan to be primary coverage over Medicare and may not elect to bypass Medicare. If services are among those normally covered by Medicare, you or your doctor or hospital (your health care "provider") must submit a claim for those services first to Medicare. Medicare will calculate its benefits and will send you an *Explanation of Medicare Benefits* (EOMB) form. This form must be attached to any claim you send to BCBSNM. **NOTE:** For services received in New Mexico, a "crossover" claim should automatically be sent by the Medicare Part B carrier or Part A intermediary to BCBSNM for secondary benefit determination. If your claims are not being sent by Medicare to BCBSNM, please call a Customer Service Advocate to verify that the correct Medicare HIC number is on file for you. For details on how to submit claims when your claim is not automatically crossed-over from Medicare, see *Section 8: Claims Payments and Appeals.*

If you plan to receive a service that is not covered by Medicare (such as while outside the United States), it is your responsibility to call Customer Service and verify that the service will be covered under this Plan.

Active Employees and Employee Eligible Family Members

If you are an active employee or the eligible family member of an active employee and are entitled to Medicare for any reason other than end-stage renal disease, this Plan pays benefits before Medicare and this section does not apply to you.

End-Stage Renal Disease

If you become eligible for Medicare *solely* due to having ESRD (i.e., you are *not* also age 65 or older and/or you are *not* also eligible for Medicare due to a non-ESRD disability), this Plan pays benefits **before** Medicare **only** during the "ESRD coordination time period." The length of this time period may change if changes are made in Medicare Secondary Payer laws. You will be advised of the length of the ESRD coordination time period once you begin dialysis. This section does not apply to you if you are still within the initial ESRD coordination time period during which this Plan pays primary benefits.

If you complete the ESRD coordination time period or reach age 65 while eligible for Medicare as an ESRD patient, Medicare determines its benefits **before** this Plan pays its portion of covered charges. **This section of the booklet applies to such members who are primary under Medicare; your Plan benefits will be coordinated with Medicare.** See the **UNMH** for enrollment rules.

How Benefits are Paid

All expenses are subject to the same annual Plan deductible, copayment, coinsurance, and out-of-pocket limits. This Plan's benefits are determined and the balance due after Medicare or the usual Plan benefit will be paid, whichever is less. **Note:** You must be enrolled in both Parts A and B of Medicare in order to retain coverage under this **UNMH** Plan. If you privately contract with a provider, BCBSNM will calculate amounts that would have been paid by Medicare and deduct those amounts from the billed charge for a covered service in order to arrive at a benefit payment, subject to Plan deductible and coinsurance or Plan copayments.

Services that are not covered by Medicare may also be eligible for benefits under this Plan. See *Section 5: Covered Services* for a list of services that are covered by the Plan (services must be medically necessary and not listed as an exclusion in *Section 6: General Limitations and Exclusions).*

The services not subject to this Medicare coordination provision are non-Medicare-covered services that are not covered by the Plan and received at a Veteran's Administration, Department of Defense, or other government facility for a nonservice-connected condition (For outpatient service, benefits are calculated using a maximum of 20 percent of the billed charge as the covered charge, which is them subject to regular Plan deductible, coinsurance, and/or copayments. For inpatient services, the covered charge is equal to the Part A hospital deductible, subject to regular Plan deductible, coinsurance, and/or copayments.

SECTION 4: PREAUTHORIZATIONS

You or your provider must obtain preauthorization from BCBSNM *before* you are admitted as an inpatient or receive certain types of services.

In order to receive benefits:

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

These preauthorization 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 Plan, and services that are not medically necessary will be denied.

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

Please note:

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

Even when this Plan is not your primary coverage, these preauthorization 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 24 hours** for urgent care requests). If requested services are not approved, the notice will include: 1) the reasons for denial; 2) a reference to the health care plan provisions on which the denial is based; and 3) an explanation of how you may appeal the decision if you do not agree with the denial (see *Section 8: Claims Payments and Appeals*).

Retroactive approvals will not be given, except for emergency and maternity-related admissions, and you may be responsible for the charges if preauthorization is not obtained **before** the service is received.

BCBSNM IN-NETWORK PROVIDER (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 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
- before recommending that you go to an Out-of-Network (nonpreferred) provider whose services you expect to receive benefits (such requests may be denied)

Note: BCBSNM will advise you if a preauthorization request is denied.

OUT–OF–NETWORK (NONPREFERRED PROVIDERS) OR OUTSIDE NEW MEXICO

If any provider outside New Mexico (except for those contracting as In–Network (preferred providers directly with BCBSNM) or any Out–of–Network (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 preauthorization is obtained. If authorization is **not** obtained **before** services are received, **your benefits for covered services will be reduced for some services or you will be entirely responsible for the charges.** The provider may call on your behalf, but it is **your responsibility** to ensure that BCBSNM preauthorization department is called.

INPATIENT PREAUTHORIZATION

Preauthorization is required for all admissions **before** you are admitted to the hospital or other inpatient treatment facility (e.g., skilled nursing facility, residential treatment center, physical rehabilitation facility, long–term acute care (LTAC). If you are receiving services at an Out–of–Network facility (or from an In–Network facility outside New Mexico) and you do not obtain authorization within the time limits indicated in the table below, benefits for covered facility services will be **denied.**

Type of inpatient admission, readmission, or transfer:	When to obtain inpatient admission preauthorization:
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. BCBSNM must be notified as soon as possible if the mother's stay is greater than 48 hours for a routine delivery or greater than 96 hours for a C–section delivery.
Extended stay, newborn (an eligible newborn stays in the hospital longer than the mother)	**Before the newborn's mother is discharged.**

OTHER PREAUTHORIZATIONS

In addition to preauthorization review for all nonemergency inpatient services, preauthorization is required for the services listed below. Most preauthorizations may be requested over the telephone. If a *written* request is needed, have your provider call a Health Services representative for instructions for filing a written request for preauthorization. An Out–of–Network provider, or an out–of–state network provider may call on your behalf, but it is **your responsibility** to ensure that BCBSNM is called. In–Network preferred providers that contract **directly** with BCBSNM are responsible for requesting all necessary preauthorizations for you. (See "Inpatient Preauthorization" for further information regarding inpatient preauthorization requirements.)

If preauthorization is not obtained for the following services and all related services, the service will be reviewed for medical necessity and subject to one of the following actions in the chart below:

No Preauthorization Received	Claim Disposition: In–Network	Claim Disposition: Out–of–Network
Service is medically necessary	Claim is paid based on member's benefit plan	Claim is paid based on member's benefit plan
Service is **not** medically necessary	**Claim is denied; member held harmless**	**Claim is denied; member responsible for payment**

- **air ambulance** services (unless during a medical emergency)
- **PET scans**; **cardiac CT scans**; **MRIs**
- **enteral nutritional products, special medical foods,** and **certain drugs** covered under "Prescription Drugs and Other Items"

- **home infusion therapy (HIT),** excluding antibiotics
- **hospice**
- certain **injections,** including but not limited to **intravenous immunoglobulin (IVIG)**
- **infertility** related services
- **psychological testing; neuropsychological testing; electroconvulsive therapy (ECT); repetitive transcranial magnetic stimulation;** and **intensive outpatient program (IOP)** treatment
- **molecular genetic testing**
- **diagnostic sleep studies for obstructive sleep apnea**
- **radiation therapy**
- **transplant procedures** including pretransplant evaluations

All services, including those for which preauthorization is required, must meet the standards of medical necessity criteria described in *Section 5: Covered Services,* "Medically Necessary Services," and will not be covered, if excluded, for any reason. **Some services requiring preauthorization may not be approved for payment** (for example, due to being experimental, investigational, unproven, or not medically necessary). The complete list of services requiring preauthorization is subject to review and change by BCBSNM.

The preauthorization requirements noted above do not apply to mandated benefits, unless permitted by law and stated in the provisions of a specific mandated benefit. The medical necessity requirements noted above do not apply to mandated benefits, unless permitted by law.

It is strongly recommended that you request a predetermination for benefits for high-cost services in order to reduce the likelihood of benefits being denied *after* charges are incurred. See "Advance Benefit Information/Predetermination" later in this section for further information.

Preauthorization of Mental Health/Chemical Dependency Services

All inpatient mental health and chemical dependency services must be preauthorized by the BCBSNM Behavioral Health Unit (BHU) at the phone number listed on the back of your ID card. Preauthorization is also required for outpatient psychological testing, neuropsychological testing, intensive outpatient program (IOP) treatment, and electroconvulsive therapy (ECT) for treatment of mental disorder and/or chemical dependency. Preauthorization is **not** required for outpatient/office group, individual, or family therapy visits to a physician or other professional provider licensed to perform covered services under this health plan.

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

If you or your provider do not call for preauthorization of nonemergency **inpatient** services, benefits for covered, medically necessary inpatient facility care may be reduced by an amount that is equal to the preauthorization (or admission review), if any, indicated for medical/surgical admissions. If inpatient services received without preauthorization are determined to be not medically necessary or not eligible for coverage under your Plan for any other reason, the admission and all related services will be denied. In such cases, **you may be responsible for all charges.**

If preauthorization is **not** obtained before you receive psychological testing, IOP treatment, neuropsychological testing, or electroconvulsive therapy, or repetitive transcranial magnetic stimulation, your claims may be denied as being **not medically necessary.** In such cases, **you may be responsible for all charges.** Therefore, you should make sure that you (or your provider) have obtained preauthorization for outpatient services *before* you start treatment.

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

Summary of Contact Information for Preauthorization, Customer Service, Claim Submission, and Appeal (or Reconsideration) Processes for Medical/Surgical and Behavioral Health Services:			
Process:	**Type of Service:**	**Phone:**	**Send to:**
Request preauthorization	Medical/surgical	1-800-325-8334	Send to P.O. number listed on inside cover.
	Mental health/chemical dependency	1-888-898-0070	BH Unit P.O. Box 27630, Albuquerque, NM 87125-7630
Customer Service Inquiry	Medical/surgical	1-800-432-0750	Send to P.O. number listed on inside cover.
	Mental health/chemical dependency	1-888-898-0070	BH Unit P.O. Box 27630 Albuquerque, NM 87125-7630
Submit claim (post-service)	Medical/surgical		Send claim to P.O. number listed on inside cover.
	Mental health/chemical dependency		BH Unit P.O. Box 27630 Albuquerque, NM 87125-7630
Request **appeal** or reconsideration of **claim** or **preauthorization** decision	Medical/surgical	1-800-205-9926	BCBSNM Appeals Unit P.O. Box 27630 Albuquerque, NM 87125-9815
	Mental health/chemical dependency	1-888-898-0070	BCBSNM Appeals Unit P.O. Box 27630 Albuquerque, NM 87125-9815
Grievance Assistance – Office of Superintendent of Insurance (OSI), Managed Health Care Bureau	Medical/surgical; Mental health/ chemical dependency	1-855-427-5674	OSI P.O. Box 1689 Santa Fe, NM 87504-1689

If You Are Not Satisfied

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

ADVANCE BENEFIT INFORMATION/PREDETERMINATION

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/predetermination 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 group health care plan, subject to the limitations and exclusions in *Section 3: How Your Plan Works* and *Section 6: General Limitations and Exclusions*. All payments are based on covered charges as determined by BCBSNM.

MEDICALLY NECESSARY SERVICES

A service or supply is medically necessary when it is provided to diagnose or treat a covered medical condition, is a service or supply that is covered under this Plan, and is determined by BCBSNM's medical director (in consultation with your provider) 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, at its sole discretion, will determine medical necessity based on the criteria above.

If Medicare is Primary

When Medicare is primary (for example, you are under 65 and have exhausted the end-stage renal disease coordination time period under Medicare, or you are eligible for Medicare due to end-stage renal disease and turn age 65), if Medicare allows a service as medically necessary, the Plan will also consider it medically necessary. When Medicare determines that a service was not medically necessary, BCBSNM may (at your request) make its own determination regarding the service's medical necessity. However, for non-Medicare-covered services, BCBSNM determines whether a service or supply is medically necessary and, therefore, whether the expense is covered under this Plan.

AMBULANCE SERVICES

This 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 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 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 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

DENTAL-RELATED SERVICES AND ORAL SURGERY

The following services are the only dental-related services and oral surgery procedures covered under this Plan. When alternative procedures or devices are available, benefits are based upon the most cost–effective, medically appropriate procedure or device available.

Dental and Facial Accidents

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

To be covered, *initial* treatment for the accidental injury must be sought **within 72 hours** of the accident and any services required after the initial treatment must be associated with the initial accident in order to be covered. (For treatment of TMJ or CMJ injuries, see "TMJ/CMJ Services.")

Facility Charges

This Plan covers inpatient and outpatient hospital expenses for dental–related services **only** if the patient is under age six or has a nondental, hazardous physical condition (e.g., heart disease or hemophilia) that makes hospitalization medically necessary. All hospital services for dental–related and oral surgery services must be **preauthorized** by BCBSNM. **Note:** The dentist's services for the procedure will not be covered unless listed as eligible for coverage in this section.

Reminder: If hospital covered services are recommended by a nonpreferred (Out–of–Network) provider, you are responsible for assuring that your provider obtains preauthorization for outpatient covered services or benefits may be reduced or denied. (See *Section 4: Preauthorizations*.)

Oral Surgery

This Plan covers the following oral surgical procedures only:

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

TMJ/CMJ Services

This 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 temporomandibular or craniomandibular joint.

Exclusions

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

- surgeon's or dentist's charges for noncovered dental services
- hospitalization or general anesthesia for the patient's or provider's convenience
- any service related to a dental procedure that is not medically necessary
- any service related to a dental procedure that is excluded under this Plan for reasons other than being dental-related, even if hospitalization and/or general anesthesia is medically necessary for the procedure being received (e.g., cosmetic procedures, experimental procedures, services received after coverage termination, work-related injuries, etc.)
- nonstandard services (diagnostic, therapeutic, or surgical)
- removal of tori, exostoses, or impacted teeth
- procedures involving orthodontic care, the teeth, dental implants, periodontal disease, noncovered services, or preparing the mouth for dentures
- duplicate or "spare" appliances
- personalized restorations, cosmetic replacement of serviceable restorations, or materials (such as precious metals) that are more expensive than necessary to restore damaged teeth
- dental treatment or surgery, such as extraction of teeth or application or cost of devices or splints, unless required due to an accidental injury and covered under "Dental and Facial Accidents" or "TMJ/CMJ Services"
- dentures, artificial devices and/or bone grafts for denture wear, including implants

DIABETIC SERVICES

Diabetic persons are entitled to the same benefits for medically necessary covered services as are other members under 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 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, including glucose meters, see "Prescription Drugs and Other Items."

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 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, services must be received in an emergency room, trauma center, or ambulance to qualify as an emergency.) Examples of emergency conditions include, but are not limited to: heart attack or suspected heart attack, coma, loss of respiration, stroke, acute appendicitis, severe allergic reaction, or poisoning.

Emergency Room Services

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 paid at the nonpreferred provider benefit level. (Services received in an office or urgent care facility are not considered emergency care for purposes of this provision.)

Note: Under the *Standard Network*, emergency services in an Out-of-Network facility will be paid at the Standard Network level of coverage.

Emergency Admission Notification

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

Follow-Up Care

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

Urgent Care

This 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).

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

The urgent care copayment or coinsurance will apply to urgent care received in an urgent care facility (including hospital based urgent care centers) and to preauthorize urgent care received from Out-of-Network physician in their office

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

- Call your PCP and request an immediate appointment (if available).
- Visit the nearest Standard Network urgent care center. (if you are outside New Mexico, you will need BCBSNM authorization in order to receive In-Network benefits for urgent care services).
- If there is not an In-Network center nearby, call your PCP for authorization to visit another facility or other appropriate provider. If you do not receive authorization within 48 hours of receiving treatment from an Out-of-Network provider, you will receive Out-of-Network benefits for covered urgent care services. (If you obtain authorization to receive urgent care services Out-of-Network, you will receive Standard Network benefits.
- If you are outside New Mexico and need urgent care, call a Customer Service Advocate, who will connect you with the BlueCard Program. If you prefer, you may contact a BlueCard representative directly at 1-800-810-BLUE (2583). The BlueCard representative will give you the name and telephone number of a local provider. You must also call your PCP for preauthorization in order to receive In-Network benefits for services from an out-of-state provider or any Out-of-Network urgent care facility. If such services are not preauthorized, you will be eligible for Out-of-Network coverage only.

HOME HEALTH CARE/HOME I.V. SERVICES

Conditions and Limitations of Coverage

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

Preauthorization Required

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

Covered Services

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

- skilled nursing care provided on an intermittent basis by a registered nurse or licensed practical nurse
- physical, occupational, or respiratory therapy provided by licensed or certified physical, occupational, or respiratory therapists
- speech therapy provided by a speech pathologist or an American Speech and Hearing Association certified 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 "Prescription Drugs and Other Items.")
- drugs, medicines, or laboratory services that would have been covered during an inpatient admission
- enteral nutritional supplies (e.g., bags, tubing) (For enteral nutritional formulas, see "Prescription Drugs and Other Items.")
- medical supplies
- skilled services by a qualified aide to do such things as change dressings and check blood pressure, pulse, and temperature

Exclusions

This Plan does **not** cover:

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

HOSPICE CARE SERVICES

Conditions and Limitations

This 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. (See definition of a hospice benefit period in *Section 10* for more information.)

