Blue Cross Community Centennial℠

2019 Member Handbook

A Guide to Your BCBSNM Managed Care Plan

ADMINISTERED BY:

BlueCross BlueShield of New Mexico

bcbsnm.com/medicaid

BlueCross BlueShield of New Mexico

Dear Blue Cross Community Centennial Care Member,

Welcome to the Centennial Care Managed Health Care Program, administered by Blue Cross and Blue Shield of New Mexico (BCBSNM). We look forward to working with you and your health providers to help you get the health care you need.

BCBSNM has contracts with providers all over New Mexico and along its borders in Texas, Arizona, and Colorado. When a provider has a contract to provide services to Centennial Care members, those providers are in the BCBSNM Centennial Care network. Centennial Care members can choose to see any provider in the BCBSNM Centennial Care network. To see a provider that is not in the BCBSNM network, you may need to get prior authorization from us. There are exceptions to this rule. The exceptions are explained in **Section 4: Covered and Non-Covered Benefits** of this handbook.

For more information about our company (such as its structure or operations), or to find out more about our provider network and any questions you may have about our provider incentive plans, please call Member Services at **1-866-689-1523**.

Please take some time to review this handbook and any other materials you received in your welcome packet. Learning how your program works can help you make the best use of your health care benefits.

Note: The State of New Mexico Human Services Department (HSD) may change the benefits described in this handbook. If that happens, BCBSNM will notify you within 30 calendar days. This handbook is updated on a yearly basis and the most updated version will be mailed to you. If you would like to view this handbook electronically, you can view and download the most current electronic version by visiting the Blue Cross Community Centennial website at bcbsnm.com/medicaid. If you are in need of obtaining a copy in an alternate format, please call Member Services at **1-866-689-1523**.

Sincerely,

Sharon Huerta
Centennial Care CEO, Blue Cross and Blue Shield of New Mexico

PO. Box 27838 • Albuquerque, New Mexico 87125-7838
1-866-689-1523 • bcbsnm.com/medicaid

Such services are funded in part with the State of New Mexico.

Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

To ask for auxiliary aids and services or materials in other formats and languages at no cost, please call 1-866-689-1523 (TTY/TDD: 711).

Blue Cross and Blue Shield of New Mexico complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of New Mexico does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of New Mexico:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of New Mexico has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960, Civilrightscoordinator@hcsc.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-710-6984 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-710-6984 (TTY: 711).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-855-710-6984 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-710-6984 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-710-6984 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-710-6984 (TTY: 711)。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-710-6984 (رقم هاتف الصم والبكم:711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-710-6984 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-710-6984 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-710-6984（TTY: 711）まで、お電話にてご連絡ください。

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-710-6984 (ATS: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-710-6984 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-710-6984 (телетайп: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

1-855-710-6984 (TTY: 711) पर कॉल करें।

هجوت: رگـا هب نـــابز سـرافـی وگتفـــــگ می دینــک، تلایهســـت نـــابزی هب تــروص ناگیـــار اربی امش‌مهارف می دشـاب. اب 1-855-710-6984 (TTY: 711) سامت دیریگـــب.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-710-6984 (TTY: 711).

Table of Contents

Table of Contents

Table of Contents

Member Assistance

BCBSNM's Medicaid (also known as Centennial Care) plan is called Blue Cross Community Centennial. When you have a question about Centennial Care, you may call us at **1-866-689-1523**, or you may visit our office in Albuquerque. When visiting our office, an appointment is not needed.

Telephone Hours: Monday through Friday from 8 a.m. to 5 p.m. Closed Saturdays and Sundays.

Office Hours: Monday through Friday from 8 a.m. to 5 p.m. Closed Saturdays and Sundays. Closed on New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.

Location: 4373 Alexander Blvd. NE, Albuquerque, NM 87107

If you need help after hours, you may call Member Services at **1-866-689-1523** and leave a message. We will return your call by 5 p.m. the next business day.

24/7 Nurseline

If you can't reach your Primary Care Provider (PCP), the 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 PCP. If you think you have an urgent problem and your provider cannot see you right away, call the Nurseline for advice. Call toll-free: **1-877-213-2567**.

We also have a phone library of more than 1,000 health topics available through the Nurseline. More than 600 of these topics are available in Spanish.

Non-Emergency Transportation

To request a ride to a scheduled appointment, call the LogistiCare® Reservation Line at **1-866-913-4342**. Call at least three working days before your visit, Monday through Friday from 8 a.m. to 5 p.m. To return home or to arrange a ride after hours (such as for urgent care), call the Ride Assist phone line. You can call **1-866-418-9829** toll-free 24 hours a day, 7 days per week. You can read about LogistiCare in **Section 4G: Transportation Benefits.**

BCBSNM Website, Internet Help and Email

Do you need to find a provider, download the Member Handbook, view the drug list, or find forms and other plan information? Visit the BCBSNM website at **bcbsnm.com/medicaid.** You can also email Member Services from the website (go to Contact Us).

If you have Internet access, BCBSNM has online programs and tools you can use. Blue Access for Members℠ (BAM℠) is our secure member portal that allows you to:

- Read your Member Handbook
- Search for health care providers that participate with BCBSNM for Centennial Care - doctors, hospitals, others
- Submit a request to change your PCP
- Read frequently asked questions about your health plan
- Find health and wellness information
- Search a list for drugs that are covered by your health plan and learn about generic drugs
- Print a temporary ID or request a new ID
- Download forms
- Find Internet links to other services, important phone numbers, and email addresses
- Email BCBSNM a question or comment via secure messaging

To check out our online features and programs, log in to BAM. If you have never logged in to BAM before, click "Register Now" in the login box. Then follow the steps to register for BAM.

If you need help getting into BAM, call the Blue Access Help Desk toll-free at **1-888-706-0583** (TTY: **711**). The Help Desk is available 24 hours a day, seven days a week.

We encourage you to enroll in BAM and use the online features. Programs and program rules may change or end without notice as new programs are designed and/or as your needs change.

If you have questions about your Blue Cross Community Centennial health plan, call Member Services at **1-866-689-1523**.

What to Do in an Emergency

If there is a need for cardiopulmonary resuscitation (CPR), or there is an immediate threat to your life or limb, call 911. If there is no need to call 911, go to the nearest hospital or emergency room. Prior authorization is not needed for emergency services. You should call your PCP as soon as possible after receiving care to arrange follow-up services. See **Section 4A: Physical Health Benefits** for details on getting emergency care. Do not use the emergency room in a non-emergency situation. If you are a member receiving services at a Core Service Agency (CSA), you may also use your crisis plan for further instructions and contact your CSA crisis line. Before an emergency arises, please contact your assigned Care Coordinator and ask about a personal crisis plan.

Member Assistance

Interpreter Services

Tell your provider's office when making an appointment if you need an interpreter for any language other than English or for sign language. The provider should have an interpreter there during your appointment. During your visit, if your provider cannot offer you translation services, please call Member Services.

If you need oral interpretations in any language, please call Member Services. Written materials will also be translated into Spanish or another format if needed.

Deaf, hard-of-hearing, and speech-disabled callers may use the New Mexico Relay Network. Dialing 711 connects the caller to the Human Services Department/Medical Assistance Division (HSD/MAD) transfer relay service for TTY and voice calls.

Contacting Member Services

When you have questions about Centennial Care, you may call, write, or email us. You may also visit our office in Albuquerque. We are here to help you. **Call us at 1-866-689-1523**. For help at any time, you can access our telephone number, which is listed on the back of your ID card.

Writing to Member Services

Send your question to:

Blue Cross Community Centennial
P.O. Box 27838
Albuquerque, NM 87125-7838

How We Can Help

Whether you call, write, email, or visit BCBSNM, Member Services Advocates can help with the following:

- Picking a PCP or finding other Centennial Care network providers
- Arranging transportation to provider appointments
- Prior authorization requests
- Checking on a claim status
- Ordering a replacement ID card, provider directory, handbook, or member forms
- Any questions about what is covered and what is not covered under the Centennial Care program

After-Hours Help

If you need help or want to file a complaint outside normal business hours, you may call Member Services. Your call will be answered by our automatic phone system. You can use this system to:

- Leave a message for us 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

Ombudsman Specialist

The Ombudsman Specialist is available to all Centennial Care members at no cost. The Ombudsman explores problems and deals with them fairly. The Ombudsman advocates for your rights. This is done by using Medicaid guidelines and BCBSNM resources to help you. The Ombudsman wants to help you receive the benefits of your Blue Cross Community Centennial health plan.

The Ombudsman can:

- Review and address your concerns regarding services
- Address your concerns about benefits you feel should be covered but were denied
- Help you understand or clarify your rights and responsibilities
- Help you understand the covered services that are available to you
- Help you reach appropriate BCBSNM personnel
- Help you understand the pros and cons of your possible options
- Help you understand BCBSNM policies and procedures
- Help you get the most out of your health care benefits

You can reach the Ombudsman Specialist by phone or email:

Toll Free: **1-888-243-1134** TTY: **711**

Email: **NMCentennialCareOmbudsman@bcbsnm.com**

Community Social Services

The Community Social Services program is available to all Centennial Care members. This service is to help you find community resources to help keep you healthy and safe. We are the connectors between you and the many nonprofit organizations helping people in the community. Call us at **1-877-232-5518,** option 3, then option 5, between 8 a.m. to 5 p.m., Monday through Friday. We can help you find resources such as the following:

- Food pantries
- Benefit coordinators
- Early Head Start Program for your child
- Food stamps, Temporary Assistance for Families with Young Children (TANF), or Women, Infants, and Children (WIC) office
- Help with your electric bill
- Information regarding local support groups/services
- Other community resources

Health Education and Health Literacy

We offer many ways to access information about health promotions, maintenance, and prevention for you and your children. This information can teach you about healthy lifestyles and behaviors that may affect your health. Listed below are the ways to get this information. Visit our website at **bcbsnm.com/medicaid** where you can:

- Learn about health education classes near you
- Find information about how to talk to your provider or nurse during your visits
- Check out programs to manage diabetes, asthma, or stop smoking

- Learn how the case management program can help when you need careLearn how to set up a Virtual Visit with doctors and therapists for certain non-emergency conditions like allergies, asthma, cold/flu, ear infections, online counseling, and stress management

Log into Blue Access for Members to:

- Read the health newsletter
- Access the Special Beginnings program
- Take an online health assessment
- Learn how to set up a Virtual Visit with doctors and therapists for non-emergency conditions
- View wellness guidelines and health topics
- Sign up for text messages to be sent to your cell phone and email. These messages will give you information about diabetes, asthma, heart health, and fitness. You can also choose to get prescription drug reminders

Call Member Services at **1-866-689-1523** for more information.

To help you connect with community resources, we participate at community health fairs and outreach events. When an event is scheduled in your area, you will receive a mailing to let you know which health topics will be discussed and what screenings will take place.

Centennial Care gives information about health literacy at events in your community and through brochures at your provider's office. The goal is to assist you to be an informed member and to receive the full benefit of all the services Centennial Care offers. If you need any other materials, just call our Member Services Department at **1-866-689-1523** and ask a Member Advocate to help you.

Member Feedback

BCBSNM needs your help to improve our service to you. Please email, call, or write to Member Services with ideas on how BCBSNM can improve service to you.

Member Advisory Board

BCBSNM also holds several Member Advisory Board (MAB) meetings. The MAB is a team of Blue Cross Community Centennial members and BCBSNM staff who meet to talk about ways to improve the services we provide. You may get a notice in the mail or a phone call asking you to join us for a meeting. You can also call or write us and let us know you want to join. To learn more about MAB or to make a reservation, please call **505-816-4316** (TTY: **711**) or email **bccc_ab@bcbsnm.com**. You can visit our website at **bcbsnm.com/medicaid** for the most current MAB meeting dates.

Member Rights and Responsibilities

Member Rights

It is the policy of BCBSNM to make sure that you know you have the below rights.

As a member of Centennial Care, you have the right to:

- Health care when medically necessary as determined by a medical professional or BCBSNM; 24 hours per day, 7 days per week for urgent or emergency care services, and for other health care services as defined in the *Member Handbook*
- Receive health care that is free from discrimination
- Be treated with respect and recognition of your dignity and right to privacy
- Choose a PCP or provider from the BCBSNM network and be able to refuse care from certain providers (a prior authorization may be necessary to see some providers)
- Receive a copy of, as well as make recommendations about BCBSNM's member rights and responsibilities policy
- Be provided with information about BCBSNM's member rights and responsibilities, policies, and procedures regarding products, services, providers, appeals procedures, and other information about the company and get information about how to access covered services and the providers in our network
- Receive a paper copy of the official Privacy Notice from the HSD upon request
- Be assured that your MCO is in compliance with applicable federal state laws including Civil Rights Act of 1964, Age Discrimination Act of 1975, Rehab Act of 1973, Education Amendments of 1972, Americans with Disabilities Act (ADA), and Section 1557 of the Patient Protection and Affordable Care Act
- Be given the name and professional background of anyone involved in your treatment and the name of the person primarily responsible for your care
- Choose a surrogate decision-maker to be involved and assist with care decisions as appropriate; this can be done by you or your legal guardian
- Have an interpreter present when you do not speak or understand the language that is being spoken
- Participate with your provider in all decisions about your health care, including gaining an understanding of your physical and/or behavioral condition, being involved in your treatment plan, deciding on acceptable treatments, and knowing your right to refuse health care treatment or medication after possible consequences have been explained in a language you understand. Family members, legal guardians, representatives or decision-makers also have this right, as appropriate

- Talk with your provider about treatment options, risks, alternatives, and possible results for your health conditions, regardless of cost or benefit coverage and have this information documented in your medical record. If you cannot understand the information, the explanation will be provided to your family, guardian, representative, or surrogate decision-maker
- Give informed consent for physical and/or behavioral health medical services
- Decide on advance directives for your physical and/or behavioral health care. These decisions can be made by you or your legal guardian as allowed by law
- Access your medical records in accordance with the applicable federal and state laws, which means that you have the right to receive communications about your private records, request a change or addition if you feel they are incomplete or wrong, and request restricted disclosure of your medical records, and the right to be notified if accidental disclosure occurs. If the member has a legal guardian, the legal guardian has the right to access the member's medical records
- Request a second opinion from another BCBSNM provider. This can be done by you or your legal guardian
- File a grievance about BCBSNM or the care that you received or file an appeal about coverage for a service that has been denied or reduced by BCBSNM. After finishing your appeal, you can request an HSD administrative hearing. The grievance, appeal, and HSD administrative hearing processes can be used without fear of retaliation
- Receive prompt notification of termination or changes in benefits, services, or provider network
- Be free from harassment from BCBSNM or its network providers in regard to contractual disputes between BCBSNM and providers
- Select a health plan and exercise switch enrollment rights without threats or harassment
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal or New Mexico regulations on the use of restraints and seclusion
- Exercise rights without concern that care will be negatively affected
- Receive information on available treatment options and alternatives in an understandable manner

Member and Member Representative Responsibilities

It is the policy of BCBSNM to make sure that you know about the below responsibilities.