Covered Services

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

- visits from hospice physicians
- skilled nursing care by a registered nurse or licensed practical nurse
- physical and occupational therapy by licensed or certified physical or occupational therapists
- speech therapy provided by an American Speech and Hearing Association certified therapist
- medical supplies (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 "Prescription Drugs and Other Items.")
- 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 seven days** (r*espite care* provides a brief break from total care-giving by the family.)

Exclusions

This Plan does **not** cover:

- food, housing, or delivered meals
- medical transportation
- homemaker and housekeeping services
- comfort items
- private duty nursing
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this Plan
- care or services received after the member's coverage terminates

HOSPITAL/OTHER FACILITY SERVICES

Blood Services

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

Inpatient Services

Preauthorization Required

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

Covered Services

For acute inpatient medical or surgical care received during a covered hospital admission, this Plan covers room and board and other medically necessary services provided by the facility.

Medical Detoxification

This Plan also covers medically necessary services related to medical detoxification from the effects of alcohol or drug abuse. Detoxification is the treatment in an acute care facility for withdrawal from the physiological effects of alcohol or drug abuse, which usually takes about three days in an acute care facility. Benefits for detoxification services are the same as for any other acute medical/surgical condition. Preauthorization is required for all inpatient hospitalizations. See "Psychotherapy (Mental Health and Chemical Dependency)" for information about benefits for chemical dependency rehabilitation. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Exclusions

This 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)
- transplants or related services when transplant received at a facility that does not contract directly with a BCBSNM participating provider or through a BCBS transplant network. (See "Transplant Services" for more information.)
- admissions related to noncovered services or procedures
- custodial care facility admissions

Outpatient or Observation Services

Coverage for outpatient or observation services and related physician or other professional provider services for the treatment of illness or accidental injury depends on the type of service received (for example, see "Lab, X-Ray, Other Diagnostic Services" 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 Plan covers diagnostic services, including but not limited to, preadmission testing, that are related to an illness or accidental injury. Covered services include:

- x-ray and radiology services, sleep studies, diagnostic mammography, ultrasound, and imaging studies
- laboratory and pathology tests
- EKG, EEG, and other electronic diagnostic medical procedures
- genetic testing (Tests such as amniocentesis or ultrasound to determine the gender of an unborn child are not covered; see "Maternity/Reproductive Services and Newborn Care.")
- infertility-related testing (See "Maternity/Reproductive Services and Newborn Care.")
- PET (Positron Emission Tomography) scans, cardiac CT scans
- MRIs
- psychological or neuropsychological testing with **preauthorization** from BCBSNM
- 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 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 preventive oral contraceptive coverage and contraceptive devices purchased from a pharmacy, see "Prescription Drugs and Other Items."

Family Planning

Covered family planning services include:

- health education

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

For these following covered family planning services, no coinsurance, deductible, copayment, or benefit maximums will apply when received from a provider in the preferred or participating provider network. When these services are received from an Out–of–Network provider, if your plan has Out–of–Network benefits for nonemergency services, the usual Out–of–Network deductible, coinsurance, and out–of–pocket will apply.

- over–the–counter female contraceptive devices with a written prescription by a health care provider
- FDA–approved contraceptive drugs and devices from the following categories of FDA-approved contraceptive drugs, devices, and services, subject to change as FDA guidelines are modified: progestin-only contraceptives, combination contraceptives, emergency contraceptives, extended-cycle/continuous oral contraceptives, cervical caps, diaphragms, implantable contraceptives, intra-uterine devices (IUDs), injectables, transdermal contraceptives, and vaginal contraceptives devices. Covered FDA approved contraceptives drugs and devices are listed on the contraceptive drugs and devices list posted on the BCBSNM website (http://bcbsnm.com/affordable_care_act/provisions.html), or (http://www.bcbsnm.com/pdf/rx/contraceptive-list-nm.pdf) or available by contacting Customer Service at the toll–free number on your ID card
- outpatient contraceptive services such as consultations, examinations, procedures (including follow–up care for trouble you may have from using a birth control method that a family planning provider gave you) and medical services provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy
- female surgical sterilization procedures (other than hysterectomy), including tubal ligations

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

Infertility-Related Services

This Plan covers the following infertility-related treatments. (**Note:** the following procedures only *secondarily* treat infertility):

- surgical treatments such as opening an obstructed fallopian tube, epididymis, or vas deferens when the obstruction is **not** the result of a surgical sterilization
- replacement of deficient, naturally occurring hormones **if** there is documented evidence of a deficiency of the hormone being replaced
- artificial insemination infertility treatments received from the UNMH Reproductive Endocrinology Infertility Clinic (REIC) or from another provider when services are preauthorized by both REIC and BCBSNM, up to a lifetime maximum of 12 attempts or treatments per member (employee or spouse), including infertility drugs and medication (see the Summary of Benefits for applicable member cost sharing provisions related to infertility drugs purchased through a participating pharmacy.)

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

Diagnostic *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 unless eligible for benefits as part of a covered treatment received from UNMH REIC or another provider that has been preauthorized by both REIC and BCBSNM.

Exclusions

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

- male contraceptive devices, including over-the-counter contraceptive products such as condoms
- sterilization reversal for males or females
- infertility treatments and related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization unless such services are part of a covered artificial insemination treatment plan offered by and authorized by UNMH REIC and BCBSNM
- Gamete Intrafallopian Transfer (GIFT)
- Zygote Intrafallopian Transfer (ZIFT)
- cost of donor sperm

Pregnancy–Related/Maternity Services

Once your pregnancy is confirmed, you may choose either your PCP or another provider to provide maternity care and receive benefits for covered services. If you are pregnant, you should call BCBSNM before your maternity due date, soon after your pregnancy is confirmed. BCBSNM must be notified as soon as possible if the mother's stay is greater than **48 hours** for a routine delivery or greater than **96 hours** for a C-section delivery. If not notified, benefits for covered facility services may be denied.

A covered daughter also has coverage for pregnancy–related services. However, if the parent of the newborn *is* a covered child of the subscriber (i.e., the newborn is the subscriber's grandchild), benefits are **not** available for the newborn except for the first 48 hours of routine newborn care (or 96 hours in the case of a C–section).

If there is no In–Network provider in your area able to provide maternity services, you or your provider may request authorization from BCBSNM to recommend you to an Out–of–Network women's health care provider.

Covered Services

Covered pregnancy–related services include:

- hospital or other facility charges for room and board and ancillary services, including the use of labor, delivery, and recovery rooms (This Plan covers all medically necessary hospitalization, including at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a C-section delivery. **Note:** Newborns who are not eligible for coverage under this Plan will not be covered beyond the 48 or 96 hours required under federal law.)
- routine or complicated delivery, including prenatal and postnatal medical care of an obstetrician, certified nurse-midwife or licensed midwife (Expenses for prenatal and postnatal care are included in the total covered charge for the actual delivery or completion of pregnancy.) **Note:** Home births are not covered unless the provider has a preferred provider contract with his/her local BCBS Plan and is credentialed to provide the service.
- pregnancy-related diagnostic tests, including genetic testing or counseling (Services must be sought due to a family history of a gender-linked genetic disorder or to diagnose a possible congenital defect caused by a present, external factor that increases risk, such as advanced maternal age or alcohol abuse. For example, tests such as amniocentesis or ultrasound to determine the gender of an unborn child are **not** covered.)
- necessary anesthesia services by a provider qualified to perform such services, including acupuncture used as an anesthetic during a covered surgical procedure and administered by a physician, a licensed doctor of oriental medicine, or other practitioner as required by law
- when necessary to protect the life of the infant or mother, coverage for transportation, including air transport, for the medically high-risk pregnant woman with an impending delivery of a potentially viable infant to the nearest available tertiary care facility for newly born infants (See "Ambulance Services" for details.)
- services of a physician who actively assists the operating surgeon in performing a covered surgical procedure when the procedure requires an assistant

- spontaneous, or therapeutic termination of pregnancy prior to full term. (Copayment will be based on the place of treatment at the time of pregnancy termination. This plan does not cover elective abortions unless medically necessary.)

Special Beginnings

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

1–888–421–7781

Newborn Care

If you do not have coverage for your newborn on the date of birth, **you must add coverage by submitting a signed and completed enrollment/change form to the UNMH Benefits Department within 31 days of birth** in order for any newborn charges, routine or otherwise, to be covered beyond the first 48 hours of birth (or 96 hours in the case of a C–section).

Newborn Eligibility

If you do not elect to add coverage for your newborn within 31 days, and wish to add the child to coverage later, the child is considered a late applicant unless eligible for a special enrollment. **Note:** If the parent of the newborn is a covered child of the subscriber (i.e., the newborn is the subscriber's grandchild), services for the newborn are **not** covered except for the first 48 hours of routine newborn care (or 96 hours in the case of a C–section).

Routine Newborn Care

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

Covered Services

Covered services for initial routine newborn care include:

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

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

Extended Stay Newborn Care

A newborn who is enrolled for coverage within the time limits specified in *Section 2: Enrollment and Termination Information* is also covered if he/she stays in the hospital longer than the mother. The baby's services will be subject to a separate deductible, coinsurance and out-of-pocket limit.

Note: 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 denied. The baby's services will be subject to a separate deductible, coinsurance and out-of-pocket limit.

PHYSICIAN VISITS/MEDICAL CARE

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

This Plan covers medically necessary care provided by a physician or other professional provider for an illness or accidental injury. **Your choice of provider can make a difference in the amount you pay.** (See *Section 3: How Your Plan Works*.)

Office Visits and Consultations

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

Allergy Care

This 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. Allergy testing and services from Out-of-Network providers are not covered.

Breastfeeding Support and Services

The Plan covers counseling and support services rendered by a lactation consultant such as a certified nurse practitioner, certified nurse midwife or midwife, not subject to coinsurance, deductible, copayment, or benefit maximums when received from a provider in the preferred or participating provider network (if your plan has Out-of-Network benefits for nonemergency services, Out-of-Network services are subject to the usual Out-of-Network deductible, coinsurance, and out-of-pocket).

Diabetes Self-Management Education

This 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 "Prescription Drugs and Other Items" for benefits for insulin and oral agents to control blood glucose levels, glucose meters, 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 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 "Prescription Drugs and Other Items"), corrective lenses for conditions related to the genetic inborn error of metabolism, nutritional management and **preauthorized** special medical foods (as defined and described in "Prescription Drugs and Other Items"). In order to be covered, services cannot be excluded under any other provision of this benefit booklet and are paid according to the provisions of the Plan that apply to that particular type of service (e.g., special medical foods are covered under "Prescription Drugs and Other Items," 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 Plan covers most FDA-approved therapeutic injections administered in a provider's office. However, this 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, call a BCBSNM Customer Service Advocate. (When you request preauthorization, you may be directed to purchase the self-injectable medication through your drug plan.)

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

Mental Health Evaluation Services

This Plan covers medication checks and intake evaluations for mental disorders, alcohol, and drug abuse. See "Psychotherapy (Mental Health and Chemical Dependency)" for psychotherapy and other therapeutic service benefits.

Inpatient Medical Visits

With the exception of dental-related services, this Plan covers the following services when received on a covered inpatient hospital day:

- visits for a condition requiring **only** medical care, unless related to hospice care
- consultations (including second opinions) and, if surgery is performed, inpatient visits by a provider who is not the surgeon and who provides medical care **not** related to the surgery (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.)

PRESCRIPTION DRUGS AND OTHER ITEMS

When you are being treated for an illness or accident, your doctor may prescribe certain drugs or other pharmacy items and supplies as part of your treatment. Your coverage under his drug plan includes benefits for drugs that are self-administered and other items listed below. The benefits of this drug plan are subject to all other terms and conditions of the Plan (excluding the network requirements of the medical plan). For example, benefits will be provided only if drugs and supplies are medically necessary. Please see Section 4 for a list of exclusions that may apply to drugs and other items listed as covered in this section. Unless there is an emergency, you must use a participating retail pharmacy, the BCBSNM designated specialty pharmacy provider, or the BCBSNM designated mail-order service vendor, in order to receive benefits under this drug plan. **Unless there is an emergency, you must use a participating retail pharmacy, the BCBSNM designed specialty pharmacy provider, or the BCBSNM designated mail-order service vendor, in order to receive benefits under this drug plan**.

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

Pharmacy–Related Definitions

Please see all pharmacy–related definitions under "Pharmacy–Related Definitions" in *Section 10: Definitions.*

Covered Medications and Other Items

This Plan covers the following drugs, supplies and other products through this drug plan provision only when dispensed by a **participating pharmacy** under the **Retail Pharmacy Program** or **Specialty Pharmacy Drug Program** (unless required as the result of an emergency) or ordered through the **Mail Order Service** vendor:

- prescription drugs, prenatal vitamins, and medicines, unless listed as an exclusion (covered drugs/items include insulin, glucagon, prescriptive oral agents for controlling blood sugar levels and prescription contraceptive devices and medications purchased from a participating pharmacy) **Note:** Prescription contraceptive devices fitted or inserted by, and purchased directly from a physician are payable under the "Family Planning" benefit, if any, of your medical/surgical Plan.
- specialty drugs such as, but not limited to, self-administered injectable drugs such as growth hormone, Copaxone, Avonex. (Most injectable drugs require **preauthorization** from BCBSNM. Some self-administered drugs, whether injectable or not, are identified as specialty drugs and must be acquired through a participating specialty pharmacy provider in order to be covered.)
- vaccinations for flu or pneumonia, or Zostavax® vaccinations when received from certain participating pharmacies (For a list of pharmacies that are contracted with BCBSNM to provide this service, go to the BCBSNM website at www.bcbsnm.com.)
- insulin needles, syringes, glucose meters, and other diabetic supplies (e.g., glucagon emergency kits, autolets, lancets, lancet devices, blood glucose and visual reading urine and ketone test strips). (A separate copayment amount applies for each item purchased.) These items are **not** covered as a medical supply or medical equipment expense under any medical or surgical provisions of this benefit booklet. See "Supplies, Equipment, and Prosthetics" later in this section for a list of diabetic equipment that *is* covered under the medical/surgical portion of your health plan.
- nonprescription enteral nutritional products and special medical foods only when **preauthorized** and either: 1) delivered through a medically necessary enteral access tube that has been surgically placed (e.g., gastrostomy, jejunostomy) or 2) meeting the definition of special medical foods (These products must be ordered by a physician and **preauthorization** received from BCBSNM in order to be covered.) See *Section 4: Preauthorizations* for more information about preauthorization requirements.
- treatment with FDA-approved prescription drugs to assist you with quitting tobacco use or smoking. Note: For members covered under PPO medical plans only, some of these items may also be purchased from an out-of-network pharmacy. For details, see "Retail Pharmacy Program" below. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Preauthorizations

Certain prescription drugs, injectable medications and specialty pharmacy drugs may require **preauthorization** from BCBSNM. A list of drugs requiring preauthorization is available on the BCBSNM website at www.bcbsnm.com. Your physician can request the necessary preauthorization. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Step Therapy

The step therapy program helps manage costs of expensive drugs by redirecting patients, when appropriate, to equally effective less expensive, generic alternatives. The program requires that members starting a new drug treatment use generic drugs first when appropriate. Generic drugs, which are tested and approved by the U.S. Food and Drug Administration (FDA), have been shown to be safe and effective. If the generic alternative is not effective, a brand–name drug may then be acquired in the second step. You will be required to pay the applicable copayment for brand–name drugs.

Member Copayments and Coinsurance

For covered prescription drugs, insulin, diabetic supplies, and nutritional products, you pay the applicable tiered copayment or applicable coinsurance, not to exceed the actual retail price, for each prescription filled or item purchased (not to exceed supply limitations described in this section). Any coinsurance amounts due for certain covered items are noted in this benefit booklet.

Each calendar year, the copayments and coinsurance percentage amounts, are applied to your or your family's applicable annual out-of-pocket limit for that calendar year. BCBSNM pays 100% of your covered prescription drugs, insulin, diabetic supplies, and nutritional products under this drug plan for the remainder of that calendar year. Noncovered charges may not be used to meet the out-of-pocket limit under the medical portion of your health care benefits plan.

Your drug plan offers several benefit design copayment option for when you purchase drugs or supplies from a participating pharmacy, or a BCBSNM-designated specialty pharmacy provider, or BCBSNM-designated mail order service vendor. When you need a prescription order filled, you should use a participating pharmacy. Each prescription or refill is subject to the copayment or coinsurance shown on your SBC.

When you go to a participating pharmacy, you must pay any copayment, deductible (if any), and any applicable pricing difference. You may be required to pay for limited or noncovered services. No claim forms are required. If you are unsure whether a pharmacy is a participating pharmacy, you may access the website at www.bcbsnm.com or contact customer service at the toll-free number on your ID card.

See your Summary of Benefits for the drug plan copayment option that corresponds to the health benefits plan you have chosen. Except as may be specified elsewhere in this benefit book, drugs and supplies must be purchased from a participating pharmacy, or a BCBSNM-designated specialty pharmacy provider, or BCBSNM-designated mail order service in order to be covered under your drug plan.

Here's a sample of how the drug plan works under the "6-Tier Drug Plan" using the $8/$20/$45/$75/$150/$300 option:

Type of Prescription	Sample of Copayment Amounts
Preferred Generic Drug	**Tier–One copayment: $8**
Nonpreferred Generic Drug	**Tier–Two copayment: $20**
Preferred Brand–Name Drug (no generic equivalent)	**Tier–Three copayment: $45**
Nonpreferred Brand–Name Drug (no generic equivalent)	**Tier–Four copayment: $75**
Preferred Specialty Drug (no generic equivalent)	**Tier–Five copayment: $150**
Nonpreferred Specialty Drug (no generic equivalent)	**Tier–Six copayment:** $300
Vaccinations for flu or pneumonia, or Zostavax vaccinations received from certain **participating pharmacies** (For a list of pharmacies that are contracted with BCBSNM to provide this service, go to the BCBSNM website at www.bcbsnm.com.)	**No copayment**
Mail Order Service (available for Tiers 1, 2, 3 and 4 only; specialty drugs are not covered through Mail Order Service)	**$16, $40, $90, or $150** (2 times copay for Tier 1, 2, 3, or 4 drug – depending on generic/brand and Drug List status)
Nonprescription Enteral Nutritional Products and Special Medical Foods (brand–name or generic; requires preauthorization)	**50 percent** of covered charge

Under the drug plan, drugs are available at "tiered" copayment levels. The benefits you receive and the amount you pay will differ depending upon the type of drugs, or diabetic supplies, or insulin and insulin syringes, or nutritional products obtained and whether they are obtained from a participating pharmacy, or a BCBSNM-designated specialty pharmacy provider, or BCBSNM-designated mail order service vendor.

When the copayment or coinsurance for an item purchased under the drug plan is **greater** than the covered charge for the supply being purchased from a participating pharmacy, you pay the **least of**: 1) your copayment amount or 2) the pharmacy's or vendor's retail price, or 3) the covered charge (i.e., the BCBSNM–contracted rate). For claims submitted to the pharmacy benefit manager for reimbursement, you are paid the **lesser of**: 1) the sum of the drug ingredient cost, the dispensing fee that would be payable to a participating pharmacy and any sales tax minus the applicable member share or 2) the pharmacy's retail price minus the applicable member share.

New-to-Market FDA Approved Drugs

New-to-market FDA approved drugs are subject to review by Prime Therapeutics Pharmacy & Therapeutics (P&T) Committees prior to coverage of the drug.

Retail Pharmacy Program

Your drug plan provides access to the pharmacy in the retail pharmacy network. All items covered under this provision must be purchased from a participating retail pharmacy unless there is an emergency (as defined in this benefit booklet).

For a list of participating pharmacies, call Customer Service at the phone number on the back of your ID card and request a provider directory – or visit the BCBSNM website at www.bcbsnm.com. The pharmacies that are participating in the BCBSNM Retail Pharmacy Program may change from time to time. You should check with your pharmacy before obtaining drugs or supplies to make certain of its participating status.

You must present your BCBSNM identification (ID) card to the pharmacist at the time of purchase to receive your drug benefits. (You do not receive a separate prescription ID card; use your BCBSNM ID card to receive all your medical/surgical and prescription drug services covered under this Plan.) You are responsible for paying any deductibles, coinsurance amounts, copayments, any pricing differences when applicable, and limited or non–covered services. No claim forms are required when you purchase your prescriptions at a participating pharmacy.

NOTE: Specialty drugs must be purchased from the BCBSNM–designated specialty pharmacy provider in order to be covered.

You can use your ID card to purchase covered items only for yourself and covered family members. When coverage for you or a family member ends under this Plan, the ID card may not be used to purchase drugs or other items for the terminated family member(s).

If you do not have your ID card with you or if you purchase your drug or other item from a nonparticipating (Out–of–Network) pharmacy and it is eligible for coverage as indicated in the first paragraph above, such as in an **emergency**, you must pay for the purchase in full and then submit a claim directly to the BCBSNM pharmacy benefit manager, Prime Therapeutics, at the address below (do not send to BCBSNM). In such cases, you will pay the difference in cost between the pharmacy's billed amount and the covered charge, in addition to your deductible, coinsurance, and/or copayment amount. If not included in your enrollment materials, you can obtain the necessary claim forms from a Customer Service Advocate or on the BCBSNM website (www.bcbsnm.com).

Prime Therapeutics
P.O. Box 14624
Lexington, KY 40512–4624

If you are leaving the country or need an extended supply of medication, call Customer Service **at least two weeks** before you intend to leave. (Extended supplies or vacation overrides are not available through the Mail Order Service Program (see below) and may be approved only through the Retail Pharmacy Program. In some cases, you may be asked to provide proof of continued enrollment eligibility under the Retail Pharmacy Program.)

Specialty Pharmacy Program

The specialty drug delivery service integrates specialty drug benefits with your overall medical and drug plan benefits. This program provides delivery of medications directly to your provider's office or to your home if you are undergoing treatment for a complex medical condition.

Due to special storage requirements and high cost, specialty drugs are not covered unless obtained through the specialty pharmacy program. The specialty pharmacy program delivery service offers:

- coordination of coverage among you, your health care provider, and BCBSNM
- educational materials about your condition and information about managing possible medication side effects
- syringes, sharps containers, alcohol swabs, and other supplies with every shipment of FDA-approved self-injectable medications
- access to a pharmacist for urgent medication issues 24 hours a day, 7 days a week, 365 days a year

Mail Order Service

Except for supply limitations and nutritional products, all items that are covered under the Mail Order Service are the same items that are covered under the Retail Pharmacy Program and are subject to the same limitations and exclusions. To use the Mail Order Service, follow the instructions outlined in the materials provided to you in your enrollment packet. (If you do not have this information, call a Customer Service Advocate.) **Note:** Prescription drugs and other items may **not** be mailed outside the United States. Extended supplies or vacation overrides required when you are outside the country may be approved only through the Retail Pharmacy Program.

Send Mail Order Service Prescriptions to:
Prime Mail
P.O. Box 27836
Albuquerque, NM 87125-7836

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

Supply Limitations

For each copayment listed on the *Summary of Benefits,* you can obtain the following supply of a single covered prescription drug or other item (unless otherwise specified):

Program Type	Supply Maximum	Copay Requirement* (see note)
Nonprescription Nutritional Products	**30-day supply** during any 30-day period	**20 percent** of covered charges (includes prescriptions for enteral nutritional products and special medical foods as described under "Covered Drugs and Other Items")
Retail Pharmacy and Specialty Pharmacy Provider	During each one-month period, a **30-day supply or 120 units** (e.g., pills) whichever is less	**One copayment.** If more than 120 units are needed to reach a 30-day supply, another copayment will apply to each additional 120 units (or portion thereof) purchased. For oral contraceptives, the supply is limited to one menstrual cycle (normally 28 days).
Mail Order Service	During each three-month period, a **90-day supply or 360 units** (e.g., pills) whichever is less	**Two copayments.** If less than a 90-day supply is ordered, one copayment will apply. If more than 360 units are needed to reach a 90-day supply, 2 copayments will apply to each additional 360 units (or portion thereof) purchased.

NOTE: For commercially packaged items (such as an inhaler, a tube of ointment or a blister pack of tablets or capsules), you will pay the applicable copayment for each package, **regardless of the number of days supply the package represents**. For example, if two inhalers are purchased under the Retail Pharmacy Program, two copayments will apply. Under Mail-Order, you can receive up to three times the number of packages obtainable from a retail pharmacy for the same copayment amount payable under the Retail Pharmacy Program.

Dispensing Limits

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

Controlled Substances

If BCBSNM determines you may be receiving quantities of controlled substances medications not supported by FDA approved dosages or recognized treatment guidelines, benefits may be subject to a review to determine if they are medically necessary, appropriate and other coverage restrictions such as limiting coverage to services provided by a certain provider and/or participating pharmacy for the prescribing and dispensing of the controlled substance medication. For the purposes of this provision, controlled substance medications are medications restricted by state or federal laws because of their potential of addition or misuse.

Drug Plan Exclusions

In addition to services listed as not eligible for coverage in the *General Limitations and Exclusion* section of this booklet, this drug plan provision of your health plan does **not** cover:

- nonprescription and over-the-counter drugs unless specifically listed as covered, including herbal or homeopathic preparations and nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum, or prescription drugs that have over-the-counter equivalents.
- compounded medications, regardless of whether or not one or more ingredients in the compound requires a prescription (Compounds are those made by mixing or reconstituting ingredients in a manner or ratio that is inconsistent with United States Food and Drug Administration–approved indications provided by the ingredients' manufacturers.)
- prescription drugs if there is an over–the–counter product available with the same active ingredient(s), in the same strength, unless otherwise determined by the Plan, at its sole discretion
- herbal or homeopathic preparations
- drugs which by law do not require a prescription order from an authorized health care practitioner (except insulin, insulin analogs, insulin pens, oral agents for controlling blood sugar levels, and vaccinations administered through certain participating pharmacies)
- legend drugs or covered devices for which no valid prescription order is obtained
- prescriptions or other covered items purchased from a nonparticipating pharmacy, nonparticipating specialty pharmacy provider or other provider unless eligible for benefits in an emergency situation (as defined in your benefit booklet) or for members covered under PPO medical plans, as listed under "Retail Pharmacy Program" and purchased from a non-participating retail pharmacy
- refills before the normal period of use has expired, in excess of the number specified by the physician or requested more than one year following the physician's original order date (Prescriptions cannot be refilled until at least 75 percent of the previously dispensed supply will have been exhausted according to the physician's instructions. Call Customer Service for instructions on obtaining a greater supply if you are leaving home for more than a 30-day period of time.)
- replacement of drugs or other items that have been lost, stolen, destroyed or misplaced
- infertility medications that have not been preauthorized are not covered
- drugs or other items for the treatment of sexual or erectile dysfunction
- therapeutic devices or appliances, including support garments and other nonmedicinal substances

- devices or durable medical equipment of any type (even though such devices may require a prescription order) such as, but not limited to therapeutic devices, including support garments and other non-medicinal substances, artificial appliances, or similar devices
- drugs that are repackaged by a company other than the original manufacturer
- medications or preparations used for cosmetic purposes (such as preparations to promote hair growth or medicated cosmetics), including tretinoin (sold under such brand names as Retin-A) for cosmetic purposes
- nonprescription enteral nutritional products that are taken by mouth or delivered through a temporary naso-enteric tube (e.g., nasogastric, nasoduodenal, or nasojejunal tube), unless the patient meets criteria for genetic inborn errors of metabolism and the product is **preauthorized** by BCBSNM); or nonprescription nutritional products that have not been preauthorized by BCBSNM (See *Section 4: Preauthorizations* for more information about preauthorization requirements.*)*
- shipping, handling or delivery charges
- prescription drugs required for international travel or work
- appetite suppressant or diet aids; weight reduction drugs food or diet supplements and medication prescribed for body building or similar purposes
- ordinary foodstuffs that might be part of an exclusionary diet; any product that does not have and/or require a physician's prescription; food items purchased at a health food, vitamin, or similar store; food purchased on the Internet
- any drug not listed on the formulary
- devices and pharmaceutical aids
- institutional packs
- surgical supplies
- ostomy products
- diagnostic agents, except diabetics test strips
- general anesthetics
- bulk powders

Note: Prescription contraceptive devices are payable under your medical/surgical plan benefit booklet in the "Family Planning" provision of the *Covered Services* section.

Drug Exclusions

Some equivalent drugs are manufactured under multiple brand names. In such cases, the health care Plan may limit benefits to only one of the brand equivalents available. If you do not accept the brand that is covered under the Plan, the brand-name drug purchased will not be covered under any benefit level.

Blue Cross and Blue Shield of New Mexico (BCBSNM) hereby inform you that it has contracts, either directly or indirectly, with participating prescription drug providers for the provision of, and payment for, prescription drug services. All persons entitled to prescription drug benefits under individual certificates, group health insurance policies, and contracts to which BCBSNM is a party, including this contract. Pursuant to BCBSNM's contracts with participating prescription drug providers, under certain circumstances described therein, BCBSNM may receive discounts for prescription drugs dispensed to you. Actual discounts used to calculate your share of the cost of prescriptions drugs will vary. Some discounts are currently based on average wholesale price (AWP), which is determined by a third party and is subject to change.

BCBSNM may receive such discounts, although you are not entitled to receive any portion of any such discounts. The drug fees and/or discounts that BCBSNM has negotiated with Prime Therapeutics LLC (Prime) through the pharmacy benefit management (PBM) agreement will be used to calculate your share of the cost of prescription drugs for retail and mail/specialty drugs. Except for mail and/or specialty drugs, the PBM agreement requires that the fees and/or discounts that Prime has negotiated with pharmacies (or other suppliers) are passed on to BCBSNM (and ultimately to you as described above).

To help you understand how BCBSNM's separate financial agreements with participating prescription drug providers work, please consider the following example:

Assume you have a prescription dispensed and the undiscounted amount of the prescription drug is $100. How is the $100 bill paid?

- You will have to pay the coinsurance amount set out in this contract.
- For purposes of calculating your coinsurance amount, the full amount of the prescription drug would be reduced by the discount. In our example, if the applicable discount were 20%, the $100 prescription drug bill would be reduced by 20% to $80 for purposes of calculating your coinsurance amount.
- In our example, if your coinsurance obligation is 5%, you will have to pay 5% of $80, or $4. You should note that your 5% coinsurance amount is based upon the discounted amount of the prescription and not the full $100 bill.

For the mail and specialty pharmacy program owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail and/or specialty pharmacy program. BCBSNM pays a fee to Prime for pharmacy benefit services. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, claims processing, customer service response, and mail order processing.

"Weighted paid claim" refers to the methodology of counting claims for purposes of determining BCBSNM's fee payment to Prime. Each retail paid claim equals one weighted paid claim (including claims dispensed through the PBM's specialty pharmacy program); each extended supply or mail order (including mail service) paid claim equals three weighted paid claims. However, BCBSNM pays Prime a program management fee (PMF) on a per paid claim basis. "Funding Levers" means a mechanism though which BCBSNM funds the fees (net fee, ancillary fees and special project fees) owed to the PBM. Funding lever always include manufacturer administrative fees, mail order utilization, participating pharmacy transaction fees, and , if elected by BCBNM, may include rebates and retail spread. BCBSNM's net fee owed to Prime for core services will be offset by the funding levers. BCBSNM pays Prime the net fee for core services, ancillary fees and special project fees, offset by all applicable funding levers as agreed upon under the terms of its agreement with Prime. The net fee is calculated based on a fixed dollar amount per weighted paid claim.

The amounts received by Prime from BCBSNM, pharmacies, manufactures, or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled and include, but are not limited to, administrative fees charged by Prime to BCBSNM, administrative fees charge by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufactures. Currently, none of these fees will be passed on to you as expenses, or accrue to the benefit of you, unless otherwise specially set forth in this contract. Additional information about these types of fees or the amount of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 3% of the total sales for all rebatable products of such manufacturer dispensed during any given calendar year to members of BCBSNM and other Blue plan operating divisions.

Exceptions Process

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

A determination will be made within 72 hours following receipt of the request and notice of the determination will be provided to the insured. If an exception request is granted, the plan will provide coverage of the non-formulary drug for the duration of the prescription including refills.

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

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

BCBSNM's SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

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

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

PREVENTIVE SERVICES

Claims filed under this provision must clearly show that the office visit and tests were for routine or preventive care. Preventive services are covered only when received from preferred providers.

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

This Plan covers the following preventive services not subject to coinsurance, deductible, copayment, or benefit maximums when received from an In-Network provider. Out-of-Network services are subject to the usual Out-of-Network deductible, coinsurance, and out-of-pocket limit.

a. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");

b. immunizations for routine use that have in effect a recommendation by the Advisory Committee on Immuniza tion Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;

c. evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents;

d. with respect to women, to the extent not described in item "a" above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.

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

The preventive services described in items "a" through "d" above may change as USPSTF, CDC, and HRSA guidelines are modified. For more information, you may visit the BCBSNM website at www.bcbsnm.com or contact Customer Service at the toll-free number on your BCBSNM health plan identification card.