As a member of Centennial Care, you have these responsibilities:

- Give complete health information to help your provider give you the care you need
- Follow your treatment plan and instructions for medications, diet, and exercise as agreed upon by you and your provider
- Do your best to understand your physical, long-term care, and/or behavioral health conditions and take part in developing treatment goals agreed upon by you and your provider
- Make appointments ahead of time for provider visits
- Keep your appointment or call your provider to reschedule or cancel at least 24 hours before your appointment
- Tell your providers if you don't understand explanations about your health care
- Treat your provider and other health care employees with respect and courtesy
- Show your ID card to each provider before receiving medical services (or you may be billed for the service)
- Know the name of your PCP and have your PCP provide or arrange your care
- Call your PCP or the 24/7 Nurseline before going to an emergency room, except in situations that you believe are life threatening, or that could permanently damage your health, or if you are having thoughts of harm to yourself or others
- Provide information to New Mexico HSD and BCBSNM of your:
  - Current mailing address
  - Current phone number, including any land line and cell phone, if available
  - Current emergency contact information
  - Current email address, if available
- Tell New Mexico HSD and BCBSNM about changes to your phone number or address
- Tell BCBSNM if you have other health insurance, including Medicare
- Give a copy of your living will and advance directives regarding your physical, long-term care, and/or behavioral health to your PCP to include in your medical records
- Read and follow the *Member Handbook*

Section 1: Enrollment

Managed Care Program Participation

When you apply for Medicaid coverage at your Income Support Division (ISD) office, you will need to pick a managed care plan. All members have to pick a managed care plan except for Native American members who are not receiving a nursing facility level of care. If you are Native American and receiving a nursing facility level of care, or have both Medicare and Medicaid, you will have to enroll in a managed care plan.

Selecting a Managed Care Organization (MCO)

You can choose an MCO when you apply for Medicaid coverage at your local ISD office or at YESNM (**www.yes.state.nm.us**).

Auto Assignment

You are given a chance to choose an MCO when filling out your Medicaid application. If you do not choose one, one will be automatically assigned for you. You will randomly be assigned to an MCO unless you were covered by an MCO for less than six months since your coverage ended. If you re-enroll in Medicaid during this period, you will be automatically assigned back to the same MCO. Family members will be assigned to the same household MCO. Newborns will be covered by the same MCO as their mother's MCO.

Lock-In Period

During the first three months of your effective date with Centennial Care, you can choose a new MCO. After three months, you cannot choose a new MCO until your next 12-month re-enrollment period with HSD.

Recertification

Most members have to renew Medicaid coverage every 12 months. This can be done through the ISD office, or in some cases, by calling HSD at **1-888-997-2583**.

Coverage Due to Being Pregnant

Some members are eligible for Medicaid because they are pregnant. Coverage for these members lasts for two months after the pregnancy has ended.

Newborns

If the mother is enrolled in Medicaid, her newborn has Medicaid coverage for 13 months starting with the month of birth. If the mother is enrolled in an MCO, the child is enrolled in the same MCO. Up to three months after the newborn's birth, the baby's MCO can be changed if the mother (or legal guardian) requests it.

A child may be born to a mother who is not enrolled in Medicaid. If the mother has applied and is eligible for Medicaid, the child will have 12 months of coverage. If the mother applies within three months of birth, the child will have coverage from birth through the month of the child's first birthday.

During your prenatal visits, be sure to let your provider know the name of the PCP you want for your baby. After your baby is born, the hospital will complete the Notice of Birth form, which is sent to your MCO and local ISD office. It is very important to tell your local ISD office right away that your baby has been born. They will work with your MCO to get your newborn enrolled and mail ID cards to you.

Remember, the sooner your local ISD office knows your baby is born, the sooner you can arrange medical services for your baby. This includes shots and well-baby checkups. If you have any questions about enrolling your baby, call your Care Coordinator at **1-877-232-5518**, option 3, then option 2. If you do not have a Care Coordinator, call Member Services at **1-866-689-1523**.

ID Cards

Your Blue Cross Community Centennial ID card gives you the information needed for covered health care. Show your ID card to your provider when you receive services. This ID card can be used to get prescription drugs, physical health, behavioral health, long-term care, dental, and vision services. If you have Medicare or another insurance, also remember to show that card. You can also ask your provider to verify Medicaid eligibility. This can be done by the provider contacting BCBSNM or checking in the Medicaid Web Portal. Do not let anyone (other than you) use your Centennial Care ID card. If you do this, you could lose your Medicaid eligibility.

If you need to order a replacement Centennial Care ID card, you can go to **bcbsnm.com/medicaid**, log in to Blue Access for Members, and request a new ID card. Or you can call Member Services at **1-866-689-1523**. Your replacement ID card will be sent to you within 10 calendar days of ordering it. If you need services before your ID card arrives, log in to BAM and print a temporary ID. If you have never logged in to BAM before, follow the steps to register for BAM. If you need help getting into BAM, call the Blue Access Help Desk toll-free at **1-888-706-0583**.

Change in Eligibility and/or Address

A lot of important information is mailed to the address you gave to the ISD office. If you change your address or phone number, it is very important to call your ISD office right away and give them your new information. Or you can go to YESNM (**www.yes.state.nm.us**) to update your information. Medicaid eligibility is determined based on how many people are in your family. If you have a change in family size, it is important to report this to the ISD office right away.

When to Contact Your Local ISD Office

You need to call your local ISD office or go to YESNM (**www.yes.state.nm.us**) and update your information if you:

- Change your name
- Move to another address
- Change your phone number
- Have a new child, adopt a child, or place your child up for adoption
- Get other health insurance, including Medicare
- Move out of New Mexico
- Have any questions about your Medicaid eligibility

Prior Authorizations

Native American members do not need prior authorizations to visit any Indian Health Service, tribal health provider, or urban Indian provider (all together referred to as "I/T/U"). This also applies to Tribal 638 facilities. Even if these facilities and providers are out of network for Centennial Care, you can still see them. We understand the importance of your relationship with your I/T/U provider. Our Care Coordinators will help you coordinate your care with these providers.

You can receive services directly from any I/T/U provider, including facilities that are operated by Native American/Alaskan Indian tribes. You can also get prescriptions at I/T/U facilities that are not on the Drug List without obtaining prior authorization from BCBSNM.

Copayments

Native American members do not pay any copayments under the Centennial Care plan.

Care Coordinator

You can ask to be assigned to a Native American Care Coordinator. If there is a time when the Native American Care Coordinator is not available, a Community Health Representative will be present for all in-person meetings with you and a non-Native American Care Coordinator.

Native American Advisory Board

The Native American Advisory Board (NAAB) is a team of Blue Cross Community Centennial members. The members on the NAAB play a key role in advising BCBSNM how to improve its services to Native American members. NAAB meets four times a year at different locations. All Native American members are invited to attend.

You may get a notice in the mail or a phone call asking you to join us for a meeting. You can call or write us and let us know you want to join. To learn more about NAAB or to make a reservation, please call **505-816-2210** (TTY: **711**) or email **bccc_ab@bcbsnm.com**. You can visit our website at **bcbsnm.com/medicaid** for the most current NAAB meeting dates.

Section 3: Providers

All of the places and people you can receive covered services from are called providers. Examples of providers are PCPs, specialists, nurses, counselors, hospitals, urgent care centers, and pharmacies.

If you want to know more about your provider, such as where he or she went to medical school or performed their residency, their qualifications, their special expertise, or board certification status, call Member Services at **1-866-689-1523**.

Centennial Care helps manage health care costs by asking you to have your care coordinated by a PCP and to stay within a "network" of Centennial Care providers. These are independent providers that have agreed by contract to see Centennial Care members and follow the rules of the BCBSNM Centennial Care program. In this handbook, we call these independent providers "in-network" or "Centennial Care providers" or "Centennial Care network providers."

Under your Centennial Care plan, you must get services from network providers. Services from providers who are not in the Centennial Care network are called out-of-network providers, and services from them will not be covered, except in the following cases:

- Urgent care or emergency care described in **Section 4A: Physical Health Benefits**
- Family planning services
- Native Americans visiting any I/T/U providers or Tribal 638 facilities
- When prior authorization is received from BCBSNM (such as when there are no Centennial Care providers that can give you the care you need)

If you are a new member of the Centennial Care program, we may need to plan for you to switch to a Centennial Care network provider. For example, you may already be using a home health service or seeing a provider that is not in our Centennial Care network. We will approve you to continue to see this provider while we help you change to a Centennial Care provider. Just call or email Member Services. We are here to help you.

Provider Directory and Provider Finder®

To find a Centennial Care provider in your area, please visit Provider Finder on our website at **bcbsnm.com/medicaid**. The Provider Finder has a list of PCPs and other network providers. You can also find a copy of the provider directory on our website. To request a printed copy of the provider directory, call Member Services at **1-866-689-1523**. We will send one to you within 10 calendar days of your request at no cost to you. The directory lists all providers in the local Centennial Care network. The directory will not include any transportation providers. You must call LogistiCare to set up all non-emergency transportation. **You can read about LogistiCare in Section 4G: Transportation Benefit.**

The directory will tell you the provider's specialty, what languages are spoken in the office, what the office hours are, telephone numbers, and other information. To find this information on the website directory, click on the provider's name. The website directory will also give you a map to the provider's office.

Some providers are listed as taking established patients only. This means that if you are not already a patient of that provider, you cannot choose him or her as your PCP. Some of these providers may open or close their practices to new patients after a directory has already been printed. You may want to ask the PCP if he or she is accepting new patients before seeing the provider.

Primary Care Providers (PCPs)

The role of a PCP is to take care of you and help you stay healthy. Your PCP is the most important person to help you with your health care needs. They will provide most of your health care. This is who you will go to first when you are sick or need a check-up. Your PCP will keep a record of your health and your health care. Your PCP will deliver your health care services or send you to other providers when you need specialty care. You and your PCP should work as a team to take care of your health. You should be able to talk to your PCP about all of your health care needs, including your medical, behavioral health, and long-term care needs.

PCPs have signed a special Primary Care Provider agreement with BCBSNM. PCPs are located in New Mexico and along the New Mexico border of neighboring states. PCPs include:

- Family and general practice
- Internal medicine
- Gerontology
- Obstetrics (OB)/gynecology
- Pediatric health care providers
- Certified nurse practitioners and midwives
- Physician assistants

Centennial Care providers know when to request authorizations for certain services and how to work with us when you need special care. They will also help you when they believe you need hospital care.

Choosing a PCP

You must select a PCP from the Centennial Care provider network. When you enroll in Centennial Care, we will give you information on how to choose a PCP or we can help assign you a PCP.

If you have a new PCP, you should make an appointment for a physical exam as soon as possible so that you can get to know each other. You can tell your new PCP about your health conditions and talk about any concerns you have.

If you are a new member of Centennial Care and your provider is not in our network, you can continue your care with your current provider for 30 days while you find a new PCP in our network. If you are more than six months pregnant when you enroll with us, you can keep seeing your current OB provider for the rest of your pregnancy. You can call Member Services to help you with your PCP needs.

When you enroll, please let us know if you need to continue services, such as:

- Medical equipment
- Home health services
- Case management
- Surgery that has already been scheduled
- Pregnancy care
- Other ongoing care, such as radiation, chemotherapy, dialysis, diabetic care, or pain management

Please also let us know if you see I/T/U providers or if you are pregnant.

Changing PCPs

You may select a new PCP at any time by calling or writing Member Services. Tell us the name of the PCP you want. If the PCP is taking new patients, we will make the change.

- If you call on or before the 20th of the month, the PCP change will be effective the 1st day of the next month.
- If you call on or after the 21st of the month, the PCP change will be effective the 1st day of the second following month.
- We will mail you a new ID card showing the new PCP's name. Your legal guardian or representative can request this change as well. You can begin seeing your new PCP right away. You do not have to wait for your new ID card.

Medicare PCP Selection

If you are eligible for both Medicare and Medicaid, you do not have to pick a new PCP for Centennial Care. You can continue to see your Medicare PCP. You must take your Medicare ID card and your Centennial Care ID card with you any time you see a provider, including your PCP.

PCP Lock-In

If you get services that are not needed or are getting the same services from multiple providers, Centennial Care can lock you into one PCP. We will need to get approval from your PCP or the provider you are getting care from to do this. If needed, a PCP lock-in can be done for more than one provider.

Specialists

There may be times when you need to see a provider who can treat a special medical problem. A provider who takes care of specific health problems (such as heart problems, asthma, cancer, etc.), is called a specialist. These providers don't usually see patients for routine care or minor health problems.

If your PCP thinks you should see a specialist or go to another provider for medical tests, he or she may make the appointment for you. A referral is not required. Sometimes you will have to make the appointment yourself. This is called "direct access," or the ability to self-refer. You may also call Member Services if you need help seeing a specialist or getting an appointment.

Specialist PCP

A specialist may be able to act as your PCP. A PCP may help you get the treatment for all of your medical problems. BCBSNM and the specialist have to agree with the treatment. If you think you need a specialist as your PCP, please call Member Services. We will work with you and your provider to help make this change.

PCP Terminations

If your PCP tells us they are going to leave the Centennial Care network, we will make a good faith effort to send you a letter telling you within 15 days after your PCP gives their termination notice.

If your PCP is terminated or suspended from the network for potential quality or fraud and abuse reasons, you must select another PCP within 15 days of the termination. If you do not select another PCP, we will choose one for you and notify you in writing of the PCP's name, location, and office telephone number. If you need help, we will help you find a new PCP.

Referrals

BCBSNM does not require a referral when you see any in-network medical, behavioral, or long-term care provider. A referral is not needed for emergency services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, women's services, or any service, such as vision and dental.

When you need to go to a specialist, remember that your PCP knows you and your medical history. They may be able to suggest a treatment or a provider that is better for you. Please talk to your PCP if you can before making an appointment with a specialist. Some providers may not accept you as a patient if you have not received a written referral by another provider. This is sometimes referred to as a physician-to-physician referral. BCBSNM does not need to be told when this happens.

Out-of-Network Providers

Providers and facilities not listed in our provider directory or in our online Provider Finder are considered out-of-network providers. If you have Medicare, your Medicare PCP is not considered out-of-network. Services from an out-of-network provider are not covered without first getting prior authorization from BCBSNM, except in the situations listed below:

- Emergency care (life-threatening) from a hospital and emergency ambulance
- Urgent care received at an urgent care center
- Family planning such as education and counseling about birth control and pregnancy, lab tests, follow-up care, birth control pills, and devices such as IUDs and condoms, tubal ligation, and vasectomies
- Native Americans visiting I/T/U providers or Tribal 638 facilities

All out-of-network providers must also enroll in the Medicaid program by registering in the Conduent system. If your out-of-network service is preauthorized and that provider recommends another out-of-network service, it is your responsibility to make sure you have prior authorization for the new service. If you do not get prior authorization before you receive out-of-network services, you may have to pay the provider. Call BCBSNM for help or prior authorization at **1-866-689-1523**.

If BCBSNM provides prior authorization to see an out-of-network provider, you will not have to pay more than you would have if you had received services from an in-network provider.