Covered preventive services **not** described in items "a" through "d" above may be subject to deductible, coinsurance, copayments, and/or dollar maximums. Allergy injections are **not** considered immunizations under the "Preventive Services" benefit. Examples of covered services include, but are not limited to:

- routine physical, breast, and pelvic examinations
- routine adult and pediatric immunizations
- an annual routine gynecological or pelvic examination and low-dose mammogram screenings
- papilloma virus screening and cytologic screening (a Pap test or liquid-based cervical cytopathology)
- human papillomavirus vaccine (HPV) for members ages 9 – 26 years old
- periodic blood hemoglobin, blood pressure and blood glucose level tests
- periodic colorectal screening tests
- periodic blood cholesterol or periodic fractionated cholesterol level including a low-density lipoprotein (LDL) and a high-density lipoprotein (HDL) level; periodic stool examination for the presence of blood
- periodic left-sided colon examination of 35 to 60 centimeters or colonoscopy
- well-child care, including well-baby and well-child screening for diagnosing the presence of autism spectrum disorder
- periodic glaucoma eye tests
- vision and hearing screenings in order to detect the need for additional vision or hearing testing for members when received as part of a routine physical examination (A screening does *not* include an eye examination, refraction or other test to determine the amount and kind of correction needed.)
- health education and counseling services if recommended by your physician, including an annual consultation to discuss lifestyle behaviors that promote health and well-being, including smoking/tobacco use cessation counseling
- contraceptive drugs and devices

The services listed above are not limited as 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 patients 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 examination and you will receive coverage according to the benefits and limitations of your health care plan.

Routine endoscopic colon examinations and barium enemas are payable at 100 percent of covered charge. Invasive diagnostic (i.e., nonroutine) procedures, non-routine colonoscopies and other endoscopies are subject to the outpatient surgery copayment if performed in the outpatient department of a hospital or ambulatory surgery center.

Exclusions

This Plan does **not** cover:

- employment physicals, insurance examinations, or examinations at the request of a third party (the requesting party may be responsible for payment); premarital examinations; sports or camp physicals; any other nonpreventive physical examination
- hepatitis B immunizations when required due to possible exposure during the member's work
- routine eye examinations; eye refractions; or any related service or supply
- routine hearing examinations; hearing aids; or any related service or supply, unless otherwise specified in this section

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 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, an IOP (intensive outpatient program), or an alcoholism treatment program that complies with applicable state laws and regulations, and services rendered by psychiatrists, licensed psychologists, and other providers as defined in *Section 10: Definitions*. See your BCBSNM *Provider Directory* for a list of contracting providers or check the BCBSNM website at www.bcbsnm.com.

Residential Treatment Centers

Residential treatment centers are covered by this Plan. A residential treatment center is a facility offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, and structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, supervised living, group homes, boarding houses, or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients in residential treatment centers are medically monitored with 24-hour medical availability and 24-hour on-site nursing service for patients with mental illness and/or chemical dependency disorders.

BCBSNM requires that any mental health residential treatment center must be appropriately licensed in the state where it is located or accredited by a national organization that is recognized by BCBSNM as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Preauthorization Requirements

All inpatient mental health and chemical dependency services must be preauthorized by the Behavioral Health Unit at the phone number listed on the back of your ID card. Preauthorization is also required for outpatient psychological testing, neuropsychological testing, intensive outpatient program (IOP) treatment, electroconvulsive therapy (ECT), and repetitive transcranial magnetic stimulation for treatment of mental illness and/or chemical dependency. Preauthorization is **not** required for outpatient/office group, individual, or family therapy visits to a physician or other professional provider licensed to perform covered services under this health plan. You or your physician should call the Behavioral Health Unit **before** you schedule treatment. If you do not call before receiving nonemergency services, **benefits for covered services may be reduced or denied** as explained in the *Preauthorizations* section, earlier. In such cases, you may be responsible for all charges, so please ensure that you or your provider have received preauthorization for any services you plan to receive. The BHU Call Center is open 24/7 to assist members and providers with emergency admission inquiries and to respond to crisis calls.

Exclusions

This Plan does **not** cover:

- psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education
- services billed by a school, halfway house or group home, or their staff members; foster care; or behavior modification services
- maintenance therapy or care provided after you have reached your rehabilitative potential

- biofeedback, hypnotherapy, or behavior modification services
- religious or pastoral counseling
- custodial care
- hospitalization or admission to a skilled nursing facility, nursing home, or other facility for the primary purpose of providing custodial care service, convalescent care, rest cures, or domiciliary care to the patient
- services or supplies received during an inpatient stay when the stay is solely related to behavior, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of mental illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions)
- any care that is patient-elected and is not considered medically necessary
- care that is mandated by court order or as a legal alternative, and lacks clinical necessity as diagnosed by a licensed provider; services rendered as a condition of parole or probation
- special education, school testing and evaluations, counseling, therapy, or care for learning deficiencies or educational and developmental disorders; behavioral problems unless associated with manifest mental disorders or other disturbances
- non-national standard therapies, including those that are experimental as determined by the mental health professional practice
- the cost of any damages to a treatment facility

REHABILITATION AND OTHER THERAPY

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

Acupuncture and Spinal Manipulation

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

Cardiac and Pulmonary Rehabilitation

This Plan covers outpatient cardiac rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services.

Chemotherapy and Radiation Therapy

This Plan covers the treatment of malignant disease by standard chemotherapy and treatment of disease by radiation therapy.

Cancer Clinical Trials

If you are a participant in an approved cancer clinical trial, you may receive coverage for certain routine patient care costs incurred in the trial. The trial must be conducted as part of a scientific study of a new therapy or intervention for the prevention of reoccurrence, early detection, or treatment of cancer. The persons conducting the trial must provide BCBSNM with notice of when the member enters and leaves a qualified cancer clinical trial and must accept BCBSNM's covered charges as payment in full (this includes the health care Plan's payment plus your share of the covered charge).

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

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

Benefits for eligible expenses for Routine Patient Care Costs are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by:

- the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
- the National Institutes of Health;
- the United States Food and Drug Administration;
- the United States Department of Defense;
- the United States Department of Veterans Affairs; or
- an institutional review board of an institution in this state that has an agreement with the Office of Human Research Protections of the United States Department of Health and Human Services.

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

Dialysis

This Plan covers the following services when received from a dialysis provider:

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

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

Preauthorization Required

To be covered, all **inpatient**, short-term rehabilitation treatments, including skilled nursing facility and physical rehabilitation facility admissions, must receive **preauthorization** from BCBSNM. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Covered Services

This 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 when **preauthorized** by BCBSNM

Benefit Limits

Benefits are limited, if applicable, as specified in the *Summary of Benefits*. **Note:** Long-term therapy, maintenance therapy, and therapy for chronic conditions are **not** covered. This Plan covers short-term rehabilitation only.

Exclusions

This Plan does **not** cover:

- maintenance therapy or care provided after you have reached your rehabilitative potential (Even if you have not reached your rehabilitative potential, this Plan does not cover services that exceed maximum benefit limits, if any.)
- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay
- services provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered provider
- therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights)
- speech therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic; other speech services that can be carried out by the patient, the family, or caregiver/teacher
- herbs, homeopathic preparations, or nutritional supplements
- services of a massage therapist or rolfing

SUPPLIES, EQUIPMENT AND PROSTHETICS

To be covered, items must be medically necessary and ordered by a health care provider. If you have a question about durable medical equipment, medical supplies, prosthetics or appliances not listed, please call the BCBSNM Health Services Department.

Breast Pumps

The Plan covers the rental (but not to exceed the total cost) or purchase of manual, electric, or hospital grade breast pumps and supplies with a written prescription from a health care provider. The rental or purchase cost of manual, electric, or hospital grade breast pumps and supplies are not subject to coinsurance, deductible, copayment, or benefit maximums when received from an In-Network provider (if your plan has Out-of-Network benefits for nonemergency services, Out-of-Network services are subject to the usual Out-of-Network deductible, coinsurance, and out-of-pocket). Electric breast pumps are limited to 2 per calendar year.

Diabetic Supplies and Equipment

This 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 and insulin pump supplies
- blood glucose monitors, including those for the legally blind
- medically necessary podiatric appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices, and shoe modifications

Reminder: For additional diabetic supply coverage, (e.g., insulin needle and syringes, autolet, glucose meters, test strips for glucose monitors, glucagon emergency kits), see "Prescription Drugs and Other Items."

Durable Medical Equipment and Appliances

This Plan covers the following items**:**

- orthopedic appliances
- replacement of items only when required because of wear (and the item cannot be repaired) or because of a change in your condition

- oxygen and oxygen equipment, wheelchairs, hospital beds, crutches, and other medically necessary durable medical equipment
- lens implants for aphakic patients (those with no lens in the eye) and soft lenses or sclera shells (white supporting tissue of eyeball)
- either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) when needed to replace lenses absent at birth or lost through cataract or other intraocular surgery or ocular injury, to treat conditions related to genetic inborn errors of metabolism, or prescribed by a physician as the only treatment available for keratoconus (Duplicate glasses/lenses are not covered. Replacement is covered only if a physician or optometrist recommends a change in prescription due to a change in your medical condition.)
- cardiac pacemakers

This Plan covers the rental (or at the option of BCBSNM, the purchase of) durable medical equipment (including repairs to or replacement of such purchased items), when prescribed by a covered health care provider and required for therapeutic use.

Medical Supplies

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

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

Orthotics and Prosthetic Devices

This Plan covers the following items when medically necessary and ordered by a provider:

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

When alternative prosthetic devices are available, the allowance for a prosthesis will be based upon the most cost-effective item.

Exclusions

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

- air conditioners, biofeedback equipment, humidifiers, purifiers, self-help devices, or whirlpools
- items that are primarily nonmedical in nature such as Jacuzzi units, hot tubs, exercise equipment, heating pads, hot water bottles, or diapers
- nonstandard or deluxe equipment, such as 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 or rental costs that exceeds the purchase price of a new unit
- dental appliances (See "Dental-Related Services and Oral Surgery" for exceptions.)
- accommodative orthotics (deal with structural abnormalities of the foot, accommodate such abnormalities, and provide comfort, but do not alter function)
- orthopedic shoes, unless joined to braces (Diabetic members should refer to "Diabetic Supplies and Equipment" earlier in this section for information about covered podiatric equipment and orthopedic shoes.)
- equipment or supplies not ordered by a health care provider, including items used for comfort, convenience, or personal hygiene
- duplicate items; repairs to duplicate items; or the replacement of items because of loss, theft, or destruction
- 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 (For surgically implanted devices for the profoundly hearing impaired, see "Surgery and Related Services" below.)
- syringes or needles for self-administering drugs (Coverage for insulin needles and syringes and other diabetic supplies not listed as covered in this section is described under "Prescription Drugs and Other Items.")
- items that can be purchased over-the-counter, including but not limited to dressings for wounds (i.e., bed sores) and burns, gauze, and bandages
- male contraceptive devices, including over-the-counter contraceptive products such as condoms; female contraceptive devices, including over-the-counter contraceptive products such as spermicide, when not prescribed by a health care provider. (See "Maternity/Reproductive Services and Newborn Care: Family Planning" for devices requiring a prescription.)
- items not listed as covered

SURGERY AND RELATED SERVICES

To be covered, preauthorization from BCBSNM must be received for all inpatient surgical procedures. See "Preauthorizations" in *Section 4* for details.

Surgeon's Services

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

Cochlear Implants

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

Mastectomy Services

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

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

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

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

Obesity Surgery

This Plan covers the surgical treatment of morbid obesity if treatment meets medical criteria established by BCBSNM. Medical policies are posted on BCBSNM's website (http://hcsc.com/medical_policies.html) and may change without notice. Check the website for the most current medical policy or call a Customer Service Advocate for assistance. *(Morbid obesity* means 45 kilograms or 100 percent over ideal body weight.)

Reconstructive Surgery

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

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

Exclusions

This Plan does **not** cover:

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

Anesthesia Services

This Plan covers necessary anesthesia services, including acupuncture used as an anesthetic, when administered during a covered surgical procedure by a physician, certified registered nurse anesthetist (CRNA), or other practitioner licensed to provide anesthesia.

Exclusions

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

Assistant Surgeon Services

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

Exclusions

This Plan does **not** cover:

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

TRANSPLANT SERVICES

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. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Facility Must Be in Transplant Network

Benefits for covered services will be approved only when the transplant is performed at a facility that contracts with BCBSNM, another Blue Cross Blue Shield (BCBS) Plan or the national BCBS transplant network, for the transplant being provided. Your BCBSNM case manager will assist your provider with information on the exclusive network of contracted facilities and required approvals. Call BCBSNM Health Services for information on these BCBSNM transplant programs.

Effect of Medicare Eligibility on Coverage

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

Organ Procurement or Donor Expenses

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

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

Bone Marrow, Cornea or Kidney

This Plan covers the following transplant procedures if **preauthorization** is received from BCBSNM (See *Section 4: Preauthorizations* for more information about preauthorization requirements.):

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

Cost-Sharing Provisions

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

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

This Plan covers transplant-related services for a **heart, heart-lung, liver, lung or pancreas-kidney** transplant. Services must be **preauthorized** in order to be covered. All other limitations, requirements, and exclusions of this "Transplant Services" provision apply to these transplant-related services. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

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

Recipient Travel and Per Diem Expenses

If BCBSNM requires you (i.e., the transplant recipient) to temporarily relocate outside of your city of residence to receive a covered transplant, travel to the city where the transplant will be performed is covered. A standard per diem benefit **($50)** will be allocated for lodging expenses for the recipient and one additional adult traveling with the transplant recipient. If the transplant recipient is an eligible child under the age of 18, benefits for travel and per diem expenses for **two adults** to accompany the child are available.

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

Transplant Exclusions

This Plan does **not** cover:

- transplant-related services for a transplant that did not receive **preauthorization** from BCBSNM (See *Section 4: Preauthorizations* for more information about preauthorization requirements.)
- any transplant or organ-combination transplant not listed as covered
- implantation of artificial organs or devices (mechanical heart, unless covered under BCBSNM medical policy)
- nonhuman organ transplants
- care for complications of noncovered transplants or follow-up care related to such transplants
- services related to a transplant performed in a facility not contracted directly or indirectly with BCBSNM to provide the required transplant (except cornea, kidney, or bone marrow)
- expenses incurred by a member of this 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 "Prescription Drugs and Other Items.")
- donor expenses after the donor has been discharged from the transplant facility
- lodging expenses in excess of the per diem allowance, if available, and food, beverage, or meal expenses
- travel or per diem expenses:
    - incurred **more than five days before** or **more than one year following** the date of transplantation
    - if the recipient's case manager indicates that travel is not medically necessary
    - related to a bone marrow 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.

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

— Autism Spectrum Disorders

This Plan does not cover services related to autism spectrum disorders.

— Before Effective Date of Coverage

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

— Biofeedback

This Plan does not cover services related to biofeedback.

— Blood Services

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

— Complications of Noncovered Services

This Plan does not cover any services, treatments, or procedures required as the result of complications of a noncovered service, treatment, or procedure (e.g., due to a cosmetic surgery, transplant, or experimental procedure).

— Convalescent Care or Rest Cures

This Plan does not cover convalescent care or rest cures.

— Cosmetic Services

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

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

Exception: Breast/nipple surgery performed as reconstructive procedures following a covered mastectomy may be covered. However, **Preauthorization**, requested in writing, must be obtained from BCBSNM for such services. Also, reconstructive surgery, which may have a coincidental cosmetic effect, may be covered when required as the result of accidental injury, illness, or congenital defect.

— Custodial Care

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

— Dental-Related Services and Oral Surgery

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

— Domiciliary Care

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

— Duplicate (Double) Coverage

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

— Duplicate Testing

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

— Experimental, Investigational, or Unproven Services

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

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

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

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

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

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

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

— Food or Lodging Expenses

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

— Genetic Testing or Counseling

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

— Hair Loss Treatments

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

— Hearing Examinations, Procedures and Aids

This Plan does not cover audiometric (hearing) tests **unless** 1) required for the diagnosis and/or treatment of an accidental injury or an illness, or 2) covered as a preventive *screening* service (A screening does *not* include a hearing test to determine the amount and kind of correction needed.) **This 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 surgically implanted devices, see "Surgery and Related Services" in *Section 5: Covered Services.*)

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

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

— Hypnotherapy

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

— Infertility Services/Artificial Conception

This Plan does not cover infertility treatments and related services unless such services are part of a preauthorized, covered artificial insemination treatment plan offered by UNMH REIC or preauthorized by both UNMH REIC and BCBSNM. See "Infertility-Related Services" in *Section 5: Covered Services*. **This Plan does not cover** donor sperm, costs associated with the collection, preparation, or storage of sperm for artificial insemination, or donor fees.

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

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

— Late Claim Filing

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

— Learning Deficiencies/Behavioral Problems

This Plan does not cover special education, counseling, therapy, diagnostic testing, treatment, or any other service for learning deficiencies or chronic behavioral problems, whether or not associated with a manifest mental disorder, retardation, or other disturbance.

— Limited Services/Covered Charges

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

— Local Anesthesia

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

— Long-Term and Maintenance Therapy

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

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

— Medically Unnecessary Services

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

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

— No Legal Payment Obligation

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

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

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

— Noncovered Providers of Service

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

- member of your immediate family or a person normally residing in your home
- physician, other person, supplier, or facility (including staff members) that are not specifically listed as covered in this benefit booklet, such as a:
  - — health spa or health fitness center (whether or not services are provided by a licensed or registered provider)
  - — school infirmary
  - — halfway house
  - — massage therapist
  - — private sanitarium
  - — dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group
  - — homeopathic or naturopathic provider
  - — pain clinic or any provider primarily in the practice of pain management or treatment, unless eligible for benefits as part of a covered treatment received from the UNMH Pain Clinic

— Nonemergency Services

This Plan does not cover nonemergency services outside the United States.

— Nonmedical Expenses

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

- adoption or surrogate expenses
- educational programs such as behavior modification and arthritis classes (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; 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, Internet services
- personal comfort services, including homemaker and housekeeping services, except in association with respite care covered during a hospice admission
- immunizations or medications required for international travel
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; phone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- physicals or screening examinations and immunizations given primarily for insurance, licensing, employment, camp, weight reduction programs, medical research programs, sports, or for any nonpreventive purpose
- hepatitis B immunizations when required due to possible exposure during the member's work
- court- or police-ordered services unless the services would otherwise be covered or services rendered as a condition of parole or probation
- the cost of any damages to a treatment facility that are caused by the member

— Nonpreferred Provider (Out-of-Network) Services

This Plan does not cover the following services when received from a nonpreferred provider: acupuncture, spinal manipulation, home birth, family planning, and preventive care.

This Plan does not cover transplants when received from a nonpreferred provider.

This 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 Plan, except during an emergency, if you do not first obtain preauthorization.

— Nonprescription Drugs

This Plan does not cover nonprescription or over-the-counter drugs, medications, ointments, or creams, including herbal or homeopathic preparations, or prescription drugs that have over-the-counter equivalents, except for those products specifically listed as covered under "Prescription Drugs and Other Items."

— Nutritional Supplements

This 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 Plan covers other nutritional products only under specific conditions set forth under "Prescription Drugs and Other Items."

— Obesity Treatment

This Plan does not cover weight-loss or other weight-management programs, dietary control, or medical obesity treatment. The Plan does cover any surgical treatment of obesity including, gastric bypass or other type of bariatric surgery. Obesity means any diagnosis of obesity including morbid obesity according to standard medical policy. Such surgery must be preauthorized by BCBSNM and meet medical criteria for necessity.

— Out-of-Network Services

This Plan does not cover the following services when received from nonpreferred providers: routine or preventive care; transplant, smoking cessation counseling; in infertility services (unless infertility services from a nonpreferred provider are preauthorized by both UNMH and BCBSNM). See *Summary of Benefits* for more information.

— Post-Termination Services

This 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.)

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

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

— Preauthorization Not Obtained When Required

This Plan does not cover certain services if you do not obtain preauthorization from BCBSNM before those services are received. See *Section 4: Preauthorizations.*

— Private Duty Nursing Services

This Plan does not cover private duty nursing services.

— Psychotherapy (Mental Health and Chemical Dependency)

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

— Sexual Dysfunction Treatment

This 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 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 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 described under "Cessation Counseling" in *Section 10: Definitions*
- services of a massage therapist or rolfing
- transactional analysis, encounter groups, and transcendental meditation (TM); moxibustion; sensitivity or assertiveness training
- vision therapy; orthoptics
- pastoral, spiritual, or religious counseling
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this Plan
- therapy for chronic conditions such as, but not limited to, cerebral palsy or developmental delay
- any therapeutic exercise equipment for home use (e.g., treadmill, weights)
- speech therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic, other speech services that can be carried out by the patient, the family, or caregiver/teacher

— Thermography

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

— Transplant Services

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

— Travel or Transportation

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

— Veteran's Administration Facility

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

— Vision Services

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

— War-Related Conditions

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

— Weight Management

This Plan does not cover weight-loss or other weight-management programs, dietary control, or medical obesity treatment. The Plan does cover any surgical treatment of obesity including, gastric bypass or other type of bariatric surgery. Obesity means any diagnosis of obesity including morbid obesity according to standard medical policy. Such surgery must be preauthorized by BCBSNM and meet medical criteria for necessity.

— Work-Related Conditions

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

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

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

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

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

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

SECTION 7: COORDINATION OF BENEFITS (COB) AND REIMBURSEMENT

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

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

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

The following rules determine which coverage pays first:

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

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

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

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

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

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

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

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

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

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

Responsibility For Timely Notice

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

Facility of Payment

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

Overpayments – Right of Recovery

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

REIMBURSEMENT

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

- **UNMH** 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 **UNMH** has provided benefits to you or your covered family members.
- **UNMH** is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits **UNMH** provided for that sickness or injury.

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

You are required to furnish any information or assistance or provide any documents that BCBSNM and/or **UNMH** 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 6 months** after the date services or supplies were received. If a claim is returned for further information, resubmit it **within 45 days. Note:** If there is a change in the Claims Administrator, the length of the timely filing period may also change.

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 preauthorization requirements or benefits may be reduced or denied as explained in *Section 4: 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 Plan, you need to file your claim with the other coverage first. (See *Section 7: Coordination of Benefits (COB) and Reimbursement.*) After your other coverage (including health care insurance, dental or vision plan, Medicare, automobile, or other liability insurance, Workers' Compensation, etc.) pays its benefits, a copy of their payment explanation form must be attached to the claim sent to BCBSNM or to the local BCBS Plan, as instructed under "Where to Send Claim Forms" later in this section.

If the other valid coverage pays benefits to you (or your family member) directly, give your provider a copy of the 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.)

IN-NETWORK (PARTICIPATING AND PREFERRED) PROVIDERS

Your In-Network provider may have two agreements with the local BCBS Plan — a In-Network (preferred provider) contract and another participating provider contract. Some providers have **only** the participating provider contract and are **not** considered In-Network (preferred provider)s. However, all participating and In-Network (preferred provider)s 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.

In-Network (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. Remember: A provider must be contracted with BCBSNM as an HMO participating provider or be a UNM Hospital facility or a health care provider employed by UNM/UNMH in order to be considered an In-Network provider. All other providers are Out-of-Network and services you receive from the require preauthorization.

OUT-OF-NETWORK (NONPARTICIPATING) PROVIDERS

A nonparticipating provider is one that has neither a preferred or a participating provider agreement. If your Out-of-Network (nonparticipating) provider does not file a claim for you, submit a separate claim form for each family member as the services are received. Attach itemized bills and, if applicable, your other valid coverage's payment explanation, to a *Member Claim Form.* (Forms can be printed from the BCBSNM website at www.bcbsnm.com or requested from a Customer Service Advocate.) Complete the claim form using the instructions on the form. (See special claim filing instructions for out-of-country claims under "Where to Send Claim Forms" later in this section). You must submit claims for services received from Out-of-Network providers within six months after the date services or supplies were received. Any claims filed after this time limit will be refused, unless BCBSNM is satisfied that there was a valid reason why you could not submit your claim within this time limit. Note: if there is a

change in BCBSNM, the length of this timely filing period may also change. If a claim is returned for further information, resubmit it within 45 days.

Payment normally is made to the provider. However, if you have already paid the provider for the services being claimed, your claim must include evidence that the charges were paid in full. Upon approval of the claim, BCBSNM will reimburse you for covered services, based on covered charges, less any required member copayment. You will be responsible for charges not covered by the Plan.

ITEMIZED BILLS

Claims for covered service must be itemized on the provider's billing forms or letterhead stationery and must show:

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

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

Do not file for the same service twice unless asked to do so by a Customer Service Advocate. If your itemized bills include services previously filed, 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 Out-of-Network (nonparticipating) provider does not file a claim for you, you (not the provider) are responsible for filing the claim. **Remember:** In-Network (participating and preferred) providers will file claims for you; these procedures are used only when you must file your own claim.

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

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

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

Mental Health/Chemical Dependency Claims

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

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

Drug Plan Claims

If you purchase a prescription drug or other item covered under the drug plan from a nonparticipating pharmacy or other provider in an emergency, or if you do not have your ID card with you when purchasing a prescription or other covered item, you must pay for the prescription in full and then submit a claim to BCBSNM's pharmacy benefit manager. **Do not send these claims to BCBSNM.** The bills or receipts must be issued by the pharmacy and must include the pharmacy name and address, drug name, prescription number, and amount charged. If not included in your enrollment materials, you can obtain the name and address of the pharmacy benefit manager and the necessary claim forms from a Customer Service Advocate or on the BCBSNM website at www.bcbsnm.com.

Send Retail Pharmacy claims to:
Prime Therapeutics
P.O. Box 14624
Lexington, KY 40512-4624

IF YOU HAVE MEDICARE

NOTE: This section applies to you only if you are primary under Medicare and Plan benefits are going to be coordinated with Medicare as a result. If you are not sure if Medicare is primary or secondary, please see "If You Have Medicare" in *Section 3: How Your Plan Works* for a brief explanation or call the Social Security office for more information.

Filing Claims if Medicare is Primary

If you have Medicare and Medicare is primary over this Plan (i.e., a member that has exhausted the end-stage renal disease coordination time period under Medicare), when you receive health care, be sure to present both your Medicare ID card and your **UNMH** Plan ID card issued by BCBSNM. Always present your Medicare ID card to your health care providers so that they will bill Medicare first. After Medicare has paid its portion **for services received in New Mexico,** a claim should automatically be sent by the Medicare Part B carrier or Part A intermediary to BCBSNM for secondary benefit determination. (If your claims are not being sent by Medicare to BCBSNM, please call a Customer Service Advocate to verify that the correct Medicare HIC number is on file for you. Also, in order to ensure that claims are filed properly, the provider must have information form the ID cards issued to you by **both** Medicare and BCBSNM.)

If you must file a claim for services that were covered by Medicare (for example, because services were received outside New Mexico and the claim does not automatically "cross-over" once Medicare has paid its portion), you will have to file a copy of the EOMB that you receive from Medicare and all other required claim information with the local BCBS Plan. ON the EOMB you receive from Medicare, **print your Plan ID number (found on your Plan ID card issued by BCBSNM) - including the three alphabetic characters that precede the nine-digit number - and your correct mailing address and zip code.** Make a copy of the EOMB for your records.

Mail claims, EOMBs, and other needed information to the local BCBS Plan in the state where you receive services. Your provider should be familiar with this process, and in most cases, will file on your behalf. If you receive services in New Mexico and need to file a claim to BCBSNM, send the claim to:

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

Medicare-Covered Facility Services

All Medicare-participating providers of Part A services, including skilled nursing facilities and hospice agencies, will submit claims directly to Medicare. To file claims, the facility must have the information from the identification cards issued to you by **both** Medicare and BCBSNM.

After Medicare Part A has paid its portion of covered charges for services received in New Mexico, it is **not** necessary for you to file a claim for a claim for most facility services with BCBSNM. These claims are automatically submitted by the Medicare Part A intermediary to BCBSNM. An *Explanation of Benefits* will be sent to you by BCBSNM after Plan benefits have been determined. If you must file your own claim after Medicare pays its portion (for example, because services were received outside New Mexico), you must file a claim for services

received from the hospital, along with Medicare's EOMB, **to the local BCBS Plan.** (See instructions in this section.)

Medicare–Covered Non–Facility Services

A claim for physician and other professional provider services must be filed **first** with Medicare Part B Medical Insurance. (All Medicare providers must file claims for you to Medicare.)

If you have given your **UNMH** Plan ID card to your provider, the Medicare Part B carrier will send an electronic copy of the claim to BCBSNM **if the services are received in New Mexico.** If Medicare does not have your **UNMH** Plan ID number, you must file a copy of the EOMB and all other required information with BCBSNM after Medicare has sent an EOMB to you. Even though providers may file claims on your behalf, it is **your** responsibility to make sure that the claim is filed to BCBSNM. If you must file your own claim after Medicare pays its portion (for example, because services were received outside New Mexico), you must file the claim for services received from the provider, along with Medicare's EOMB, **to the local BCBS Plan.** (See instructions in this section.)

Services Not Covered by Medicare

You may have to file your claim yourself. If your provider does not file a claim for you, you must submit a separate claim form for each family member. Submit all claims as the services are received. If a service is normally covered by Medicare, you must submit a copy of the EOMB (showing Medicare's denial reason) with the claim form that you send to BCBSNM.

When an EOMB is Not Required

An EOMB indicating Medicare denied the service is required on all claims except claims for:

- services received outside the Medicare territorial limits
- services from providers with whom you have privately contracted (BCBSNM will estimate what Medicare would have paid had you not privately contracted with the provider and had submitted the claim to Medicare for payment.)
- services received from licensed professional clinical mental health counselors (LPCC) and licensed marriage and family therapists (LMFT). (However, you will need **preauthorization** from BCBSNM in order to receive benefits for covered mental health and chemical dependency services received from LPCC and LMFT providers.)

NOTE: If the services you intend to receive would be covered by Medicare if you were to obtain the service from a Medicare–eligible provider, you or your provider must call BCBSNM for **preauthorization** before receiving services from such a provider. This will verify that the services being planned will be or will not be covered under the Plan and if the services require additional preauthorization from BCBSNM. If a Medicare provider is in your area and able to provide the services you need, you may be required to receive the service from a Medicare–eligible provider in order to receive benefits under the **UNMH** Plan.

Services Outside Medicare Territorial Limits

When services are received outside the Medicare territorial limits, you must pay for the services or supplies. **Keep copies of your receipts.** File claims as you would for any other service not covered by Medicare. (Medicare defines *Medicare territorial limits* as the United States, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.)

If you receive covered services while outside the United States, call the BlueCard Worldwide Service Center, collect, at 804–673–1177 for assistance with claims filing. Or visit the Blue Cross and Blue Shield Association website to locate nearby participating physicians and hospitals.

To submit a claim for services received outside the Medicare territorial limits, you do not need an EOMB.

CLAIMS PAYMENT PROVISIONS

Most claims will be evaluated and you and/or the provider notified of the BCBSNM benefit decision within 30 days of receiving the claim. If all information needed to process the claim has been submitted, but BCBSNM cannot make a

determination within 30 days, you will be notified (before the expiration of the 30-day period) that an additional 15 days is needed for claim determination.

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

If A Claim or Preauthorization 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. (See "Grievance Procedures," later in this section.) **You also have 180 days in which to appeal a decision.**

Covered Charge

Provider payments are based upon In-Network (preferred provider) and participating provider agreements and covered charges as determined by BCBSNM. For services received outside of New Mexico, covered charges may be based on the local Plan practice (e.g., for out-of-state providers that contract with their local Blue Cross and Blue Shield Plan, the covered charge may be based upon the amount negotiated by the other Plan with its own contracted providers). You are responsible for paying copayments, deductibles, coinsurance, 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.

In-Network (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.

Out-of-Network (Nonparticipating) Providers

If covered services are received from a nonparticipating provider, payments are usually made to the subscriber (or to the applicable alternate payee when a QCMSO is in effect). The check will be attached to an EOB that explains BCBSNM's payment. In these cases, you are responsible for arranging payment to the provider and for paying any amounts greater than covered charges plus copayments, deductibles, coinsurance, 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 judgment obtained by you when the facility has not been paid its total billed charges from all other sources.

Assignment of Benefits

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

Emergency Service Pricing

Notwithstanding anything in this booklet to the contrary, for Out-of-Network emergency care services, the covered charge shall be equal to at least the greatest of the following three amounts - not to exceed billed charges:

- the median amount negotiated with In-Network providers for emergency care services furnished;
- the amount for the emergency care service calculated using the same method the Plan generally uses to determine payments for nonparticipating provider services but substituting the In-Network provider cost-sharing provisions for the Out-of-Network cost-sharing provisions; or

- the amount that would be paid under Medicare for the emergency care service.

Each of these three amounts is calculated excluding any In-Network copayment or coinsurance imposed with respect to the member.

Medicaid

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

Overpayments

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

Pricing of Noncontracted Provider Claims

The BCBSNM covered charge for some covered services received from noncontracted providers is the lesser of the provider's billed charges or the BCBSNM "noncontracting allowable amount." The BCBSNM noncontracting allowable amount is based on the **Medicare Allowable** amount for a particular service, which is determined by the Centers for Medicaid and Medicare Services (CMS). The Medicare Allowable is determined for a service covered under your BCBSNM health plan using information on each specific claim and, based on place of treatment and date of service, is multiplied by an "adjustment factor" to calculate the BCBSNM noncontracting allowable amount. The adjustment factor for nonemergency services are:

- 100% of the base Medicare Allowable for inpatient facility claims
- 300% of the base Medicare Allowable for outpatient facility claims
- 200% of the base Medicare Allowable for freestanding ambulatory surgical center claims
- 100% of the base Medicare Allowable for physician, other professional provider claims, and other ancillary providers of covered health care services and supplies

Certain categories of claims for **covered services** from noncontracted providers are excluded from this noncontracted provider pricing method. These include:

- services for which a Medicare Allowable cannot be determined based on the information submitted on the claim (in such cases, the covered charge is 50 percent of the billed charge)
- home health claims (the covered charge is 50 percent of the billed charge)
- services administered and priced by any subcontractor of BCBSNM or by the Blue Cross and Blue Shield Association
- claims paid by Medicare as primary coverage and submitted to your health plan for secondary payment
- New Mexico ground ambulance claims (for which the state's Office of Superintendent of Insurance sets fares)
- covered claims priced by a non-New Mexico BCBS Plan through BlueCard using local pricing methods

Pricing for the following categories of claims for **covered services** from noncontracted providers will be priced at billed charges or at an amount negotiated by BCBSNM with the provider, whichever is less:

- covered services required during an emergency and received in a hospital, trauma center, or ambulance
- for PPO health plans, services from noncontracted providers that satisfy at least one of the three conditions below and, as a result, are eligible for the In-Network (preferred provider) benefit level of coverage

  -covered services from noncontracted providers within the United States that are classified as "unsolicited" as explained earlier in *Section 3: How Your Plan Works* and as determined by the member's Host Plan while outside the service area of BCBSNM

-**preauthorized** transition of care services received from noncontracted providers

-covered services received from a noncontracted anesthesiologist, pathologist, or radiologist while you are a patient at a **contracted** facility receiving covered services or procedures that have been preauthorized, if needed

BCBSNM will use essentially the same claims processing rules and/or edits for noncontracted provider claims that are used for contracted provider claims, which may change the covered charge for a particular service. If BCBSNM does not have any claim edits or rules for a particular covered service, BCBSNM may use the rules or edits used by Medicare in processing the claims. Changes made by CMS to the way services or claims are priced for Medicare will be applied by BCBSNM within 90–145 days of the date that such change is implemented by CMS or its successor.