Filing Claims for In-Network Providers

All Centennial Care providers file claims to BCBSNM. BCBSNM makes payments directly to your providers. Be sure these providers know you have Centennial Care coverage. Do not file claims for in-network services yourself.

Filing Claims for Out-of-Network Providers

If you have to pay for out-of-network services or an out-of-network provider does not file a claim for you, you must submit receipts or itemized medical bills to BCBSNM. This needs to be done as soon as possible. We will then file the claim for you. You may be responsible for charges not covered by Centennial Care. If you have questions, call Member Services and we will be happy to help you. Centennial Care does not cover services outside the United States.

Mail receipts and itemized medical bills for covered services of out-of-network providers to:

Blue Cross and Blue Shield of New Mexico
P.O. Box 27838
Albuquerque, NM 87125-7838

Most claims will be processed, and the provider will be notified of BCBSNM's benefit decision within 30 days of receiving the claim.

Itemized Bills

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

- Member's Centennial Care ID number
- Member's name and address
- Member's date of birth
- Name and address of health care provider, including tax ID number or social security number
- 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 receipt, canceled check, or other proof of payment

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 as 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.

Making an Appointment

To make an appointment, please follow these steps:

- For routine visits or sudden illnesses, call your provider's office and tell them you are a Centennial Care member. Your provider's office will help you.
- When you get to the provider's office, show your Centennial Care ID card. If you have a Medicare or other insurance ID card, please be sure to show that as well.
- You may contact your Core Service Agency (CSA) or other behavioral health provider for an appointment for routine or urgent needs.
- You may also contact your assigned Care Coordinator if you need assistance.
- If you need a ride to your provider's office or behavioral health appointment please call LogistiCare.

If you go to a provider's office without an appointment, the provider may not be able to see you. Please call your provider before you go to his or her office.

We do not guarantee that a certain type of room or service will be available at any hospital or other facility within the Centennial Care provider network, or that the services of a particular hospital, provider, or other provider will be available.

Transportation to Appointments

If you do not have a car or anyone to give you a ride, you may be eligible for transportation to help you get to your non-emergency medical, behavioral, and long-term care appointments. LogistiCare coordinates all non-emergency transportation for Centennial Care members. This includes food and lodging expenses when you have to travel a long distance to get covered medical care. Call LogistiCare at least three working days before your routine appointment to schedule a ride. More information about LogistiCare is provided in the section regarding non-emergency transportation services. See **Section 4: Covered and Non-Covered Benefits** for more information on transportation services.

Second Opinions

Getting a second opinion means seeing another provider about your illness or your treatment after your own PCP or specialist has seen you. You have a right to see another provider if:

- You disagree with your PCP or specialist
- You have more concerns about your illness
- You want another provider to approve your treatment plan
- You need more information about treatment than your provider has suggested
- Your PCP or specialist does not want to give you a referral to another provider who requires that you have a referral

You must get your second opinion from providers who are in the Centennial Care network or get a prior authorization from BCBSNM to see a provider outside the network. We will cover a second opinion from a qualified provider outside the network at no cost to you only if one is not available in our network. You must have prior authorization from BCBSNM before getting a third or fourth opinion.

Cancelling an Appointment

If you need to cancel an appointment tell your provider's office as soon as possible. Try to tell them at least 24 hours before the appointment time.

If you are going to be late, please call your provider's office. You may be asked to schedule a new time for your visit.

If you have arranged for a ride to your provider's office, call LogistiCare and cancel or reschedule your ride. You need to cancel your ride at least two hours before you were supposed to be picked up.

Always Talk to Your Doctor

None of BCBSNM's programs or services replace in any way the care you can get from your doctor or other health care providers. Always talk to your doctor or other health care providers about your health. None of the doctors and other health care providers mentioned in this handbook are employed by BCBSNM. They are all independent from BCBSNM.

Section 4: Covered and Non-Covered Benefits

Your Centennial Care plan covers medical, behavioral, long-term care, dental, vision, transportation, and prescription services for eligible members. All members are covered for these services. The amount, duration, and scope of all covered and non-covered benefits are described in this section.

You must use Centennial Care network providers except for the below situations:

- Emergency care **(see Section 4A)** from a hospital or emergency ambulance service
- Urgent care received at an urgent care center
- Family planning, such as education and counseling about birth control and pregnancy, lab tests, follow-up care, birth control pills, devices such as IUDs and condoms, tubal ligations, and vasectomies
- Native Americans visiting I/T/U providers or Tribal 638 facilities

If you have to see an out-of-network provider for any other reason, you must first get prior authorization from BCBSNM.

Prior Authorization

What is a prior authorization? Not all services are automatically covered. Prior authorization means that BCBSNM has the chance to approve or deny coverage before you receive the service. If you go to a provider in the Blue Cross Community Centennial network, the provider will ask BCBSNM for you. If BCBSNM does not fully approve coverage, you can file an appeal. See **Section 7: Grievances and Appeals**.

To go outside of the Centennial Care network of providers, to be admitted to the hospital, or to receive certain services, such as home health care, you will need a prior authorization from BCBSNM. The Centennial Care network of providers will get approvals for you. BCBSNM may not approve the request. If the request for these types of services is denied by BCBSNM, you and your provider will be notified and the reason for the denial will be explained. Standard requests are reviewed as quickly as your health condition requires but no later than 14 days after BCBSNM receives the request from your provider. A 14-day extension may be granted if requested by your provider or if there is a reason that the delay would be in your best interest.

BCBSNM can deny your claim if your primary insurance company provider does not follow required procedures, including receiving prior authorization or timely filing.

Copayments

A copayment is a charge you are responsible for paying for your service. Members may have to pay a copayment beginning March 1, 2019, for some services received under the Centennial Care plan.

The below copayments may apply to members:

Type of Service	Copayment
Getting a name-brand drug when a generic version of the same drug is available (exceptions are drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions, family planning drugs/supplies/items, prenatal drug items, immunizations, or if you get a prior authorization for a special exception). You will not be charged a copay if your doctor that prescribed you the medication determines that the generic version is not as effective to treat your condition. If your doctor has determined that the name-brand drug is medically necessary, they must bill the claim with a "dispense as written" indicator.	$8/prescription
Use of the emergency room for non-emergencies. Hospital determines if emergent.	$8/visit
You may not have copayments if: • **You are a Native American** • **You are on the DD waiver** • **You are receiving hospice services.** • **You have a household income of 0% federal poverty level (FPL)** • **Individuals whose Category of Eligibility (COE) is Fee-For-Service** • **Individuals in an Institutional Care COE**	

If you have a copayment, it must be received at the time of service. If you cannot make the copayment, you will need to make arrangements with your provider to pay later. If you are billed and do not pay your bill, the provider and/or Centennial Care may use legal action to collect payment from you. If you have been incorrectly charged for co-payments, you have the right to be repaid by your provider. If you do not pay your copayments, you will not lose your Medicaid benefits.

Other Times You May Have to Pay for Services

There may be times when Centennial Care will not pay for services you received. You may have to pay for services in the following times:

- If you did not follow prior authorization guidelines and still received the service
- If you agree to pay for non-covered services in writing with your provider

Providers cannot bill you for them not following Centennial Care procedures. If you cannot pay for services that were not covered, you will not lose your Medicaid benefits.

Maximum Copayments

If you have copayments and reach the maximum copayment amount during the quarter, copayments will not be required for the rest of the quarter (following the date that BCBSNM verifies that the maximum copayment amount has been reached). BCBSNM will inform you if the maximum copayment amount has been reached.

You have the right to request from your MCO the amount of your household's total copayments at any time. If you disagree with that amount, you may file an appeal with BCBSNM. Please see **Section 7: Appeals and Grievances** of this handbook. If you have questions about your copayment maximum or to request your household's total copayments, please call Member Services at **1-866-689-1523** (TTY: **711**).

If you disagree with your household income calculated by the ISD office, you can request an HSD administrative hearing. If you have any questions about HSD administrative hearings, call the Fair Hearing Bureau. You can call them at **1-800-432-6217**, then press option 6, or by faxing them at 505-476-6215.

Other Insurance

If you or your family have other medical or dental plan coverage, including Medicare, it is very important that you tell your local ISD office. Also, tell your provider before your appointment. If you do not know how to contact your local ISD office, call HSD/MAD at **1-888-997-2583** to get information. You will need to tell BCBSNM about your other health insurance. This will help us coordinate your health care coverage so that your medical services get paid correctly. Please call Member Services at **1-866-689-1523**.

Always show your Centennial Care ID card and other health insurance ID cards when you see a provider and go to the hospital. The other insurance plan needs to be billed for your health care services before Centennial Care can be billed. BCBSNM's staff will work with the other insurance plan on payment for these services. One exception to this is if you also have Indian Health Services (IHS) coverage. Medicaid will pay before IHS does.

Please contact BCBSNM if you have been hurt in a car accident or if you receive services for an injury at work. This may involve insurance coverage through other companies and will help get your medical services paid. This is also called subrogation.

If this happens, BCBSNM has the following rights:

- 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 the Member or the Member's legal representative as a result of that sickness or injury, in the amount of the total Covered Charges for Covered Services for which BCBSNM has provided benefits to the Member.
- BCBSNM is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits BCBSNM provided for that sickness or injury.
- BCBSNM shall have the right to first reimbursement out of all funds the Member, the Member's covered family Members, or the Member's legal representative, are or were able to obtain for the same expenses for which BCBSNM has provided benefits as a result of that sickness or injury.
- The Member is required to furnish any information or assistance or provide any documents that BCBSNM may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

If you have both Medicare and Medicaid, you have more than one insurance coverage. Medicare is considered your primary insurance and Centennial Care is your secondary insurance. Your Centennial Care benefits will not change your primary insurance benefits.

If you have a care coordinator, they will work with your primary insurance to help set up your health care. If you do not have a Care Coordinator, call Member Services at **1-866-689-1523** and they will be able to help. If you have both Medicare and Centennial Care, Medicare Part D will cover most of your drugs. You will still have to pay Medicare Part D copays unless you live in a nursing facility. If you have Medicare, you can use your current provider. You can get Medicare specialty services without approval from BCBSNM. We will work with your provider for the services you get. We can help you pick a provider if you do not have one. This provider can set up your Centennial Care and Medicare services. Centennial Care may cover some services that are not covered by Medicare.

Outside New Mexico

If you are outside of New Mexico but within the United States and need emergency services, go to the nearest emergency room. Claims for covered emergency medical/surgical services received outside New Mexico from providers that do not contract as Centennial Care providers should also be mailed to BCBSNM. If a 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 out-of-network provider. Please mail both forms to BCBSNM. If you would like to see an out-of-state provider for non-emergency services, you must first receive prior authorization from BCBSNM. If you do not get a prior authorization, the services will not be covered.

Duplicate (Double) Coverage

Centennial Care 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. If you have any other health care coverage, you must let us know.

Experimental, Investigational, or Unproven Services

Centennial Care does not cover any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical practice, as defined below. With one exception, Centennial Care also does not cover any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical practice that is considered experimental, investigational, or unproven. The one exception is for certain services in qualifying cancer trials per HSD rules. 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, 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, III, or IV clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its capability, or its capability as compared with the standard means of treatment or diagnosis.
- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug, or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.
- The guidelines and practices of Medicare, the FDA, or other government programs or agencies may be considered in a determination; however, approval by other bodies will neither constitute nor necessitate approval by BCBSNM.
- Reliable evidence means only published reports and articles in authoritative peer-reviewed medical and scientific journals; the written protocol or protocols used by the treating facility, or the protocol(s) of another facility studying mainly the same medical treatment, procedure, device, or drug; or the written informed consent used by the treating facility or by another facility studying mainly the same medical treatment, procedure, device, or drug.

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 are performed
- The physician or other professional provider has had the appropriate training and experience to provide the treatment or procedure

If you disagree with BCBSNM's decision regarding any item or service, you may file an appeal. See **Section 7: Grievances & Appeals**.

No Effect on Treatment Decisions

Benefit decisions by BCBSNM (like prior authorizations) are different from treatment decisions by you and your health care providers. Regardless of any benefit decision, the final decision about your care and treatment is between you and your health care provider.

Medically Unnecessary Services

Centennial Care does not cover services that are not medically necessary. Medically necessary services are clinical and rehabilitative physical or behavioral health services that:

- Are necessary to prevent, diagnose, or treat medical conditions, or are needed to enable the patient to attain, maintain, or regain functional capacity
- Are delivered in the amount, duration, scope, and setting that is clinically appropriate to the specific health care needs of the patient
- Are provided within professionally accepted standards of practice and national guidelines
- Are required to meet the physical, behavioral, and long-term needs of the patient and are not primarily for the convenience of the patient, the provider, or BCBSNM

BCBSNM determines whether a service or supply is medically necessary, and whether it is covered. Because a provider prescribes, orders, recommends, or approves a service or supply, does not make it medically necessary, or make it a covered service, even if it is not specifically listed as an exclusion.

Cosmetic Services

Centennial Care does not cover cosmetic services, which are defined as services that are provided primarily to alter and/or enhance appearance in the absence of documented impairment of physical function.

This coverage exclusion does not apply to primary gender reassignment chest and/or genital surgeries nor to pharmaceutical gender reassignment services, all of which require prior authorization from BCBSNM.

No Legal Payment Obligation

Centennial Care does not cover services for which you have no legal obligation to pay or that are at no cost, including:

- Charges made only because benefits are available under this program
- Services for which you have received a discount that you have arranged
- Volunteer services
- Services provided by you or a family member for yourself, or by a person ordinarily residing in your household

Preventive Services

Preventive health care is for everyone. Preventive health care can keep you healthy and prevent illness. Below are some of the screenings and services available to you and your children.

Well-Child Visits

Well-child visits are for children from birth to age 21. Your child's PCP can check your child's health, growth, development, and provide immunizations. This can occur many times throughout childhood. Well-child visits can sometimes be done when your child sees the PCP for a sick visit.

Your PCP will guide you if more services are needed.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

EPSDT services are provided to every Medicaid-eligible child from birth to age 21. Centennial Care wants your child to be healthy. Centennial Care will provide checkups and preventive services through your child's regular provider. A well-child checkup will be provided for your child. Your child should have exams at the ages shown on the chart below.

Well-Child Health Check Schedule with your PCP	
Under age 1	3 – 5 days, 1 month, 2 months, 4 months, 6 months, and 9 months
Ages 1 to 30 months	12 months, 15 months, 18 months, 24 months, and 30 months
Ages 3 to 21 years	Each year

These exams may include vaccinations or shots. If your child has not had his or her checkup this year, call the provider and schedule one.

- **Lead Testing:** The provider will need to do a blood test to make sure your child does not have too much lead. Your child should be checked at 12 months and 24 months of age or if they have never been checked.
- **Dental Exam:** Your child should have their teeth cleaned and receive fluoride treatments every six months.
- **Private Duty Nursing:** When your child's provider wants a nurse to provide care at home or at school.
- **Personal Care Services:** When your child's provider wants a caregiver to help your child with eating, bathing, dressing, and toileting.

EPSDT also provides hearing services, vision services, school-based services, and more. If you have questions, please contact your Care Coordinator. If you need a Care Coordinator, call **1-877-232-5518**, select option 3.

Health problems should be identified and treated as early as possible. When your child needs assistance with daily activities due to a qualifying medical condition, special services like Private Duty Nursing or Personal Care Services will be provided under EPSDT through Centennial Care.

Immunizations help keep you well. You can receive shots at a PCP visit. Many immunizations are needed before the age of two years. Yearly flu shots are important, too. Ask your PCP which shots you need. Teenage children will also need to receive some shots.

Adults

There are recommended health screenings for both men and women. Women age 40 through 74 should talk with their provider about having a mammogram every one to two years. Both men and women age 50 and older should be screened for colon cancer. These are just a few of the necessary screenings.

During PCP visits, talk with the provider about exercise, eating right, and safety issues for children and adults. Your PCP can measure height and weight to ensure you and/or your child is at a healthy weight.

Medical/Surgical Services

A list of covered services available for the Standard Medicaid Plan and Alternative Benefit Plan (ABP) is included in the table below. The "✓" in the column will tell you if the service(s) are covered for the Standard Medicaid Plan and the ABP.

The ABP is a part of the New Mexico Medicaid Centennial Care program. The ABP offers coverage for Medicaid-eligible adults ages 19-64 who have income up to 138% of the Federal Poverty Level (FPL), which includes the Medicaid Expansion Population and Transitional Medical Assistance categories. If you are eligible for ABP covered services, please refer to the services listed under the column titled, "ABP Covered Service."

If you are an ABP member and have a physical or behavioral health condition that meets certain criteria, you may be eligible for covered services under the column titled, "Standard Medicaid Plan Covered Service."

In the chart below, it sometimes says that prior authorization is "dependent on exact service." That means you will need to call Member Services to find out if the exact service you are checking on requires prior authorization. To learn more about prior authorizations, please see page 22 of this handbook.

The following services are covered when medically necessary:

Service	Standard Medicaid Plan Covered Service	ABP Covered Services	Prior Authorization?
Allergy care, including tests and serum	✓	✓	Dependent on exact service
Anesthesia Services	✓	✓	No
Bariatric surgery	✓	Lifetime limit	Yes
Breast pumps and replacement supplies	✓	✓	No - subject to benefit and Durable Medical Equipment (DME) dollar amount
Cancer clinical trials	✓	✓	Yes
Chemotherapy and radiation therapy	✓	✓	Yes

Note: These services are covered when medically necessary.
Other terms, conditions, and/or limitations may apply.

Service	Standard Medicaid Plan Covered Service	ABP Covered Services	Prior Authorization?
Community Interveners for Deaf and Blind	✓	✓	Yes
Covered services provided in school-based health clinics	✓	✓	No
Dialysis services	✓	✓	Notification is required
DME and supplies	✓	✓ Limits apply	All medical supplies costing $1,500 or more require prior authorization; please call Member Services and ask to speak with a Care Coordinator/Case Manager for more information
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	✓	✓ Age limited	No
Emergency dental care	✓	✓	No
Emergency services	✓	✓	No
EPSDT personal care services	✓	✓ Age limited	Yes - if your child is disabled, he or she may qualify for more services; please call Member Services and ask to speak with a Care Coordinator/Case Manager for more information
EPSDT private duty nursing	✓	✓ Age limited	Yes - if your child is disabled, he or she may qualify for more services; please call Member Services and ask to speak with a Care Coordinator/Case Manager for more information
EPSDT rehabilitation services	✓	✓ Age limited	Yes - if your child is disabled, he or she may qualify for more services; please call Member Services and ask to speak with a Care Coordinator/Case Manager for more information
Family planning	✓	✓	No
Ground and air ambulance	✓	✓	Ground - No Air - Yes, fixed wing air ambulance
Hearing services and devices	✓	✓	Yes
Home birthing	✓	✓	Dependent on exact service
Home health care and intravenous services	✓	✓ Limits apply	Yes
Hospice services	✓	✓	Yes

Note: These services are covered when medically necessary.
Other terms, conditions, and/or limitations may apply.

Section 4A: Physical Health Benefits

Service	Standard Medicaid Plan Covered Service	ABP Covered Services	Prior Authorization?
Hospital services (inpatient, outpatient, and skilled nursing)	✓	✓	Dependent on exact service
Inhalation therapy services	✓	✓	No
Injections	✓	✓	Dependent on exact service
Inpatient rehabilitative facilities	✓	✓ Skilled nursing or acute rehab facility only	Yes
IV outpatient services	✓	✓	Yes
Laboratory, X-ray, EKGs, medical imaging services, and other diagnostic tests	✓	✓	Dependent on exact service
Long-term services and supports	✓	✓	Yes - please call Member Services and ask to speak with a Care Coordinator for more information
Molecular genetics	✓	✓	Yes
Nursing facility services	✓	✓	Yes
Nutritional counseling services	✓	✓	Dependent on exact service
Nutritional services	✓		Yes
Office visits to PCPs or specialists, including dieticians, nurse practitioners, and physician assistants	✓	✓	No
Organ and tissue transplant services	✓	✓ Lifetime limit	All transplant and pre-transplant evaluations require prior authorization
Orthotics and prosthesis	✓	✓ Limits apply	Dependent on exact service
Outpatient professional services	✓	✓	No
Outpatient surgery	✓	✓	Dependent on exact service
PET, MRA, MRI, and CT scans	✓	✓	Dependent on exact service
Pharmaceutical gender reassignment services	✓	✓	Yes
Physical therapy	✓	✓ Limits apply	Dependent on exact service
Podiatry (foot and ankle) services	✓	✓ Limits apply	Dependent on exact service
Pregnancy-related and maternity services, including pregnancy termination procedures	✓	✓	No

Note: These services are covered when medically necessary.
Other terms, conditions, and/or limitations may apply.

Service	Standard Medicaid Plan Covered Service	ABP Covered Services	Prior Authorization?
Primary gender reassignment (male-to-female or female-to-male) chest and/or genital surgeries	✓	✓	Yes
Routine physicals, children's preventive health programs and Tot-to-Teen checkups	✓	✓	No
Smoking cessation services	✓	✓	No
Special rehabilitation services, such as physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary rehabilitation	✓	✓ Limits apply	Dependent on exact service
Telemedicine services	✓	✓	No
Treatment of diabetes	✓	✓	Dependent on exact service
Urgent care services	✓	✓	No

Note: These services are covered when medically necessary.
Other terms, conditions, and/or limitations may apply.

All services received from an out-of-network provider must have a prior authorization except for the examples listed in **Section 3: Providers**.

Non-Covered Medical Services

Centennial Care does not cover the following medical services:

- Abdominoplasty (unless necessary to restore appropriate hygiene following significant weight loss)
- Acupuncture, massage therapists, hypnotherapy, rolfing, biofeedback, naprapathy, or chiropractic services
- Blepharoplasty (unless necessary to restore unobstructed vision)
- Brow lift
- Calf implants
- Cheek implants
- Chin or nose implants
- Cosmetic services, including plastic surgery, wigs, hairpieces, or medications for hair loss
- Duplicate equipment
- External penile prosthesis (vacuum erection devices)
- Face lift (rhytidectomy)
- Facial bone reconstruction sculpturing/reduction, includes jaw shortening, forehead lift or conturing
- Hair removal (may include donor skin sites) or hair transplantation (electrolysis or hairplasty)
- Infertility services and treatments
- Laryngoplasty
- Lip reduction or lip enhancement
- Liposuction/lipofilling or body contouring or modeling of waist, buttocks, hips, and thighs reduction
- Medical services provided to a person who is an inmate of a public institution

- Neck tightening
- Pectoral implants
- Personal care items, like toothbrushes, or television sets in hospital rooms
- Private room expenses, unless your medical condition requires isolation and charges are preauthorized by BCBSNM
- Reduction thyroid chondroplasty or trachea shaving (reduction of Adam's apple)
- Redundant/excessive skin removal
- Reproductive services including but not limited to procurement cryopreservation/freezing, storage/banking, and thawing of reproductive tissues, such as oocytes, ovaries, embryos, spermatozoa, and testicular tissue
- Reversal of a voluntary sterilization
- Rhinoplasty (nose correction)
- Services received outside the United States, including emergency services
- Skin resurfacing
- Some durable medical equipment and supplies (Centennial Care suppliers of these services know what is covered by Medicaid and what needs prior authorization)
- Temporomandibular joint or craniomandibular joint treatment
- Testicular expanders
- Voice modification surgery, and/or voice (speech) therapy or voice lessons

Family Planning Services

Family planning or birth control helps you decide when you are ready to have a baby. To get help with your decision, you can see your PCP, any qualified family planning center, or other provider. This includes an OB/GYN provider or going to Planned Parenthood. You can get family planning services in or out-of-network. You can do this without asking your PCP. This includes adolescents. Members have the right to refer themselves to an in-network women's health specialist for routine and preventive women's health services.

Centennial Care offers the following family planning services and related services to all members. You have the right to receive these services when you need them:

- Family planning counseling and health education, so you will know which birth control method, if any, is best for you
- Lab tests if you need them to help you decide which birth control you should use
- Follow-up care for trouble you may have from using a birth control method that a family planning provider gave you
- Birth control pills
- Pregnancy testing and counseling

Centennial Care also offers the following FDA-approved devices and other procedures:

- Injection of Depo-Provera for birth control purposes
- Diaphragm, including fitting
- IUDs or cervical caps, including fitting, insertion, and removal
- Contraceptive arm implants, including insertion and removal
- Surgical sterilization procedures, such as vasectomies and tubal ligations

You do not need to get prior authorization from BCBSNM if you wish to visit Planned Parenthood or other out-of-network providers for family planning services. If you need a ride to the provider's office, please contact LogistiCare for prior authorization.

Pregnancy-Related and Maternity Services

Once you are sure you are pregnant, you may choose either your PCP or another Centennial Care network provider to provide maternity care. The provider is then responsible for notifying BCBSNM of any admissions or home birth plans.

If you are pregnant or think you may be pregnant, you or your provider should call BCBSNM right away. The care of a pregnant mother is important and the mother's health can affect the health of her newborn. When you call, we will:

- Help you choose a primary OB/GYN provider or certified nurse midwife for your pregnancy
- Have you enroll in our special program for pregnant members, Special Beginnings
- Help you choose a PCP for your baby (if your baby is eligible for Centennial Care coverage)

You may self-refer to any Centennial Care provider for your maternity care. If there is no Centennial Care maternity services provider in your area, you or your provider may request prior authorization from BCBSNM to go to an out-of-network women's health care provider.

Centennial Care covers all medically necessary hospitalizations, including up to 48 hours of inpatient care following a vaginal delivery and 96 hours following a C-section delivery. If you need emergency services and must go to a hospital outside the network (such as while you are traveling), call Member Services within 48 hours or as soon as possible so we can help coordinate your care and arrange for follow-up services.

If you are pregnant on the date you become a Centennial Care member and you are already seeing a provider, please call Member Services so that we can approve your visits to the provider if she or he is outside our network. If you are in your first or second trimester, in most cases you will be allowed to continue your care with that provider for at least 30 days. If you are six months or more than six months pregnant, you can continue seeing your provider for the rest of your pregnancy.

Prenatal Care

Early and regular prenatal care is very important for you and your baby's health. Your provider or midwife will:

- Give you information about childbirth classes
- Tell you how often you need to visit your provider or midwife after your first visit. Usually you will visit your provider or midwife every four weeks until you are about six months pregnant. Then you will visit your provider or midwife every two weeks until your last month. You will continue visiting your provider or midwife every week during the last month
- Schedule you for routine lab work and other tests that will check the health of you and your baby
- Let you know about good nutrition and exercise, about the dangers of smoking, alcohol/drug use, and other behavior, and give you information about vitamins, breast feeding, infant safety car seats, and cribs
- Ask you to return to see your provider for a postpartum visit between 21 to 56 days after you have your baby
- Help you in the future with family planning (such as birth control)
- Talk to you about preventing sexually transmitted diseases (STDs), flu shots during pregnancy, and whether or not to get a rubella shot after delivery

Special Beginnings®

This maternity program is for Centennial Care members whenever you need it. It can help you better understand and manage your pregnancy, so you should enroll in the program within three months of becoming pregnant. When you enroll, you'll receive a questionnaire to find out if there may be any problems during your pregnancy to watch 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** (TTY: **711**).

If you enroll in our Special Beginnings program, you can receive a car seat, portable crib, wrap baby carrier, or join prenatal education classes either in person or online. There is no cost to you. Other requirements do apply. Please see **Section 4H: Value-Added Services** for more information. Or you can call **1-888-421-7781** (TTY: **711**) to learn more.

Safe Sleep for Baby

Safe sleep for your baby is as simple as ABC. Learn about safe sleep for your baby by contacting BCBSNM's Special Beginnings program at **1-888-421-7781** (TTY: **711**).

Birthing Options Program

You can choose to have your pregnancy-related services provided at home or in a birthing center by a licensed certified nurse-midwife (CNM) or by a licensed direct-entry midwife (DEM). These services will be covered only if they are provided by health care providers who have an approved Provider Agreement with HSD/MAD. If you are planning to have your baby at home or in a birthing center, you must have prior authorization from BCBSNM. This will help us make sure you are seeing a provider or midwife that can provide such services under the Centennial Care program.

If you are interested in having a midwife, call us and ask for a midwife packet, and follow the instructions. If you choose a midwife for at-home or birthing center delivery, it is your right and responsibility to:

- Ask the midwife if he or she has malpractice insurance
- Receive the confirmation or release statement from the midwife
- Sign the confirmation release or statement sent to you by the midwife
- Receive an "informed consent" or "informed choice" agreement from the midwife about complications that may or may not occur

If the midwife does not have malpractice insurance, you are assuming all risks of damage and injury.

Centennial Home Visiting Program

Some first-time mothers and families with children under 5 years of age may qualify to participate in the Centennial Home Visiting Program. Two programs are available.

Nurse Family Partnership (NFP)

If you are a first-time mother, less than 28 weeks pregnant, and live in a service area, you may be eligible to receive help from a personal nurse who will come to your home and provide advice, support, information and screenings during your pregnancy and after your baby arrives, up to age 2.

Parents as Teachers (PAT)

If you are pregnant or have a child that is 5 years old or younger, and live in a service area, you may be eligible to receive help from a certified parent educator. The parent educator will provide support, guidance, screenings, resources and activities for you and your child that promote early learning and development.

Learn more about the Centennial Home Visiting Program by contacting BCBSNM's Special Beginnings program at **1-888-421-7781** (TTY: **711**).

Hospital Services

Services you get in a hospital are covered. You may stay in the hospital overnight or visit the emergency room. Some examples of services you might get in a hospital are:

- Emergency room care
- Medical care for when your provider admits you to the hospital
- Physical therapy
- Lab test
- X-rays

Many hospital services must be approved before you go to the hospital. For more information about hospital services, call Member Services at **1-866-689-1523**.