IMPORTANT: Regardless of the pricing method used, the BCBSNM covered charge will usually be less than the provider's billed charge and **you will be responsible** for paying to the provider the difference between the BCBSNM covered charge and the noncontracted provider's billed charge for a covered service. **This difference may be considerable.** The difference is **not** applied to any deductible or out–of–pocket limit. In the case of a noncovered service, you are responsible for paying the provider's full billed charge directly to the provider. **Reminder:** Contracted providers will **not** charge you the difference between the BCBSNM covered charge and the billed charge for a covered service.

COMPLAINTS (GRIEVANCES) AND APPEALS: SUMMARY OF PROCEDURES

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

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

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

BCBSNM Contacts for Appeals

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

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

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

Eligibility and Other Administrative Grievance – UNM Hospitals is responsible for determining employee eligibility for coverage. If you have a complaint about your eligibility, termination, contribution for coverage, or any other issue related to eligibility, please contact Employee Benefits Services or Human Resources.

External Action – If you are still not satisfied after having completed the BCBSNM complaint, appeals, grievance, or reconsideration procedure, you may have the option of taking other steps, as outlined in the Appendix: Notice – Inquires/Complaints and Internal/External Appeals for Self-Funded Plans (see Appendix in the back of this booklet) applicable to your health plan.

Request for Medicare Reconsideration – When Medicare Part A or B denies part or all of a claim, you can obtain from a local Social Security Office information on how to request reconsideration or review of denied Medicare claims and a description of your rights to appeal Medicare claims decisions.

If Medicare makes an additional payment after reconsideration, file the new Explanation of Medicare Benefits form (EOMB) to BCBSNM for additional reimbursement under this Plan..

External Actions

If you are still not satisfied after having completed the BCBSNM complaint, appeal, grievance, or reconsideration procedure, you may have the option of taking other steps, as outlined in the *Appendix: Notice – Inquiries/Complaints and Internal/External Appeals for Self-Funded Plans* notice applicable to your health plan. No legal action may be taken or arbitration demand made earlier than **60 days** after BCBSNM has received the claim for benefits or preauthorization request, or later than **three years** after the date that the claim for benefits should have been filed with BCBSNM.

Retaliatory Action

BCBSNM and UNMH shall not take any retaliatory action against you for making a complaint or filing an appeal under this health plan.

Binding Arbitration

If a dispute about coverage, benefits, or handling of claims or appeals continues after you have followed an exhausted the complaint and appeal process set forth above, the issue or claim may be submitted to binding arbitration. The rules for arbitration shall be the Commercial Arbitration Rules developed by the American Arbitration Associations (AAA) and any other applicable AAA rules for procedures. You may obtain a copy of these rules from a BCBSNM Customer Service Advocate. The rules are also available from the American Arbitration Association's website (www.ard.org).

The decisions in arbitration are binding upon both you and the Plan. Judgement on the awarded given in arbitration may be enforced in any court that has proper authority. Damages, if any, are limited to the amount of the benefit payment in dispute plus reasonable costs. UNM Hospitals (including the Board of Regents of the University of New Mexico) and the Claims Administrator (including BCBSNM and Health Care Service Corporation (HSCS)), are not liable for punitive damages or attorney fees. This is a mandatory arbitration clause, meaning that if you choose to continue with your dispute against BCBSNM or UNM Hospitals, it must be through a AAA arbitration. You are barred from filing a legal action (civil lawsuit) again UNM Hospitals, the Board of Regents of the University of New Mexico, or BCBSNM (including HSCS).

No arbitration demand may be made less than 60 days after BCBSNM has received the claim for benefits or preauthorization request, or later than three years after the date that the claim for benefits should have been filed with BCBSNM.

SECTION 9: GENERAL PROVISIONS

AVAILABILITY OF PROVIDER SERVICES

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

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.

CHANGES TO THE BENEFIT BOOKLET

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

DISCLAIMER OF LIABILITY

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

Nothing in this benefit booklet is intended to limit, restrict, or waive any member rights under the law and all such rights are reserved to the individual.

DISCLOSURE AND RELEASE OF INFORMATION

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

EXECUTION OF PAPERS

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

INDEPENDENT CONTRACTORS

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

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

MEMBER RIGHTS

All members have these rights:

- The right to available and accessible services, when medically necessary, as determined by your primary care or treating physician in consultation with BCBSNM, 24 hours per day, 7 days a week, or urgent or emergency care services, and for other health services as defined by your benefit booklet.
- The right to be treated with courtesy and consideration, and with respect for your dignity and your need for privacy.

- The right to have their privacy respected, including the privacy of medical and financial records maintained by BCBSNM and its health care providers as required by law.
- The right to be provided with information concerning BCBSNM's policies and procedures regarding products, services, providers, and appeals procedures and other information about the company and the benefits provided.
- The right to receive from your physician(s) or provider, in terms that you understand, an explanation of your complete medical condition, recommended treatment, risk(s) of treatment, expected results and reasonable medical alternatives, irrespective of BCBSNM's position on treatment options. If you are not capable of understanding the information, the explanation shall be provided to your next of kin, guardian, agent or surrogate, if able, and documented in your medical record.
- The right to file a complaint or appeal with BCBSNM and to receive an answer to those complaints within a reasonable time.
- The right to detailed information about coverage, maximum benefits, and exclusions of specific conditions, ailments or disorders, including restricted prescription benefits, and all requirements that you must follow for preauthorization and utilization review.
- The right to make recommendations regarding BCBSNM's member rights and responsibilities policies.
- The right to a complete explanation of why care is denied, an opportunity to appeal the decision to BCBSNM's internal review and the right to a secondary appeal.

MEMBER RESPONSIBILITIES

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

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

MEMBERSHIP RECORDS

BCBSNM will keep membership records and the employer will periodically forward information to BCBSNM to administer the benefits of this Plan. You can inspect all records concerning your membership in this 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.

TRANSFER OF BENEFITS

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

SECTION 10: DEFINITIONS

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

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

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

Adjustment factor — The percentage by which the Medicare Allowable amount is multiplied in order to arrive at the "noncontracting allowable amount." (See definition of "Covered charge.") Adjustment factors will be evaluated and updated no less than every two years.

Administrative Services Agreement — A contract for health care services which by its terms limits eligibility to members of a specified group. The Administrative Services Agreement includes the Benefit Program Application and may include coverage for family members.

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

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

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

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.

Benefit booklet — This document or evidence of coverage issued to you along with your separately issued *Summary of Benefits*, explains the benefits, limitations, exclusions, terms, and conditions of your health coverage.

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

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

BlueCard — BlueCard is a national program that enables members of one Blue company to obtain healthcare services while traveling or living in another Blue company's service area. The program links participating healthcare providers with the independent Blue companies across the country and in more than 200 countries and territories worldwide., through a single electronic network for claims processing and reimbursement.

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

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

Calendar year — A calendar year (also known as a benefit period) is a period of one year that begins on January 1 and ends on December 31 of the same year (also referred to as calendar year). The initial calendar year benefit period is from a 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 of cancer for which standard cancer treatment has not been effective or does not exist. It does not include trials designed to test toxicity or disease pathophysiology, but must have a therapeutic intent and be provided as part of a study being conducted in a cancer clinical trial in New Mexico. The scientific study must have been approved by an institutional review board that has an active federal-wide assurance of protection for human subjects and include all of the following: specific goals, a rationale and background for the study, criteria for patient selection, specific direction for administering the therapy or intervention and for monitoring patients, a definition of quantitative measures for determining treatment response, methods for documenting and treating adverse reactions, and a reasonable expectation based on clinical or pre-clinical data, that the treatment will be at least as effective as standard cancer treatment. The trial must have been approved by a United States federal agency or by a qualified research entity that meets the criteria established by the federal National Institutes of Health for grant eligibility.

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

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

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

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

- is designed to build positive behavior change practices and provides counseling at a minimum on: establishment of reasons for quitting, understanding nicotine addiction, techniques for quitting, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse prevention information, and follow-up;
- operates under a written program outline that meets minimum requirements established by the Office of Superintendent of Insurance;

- employs counselors who have formal training and experience in tobacco cessation programming and are active in relevant continuing education activities; and
- uses a formal evaluation process, including mechanisms for data collection and measuring participant rate and impact of the program.

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

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

Child — See definition of "Eligible Family Member" in *Section 2: Enrollment and Termination Information.*

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

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

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

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

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

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

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

Contracted provider — A provider that has a contract with BCBSNM or another BCBS Plan to bill BCBSNM (or other BCBS Plan) directly and to accept this health plan's payment (provided in accordance with the provisions of the contract) plus the member's share (coinsurance, deductibles, copayments, etc.) as payment in full for covered services. Also see "Network provider (In-Network provider)," in this section.

Copayment — The fixed-dollar amount (or, in some cases, a percentage) that you must pay to a health care provider upfront in order to receive a specific service or benefit covered under this Plan. Copayments are listed on the *Summary of Benefits.*

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 that BCBSNM allows for covered services using a variety of pricing methods and based on generally accepted claim coding rules. The covered charge for services from "contracted providers" is the amount the provider, by contract with BCBSNM (or another entity, such as another BCBS Plan), will accept as payment in full under this health plan. For information about pricing of noncontracted provider claims, see "Pricing of Noncontracted Provider Claims" in *Section 8: Claim Payments and Appeals*.

Noncontracting allowable amount — The maximum amount, not to exceed billed charges, that will be allowed for a covered service received from a noncontracted provider in most cases. The BCBSNM noncontracting allowable amount is based on the **Medicare Allowable** amount for a particular service, which is determined by the Centers for Medicaid and Medicare Services (CMS).

Medicare Allowable — The amount allowed by CMS for Medicare-participating provider services, which is also used as a base for calculating noncontracted provider claims payments for some covered services of noncontracted providers under this health plan. The Medicare Allowable amount will not include any additional payments that are not directly tied to a specific claim, for example, medical education payments. If Medicare is primary over this health plan, and has paid for a service, the covered charge under this health plan may be one of the two following amounts:

Medicare-approved amount — The Medicare fee schedule amount upon which Medicare bases its payments. When Medicare is the primary carrier, it is the amount used to calculate secondary benefits under this health plan when no "Medicare limiting charge" is available. The Medicare-approved amount may be less than the billed charge.

Medicare limiting charge — As determined by Medicare, the limit on the amount that a nonparticipating provider can charge a Medicare beneficiary for some services. When Medicare is the primary carrier and a limiting charge has been calculated by Medicare, this is the amount used to determine your secondary benefits under this health plan. **Note:** Not all Medicare-covered services from nonparticipating providers are restricted by a Medicare limiting charge.

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

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

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

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

Deductible — The amount of covered charges that you must pay in a calendar year before this Plan begins to pay its share of covered charges you incur during the same benefit period. If the deductible amount remains the same during the calendar year, you pay it only once each calendar year and it applies to all covered services you receive during that calendar year.

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

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

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 abuse treatment facility— An appropriately licensed provider primarily engaged in detoxification and rehabilitation treatment for chemical dependency.

Drug plan— The benefits and coverage for prescription drugs, insulin, diabetic supplies, nonprescription enteral nutritional products and special medical foods required for inborn errors of metabolism.

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

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

Eligible family members — See "Eligible Family Members" in *Section 2: Enrollment and Termination Information* for more information about eligible family members.

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, services must be received in an emergency room, trauma center, or ambulance to qualify as an emergency. Examples of emergency conditions include, but are not limited to: heart attack or suspected heart attack, coma, loss of respiration, stroke, acute appendicitis, severe allergic reaction, or poisoning.

Employee probationary period — The number of months or days of continuous employment beginning with the employee's most recent date of hire and ending on the date the employee first becomes eligible for coverage under the employer's group. Your employer determines the length of the probationary period.

Employee+One coverage — Coverage that lists the subscriber (employee) and either the subscriber's spouse or one eligible child as covered members under the Plan.

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).

EOMB — The "Explanation of Medicare Benefits form that Medicare" beneficiaries receive from Medicare explaining Medicare's payment or denial of a claim.

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).

Family coverage — Coverage that lists the subscriber (employee) and two or more eligible family members (spouse, domestic partner, or child) as covered members under the plan.

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

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

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

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

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

Habilitative services — 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.

Health Care Facility — An institution providing health care services, including a hospital or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing facility, a residential treatment center, a home health care agency, a diagnostic laboratory or imaging center, and a rehabilitation or other therapeutic health setting.

HMO–participating provider — Either a facility (e.g., a hospital) or a professional provider (e.g., a physician) that, for the service being provided, contracts with BCBSNM, either directly or indirectly, as an HMO–participant provider or, for the transplant being provided, with the national BCBS transplant network to provide health care services to members with an expectation of receiving payment (other than copayments) directly or indirectly from BCBSNM. These providers are part of the Standard Network under the *Standard Network*. See "In–Network Provider" for more information.

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.)

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

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

Initial enrollment eligibility date — A 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.

In-Network Provider — Any provider in the *Standard Network*

Standard (LoboCare) Network Providers – Health care providers employed by UNM/UMNH, including all UNM Hospitals. The network also includes a limited number of non-UNM/UNMH HMO-participating health care providers that contract with BCBSNM as part of the Standard Network.

An In-Network Provider may be either facility (e.g., a hospital) or a professional provider (e.g., a physician) that is a UNM Hospital facility or a health care provider employed by UNM/UNMH or, for the service begin provided, contract with BCBSNM, a contractor of subcontractor of BCBSNM, or the national BCBS Association transplant network to provide health care services to managed care plan members with an expectation of receiving payment (other than copayments, coinsurance or deductible) directly or indirectly from BCBSNM. An I-Network Provider also agrees to bill BCBSNM directly and to accept this Plan's payment (provided in accordance with the provisions of the contract) plus the member's copayment as payment in full for covered services. BCBSNM will pay the In-Network provide directly. (A provider that contracts with BCBSNM or another BCBS Plan, but is not part of the BCBSNM HMO participating network is not considered an In-Network Provider under either network.

BCBSNM may add, change, or terminate specific HMO participating network provider at its discretion or recommend a specific provider for specialized care as medical necessity warrants. Network providers are not requires by BCBSNM to comply with any specified numbers, targeted average, or maximum durations of patient visits.

Inpatient services — Care provided while you are confined as an inpatient in a hospital or treatment center for at least 24 hours. Inpatient care includes partial hospitalization (a nonresidential program that includes from 5-12 hours of continuous mental health or chemical dependency care during any 24-hour period in a treatment facility).

Intensive outpatient program (IOP) — Distinct levels or phases of treatment that are provided by a certified/licensed chemical dependency or mental health program. IOPs provide a combination of individual, family, and/or group therapy in a day, totaling nine or more hours in a week.

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

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

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

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

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

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

LoboCare Network — the Standard Network. See "In-Network Providers" earlier in this section.

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

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

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

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

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

Medical 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 family member) who is enrolled for coverage and entitled to receive benefits under this Plan in accordance with the terms of the Administrative Service Agreement. Throughout this benefit booklet, the terms "you" and "your" refer to each member.

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

Network provider (In-Network provider) — A contracted provider that has agreed to provide services to members in your *specific* type of health plan (e.g., PPO, etc.).

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

Noncontracting allowable amount— See definition of "Covered charge" earlier in this section.

Nonparticipating provider — An appropriately licensed health care provider that has not contracted directly or indirectly, for the service being provided, with BCBSNM. See the *Summary of Benefits* for those services that are not covered if received from a nonpreferred provider (all nonparticipating providers are also nonpreferred providers).

Nonpreferred provider — Providers that have not contracted with BCBSNM, either directly or indirectly (for example, through another BCBS Plan). These providers may have "participating-only" or "HMO" provider agreements, but are **not** considered "preferred" providers and are **not** eligible for Preferred Provider coverage under your health plan -unless listed as an exception under "Benefit Exceptions for Nonpreferred Providers" earlier in the booklet. **Note: See the *Summary of Benefits* for those services that are not covered if received from a nonpreferred provider.**

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.

Open enrollment — The designated period prior to the group's anniversary date during which any eligible, active employee and his/her eligible family members may enroll under this Plan, newly acquired family members may be added to an employee's coverage, and subscribers may change coverage.

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 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–area services — Covered services that are provided to you when outside the BCBSNM HMO service area. The service area includes all counties in New Mexico.

Out–of–Network Provider — Under the *Standard Network*, any provider that is not in the Standard Network :

BCBS–participating provider – A provider that contracts directly or indirectly with BCBSNM or another BCBS Plan for the service being provided (but is not part of the Standard Network. These providers will accept the covered charge (i.e., the Plan's payment and your share of covered charges) as payment in full for covered services. They will also file claims on your behalf, but are not obligated to obtain preauthorization on your behalf. If the proper preauthorization for their services is not received, you are responsible for paying any services that re denied as a result.

Nonparticipating Providers – An appropriately licensed Out–of–Network health care provider that has not contracted with BCBSNM or, in the states where services are provided, with the local BCBS Plan as a BCBS –participating provider for the service being provided. These providers will not write off the difference between their billed charge and their covered charge. This difference can be considerable – and it is not applied to any deductible or out–of–pocket limit under the Plan. You will be entirely responsible for payment of this difference. Nonparticipating providers are also not obligated to file claims on your behalf.

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

Outpatient services — Medical/surgical services received in the outpatient department of a hospital, observation room, emergency room, ambulatory surgical facility, freestanding dialysis facility, or other covered outpatient treatment facility.

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

Participating pharmacy — See the definition of "Provider."

Participating provider — See "HMO–participating provider" to learn more about the BCBS HMO–contracted subject of Standard Network provides under the *Standard Network*. See "Out–of–Network Providers: BCBS–participating providers," in this section to learn about other Out–of–Network providers that contract with a BCBS Plan, but not as MHO–contracted providers. (if the term is being used in reference to a Medicare–covered services, see "Medicare–participating provider.")

Pharmacy–related definitions — The definitions below are specifically related to pharmacy services.

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

Coinsurance — A **percentage** amount paid by you for each covered specialty pharmacy prescription order filled through a designated specialty pharmacy provider.

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

Drug List — A list of non-specialty prescription drugs and specialty drugs preferred for use by BCBSNM for pharmacy benefits under BCBSNM health plans. (Specialty drugs are also listed on the separate specialty drug list). The drugs on the drug list have been selected to provide coverage for a broad range of diseases. Each drug listed shows to which tiered category it belongs under your 6-tier drug plan: tier 1 for preferred generic drugs; tier 2 for nonpreferred generic drugs, tier 3 for preferred brand-name drugs; and tier 4 for nonpreferrred brand name drugs, tier 5 for preferred specialty drugs, and tier 6 for nonpreferred specialty drugs. How your cost for a covered prescription drug is determined, in accordance with the applicable tier to which it belongs, is described in the "Member Copayment and Coinsurance" section of this rider. Brand-Name Drugs may be included on the drug list when a generic drug is not available to treat a specific medical condition or the brand-name drug offers a significant advantage over available generic drugs as determined by BCBSNM. The drug list is developed using information from the American Medical Association, Academy of Managed Care Pharmacies, and other pharmacy- and medical-related organizations. The drug list is subject to periodic review and change by BCBSNM. A copy of it is available on the BCBSNM website at www.bcbsnm.com. You may also contact a customer service advocate, and BCBSNM-contracted providers may contract their network representative, for a copy.

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).

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

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

Pharmacy — A state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any provider's office, and where drugs and devices are dispensed under prescription orders to the general public by a pharmacist licensed to dispense such drugs and devices under the law of the state in which he/she practices.

Nonpreferred brand-name drug — A covered **non-specialty** brand-name prescription drug product or other item that is **not** identified on the *Preferred Drug List.* See "Specialty drugs," below if the drug is listed on the *Specialty Drug List*.

Nonpreferred generic drug — A covered generic drug product or other item that is not identified on the drug list as preferred and is subject to the nonpreferred generic drug tier payment level.

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

Preferred brand-name drug — A covered **non-specialty** brand-name prescription drug product or other item that is identified on the *Preferred Drug List.*

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

Prescription drugs, medicines and devices — Those that are taken at the direction and under the supervision of a provider, that require a prescription before being dispensed, and are labeled as such on their packages. All prescription drugs, medicines and devices must be approved by the FDA, and must not be experimental, investigational, or unproven. (See "Experimental, Investigational, or Unproven Service" in *Section 6: General Limitations and Exclusions*.)

Special medical foods — Nutritional substances in any form that are consumed or administered internally under the supervision of a physician, specially processed or formulated to be distinct in one or more nutrients present in natural foods; intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and essential to optimize growth, health, and metabolic homeostasis. Special medical foods are not for use by the general public and may not be available in stores or supermarkets. Special medical foods are not those foods included in a health diet intended to decrease the risk of disease, such as reduced-fat foods, low sodium foods, or weight loss products.

Specialty drugs — Prescription drugs that: a) are high cost, b) are used in limited patient populations or indications, c) are typically self-injected, d) have limited availability, require special dispensing or delivery, and/or patient support is required and, therefore, are difficult to obtain via traditional pharmacy channels, and/or e) require complex reimbursement procedures. These drugs must be purchased through the designated BCBSNM specialty pharmacy provider in order to be covered. Specialty drugs are subject to the Tier 5 or Tier 6 copayment level; see "Member Copayments and Coinsurance".

Nonpreferred specialty drug — A **specialty** drug that is on the *Specialty Drug List* but is **not** identified as being a "preferred" specialty drug. A covered nonpreferred specialty drug is subject to the **Tier 6** copayment level.

Preferred specialty drug — A **specialty** drug that is on the *Specialty Drug List* and is identified as being a "preferred" specialty drug. A covered preferred specialty drug is subject to the **Tier 5** copayment level.

Specialty Drug List — A list of the names of specialty drugs indicating for each whether it is considered "preferred" or "nonpreferred," and which must be purchased through BCBSNM's specialty pharmacy provider. Preferred specialty drugs are considered the drug of choice and you will pay the Tier 5 copayment for them. You will pay a Tier 6 copayment for covered nonpreferred specialty drugs. The *Specialty Drug List* is subject to periodic review and change by BCBSNM. If you need a list of specialty drugs, request it from a Customer Service Advocate or visit the BCBSNM website at www.bcbsnm.com.

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," below.

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

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

Preauthorization — An advance confirmation to determine medical necessity, as may be required where permitted by law, for certain services to be eligible for benefits.

Predetermination — An advance confirmation, or "predetermination," of benefits for a requested covered service. Predetermination does not guarantee benefits if the actual circumstances of the case differ from those originally described.

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

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

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

Primary Care Provider (PCP) — See definition of "Provider."

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

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 residential treatment center, 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.

Professional provider: A physician or health care practitioner, including a pharmacist, who is licensed, certified, or otherwise authorized by the state to provide health care services consistent with state law.

In–Network Specialist: A health care practitioner who is in the *Standard Network* , has an HMO network contract with BCBSNM – but has not signed an agreement to operate as a PCP. A specialist does not include hospitals or other treatment facilities, urgent care facilities, pharmacies, equipment suppliers, ambulance companies, or similar ancillary health care service providers.

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

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

PPO Specialist: A practitioner of the healing arts who is in the Preferred Provider Network – but does not belong to one of the specialties defined above as being for a "Primary Preferred Provider" (or "PPP"). A specialist does not include hospitals or other treatment facilities, urgent care facilities, pharmacies, equipment suppliers, ambulance companies, or similar ancillary health care providers.

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

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

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

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

Rehabilitative service — Including, but not limited to speech therapy, physical therapy and occupational therapy. Treatment, as determined by your physician that must be limited to therapy which is expected to result in significant improvement in the conditions for which it is rendered, "rehabilitative services" must expected to help a person regain, maintain or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, inquiry or disabling condition.

Residential Treatment Center — A facility offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, and structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, supervised living, group homes, boarding houses, or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients in residential treatment centers are medically monitored with 24-hour medical availability and 24-hour on-site nursing service for patients with mental illness and/or chemical dependency disorders.

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

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

- routine hospital nursery services, including alpha-fetoprotein IV screening
- routine medical care in the hospital after delivery

- pediatrician
- services related to circumcision of a male newborn
- standby care at a C-section procedure

Routine patient care cost — 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.

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

Routine screening mammography does **not** include "diagnostic mammography" which is a mammogram done after an abnormal finding has first been detected, or screening the opposite breast when the other breast has cancer. Routine colonoscopy does **not** include colonoscopy done for follow-up of colon cancer. A colonoscopy is still considered screening if, during the colonoscopy, **previously unknown** polyps were removed. Colonoscopies performed to remove **known** polyps are not routine screening colonoscopies. Routine screening colonoscopy does not include upper endoscopy (esophagogastroduodenal endoscopy), sigmoidoscopy, or computerized tomographic colonography (sometimes referred to as "virtual colonoscopy").

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

www.bcbsnm.com/health/know_your_numbers

Service area — BCBSNM's managed care plan service area is the geographic area where BCBSNM is licensed to conduct HMO business (all counties in New Mexico).

Short-term rehabilitation — Inpatient, outpatient, office- and home-based occupational, physical, and speech therapy techniques that are medically necessary to restore and improve lost bodily functions following illness or accidental injury. (This does not include services provided as part of an approved home health or hospice admission, which are subject to separate benefit limitations and exclusions, and does not include alcohol or drug abuse rehabilitation.)

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

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

- is licensed in accordance with state or local law; *and*
- is a Medicare-participating facility; *and*
- is primarily engaged in providing skilled nursing care to inpatients under the supervision of a duly licensed physician; *and*
- provides continuous 24-hour nursing service by or under the supervision of a registered nurse; *and*
- does **not** include any facility that is primarily a rest home, a facility for the care of the aged, or for treatment of tuberculosis, or for intermediate, custodial care or educational care.

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

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

Special enrollment — When an otherwise eligible employee or eligible family member did not enroll in the Plan when initially eligible, there are certain instances (or "qualifying events") during which the employee and his/her eligible family members, if any, may enroll in the Plan at a later date – or more than 31 days after becoming eligible – and not considered late applicants. The "special enrollment" period is the period of time during which an otherwise late applicant may apply for coverage outside the annual open enrollment period.

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

Specialty pharmacy provider — See definition of "Participating Pharmacy."

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

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

Subscriber — The individual whose employment or other status, except for family dependency, is the basis for enrollment eligibility, or in the case of an individual contract, the person in whose name the contract is issued.

Summary of Benefits and Coverage (SBC) — The separately issued schedule that defines your coinsurance requirements, deductibles, copayments, out-of-pocket limits, and annual or lifetime benefits, and provides an overview of covered services. It is referred to as the *Summary of Benefits* throughout this benefit booklet.

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

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.

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.

UNM Hospitals Plan (the Plan) — The health plan administered by Blue Cross and Blue Shield of New Mexico (BCBSNM). The Plan is specifically described in this UNM Hospitals Managed Care benefit booklet, any endorsements, addendum, and/or riders, and your separately issued Summary of Benefits.

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).

Utilization management — A system for reviewing the appropriate and efficient allocation of medical services and hospital resources given or proposed to be given to a patient or group of patients.

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

Women's health care provider — Either an obstetrician-gynecologist (an OB/GYN specialist), a family practitioner, a certified nurse-midwife, another physician specializing in women's health, or a physician assistant or certified nurse practitioner who specializes in women's health.

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 Plan and under federal law, contact the Plan administrator or see *Section 2: Enrollment and Termination Information* of this benefit booklet.

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

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of health care plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the health care plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and eligible children of employees may be qualified beneficiaries. Under the Plan, generally most qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Contact the employer and/or COBRA administrator for specific information for your Plan.

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

- your hours of employment are reduced; 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 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 eligible children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens and if your group is subject to the provisions of COBRA:

- the parent-employee dies;
- the parent-employee's hours of employment are reduced;
- the parent-employee's employment ends for any reason other than 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 Plan as an "eligible child".

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

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

- the end of employment;
- the reduction of hours of employment;
- the death of the employee;
- the enrollment of the employee in Medicare (Part A, Part B or both).

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

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

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

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

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

Disability Extension of 18-month Period of Continuation Coverage

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

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

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

In all of these cases, you must make sure that the Plan administrator is notified of the second qualifying event **within 60 days** of the second qualifying event. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

IF YOU HAVE QUESTIONS

If you have questions about COBRA continuation coverage, contact the UNMH Benefits Department or the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

In order to protect your family's rights, you should keep the Plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Plan administrator.

PLAN CONTACT INFORMATION

Contact the UNMH Benefits Department for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

Appendix: Notice – Inquiries/Complaints and Internal/External Appeals for Self–Funded Plans

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

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

GENERAL INQUIRIES AND COMPLAINTS

Inquiry – A general request for information regarding claims, benefits, or membership.

Complaint – An expression of dissatisfaction by you, either orally or in writing. Issues may include, but are not limited to, claims payments or denials, quality of care, and locating a network provider.

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

INITIAL INTERNAL REVIEW OF CLAIMS/PREAUTHORIZATION REQUESTS

When you or your treating health care professional requests a preauthorization or files a claim for a health care service, BCBSNM first determines whether the requested service is covered under your Plan. If the requested service is not covered, BCBSNM will not review for medical necessity, but will send you notice that there is no coverage for the requested service.

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

Preauthorization – A decision by BCBSNM that a health care service has been reviewed and, based upon the information available, meets BCBSNM's requirements for coverage and medical necessity.

TIMING OF REQUIRED NOTICES AND EXTENSIONS

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

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

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

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

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

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

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

POST-SERVICE CLAIMS	
Type of Notice or Extension	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	**30 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to the Claims Administrator within:	**45 days** after receiving notice

The Claims Administrator must notify you of the claim determination (whether adverse or not):	
if the claim is complete, as soon as possible (taking into account medical exigencies), but no later than:	**30 days**
after receiving the completed claim (if the initial claim is incomplete), within:	**45 days**

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

Concurrent Care

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

MANNER AND CONTENT OF CLAIM/PREAUTHORIZATION DENIAL NOTICES

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

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

- subject to privacy laws and other restrictions, if any, the identification of the claim, the date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- the specific reason(s) for determination;
- a reference to the specific health plan provision(s) on which the denial is based, or the contractual, administrative or protocol for the determination;
- the specific internal rule, guideline, protocol, or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request;
- an explanation of the scientific or clinical judgment relied on in the determination, if the denial was based on medical necessity, experimental treatment, or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- a description of additional information that may be needed to perfect the request or claim and an explanation of why such material is needed;
- a description of BCBSNM's internal review/appeals and external review procedures and time limits (and how to initiate a review/appeal or external review) including a statement of your right, if any, to pursue any state and, if applicable, federal legal remedies, including bringing a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;
- in certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- in certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
- the right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;

- in the case of a denial of an urgent care clinical claim, a description of the expedited internal review procedure applicable to such claims (an urgent care claim decision may be provided orally, so long as written notice is furnished to you within three days of oral notification);
- contact information for applicable office of health insurance consumer assistance or ombudsman.

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

INTERNAL APPEAL PROCEDURES

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

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

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

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

Expedited Clinical Appeals

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

Upon receipt of an expedited pre-service or concurrent clinical appeal, the Claims Administrator will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Claims Administrator shall render a determination on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by the Claims Administrator.

How to Appeal an Adverse Benefit Determination

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

An appeal of an *Adverse Benefit Determination* may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized

representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your ID card.

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

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

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

- In support of your Claim review, you have the option of presenting evidence and testimony to the Claim Administrator. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an *Adverse Benefit Determination* or at any time during the Claim review process.

The Claim Administrator will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of your Claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial *Adverse Benefit Determination*. Such new or additional evidence or rationale and information will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. The appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors, but who were not involved in making the initial denial of your claim. If the initial benefit determination regarding the claim is based in whole or in part on a medical judgement, the appeal determination will be made by a Physician associated or contracted with us and/or by external advisors, but who were not involved in making the initial denial of your claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator or your employer.

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

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

Timeframe for Completion of Internal Appeal

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

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

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

Manner and Content of Notification of Internal Appeal Decision

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

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

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

INDEPENDENT EXTERNAL REVIEW

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

1. Request for external review. Within four months after the date of receipt of a notice of an *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* from BCBSNM, you or your authorized representative must file your request for standard external review.

2. Preliminary review. Within five business days following the date of receipt of the external review request, BCBSNM must complete a preliminary review of the request to determine whether:

- You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
- The *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
- You have exhausted BCBSNM's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the "Exhaustion" section below for additional information about the exhaustion of the internal appeal process; and

- You or your authorized representative has provided all the information and forms required to process an external review.

You will be notified within one business day after BCBSNM completes the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, BCBSNM will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).