Urgent Care Services

Urgent care is needed for sudden illnesses or injuries that are not life-threatening. If you can wait a day or more to receive care without putting your life or a body part in danger, you may not need urgent care. If you think you need urgent care, you can choose any of the following steps:

- Call your PCP or behavioral health provider's office and say you need to see a provider as soon as possible, but there is no emergency. If your provider tells you to go to the emergency room because he or she cannot see you right away and you do not believe you have an emergency, please call our toll-free 24/7 Nurseline at **1-877-213-2567** for advice.
- Ask your provider to recommend another provider if your provider is not able to see you within 24 hours.
- Contact your Core Service Agency (CSA) or other behavioral health provider if you feel you need urgent behavioral health care.
- Visit the nearest urgent care center in the Centennial Care network.
- If there is not an in-network urgent care center nearby, go to the closest urgent care center.
- If you are outside New Mexico and need urgent care, call Member Services for help or go to a local urgent care center.
- If you do not know if your condition is urgent, you can call the 24/7 Nurseline for advice.

BCBSNM does not cover follow-up care from out-of-network providers without prior authorization.

Emergency Medical Conditions

An emergency medical condition is a behavioral or physical health condition that is bad enough for an average person to think that without immediate help, there is serious danger to the health, bodily functions, body parts, organs, or appearance of that person or that person's unborn child.

Emergency Services

An emergency is a medical or behavioral condition that has symptoms so severe (including severe pain), that if you do not receive care right away, your health might seriously suffer (in the case of a pregnant woman, the health of the unborn child.) An emergency might also be when you believe you might ruin a bodily function, lose an organ, or lose a body part if you do not get medical attention right away.

To find out if you have an emergency, you should ask yourself:

- Do you have a severe medical or behavioral condition (including severe pain)?
- Do you believe your health could be seriously harmed if you don't get health care right away?
- Do you believe your life or the lives of others could be seriously harmed if you don't get health care right away?
- Do you believe a bodily function, body part, or organ can be damaged if you don't get health care right away?

If you answered "yes" to one or more of these questions, you may have an emergency. Here are some examples of emergencies:

- Heart attack
- Stroke
- Bad chest pain or other pain that does not go away
- Hard time breathing
- Bleeding that does not stop
- Loss of consciousness (passing out)
- Seizures
- Poisoning or drug overdose
- Severe burns
- Serious injury from an accident or fall
- Broken bones
- Injured eye or sudden loss of eyesight
- Feelings of wanting to hurt yourself or others

If you have an emergency, you do not need to call BCBSNM before going to the emergency room or calling 911 for emergency ambulance services. In an emergency, you do not have to worry about whether or not the emergency room or ambulance is in the Centennial Care network.

What to Do in an Emergency

If CPR is necessary, or if there is an immediate threat to your life or a limb, call **911**. If you do not call **911**, go to the nearest medical facility or trauma center.

What is Not an Emergency

Do not go to an emergency room if you are not having a true emergency. The emergency room is for patients who are very sick or injured and should never be used because it seems easier for you or your family. You may have to wait to be seen for a very long time and the charges for emergency room services are very expensive even if you have only a small problem. Members who use an emergency room when it is not necessary may be responsible for paying an emergency room copayment.

If you have an illness or problem, call your PCP first. If you cannot get in touch with your PCP, call the toll-free 24/7 Nurseline at **1-877-213-2567**. Call **711** for TTY service. A nurse from the Nurseline may suggest that you go to your PCP, an urgent care center, or the nearest emergency room. If your PCP's office is closed, the Nurseline can also help you decide what you should do.

If you know that your illness is not serious or life-threatening and you go to the emergency room or call an ambulance anyway, you may be billed. If you are billed and do not pay your bill, the provider and/or Centennial Care may use legal action to collect payment from you.

Emergency Room and Ambulance Services

If you have an emergency, you do not need to call BCBSNM before going to the emergency room or calling 911 for emergency ambulance services. In an emergency, you do not have to worry about whether or not the emergency room or ambulance is in the Centennial Care network.

Observation Stays in the Hospital

If you are admitted to the hospital after an emergency room visit and you only need to stay a few days, your care could be covered as an observation stay instead of an inpatient stay. Your provider will be notified when your illness qualifies as an observation stay.

Follow-Up Care

After a visit to the emergency room, you may need follow-up care. The health care you receive will either keep your health stable or improve or resolve your health problem. This is called post-stabilization care. This type of care may require prior authorization from BCBSNM. You may receive post-stabilization care in a hospital or other facility. Centennial Care covers this care. For other follow-up care, such as medicine refills or having a cast removed, go to your PCP's office. For help on how to find post-stabilization providers and get to their locations, call Member Services at **1-866-689-1523**.

What is Not Covered for Emergency Care

- Follow-up care outside New Mexico if you could return to New Mexico to receive care without medically harmful results
- Follow-up care received from an out-of-network provider if it is not preauthorized by BCBSNM
- Services received outside the United States

Section 4B: Behavioral Health Benefits

Behavioral health services help to support people facing emotional problems, mental illness, and/or substance abuse. Sometimes, behavioral health conditions may occur in combination with each other, or in addition to a physical condition. Covered services are services paid for by Centennial Care. The type of service you may need depends on your situation. A Care Coordinator can help you find out what services are covered for you and whether the service will need prior authorization. To learn more about prior authorizations, please see page 22 of this handbook. If you need a Care Coordinator, call **1-877-232-5518**. A list of covered services available for the behavioral health benefit on the Standard Medicaid Plan and Alternative Benefit Plan (ABP) is included in the table below. The "✓" in the column will tell you if the service(s) are covered for the Standard Medicaid Plan and the ABP.

The ABP is a part of the New Mexico Medicaid Centennial Care program. The ABP offers coverage for Medicaid-eligible adults ages 19-64 who have income up to 138% of the Federal Poverty Level (FPL), which includes the Medicaid Expansion Population and Transitional Medical Assistance categories. If you are eligible for ABP covered services, please refer to the services listed under the column titled, "ABP Covered Service."

If you are an ABP member and have a physical or behavioral health condition that meets certain criteria, you may be eligible for covered services under the column titled, "Standard Medicaid Plan Covered Service."

Service	Standard Medicaid Plan Covered Service	ABP Covered Services	BH Age	Prior Authorization?
Applied Behavior Analysis (ABA) Stage 1 and 2	✓	✓ Age limited	Up to age 21	No
ABA Stage 3	✓	✓ Age limited	Under age 21	Yes
Assertive Community Treatment	✓	✓	All ages	No
Behavioral Management Services	✓	✓ Age limited	All ages	No
Comprehensive Community Support Services (CCSS)	✓	✓	All ages	No
Day Treatment	✓	✓ Age limited	All ages	No
Days Awaiting Placement	✓	✓	Under age 21	Yes
Developmental Testing	✓	✓	All ages	No
Electroconvulsive Therapy	✓	✓	All ages	Yes
Emergency Services	✓	✓	All ages	No
Family Peer Support Services	✓	✓	All ages	No
Family Support (Behavioral Health)	✓	✓	All ages	No
Group Home	✓	✓ Age limited	All ages	Yes

Note: These services are covered when medically necessary.
Other terms, conditions, and/or limitations may apply.

Section 4B: Behavioral Health Benefits

Service	Standard Medicaid Plan Covered Service	ABP Covered Services	BH Age	Prior Authorization?
Hospital Outpatient	✓	✓	All ages	Dependent on exact service
Inpatient Psychiatric Service	✓	✓	All ages	Yes
Inpatient Rehabilitative Facilities	✓	✓	All ages	No
Inpatient Substance Abuse Services	✓	✓	All ages	Yes
Intensive Outpatient Programs	✓	✓	All ages	No
Medication Assisted Treatment for Opioid Dependence	✓	✓	All ages	No
Multi-Systemic Therapy	✓		All ages	No
Outpatient Behavioral Health Services	✓	✓	All ages	No
Outpatient Professional Services	✓	✓	All ages	No
Partial Hospitalization	✓	✓ Age limited	All ages	Yes, requires prior authorization beyond 45 days
Peer Support Services	✓	✓	All ages	No
Psychological/Neuropsychological Testing	✓	✓	All ages	No
Psychosocial Rehabilitation (PSR) Program	✓	✓	All ages	No
Residential Treatment Center Services	✓	✓ Age limited	Under age 21	Yes
Respite Care (up to age 21)	✓	✓	All ages	No
School Based Counseling	✓	✓	All ages	No
Screening, Brief Intervention, Referral to Treatment (SBIRT) Services	✓	✓	Age 11 and older	No
Standard Office Visits to Mental Health Specialists (which could include counselors, social workers, psychiatrists, or psychologists)	✓	✓	All ages	No
Sub Acute Residential	✓	✓ Age limited	Under age 21	Yes
Substance Abuse Residential	✓	✓	All ages	Yes
Telemedicine Services	✓	✓	All ages	No
Treatment Foster Care	✓	✓ Age limited	All ages	Yes

Note: These services are covered when medically necessary.
Other terms, conditions, and/or limitations may apply.

You do not need a referral from your PCP to get behavioral health services. You can call Member Services at **1-866-689-1523** to get more information. If you are not sure what kind of help you need, call Member Services and they will help you find a provider or help you speak to a Care Coordinator. You may need to complete an assessment with the help of your Care Coordinator and meet certain conditions to get behavioral health services. A licensed clinician may need to determine that the services are medically necessary.

If you do not have a personal crisis plan, please talk to your behavioral health provider or call the 24/7 Nurseline at **1-877-213-2567**. It is important that you make a plan in advance that may help you prevent crisis or relapse.

In an emergency, (such as if you feel like hurting yourself or others, or if you are not able to take care of yourself), call 911 or go to the nearest hospital emergency room.

What is Not Covered for Behavioral Health Benefits

Non-covered services are the services not paid for by Centennial Care. These services would be paid for by you. Call Member Services at **1-866-689-1523** for more information about if a service is covered or not covered.

Centennial Care does not cover the following behavioral health services:

- Activity therapy, group activities, and other services that are primarily recreational in nature
- Biofeedback
- Educational or vocational services related to traditional academic subjects or vocational training
- Experimental or investigational procedures, technologies, or non-drug therapies and related services
- Hypnotherapy
- Services provided by non-licensed counselors, therapists, or social workers
- Services that do not meet the standard of medical necessity as defined in Centennial Care rules
- Treatment for personality disorders for adults age 21 and older without a diagnosis indicating medical necessity for treatment
- Treatment of mental retardation alone
- Treatment provided for adults age 21 and older in alcohol or drug residential centers

Certified Peer Support Workers

Certified Peer Support Workers (CPSWs) provide a bridge between you and your Care Coordinator. They work with different agencies to develop a bond to help you and your family use resources that benefit you.

You can call Member Services at **1-866-689-1523** (TTY: **711**) to receive helpful information on how to contact a behavioral health CPSW or wellness center.

Section 4C: Long-Term Care and Community Benefits

Your Centennial Care plan covers long-term care services. Long-term care includes medical and non-medical care for people who have disabilities or long-lasting illnesses. Long-term care helps meet health or personal needs. Most long-term care is to help people with support services such as activities of daily living like dressing, bathing, and using the bathroom. Long-term care can be provided in the home, in the community, in assisted living, or in the nursing home. It is important to remember that you may need long-term care at any age.

If your care requires it, coverage is available for nursing facilities and swing bed hospital services. Prior authorization is required. If you live in a nursing home and want to move out, we want to help you find a place that is right for you. Please call your Care Coordinator to learn more about the Community Benefit. This benefit offers the same needed care services at home for members who are eligible for nursing facility services.

You may be eligible for the Community Benefit based on Medicaid eligibility requirements or through eligibility based on medical need as determined on program availability through HSD/MAD.

If you do not utilize Community Benefit Services for 90 consecutive calendar days, it could result in you no longer being able to access Community Benefit Services or a loss of Medicaid eligibility.

To determine if you meet the Medicaid eligibility requirements, your Care Coordinator will do an assessment of your level of care. If the assessment shows you need a nursing facility level of care, you will be eligible for the Community Benefit.

If you are eligible for the Community Benefit, you will have the option to select either the Agency-Based Community Benefit (ABCB) or the Self-Directed Community Benefit (SDCB).

Community Benefit Services

A list of the services available for the community benefit is included in the table below. Please remember that some of these services are only covered for agency-based community benefits (ABCB) and some for self-directed community benefits (SDCB). The "✓" in the column will tell you if the service(s) are covered for ABCB, SDCB, or both. To learn more about prior authorizations, please see page 22 of this handbook.

Service	ABCB	SDCB	Prior Authorization?	Details
Adult Day Health	✓		Yes	
Assisted Living	✓		Yes	These services will not be covered for individuals in Assisted Living Facilities, Personal Care, Respite Environmental Modifications, Emergency Response, or Adult Day Health. The Assisted Living Program is responsible for all of these services at the Assisted Living Facility.
Behavioral Support Consultation	✓	✓	Yes	

Service	ABCB	SDCB	Prior Authorization?	Details
Community Transition (community reintegration members only)	✓		Yes	**Limit:** Coverage for these services is limited to $3,500 per person every five years.Deposits for Assisted Living Facilities are limited to a maximum of $500.In order to be eligible for this service, the person must have a nursing facility stay at least 90 days prior to transition into the community.
Customized Community Supports		✓	Yes	
Emergency Response	✓	✓	Yes	
Employment Supports	✓	✓	Yes	
Environmental Modification	✓	✓	Yes	**Limit:** Coverage for these services is limited to $5,000 every 5 years
Home Health Aide	✓	✓	Yes	
Nutritional Counseling	✓	✓	Yes	
Personal Care Services (consumer-directed and consumer-delegated)	✓		Yes	
Private Duty Nursing Services for Adults (RN or LPN)	✓	✓	Yes	
Related Goods (phone, internet, printer etc.)		✓	Yes	**Limit:** Coverage is limited to $2,000 every year (this is separate from the one-time funding for start-up goods). Experimental or prohibited treatments and goods are not covered.
Respite	✓	✓	Yes	**Limit:** Coverage is limited annually to 300 maximum hours per care plan year.
Self-Directed Personal Care (Homemaker)		✓	Yes	
Skilled Maintenance Therapy Services (occupational, physical and speech therapy)	✓	✓	Yes	A signed therapy referral for treatment notice must be provided from the member's Primary Care Provider.
Specialized Therapies (acupuncture, biofeedback, chiropractic, cognitive rehabilitation therapy, hippotherapy, massage therapy, naprapathy, Native American healers)		✓	Yes	**Limit:** Coverage is limited to $2,000 every year (annually) for all combined therapy services (Value-Added Services have separate limits)
Start-up Goods		✓	Yes	**Limit:** One-time coverage up to $2,000
Transportation - Non-Medical		✓	Yes	**Limit:** Only vehicle mileage and bus/taxi passes are covered. Coverage is limited to a total of $1,000 every year for vehicle mileage and bus/taxi passes. Not a covered service for minors. Limited to a 75-mile radius of the member's home.

Agency-Based Community Benefit

You will need to work with your Care Coordinator, based on your comprehensive needs assessment, to coordinate your care.

What is Not Covered for Agency-Based Community Benefit Services

Certain procedures, services, or miscellaneous items are not covered under the ABCB plan. To get more information on what is not covered, please contact your Care Coordinator for more information.