3. Referral to Independent Review Organization. When an eligible request for external review is completed within the time period allowed, BCBSNM or your employer will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, BCBSNM will take action against bias and to ensure independence. Accordingly, BCBSNM must contract with at least three IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

- Utilization of legal experts where appropriate to make coverage determinations under the plan.
- Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
- Within five business days after the date of assignment of the IRO, BCBSNM must provide to the assigned IRO the documents and any information considered in making the *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination*. Failure by BCBSNM to timely provide the documents and information must not delay the conduct of the external review. If BCBSNM fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination*. Within one business day after making the decision, the IRO must notify BCBSNM and you or your authorized representative.
- Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to BCBSNM. Upon receipt of any such information, BCBSNM may reconsider its *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* that is the subject of the external review. Reconsideration by BCBSNM must not delay the external review. The external review may be terminated as a result of the reconsideration only if BCBSNM decides, upon completion of its reconsideration, to reverse its *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* and provide coverage or payment. Within one business day after making such a decision, BCBSNM must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from BCBSNM.
- Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during BCBSNM's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
    - — Your medical records;
    - — The attending health care professional's recommendation;
    - — Reports from appropriate health care professionals and other documents submitted by BCBSNM, you, or your treating provider;
    - — The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;

— Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

— Any applicable clinical review criteria developed and used by BCBSNM, unless the criteria are inconsistent with the terms of the plan or with applicable law; and

— The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

- Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to BCBSNM and you or your authorized representative.
- The notice of final external review decision will contain:

— A general description of the reason for the request for external review, including information sufficient to identify the claim;

— The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

— References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

— A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

— A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either BCBSNM and you or your authorized representative;

— A statement that judicial review may be available to you or your authorized representative; and

— Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

- After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. Reversal of plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, BCBSNM immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

1. Request for expedited external review. BCBSNM must allow you or your authorized representative to make a request for an expedited external review with BCBSNM at the time you receive:

- An *Adverse Benefit Determination* if the *Adverse Benefit Determination* involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A *Final Internal Adverse Benefit Determination*, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the *Final Internal Adverse Benefit Determination* concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, BCBSNM must determine whether the request meets the reviewability requirements set forth in the "Standard External Review" section above. BCBSNM must immediately send you a notice of its eligibility determination that meets the requirements set forth in the "Standard External Review" section above.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, BCBSNM will assign an IRO pursuant to the requirements set forth in the "Standard External Review" section above. BCBSNM must provide or transmit all necessary documents and information considered in making the *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

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

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

EXHAUSTION

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

You will be deemed to have exhausted the internal review process and may request external review if BCBSNM waives the internal review process or has failed to comply with the internal claims and appeals process. If you have been deemed to have exhausted the internal review process due to BCBSNM's failure to comply with the internal claims and appeals process, you may also have the right to pursue any available remedies under 502(a) of ERISA or under state law.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

OTHER EXTERNAL ACTIONS

If you are still not satisfied after having completed BCBSNM's or, for eligibility and employee contribution issues, your employer's complaint, appeal, grievance, or reconsideration procedure, you may have the option of taking one of the following steps. No legal action at law or in equity may be taken or arbitration demand made earlier than 60 days after the Claims Administrator has received the claim for benefits or preauthorization request, or later than three years after the date that the claim for benefits should have been filed with the Claims Administrator.

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

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

Call toll-free at (866) 444-EBSA (3272) or visit the EBSA Web site at www.askebsa.dol.gov

The Managed Health Care Bureau of the New Mexico Office of Superintendent of Insurance is also available to assist you with questions or complaints about the Claims Administrator's appeal process:

Office of Superintendent of Insurance
1120 Paseo de Peralta
Room 428
Santa Fe, NM 87501
(855) 427-5674 (1-855-4 ASK OSI)
http://www.OSI.state/nm.us

RETALIATORY ACTION

BCBSNM and your employer shall not take any retaliatory action against you for making a complaint, filing an appeal, or requesting external review under this health plan.

NOTE: BCBSNM provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims, except as may be specified in the Administrative Services Agreement.

APPENDIX B: PRIVACY NOTICE (PROVIDED BY YOUR EMPLOYER)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATON. PLEASE REVIEW IT CAREFULLY.

Effective Date: August 1, 2010

UNM Hospital Health Plans
NOTICE OF PRIVACY PRACTICES

UNM Hospitals Human Resources – Benefits Department
933 Bradbury Drive SE, HOPE Ste 3002, Albuquerque, NM 87106
(505) 272-0493

General Information About This Notice

UNM Hospitals (UNMH) continues its commitment to maintaining the confidentiality of your private medical information. This Notice describes our efforts to safeguard your health information from improper or unnecessary use or disclosure. ***This notice only applies to health-related information received by or on behalf of the Health Plans listed below.*** A federal law, known as HIPAA, requires us to provide you with a summary of the Health Plan's privacy practices and related legal duties, and your rights in connection with the use of disclosure of your Health Plan information.

This Notice applies to UNMH employees, former employees, and depends who may participate in any of the following benefit programs offered by UNMH (collectively referred to in this Notice as the "Health Plans"):

- Medical benefits under the UNMH Health Plan (administered by Blue Cross and Blue Shield of New Mexico)
- Dental benefits under the UNMH Dental Plan (administered by Delta Dental of New Mexico)
- Healthcare FSA benefits under the UNMH Flexible Spending Account Program (administered by Stanley, Hunt, Dupree & Rhine)

In this Notice, the terms "we", "us", and "our" refer to the Health plans, all UNMH employees involved in the administration of the Health Plans, and all third parties who perform services for the Health Plans. Actions by or obligations of the Health Plans include these UNMH employees an third parties. However, UNMH employees perform only limited Health Plan functions – most Health Plan administrative functions are performed by third party service providers.

What is Protected?

Federal law requires the Health Plans to have a special policy for safeguarding a category of medical information called "protected health information," or "PHI," received or created in the course of administering the Health Plans. PHI is health information that can be used to identify you and that related to:

- your physical or mental health conditions,
- health care services provided to you, or.
- payment for your health care.

Your medical and dental records, your claims for medical and dental benefits, and the explanations of benefits (EOBs) sent in connection with payment of your claims are all examples of PHI.

If UNMH obtains your health information in another way – for example, if you are hurt in a work accident or if you provide medical records with your request for leave under the Family and Medical Leave Act (FMLA) – then UNMH will safeguard that information in accordance with other applicable laws and UNMH policies. Similarly, health information obtained by a non-health related benefits program, such as the long-term disability program is not protected under this Notice. This notice does not apply in those types of situations because the health information is not received or crated in connection with a Health Plan.

The remainder of this Notice generally describes our rules and respect to your PHI received or created by the Health Plans.

Uses and Disclosures of Your PHI

To protect the privacy of your PHI, the Health Plans not only guard the physical security of your PHI, but also limit the way your PHI is used or disclosed to others. We may use or disclose your PHI in certain permissible ways described below. To the extend required under federal health information privacy law, we use the minimum amount of your PHI necessary to perform these tasks.

- To determine proper payment of your Health Plan benefit claims. The health Plans use and disclose your PHI to reimburse you or your doctor or health care providers for covered treatment and services. For example, your diagnosis information may be used to determine whether a specific procedure is medically necessary or to reimburse your doctor for your medical care.
- For the administration and operation of the Health Plans. We use and disclose your PHI for numerous administrative and quality control functions necessary for the Health Plans' proper operation. For example, we may use your claims information for fraud and abuse detection act ivies or to conduct data analysis for benefit utilization.
- To inform you or your health care provider and treatment alternatives or other health-related benefits that may be offered under a Health Plan. For example, we may use your claims data to alert you to an available case management program if you become pregnant or are diagnosed with diabetes or liver failure.
- To a health care provider if needed for your treatment. For example, we may disclose your prescription information to a pharmacist regarding a drug interaction concern.
- To a non-UNMH health plan to determine proper payment of your claim under the other plan. For example, we may exchange your PHI with your spouse's health plan for coordination of benefits purposes.
- To a health care provider or to a non-UNMH health plan for certain administration and operations purposes. We may share your PHI with another health plan or health care provider who has a relationship with you for quality assessment and improvement activities, to review the qualifications of health care professionals who provide car you to you, or for fraud and abuse detection and prevention purposes.
- To a family member, friend, or other person involved in your health care, if you do not object, or it can reasonably be inferred that you do not object, to the sharing of your PHI, or, in the event of an emergency.
- To comply with an applicable federal, state, or local law, including workers' compensation or similar programs.
- For public health reasons, including (1) to a public health authority for the prevention or control of disease, injury or disability; (2) to a proper government or health authority to report child abuse or neglect; (3) to report reactions to medications or problems with products regulated by the Food and Drug Administration; (4) to notify individuals of recalls of medication or products that may be using; or (5) to notify a person who may have been exposed to a communicable disease or who may be at risk for contracting or spreading a disease or condition.
- To report a suspected case of abuse, neglect or domestic violence, as permitted or required by applicable law.
- To comply with health oversight activities, such as audits, investigations, inspections, licensure actions, and other government monitoring and activities related to health care provision or public benefits or services.
- To the U.S. Department of Health and Human Services to demonstrate our compliance with federal health information privacy law.
- To respond to an order of court or administrative tribunal.
- To respond to a subpoena, warrant, summons or other legal request if sufficient safeguards, such as protective order, are in place to maintain your PHI privacy.
- To a law enforcement official for a law enforcement purpose.
- For purposes of public safety or national security.
- To allow a coroner or medical examiner to identify you or determine your cause of death.
- To allow a funeral directory to carry out his or her duties.
- To respond to a request by military command authorities if you are or were a member of the armed forces.

Certain UNMH employees may access your PHI to perform administrative functions on behalf of the Health Plans. Absent your written permission, however, UNMH employees will only use or disclose your PHI as described above. UNMH employees will not access your PHI for reasons unrelated to Health Plan administration. UNMH will not use your PHI for any employment related reason without your express written authorization.

State law may further limit the permissible ways the Health Plans use or disclose your PHI. If an applicable state law imposes stricter restrictions on the health Plans, we may comply with that state law.

Other Uses and Disclosures of Your PHI

Before we use or disclose your PHI for any other purpose, we must obtain your written authorization You may revoke your authorization, in writing, at any time. If you revoke your authorization, the health Plans will no longer use or disclose your PHI except as described above (or as permitted by any other authorization that have not been revoked). However, please understand that we cannot retrieve any PHI disclosed to a third party in reliance on your prior authorization.

Your Rights

Federal law provides you with certain rights regarding your PHI. Parents of minor children and other individuals with legal authority to make health decisions for a Health Plan participant may exercise these rights on behalf of the participant, consistent with state law.

Right to request restrictions: You have the right to request a restriction or limitation on the Health Plans' use or disclosure of your PHI. For example, you may ask us to limit the scope of your PHI disclosures to a case manager who is assigned to you for monitoring a chronic condition. Because we use your PHI only as necessary to pay Health Plan benefits, to administer the Health Plans, and to comply with the law, it may not be possible to agree to your request. The law does not require the Health Plans to agree to your request for restriction. However, if we do agree to your requested restriction or limitation, we will honor the restriction until you agree to terminate the restriction or until we notify you that we are terminating the restriction on an going forward basis.

Restriction request forms are available from the University's Privacy Officer. You may make a request for restriction on the use and disclosure of your PHI to the University's Privacy Officer. Contact information for the University's Privacy Officer is listed on the front of this Notice. When making such a request, you must specify: (1) the PHI you want to limit; (2) how you want the Health Plans to limit the use and/or disclosure of that PHI; and (3) to whom you want the restrictions to apply.

Right to receive confidential communications: You have the right to request that the Health Plans communicate with you about your PHI at an alternative address or by alternative means if you believe that communication through normal business practices could endanger you. For example, you may request that the Health Plans contact you only at work at not at home.

You may request confidential communication on your PHI by completing an appropriate form available from the University's Benefit's & Employee Services Department, UNMH Human Resources Division (the Benefits Department). You should send your written request for confidential communication to the Benefits Department at the address listed on the front of this Notice. We will honor all reasonable requests. You must make sure your request specifies how or where you wish to be contacted.

Right to inspect and copy your PHI: You have the right to inspect and copy your PHI contained in records that the Health Plans maintain for enrollment, payment, claims determination, or case or medical management activities, or that we use to make enrollment, coverage, or payment decisions about you.

However, we will not give your access to PHI records created in anticipation of a civil, criminal, or administrative action or proceeding. We will also deny your request to inspect and copy your PHI if a licensed health care professional hired by the Health Plan has determined that giving you the requested access is reasonably likely to endanger the life or physical safety of you or another individual or to cause substantial harm to you or another individual, or that the record makes references to another person (o0ther than a health care provider), and that the requested access would likely cause substantial harm to the other person.

In the unlikely event that your request to inspect or copy your PHI di denied, you may have that decision review. A different licensed health care professional chosen by the Health Plans will review the request and denial, and we will comply with the health care professionals decision.

You may make a request to inspect or copy your PHI by completing the appropriate form available from the Benefits department and sending it to the Benefits Department at the address listed on the front of this Notice. We may charge you a fee to recover the costs of copying, mailing or other supplies directly associated with your request. You will be notified of any costs before you incur any expenses.

Right to amend your PHI: You have the right to request an amendment of your PHI if you believe the information the Health Plans have about you is incorrect or incomplete. You have the right as long as your PHI is maintained by the Health Plans. We have contracted with third party administrators for the health benefits identified on the first page of this Notice. These third party administrators will correct any mistakes if either we or they created the PHI or if the person or entity that originally create the PHI is no longer available to make the amendment.

You may request amendments of your PHI by completing the appropriate form available from the University's Privacy Officer and sending it to the University's Privacy Officer at the address listed on the front of this Notice. Be sure to include evidence to support your request because we cannot amend PHI that we believe to be accurate and complete.

Right to receive an accounting of disclosures of PHI: You have the right to request a list of certain disclosures of your PHI by the health Plans. The accounting will not including(1) disclosures necessary to determine proper payment of benefits or to operation the health Plans, (2) disclosures we make to you, (3) disclosures permitted by your authorization, (4) disclosures to friend or family members made in your presence or because of an emergency, or (5) disclosures for national security purposes. Your first request for an accounting within a 12-month period will be free. We may charge you for costs associated with providing you additional accounting. We will notify you of the costs involve, and you may choose to withdraw or modify your request before you incur any expenses.

Accounting request forms are available from the University's Privacy Officer and you may request such an accounting of disclosures from the University's Privacy Officer at the address listed on the front of this Notice. When making your request, you must specify the time period for the accounting, which may not be longer than six years and may not include dates prior to April 14, 2003, and the form (e.g., electronic, paper) in which you would like the accounting.

Right to file a complaint: If you believe your rights have been violated, you should let us know .immediately We will take steps to remedy any violations of the Health Plan's privacy policy or of this Notice.

You may file a formal complaint with our Privacy Officer and/or with the United States Department of Health and Human Services at the address below. You should attach any documents or evidence that supports your belief that your privacy rights have been violated. We take your complaints very seriously. UNMH prohibits retaliation against any person for filing such a complaint.

Complaints should be sent to:

University of New Mexico
Privacy Officer
1 University of New Mexico
MSC 08 4760
Albuquerque, New Mexico 87131-0001
Phone: (505) 272-1493
Fax: (505) 272-2461
TDD: (505) 272-2111

Region VI (New Mexico), Office for Civil Rights,
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, Texas 75202
Phone: (214) 767-4056
Fax: (214) 767-0432
TDD: (214) 767-8940
www.hhs.gov/ocr/hipaa

Additional Information About This Notice

Changes to this Notice: We reserve the right to change the health Plans' privacy practices as described in this Notice. Any change may affect the use and disclosure of your PHI already maintained by the health Plans, as well as any of your PHI that the Health Plans may receive or create in the future. If there is a material change to the terms of this Notice, you will receive a revised Notice.

How to obtain a copy of this Notice: You can obtain a copy of the current Notice by writing to the Benefits Department at the address listed on the front of this Notice.

No guarantee of employment: This Notice does not create any right to employment for any individual, nor does it change UNMH's right to discharge any of its employees at any time, with or without cause, or as provided by the terms of any applicable collective bargaining agreement.

No change to Health Plan benefits: This Notice explains your privacy rights as current, format, or potential participant in the UNMH Health Plans. The Health Plans are bound by the terms of this Notice as they relate to the privacy of your protected health information. However, this Notice does not change any other rights or obligations you may have under the Health Plans. You should refer to the Health Plan documents for additional information regarding your Health Plan benefits.

END

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 **UNMH** and Blue Cross and Blue Shield of New Mexico (BCBSNM) includes the following documents:

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

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

- the Benefit Program Application from the employer; and
- the Administrative Services Agreement between BCBSNM and **UNMH**.

The above documents constitute the entire legal agreement between BCBSNM and **UNMH**. 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.

UNMH reserves the right to amend, modify, or discontinue coverage provided for employees and their dependents. This benefit booklet is not an implied contract and does not guarantee benefits or employment.

BCBSNM provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims, except as may be specified in the Administrative Services Agreement.

BlueCross BlueShield
of New Mexico