Self-Directed Community Benefit

The SDCB is certain Home and Community-Based Services that are available to eligible members meeting nursing facility level of care. Self-direction gives you the opportunity to have choice and control over how your Community Benefits services are provided. You can also choose who provides the services and how much providers are paid in accordance with SDCB-approved rates.

Your Participation

If you choose SDCB, you must participate in the ABCB for a minimum of 120 calendar days before you can switch to SDCB. When you switch over to SDCB, you will need an Employer of Record (EOR), Care Coordinator, and Support Broker. You can be the EOR or designate someone on your behalf. The EOR, with assistance from the support broker and care coordinator, will be responsible for the following activities:

- Managing a self-directed budget
- Recruiting, hiring, and supervising providers
- Developing job descriptions for direct supports
- Completing employee forms
- Approving timesheets and purchase orders
- Getting quotes for services
- Completing all required documentation
- Developing a back-up plan
- Attending training
- Reporting incidents, such as fraud and abuse

Support Broker

A Support Broker provides support to you or your family in arranging, directing and managing your SDCB services. The Support Broker supports, as well as develops, monitors, and implements your SDCB care plan and budget.

A Support Broker will be available to help you make sure you meet all of the requirements. To get a Support Broker, call a Care Coordinator at **1-877-232-5518**.

Recruiting, Hiring, Supervising, and Firing Providers

The EOR is the person responsible for directing the work under the SDCB. The EOR will recruit, hire, and fire all employees. The EOR will make all work schedules and assign tasks. The EOR will supervise and give training to all employees.

When the EOR works with employees, they will set how much employees will be paid. The payment rates must stay within the set range of rates. The EOR must:

- Track money spent on paying employees
- Track money spent on goods and services
- Approve employee time sheets

The EOR cannot be paid for doing the EOR tasks.

What is Not Covered for Self-Directed Community Benefit Services

Centennial Care does not cover the following SDCB services:

- Services covered by the Medicaid state plan (including EPSDT), MAD school-based services, Medicare, and other third parties
- Any service or good that would violate federal or state statutes, regulations, or guidance
- Formal academic degrees or certification-seeking education
- Food and shelter expenses, including property-related costs
- Experimental or investigational services, procedures, or goods
- Any goods or services a household not including a person with a disability, would be expected to pay for as a regular expense
- Any goods or services to be used primarily for recreational purposes
- Personal goods or items not related to the disability
- Animals and costs of maintaining animals, with the exception of training and certification for service dogs
- Gas cards and gift cards; items that are purchased with SDCB program funds may not be returned for store credit, cash, or gift cards
- Purchase of insurance
- Purchase of a vehicle and long-term lease or rental of a vehicle
- Purchase of recreational vehicles
- Firearms, ammunition, or other weapons
- Gambling, games of chance, alcohol, tobacco, or similar items
- Vacation expenses, including airline tickets, cruise ship or other means of transport, guided tours, meals, hotel, lodging, or similar recreational expenses
- Purchase of usual and customary furniture and home furnishings, unless adapted to the eligible recipient's disability or use, or of specialized benefit to the eligible recipient's condition; requests for adapted or specialized furniture must include a doctor's order from a member's health care provider and when appropriate a denial of payment from any other sources
- Regularly scheduled upkeep, maintenance, and repairs of a home and addition of fences, storage sheds, or other outbuildings
- Regularly scheduled upkeep, maintenance and repairs of a vehicle, or tire purchase or replacement, except upkeep and maintenance of modifications or alterations to a vehicle or van, which is an accommodation directly related to the SDCB member's qualifying condition or disability; request must include documentation that the adapted vehicle is the SDCB member's primary means of transportation
- Clothing and accessories
- Training expenses for paid employees
- Conference or class fees may be covered for eligible recipients or unpaid caregivers, but costs associated with such conferences or classes cannot be covered, including airfare, lodging, or meals
- Consumer electronics such as computers, printers, and fax machines, or other electronic equipment that does not meet criteria
- Cell phone services that include fees for data in excess of $100 per month, or more than one cell phone line per eligible recipient

Section 4D: Prescription Drug Benefits

Centennial Care covers drugs and other items listed in this section only when bought at an in-network pharmacy (unless required in an emergency), or ordered through the Mail-Order Service.

Drug List

The Blue Cross Community Centennial Drug List is a list of drugs that are covered under Centennial Care. HSD approves the Drug List for all Medicaid managed care plans and it is updated quarterly. BCBSNM will send a copy of the Drug List if you request one. You can also see the Drug List on our website, **bcbsnm.com/medicaid**.

Centennial Care will usually cover only the drugs on the Drug List. When there is a brand-name drug and a generic version of the same drug, only the generic drug is covered. Requests to pay for a brand-name drug instead of the generic drug may be denied because:

- Brand-name drugs and generic drugs are made exactly the same.
- Generic drugs usually cost less.
- Generally, a trial of at least two covered generic drugs is required before a brand-name drug will be covered. In some cases, all available generic therapeutic alternatives must be tried first.

Exceptions

To make sure you do not have any problems filling your prescriptions, always ask your provider to check the Drug List. If your provider prescribes a drug that is not on the list or that is not already approved to treat your condition, the provider must have prior authorization from BCBSNM before you can get that medicine. A prior authorization is sometimes called an "exception." Without prior authorization, the pharmacy will not be able to fill your prescription. We will look at your provider's request and give approval only if we find the drug is medically necessary. Most of the time, we give approval for two reasons:

- A similar drug on the list does not improve your health as much as the drug you are asking for
- A similar drug on the list is harmful to your health

In an emergency, BCBSNM will respond to your provider's request within 72 hours. You may use the appeals process (see **Section 7: Grievances & Appeals**) if your request is denied.

Native Americans receiving prescriptions from I/T/U providers may receive drugs that are not on the Drug List without getting prior authorization from BCBSNM.

Covered Medications and Other Items

Centennial Care covers the following drugs, supplies, and other products when purchased from an in-network pharmacy and prescribed by a Centennial Care network provider:

- Prescription drugs and medicines on the Drug List, unless listed as an exclusion
- Certain vaccines that can be given at a pharmacy (such as flu shots)
- Specialty pharmacy drugs such as self-administered injectable drugs. Most injectable and high-cost drugs require prior authorization from BCBSNM. Some self-administered drugs, whether injectable or not, are specialty pharmacy drugs and you must order them through an in-network specialty pharmacy provider in order to be covered
- Insulin, insulin needles, syringes, and other diabetic supplies (e.g., glucagon emergency kits, autolet, injection aids, lancets, blood glucose and visual reading urine and ketone test strips)
- Non-prescription medications and birth control items on the Drug List and prescribed by your provider. These will not be covered if a prescription is filled anywhere other than at an in-network pharmacy. Non-prescription medications are subject to quantity limits (usually 1 package size per 30 days). Some over-the-counter products will not be covered for members under the age of 4 or over the age of 18
- Two 90-day courses of treatment, of preauthorized prescription or over-the counter drugs to help you quit tobacco use or smoking. Starting this drug to help you quit smoking counts as one of your two allowable drug treatments. If you stop taking the drugs during the 90-day period, this still counts as one complete drug therapy treatment. For example, if you receive a one-month supply of a prescription drug to quit smoking and do not keep taking the drug beyond one month, you will have used up one of your two calendar year treatments with the 30-day supply. A smoking cessation support program must be used in combination with this drug therapy treatment. If you are not enrolled in a support program, we will enroll you in the BCBSNM program

Retail Pharmacy Program

All items must be purchased from an in-network retail pharmacy. Some drugs must be purchased from an in-network specialty pharmacy provider to be covered. See your provider directory for a list of in-network pharmacies and specialty pharmacy providers. If you do not have a directory, call Member Services for a list or visit the BCBSNM website at **bcbsnm.com/medicaid**.

You must present your ID card to the pharmacist at the time of purchase to receive this benefit. If you have both Medicare and Centennial Care, Medicare Part D will cover your drugs. You will still have to pay Medicare Part D copays, unless you live in a nursing facility. If you have other insurance, make sure to show that card too.

You do not receive a separate prescription drug ID card. Use your Centennial Care ID card to receive all services covered under this program.

If you do not have your Blue Cross Community Centennial card with you, or if you purchase your prescription or other covered item from an out-of-network pharmacy in an emergency, you may have to pay for the purchase in full and then submit the pharmacy receipts. If possible, you should ask the pharmacy to call BCBSNM before filling the prescription so that we can make payment directly to the pharmacy.

If you are leaving the country and need a larger supply of medication, call Member Services at least two weeks before you plan to leave. In some cases, you may be asked to provide proof of continued eligibility under Centennial Care.

Drug Plan Supply Limits

You can get up to a 30-day supply of a single covered prescription drug or other item or up to 120 pills, whichever is less. For commercially packaged items (such as an inhaler, a tube of ointment, or a blister pack of tablets or capsules), you will receive one package as a 30-day supply. You may need to pay a copayment for each package. For example, if two inhalers are purchased, two copayments may apply for some members.

90-Day Supply

You can fill a 90-day supply of medications used to treat chronic conditions through our mail-order program. Narcotic pain medications (opioids) are not allowed for mail-order.

Mail-Order Program

You can use the mail-order program to order a 90-day supply of a medication that you use regularly for a long-term or chronic condition. To use the mail-order program, call Member Services. We will help you fill out a mail-order form so you will get your medication in the mail.

What is Not Covered for Prescription Drugs and Other Items

Centennial Care does not cover the following prescription drugs and other items:

- Prescription, nonprescription, and over-the-counter drugs that are not listed as covered on the Drug List, including herbal or homeopathic preparations
- Drugs or other items purchased from an out-of-network pharmacy or any other provider that does not contract with BCBSNM, unless in an emergency
- Refills needed earlier than expected if you had taken the number of pills each day the provider indicated. Call Member Services 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
- Drugs or other items for treatment of any sexual dysfunction
- Medications or preparations for cosmetic purposes, such as for hair growth or medicated cosmetics, including tretinoin (sold under such brand names as Retin-A) for cosmetic purposes
- Non-prescription enteral nutritional products taken by mouth or delivered by a temporary naso-enteric tube (e.g., nasogastric, nasoduodenal, or nasojejunal tube), unless you have a genetic inborn error of metabolism and the product is preauthorized by BCBSNM
- Shipping, handling, or delivery charges, unless preauthorized by BCBSNM
- Drugs required for international travel or work
- Food, diet supplements, or special medical foods. Coverage does not include commercially available food alternatives, such as low- or sodium-free foods, low- or fat-free foods, low- or cholesterol-free foods, low- or sugar-free foods, low- or high-calorie foods for weight loss or weight gain, or alternative foods due to food allergies or intolerance
- Drugs, medicines, drug combinations, or devices not approved by the FDA and any products experimental, investigational, or unproven
- Methadone used in drug treatment programs
- Personal care items, such as nonprescription shampoo or soap
- Probiotics
- Weight loss or weight control drugs
- Cough and cold products for members under the age of 4

- Drug Efficacy Study Implementation (DESI) drugs; compounded drugs that use a product that has not been approved by the FDA for the intended use; compound drugs that do not have a national drug code and have not been approved by the FDA for use in humans; repackaged drug products
- The following over-the-counter products for members over the age of 21:
  - Pain relievers/fever reducers
  - Ear, nose, and throat products (except sodium chloride inhalation solution)
  - Stomach products (to treat heartburn, constipation, diarrhea)
  - Eye products (except eye lubricants)
  - Cough/cold products
  - Benzoyl peroxide
  - Antibiotics for use on the skin
  - Supplements (except oral electrolyte replacement and prenatal vitamins)
  - MCT Oil
  - Neutra-Phos, Neutro-Phos K

Brand-Name Exclusion

Some drugs are sold under more than one brand name. Centennial Care may cover only one of the brand names being sold for a single drug. If you do not accept the brand that is covered under Centennial Care, the brand name drug you want will not be covered.

Pharmacy Lock-In

In some special cases, we may tell a member that he or she must purchase drugs only from a certain pharmacy. This is known as "pharmacy lock-in." We will tell you and/or your representative before you are placed on pharmacy lock-in. You will have the chance to file a grievance against BCBSNM's decision to place you on a pharmacy lock-in. See **Section 7: Grievances & Appeals**. Only one pharmacy can be a lock-in pharmacy.

You will be removed from pharmacy lock-in when the problems have been fixed.

Section 4E: Vision Benefits

Centennial Care covers routine vision care, eyeglasses, and eye checkups through a program administered by Davis Vision.

The following services are covered under your Centennial Care plan:

Covered Service	Time Limit	Age Applies To
Minor repairs to eyeglasses	Any time	All ages
Lens tinting if certain conditions are present	Any time	All ages
Lenses to prevent double vision	Any time	All ages
Eye exam for medical conditions (diabetes, cataracts, hypertension, and glaucoma)	Every 12 months	All ages
One routine eye exam	Every 12 months	Under age 21
Frames	Every 12 months	Under age 21
Replacement lenses, if lost, broken, or have deteriorated	Any time	Under age 21
Corrective lenses	1 set every 12 months	Under age 21
One routine eye exam	Every 36 months	Age 21 and older
Frames	Every 36 months	Age 21 and older
Replacement lenses for members with a developmental disability, if lost, broken, or have deteriorated	Any time	Age 21 and older
Corrective lenses	1 set every 36 months	Age 21 and over

Please call Member Services at **1-866-689-1523** for more information on prior authorizations.

You may receive more than the standard number of eye exams each year if you have diabetes or other diseases that could affect your eyesight.

What is Not Covered for Vision Care

Centennial Care does not cover the following vision care services:

- Eyeglass or contact lens insurance
- Orthoptic assessment and treatment
- Low vision aids
- Anti-scratch, anti-reflective, or mirror coating
- Photochromic lenses or tint, unless medically necessary
- Trifocals
- Laser vision correction
- Eyeglass cases
- Progressive lenses
- Ultraviolet (UV) lenses

ABP Members

ABP members do not have routine vision benefits. Limited vision coverage is available as a value-added service. Please see **Section 4H: Value-Added Services** for more information.

The ABP plan only covers vision services that are medically necessary for the diagnosis of and treatment of eye diseases. One eye exam will be covered every 36 months only for the detection of an eye disease or injury. Refractions are not covered under the ABP plan, except for aphakia following the removal of the lens.

Section 4F: Dental Benefits

Centennial Care covers services for eligible members through a program administered by DentaQuest®. Dental visits are necessary for good health. Regular dental checkups and cleanings are important for children as well as adults. Schedule a well-baby checkup with your dental provider by the time your baby is two years old.

If you need oral surgery or have an accident that injures your teeth, the services may be covered through Centennial Care as part of the medical/surgical program. Please call Member Services at **1-866-689-1523** before receiving such services so you know which providers will be approved for payment.

Covered Dental Services

The services listed in the chart on page 55 are covered under your Centennial Care plan.

What is Not Covered for Dental Services

Centennial Care does not cover the following dental services if for cosmetic reasons:

- Permanent fixed bridges
- Cosmetic services
- Desensitization, re-mineralization, or tooth bleaching
- TMJ disorders, bite openers, and orthotic appliances
- Implants and implant-related services

Finding a Dentist

If you need to find a dentist in your area, call Member Services or check the provider directory. A paper copy of the directory is available to you at no charge, or on our website at **bcbsnm.com/medicaid**.

Member Services has information about handicap-accessible offices, other languages the dentist speaks, and if the dentist is an expert with children or individuals who have special health care needs. Once you choose a dentist, call the dentist to make an appointment and find out if the service will be covered by Centennial Care.

Urgent Dental Care

If you have an urgent dental problem, you should be seen within 24 hours. An urgent problem means you need to be seen that day, but it is not serious enough to go to an emergency room. Most dental problems are not considered emergencies under the medical/surgical plan. If you have an urgent dental problem and cannot find a dentist to see you within 24 hours, please call Member Services.

Non-Urgent Dental Care

If you have a non-urgent dental problem, you should be seen within 14 days. A non-urgent problem means you have symptoms, but you do not need to see a dentist that same day.

Routine Dental Checkup

If you need a regular dental checkup or have a dental condition that is not causing you problems or pain, you should be seen within 60 days of your request. If your dentist cannot see you within 60 days, please call Member Services. We may be able to send you to another dentist who can see you sooner.

Section 4F: Dental Benefits

With any questions about your dental coverage, please call Member Services at **1-866-689-1523.** To learn more about prior authorizations, please see page 22 of this handbook.

Covered Service	Time Limit	Age Applies To	Prior Authorization?
Dental services in a hospital	N/A	Under age 21; unless over the age of 21 with a developmental disability	No – Dentist Yes – Facility
Emergency services	No limit	All ages	No
Fillings; prefabricated stainless steel crown per permanent or deciduous tooth; one prefabricated resin crown per permanent or deciduous tooth; and one recementation of a crown or inlay; and one recementation fixed bridge	N/A	All ages	No
Fixed space maintainers (passive appliances)	N/A	Under age 21	Yes
General anesthesia and IV sedation, including nitrous oxide	N/A	Under age 21	Yes
General anesthesia and IV sedation, not including nitrous oxide	N/A	Age 21 and older	Yes
Incision and drainage of an abscess	N/A	All ages	No
One cleaning	Every 6 months	Under age 21	No
One cleaning	Every 12 months; every 6 months for members with developmental disabilities	Age 21 and older	No
One complete oral exam	Every 6 months	Under age 21	No
One complete oral exam	Every 12 months	Age 21 and older	No
One complete series of intraoral X-rays (with one added set of bitewing X-rays)	Every five years; added set of bitewing X-rays once every 12 months	All ages	No
One fluoride treatment	Every 6 months	Under age 21	No
One fluoride treatment	Every 12 months	Age 21 and older	No
One sealant for each permanent molar (replacement of a sealant within the five-year period requires prior authorization)	Every 5 years	Under age 21	No
Orthodontic services (braces)	N/A	Under age 21	Yes
Periodontic scaling and root planning	N/A	All ages	Yes
Reimplantation of permanent tooth	N/A	Under age 21	No
Therapeutic pulpotomy	N/A	Under age 21	No
Tooth extractions (pulling of teeth)	N/A	All ages	No
Two denture adjustments	Every 12 months	All ages	No

Note: Federally Qualified Health Center members will not need prior authorization on any dental service.

Section 4G: Transportation Benefits

If you do not have a car or anyone to give you a ride, you may be eligible for transportation to help you get to your non-emergency medical, long-term care, or behavioral health appointments. If you have an emergency and you need help getting to an emergency room, call 911.

LogistiCare coordinates all non-emergency transportation for members, including food and lodging expenses, when you have to travel a long distance to get covered medical, long-term care, or behavioral services. You can use these benefits only for medical, long-term care, and/or behavioral needs. Transportation for any non-medical reason is not covered.

The services in the table below are covered under your Centennial Care plan. To learn more about prior authorizations, please see page 22 of this handbook.

Covered Service	Prior Authorization?	Prior Notice to LogistiCare
Ride to routine appointment	No	3 working days up to two weeks
Ride to behavioral health appointment	No	3 working days up to two weeks
Mass transit	No	4 working days
Mileage reimbursement	Yes	14 days prior up to the day of appointment
Meals	Yes	3 working days
Lodging	Yes	3 working days

What is Not Covered for Transportation Services

Centennial Care does not cover the following transportation services:

- Transportation to a pharmacy to get prescriptions, or to a medical supply store to get medical supplies or durable medical equipment
- Transportation for non-medical needs
- Transportation to a provider who is 65 miles or farther away from where you live, without special authorization from BCBSNM
- Transportation to an out-of-network provider without special authorization from BCBSNM

Scheduling Transportation for Routine Care

Call the Reservation Line phone number to schedule a ride to your appointment from 8 a.m. to 5 p.m., Monday through Friday at **1-866-913-4342**. When you call LogistiCare's Reservation Line, tell them you are a Centennial Care member and give them your ID number. Give them the date and time of your appointment and tell them where you are going. Call LogistiCare at least three working days before your routine appointment to schedule a ride. Saturdays, Sundays, and holidays are not working days. If you do not call at least three working days before your appointment, your request may be denied. This three-day notice does not apply to urgent care. When you call for a ride on the same day as your appointment, LogistiCare must call your provider to verify you have an appointment, and your ride may take up to four hours to arrive. If you need to see a provider on a regular basis, you may schedule your ride two weeks (10 working days) ahead of time.

Call the Ride Assist phone line at **1-866-418-9829** to be picked up after seeing your provider, or after being discharged from a hospital, or if your ride is late. Drivers are required to wait only five minutes, so be sure you are ready to leave when the driver arrives. If you are not ready within five minutes, the driver will not wait longer because he or she has other people to transport.

LogistiCare can help transport you if you have a special health care need. LogistiCare will keep notes on any special transportation needs, and provide a driver trained in CPR, if needed. When you call LogistiCare, be sure to mention if you have special needs.

If your medical appointment is canceled and you have already made arrangements with LogistiCare, please call LogistiCare at least two hours before you were supposed to be picked up to cancel your ride.

If you live in an area with public transportation, LogistiCare may give you a mass transit pass to get to your medical, long-term care, or behavioral health appointments. You must request a mass transit pass four working days before your appointment. To find out about getting a mass transit pass, please call LogistiCare at **1-866-913-4342**.

Transportation Services Needing Prior Authorization for Long Distance Travel

If you must travel more than 65 miles one way or must travel outside New Mexico to receive health care, you must call LogistiCare for approval to request transportation. If you have to travel to another city or state for an approved appointment, it is important to make plans for these trips as soon as possible and no later than three working days before the appointment.

Meals and Lodging

Through LogistiCare, Centennial Care may pay for your meals when you travel to another city or state for an approved appointment. If you go to an appointment and are away from home for eight hours or more, you can be repaid for your meals if you get authorization from LogistiCare no fewer than three working days before you travel. You will be repaid up to $18 per day when you are away from home.

When a trip takes more than four hours one way and an overnight stay is medically necessary to receive covered services, you may call LogistiCare to arrange for lodging. All lodging expenses must be coordinated by LogistiCare. Do not arrange your own lodging for any expenses not coordinated and authorized in advance by LogistiCare. The lodging provider can be paid up to $58 per night on a weekday in New Mexico, and up to $81 per night on a weekend or for out-of-state travel any day.

If you need to get paid for lodging that was authorized by LogistiCare, you are required to fill out a Transportation Meals and Lodging Expense Report for lodging and meals, which is available on the BCBSNM website at **bcbsnm.com/medicaid** (under Member Resources, Forms, then click on View and Download Forms) or by calling Member Services.

When you call LogistiCare to approve meals and/or lodging, you will be given an authorization/job number if the travel is approved. You must include original receipts for each meal and lodging expense (not photocopies) and write your authorization/job number on the LogistiCare Expense Report you send in to LogistiCare. You will not be paid for meals or lodging if the form and receipts are received more than 30 days after you travel. Mail the form to the address shown on the form.

Payment for Mileage

You might be able to be repaid for mileage if you have to drive your own vehicle to a covered appointment. This must be authorized by LogistiCare. Do not expect to be paid for mileage if you do not call the LogistiCare Reservation Line first at **1-866-913-4342**. LogistiCare will verify you have an appointment and will tell you the number of miles covered. You may call up to 14 days in advance, but no later than the day of the appointment. If LogistiCare authorizes your trip, you will be given a trip/job number. Please do not lose this trip/job number. You will need it to be paid for your mileage. If you cannot drive yourself, a friend or family member may drive you. He or she can get mileage reimbursement as well. The same procedures and authorization requirements apply.

After you receive approval, complete a Mileage Reimbursement Form and take it with you to your appointment. The provider's office must sign the form and you must write the trip/job number given to you by LogistiCare in the area titled "trip/job #." If the trip is approved and the provider has signed the form, you will be repaid for mileage costs based on the BCBSNM mileage reimbursement rate. This rate is for a round trip from your home to the provider's office or to the hospital.

You will not be paid if the form is received more than 30 days after the appointment, or if the trip was not approved in advance by LogistiCare. Send the completed and signed form to LogistiCare within 30 days of the appointment.

Type of County	County Name	Distance Between PCP's Office and Your Home
Urban	Bernalillo, Doña Ana, Los Alamos, Santa Fe	30 miles
Rural	Chaves, Curry, Eddy, Grant, Lea, Luna, McKinley, Otero, Rio Arriba, Roosevelt, Sandoval, San Juan, Taos, Valencia	45 miles
Frontier	Catron, Cibola, Colfax, DeBaca, Guadalupe, Harding, Hidalgo, Lincoln, Mora, San Miguel, Sierra, Socorro, Torrance, Quay, Union	60 miles

Address for Expense Reports and Mileage

LogistiCare Claims Department
New Mexico Mileage Reimbursement
2552 West Erie Drive, Suite 101
Tempe, AZ 85282-3100

Transportation Services for Rides to PCP Offices Requiring Authorization

If you choose a PCP who is farther from your home than the distances shown above (based on the county you live in), you will not be able to receive rides to and from the PCP's office, unless you receive special authorization from BCBSNM. If there is a PCP closer to you, you may be asked to change PCPs, or you will have to arrange your own rides to and from your PCP's office.

Rides to Out-of-Network Providers

You will have to call BCBSNM Member Services first, if you need a ride to any out-of-network provider (even for family planning and even if you already have prior authorization for the visit). The approval for a ride to an out-of-network provider is different from any prior authorization you might have received for the provider visit itself.

When you call BCBSNM, you will be issued a confirmation number that you must give to LogistiCare when you call them about arranging a ride. LogistiCare must call BCBSNM and make sure any ride to an out-of-network provider will be covered. LogistiCare will verify with BCBSNM that the confirmation number you gave over the phone is correct.

Only BCBSNM can authorize LogistiCare to give you a ride to an out-of-network provider.

Accompanying Persons or Family Members

Centennial Care covers one other person to ride with you to your appointments (including that one other person's meals and lodging, if applicable) in the following situations:

- You are under the age of 18 and the other person to ride with you is your parent or legal guardian; or
- It is medically necessary for the other person to ride with you. Your medical provider must provide proof of medical necessity in writing. The other person to ride with you must be at least 18 years of age.

Except in the previous situations, Centennial Care does not cover other persons to ride with you to your appointments. For example, Centennial Care does not cover your minor children to ride with you to your appointments.

Picking Up Medical Supplies and Prescriptions

You must make your own arrangements to pick up prescriptions, medical supplies, and durable medical equipment. These items may also be delivered to your home, but you will have to make your own arrangements for delivery.

Section 4H: Value-Added Services

In addition to covering the services required by state law, your Blue Cross Community Centennial health plan offers extra services to help keep you and your family healthy. These are called "value-added services."

Some value-added services are not always available all year and may have additional limits and steps. Call Member Services at **1-866-689-1523** for more details. Also, some services may change from year to year. See the following page for a list of value-added services.

Section 4H: Value-Added Services

Value-Added Service	Applies To	Members on Standard Medicaid Plan	Members on Alternative Benefit Plan (ABP)	Members on ABP-Exempt Plan	Prior Authorization Required for Value-Added Service?
Physical Health Services					
Dental Varnish in a PCP's Office	Birth to age three	✓	Not eligible	Not eligible	No
Extended Lodging for Homeless Members (post-hospitalization lodging)	Homeless members	✓	✓	✓	Yes
Eyeglasses for Members in the Medicaid Expansion Population (includes eye exam and eyeglasses)	Members age 21 and older with diabetes and high blood pressure	Not a value-added service; standard benefits apply	✓	Not a value-added service; standard benefits apply	Yes
Home Meal Delivery	Members who are transitioning from a nursing facility into the community	✓	✓	✓	No
Native American Traditional Healing and Wellness (reimbursement for traditional healing practices used to treat medical conditions)	Native American members	✓	✓	✓	Yes
Remote Monitoring Program	Members with chronic conditions	✓	✓	✓	Member must participate in the Paramedicine Program; requires an assessment for need
Maternity Services					
Full Medicaid Benefits for Pregnant Women in COEs 301 and 035 (full benefits including dental, vision, prescription drugs, and behavioral health)	Certain pregnant members	✓	Not a value-added service; standard ABP benefits apply	Not a value-added service; standard ABP benefits apply	Only if a particular service should require one
Infant Car Seat*#	Pregnant members	✓	✓	✓	Yes
Portable Infant Crib*^#	Pregnant members	✓	✓	✓	Yes
Prenatal Education (in person and online)*^	Pregnant members	✓	✓	✓	No
Wrap Baby Carrier*†	Pregnant members	✓	✓	✓	No
Behavioral Health Services					
Electroconvulsive Therapy (ECT) (treatment for psychiatric conditions)	Members who meet standard ECT medical necessity criteria	✓	Not a value-added service; standard ABP benefits apply	Not a value-added service; standard benefits apply	Yes
Transitional Living for Chemically Dependent/Psychiatrically Impaired Adults 18 Years Old or Older	Members enrolled in outpatient substance abuse center or in active treatment for psychiatric issues	✓	Not eligible	Not eligible	Yes
Wellness/Drop-in Centers and Family Support Centers	Medicaid members	✓	✓	✓	No

*Must join the Special Beginnings® program to redeem
^Must join the Safe Sleep program to redeem
†Must complete postpartum follow-up appointment to redeem
#Must complete prenatal visit requirements to redeem

Section 4I: Member Rewards

Every member of Centennial Care is able to enroll in the Centennial Rewards Program. The Rewards Program allows you to earn "credits" by just taking part in certain healthy actions.

To use your credits, enrollment is required. You can enroll at **centennialrewards.com** or call Centennial Rewards at **1-877-806-8964**. Credits can be used by making choices from a catalog. You can order catalog items through BCBSNM's website or by calling Centennial Rewards at **1-877-806-8964**.

You will get your Centennial Rewards Program catalog when you earn your first credits.

Below are the Healthy Actions and the Reward Benefits (also called "credits"). Check **centennialrewards.com** for any new Healthy Actions throughout the year.

If you would like to know more about this program, please call toll-free **1-877-806-8964**.

Healthy Action	Reward/Credit
Annual Dental Visit - Adult	$25 per visit, max of one visit per year
Annual Dental Visit - Child	$35 per visit, max of one visit per year
Asthma Controller Medication Compliance (Children)	$5 for every 30-day refill ($60 annual max)
Bone Mineral Density Test - Females 65+	$35 per test, max of one per lifetime
Diabetes - Annual Recommended Tests (A1C, eye exam, nephropathy exam)	$20 for each test ($60 annual max)
Perinatal (1st trimester and postpartum visits)	$25 per visit, $50 max per year
Treatment Compliance - Bipolar	$5 for every 30-day refill ($60 annual max)
Treatment Compliance - Schizophrenia	$5 for every 30-day refill ($60 annual max)
Well-Child PCP Visit (Age 0-15 months)	$5 per milestone, $30 max per year
Healthy Movement	**Reward/Credit**
Step-Up Walking Program	Earn up to $50 per year and a free pedometer

Note: Credits are for qualifying catalogue use only. The "$" symbol is for convenience only. Credits have no cash or monetary value and can never be exchanged or redeemed for cash. They are not transferable to other persons. They may not be combined with other member's credits or with other rewards or incentive programs offered by Centennial Care.

Section 5: Alternative Benefit Plan

The Alternative Benefit Plan (ABP) is a part of the New Mexico Medicaid Centennial Care program. The ABP offers coverage for Medicaid-eligible adults ages 19-64 who have income up to 138% of the Federal Poverty Level (FPL), which includes the Medicaid Expansion Population and Transitional Medical Assistance categories.

There are two kinds of ABP benefit packages.

ABP Benefit Package

If you are eligible for the ABP benefit package, all of the detail outlined in this member handbook applies to you except for some of the covered and non-covered services. Value-added services are also different. To find out if a service is covered, you can check the covered services in Sections 4A – 4G or call Member Services at **1-866-689-1523**.

ABP Exempt Benefit Package

If you are an ABP member and have a physical or behavioral health condition that meets certain criteria, you may be eligible to move to the Expansion State Plan. This is also called ABP Exempt. Examples of the criteria are listed below:

- Individuals who qualify for medical assistance on the basis of being blind or disabled
- Individuals who are terminally ill and are receiving benefits for hospice care
- Pregnant members
- Individuals who meet Medically Frail Criteria; to learn more about Medically Frail Criteria, call Member Services at **1-866-689-1523** or ask your Care Coordinator

You may meet the Medically Frail Criteria if you have one of the following conditions:

- Disabling mental disorder, including individuals up to age 21 with serious emotional disturbances and adults with serious mental illness
- A continuing substance use disorder
- A serious medical condition
- A disability that weakens your ability to perform one or more activities of daily living
- A disability determination based on Social Security criteria

Your condition will be reviewed by a Care Coordinator to see if you meet these criteria. You can also call us to ask us to complete this review at any time if you think you meet the criteria for ABP Exempt. BCBSNM will let you know of your exempt status within 10 business days. If you do not have a Care Coordinator, please call Member Services at **1-866-689-1523** (TTY: **711**).

If you meet criteria and choose to move to the ABP Exempt benefit package, you will then have the same benefits and provider network as the standard Medicaid plan. This means that everything in this handbook about standard Medicaid, except value-added services, also applies to you. If you meet ABP Exempt criteria during the middle of the month, you will be moved to that plan the 1st of that same month.

Under the ABP Exempt benefit package, you can also access community benefits and nursing facility care when the requirements for those services are met. To determine if you meet the Medicaid eligibility requirements, your Care Coordinator can do an assessment of your level of care. If the assessment shows you need a nursing facility level of care, you will be also be eligible for the Community Benefit.

ABP Exempt Covered and Non-Covered Services

ABP Exempt members have the same benefits as the standard Medicaid plan. Please see **Section 4: Covered and Non-Covered Benefits** of this handbook for more information.

Value-Added Services

ABP Value-Added Services

See the table in **Section 4H: Value-Added Services** for a list of ABP value-added services.

ID Cards

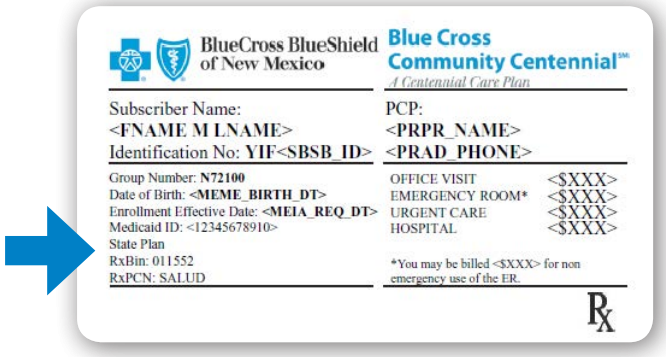
ABP ID Cards

When you apply for Medicaid coverage, you will know that you are eligible for the ABP. Another way to know is by looking at the front of your Centennial Care ID card. Your ID card will say it. Please see the example below:


BlueCross BlueShield of New Mexico
Blue Cross Community Centennial℠
A Centennial Care Plan
Subscriber Name:
<FNAME M LNAME>
Identification No: YIF<SBSB_ID>
PCP:
<PRPR_NAME>
<PRAD_PHONE>
Group Number: N72100
Date of Birth: <MEME_BIRTH_DT>
Enrollment Effective Date: <MEIA_REQ_DT>
Medicaid ID: <12345678910>
Adult Benefit Plan
RxBin: 011552
RxPCN: SALUD
OFFICE VISIT <$XXX>
EMERGENCY ROOM* <$XXX>
URGENT CARE <$XXX>
HOSPITAL <$XXX>
*You may be billed <$XXX> for non emergency use of the ER.
Rx

ABP Exempt ID Cards

When you move to ABP Exempt, you will also receive a new ID card. The front of your ID card will say "State Plan" Please see the example below:


BlueCross BlueShield of New Mexico
Blue Cross Community Centennial℠
A Centennial Care Plan
Subscriber Name:
<FNAME M LNAME>
Identification No: YIF<SBSB_ID>
PCP:
<PRPR_NAME>
<PRAD_PHONE>
Group Number: N72100
Date of Birth: <MEME_BIRTH_DT>
Enrollment Effective Date: <MEIA_REQ_DT>
Medicaid ID: <12345678910>
State Plan
RxBin: 011552
RxPCN: SALUD
OFFICE VISIT <$XXX>
EMERGENCY ROOM* <$XXX>
URGENT CARE <$XXX>
HOSPITAL <$XXX>
*You may be billed <$XXX> for non emergency use of the ER.
Rx

Provider Network

The providers you are eligible to see are the same as the standard Medicaid plan for both of the ABP benefit packages. More information about providers can be found in **Section 3: Providers** of this handbook.

Copayments

ABP and ABP Exempt Copayments

The below copayments may apply to ABP and ABP Exempt members. They are the same as the standard Medicaid plan.

Type of Service	Copayment
Getting a name-brand drug when a generic version of the same drug is available (exceptions are drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions, family planning drugs/supplies, or if you get a prior authorization for a special exception)	$8.00/ prescription
Use of the emergency room for non-emergencies	$8.00/visit

Section 6: Care Coordination

Considering Your Needs

To give you extra help getting appropriate care when and where you may need it, we have a number of programs to help you. The first step is to work with you to perform a Health Risk Assessment sometimes called an HRA. We will call you on the phone to ask health questions. These questions help us assist you with any needs related to your health condition. Our goal is to work with you to develop a care plan based on your needs and preferences.

BCBSNM will look at your completed Health Risk Assessment, to identify your medical, long-term care, and behavioral health needs. BCBSNM will then assign you to the right Care Coordination level to help you.

Care Coordination Levels

Level 2: You will have a Care Coordinator who will work directly with you. Your Care Coordinator will be in contact with you to conduct a Comprehensive Needs Assessment (CNA). We use this assessment to help connect you with providers who can help with your identified needs. It will happen in person in your home. Your Care Coordinator will be in contact with you often to monitor your care plan and provide you education on concerns you may be dealing with.

Level 3: You will have a Care Coordinator who will work directly with you. This Care Coordinator knows a lot about special health needs. Your Care Coordinator will contact you to conduct a CNA in person with you. This assessment helps us make sure you are getting all the care you need from the right providers. It will happen in person in your home. Your Care Coordinator will be in contact with you often to monitor your care plan. You can talk to your Care Coordinator about any education you may need to help you with your illness.

If your medical health, behavioral health, or long-term needs change, or if you are in the hospital, please contact your Care Coordinator. This is also referred to as reporting a change in health status. Keep in touch with your Care Coordinator and let them know if your phone number or address changes. This helps your Care Coordinator give you the assistance you need. If you do not have a Care Coordinator and need help with your care, please call Care Coordination at **1-877-232-5518** and select option 3.

Care Coordination

Care Coordination is a service that provides extra help to members with special health care needs, whether at home or in the hospital. Care Coordination focuses on you, the member, and when appropriate, your family. It is sensitive to your cultural background. Care Coordination can help you better identify your health care needs. It also helps you get appropriate services. This includes coordination of services between doctors in our Blue Cross Community Centennial network as well as out-of-network doctors, as appropriate. This includes your medical, behavioral, and long-term needs.

If you have special needs, BCBSNM will assign you a Care Coordinator who speaks your preferred language and is responsible for coordinating your health care services by:

- Giving you information about providers in BCBSNM's network who may address those needs
- Coordinating medical, behavioral, and long-term care services
- Assisting in coordinating care when you also have Medicare or other coverage
- Getting help with different appointments, non-emergency transportation, or other needs; or getting community services not covered by Centennial Care
- Making sure care coordination is provided when needed

You can call your Care Coordinator at **1-877-232-5518** to discuss your medical, behavioral, and long-term care needs. Call **711** for TTY service.

Getting Help with Special Health Care Needs

Some members need extra help with their health care. They may have long-term health problems and need more health care services than most members. They also may have medical, behavioral, or long-term care problems that limit their ability to function. We have special programs to help members with special health care needs.

If you believe you or your child has special health care needs, please call a Care Coordinator at **1-877-232-5518** and select option 3. The Care Coordinator can provide you with a list of resources to help you with your special needs. We also provide education for members with special health care needs and their caregivers. Information is provided about how to deal with stress and/or a chronic illness.

Community Social Services

The Community Social Service (CSS) program is designed to connect you to local resources necessary to improve your health. These social needs impact your overall health and wellness. This program can help you with your needs related to non-emergency transportation issues, hunger, place of residence, and understanding your health.

Local community resources are available to help you. All staff members in the program make your cultural needs a priority. We contract with Core Service Agencies (CSA) and other providers throughout the state. These community-based agencies, via Community Health Workers (CHW) may conduct home visits, well checks, coordinate transportation to medical appointments, and provide some health education, among other tasks assigned to meet your needs.

If you have a community social need, CSS helps you by:

- Connecting with you through a local CHW either by phone or in person, if one is available in your area
- Providing you with the local contacts you may need to locate a food pantry, a public service agency for help with Women Infants and Children (WIC), food stamps, temporary assistance for families with young children (TANF), or a program that covers the costs of electricity
- Setting up a PCP for you so you have a medical or behavioral health home where you can get to know the staff as they learn to know more about you. These offices are called "homes" because they coordinate care among doctors, pharmacists, and therapists

You can call BCBSNM Community Social Services at **1-877-232-5518**.

Supportive Housing

Supportive Housing is a service to help members with housing needs.

The goal of this service is to first determine housing needs and then find the right community resources to help.

Some of these services include:

- Finding and applying for housing
- Checking the home for safety features such as smoke detectors.
- Getting necessary household supplies
- Creating a housing plan
- Coaching on how to keep good relationships with neighbors and landlords
- Coaching on how to follow rules from the landlord
- Education on renter rights and responsibilities
- Assistance in fixing renter issues
- Regular review and updates to housing plan
- Helping find community resources to help with keeping the house in working order

To receive this service, members must meet certain requirements. To find out if you qualify for these services, please call the BCBSNM Supportive Housing Specialist at **1-877-232-5518** (TTY: **711**).

Utilization Management

Utilization Management means we look at medical records, claims, and prior authorization requests to make sure services are medically necessary, provided in the right setting, and consistent with the condition reported.

If this management is done before a service is received, it is part of the "prior authorization" process. If it is done while a service is still being received, it is part of the "concurrent review" process. If it is done after a service is received, it is called "retrospective review."

Utilization Management decisions are based only on appropriateness of care and service. BCBSNM does not reward providers or persons conducting our programs for denying services and does not offer incentives to program decision-makers that would encourage them to approve fewer services than you need. We want to help you get the care you need in the best way possible.

The amount, duration, or scope of service will not be denied solely because of your specific condition, diagnosis, or illness.

A service must be medically necessary, even if a prior authorization is not required. All services are subject to review. If the service is found not needed, you may have to pay for the service in agreement with state and federal guidelines.

There is a difference between a grievance and an appeal.

Grievance (Complaint)

A grievance is also known as a complaint. It is an expression of dissatisfaction about any matter or part of BCBSNM or its services, other than an Adverse Benefit Determination. You can also file a grievance if you are not happy with a provider. For example, a grievance is a complaint about the quality of the provider network or any other service BCBSNM provides.

Filing a Grievance

If you have a grievance about BCBSNM or a provider, call our Member Services line at **1-866-689-1523** or call 711 for TTY service for help. Member Services can help you file a grievance by getting you in contact with the Centennial Care Appeals/Grievance Coordinator.

Grievance Address and Phone Number

To file a grievance, contact the Centennial Care Appeals/Grievance Coordinator by writing a letter to the address below. You can also call Member Services, email us using the email form on our website at **bcbsnm.com/medicaid**, or send a fax to the number below.

Centennial Care
Appeals/Grievance Coordinator
P.O. Box 27838
Albuquerque, NM 87125-7838
Telephone (toll-free): **1-877-232-5520**
Fax: **1-888-240-3004**
Email: Go to **bcbsnm.com/medicaid** and complete the email form

Telephone hours are Monday through Friday from 8:00 a.m. to 5:00 p.m.
Closed Saturdays and Sundays.

If you want to leave us a message about your grievance after normal business hours, you may call **1-877-232-5520** (TTY: **711**). We will return your message by 5:00 p.m. the next business day.

Time Limits for Filing a Grievance

You may file a grievance either verbally or in writing at any time from the date the dissatisfaction occurred. We will send you a letter within five (5) business days of the receipt of your grievance to let you know we received it and are working to resolve it within 30 calendar days. If you have information that supports your grievance, please send that to us as well. We will add it to your file for consideration. Please send this information to the address, fax, or email address listed above.

Time Frame for an Answer to a Grievance

BCBSNM has 30 calendar days to review and respond to your concerns or as fast as your health condition requires. Your grievance will be reviewed by someone who was not involved and can research the problem. We will send you a letter within 30 calendar days to let you know how your concerns were answered. In some cases, we may need an extra 14 calendar days and will ask the State of New Mexico for more time, if this is in your best interest. You will be sent a letter within 2 calendar days of the decision to extend the timeframe. You may also ask for more time if you need it to explain your grievance. This extra time is called an extension.

People Who can File a Grievance

A member may file a grievance verbally or in writing. The legal guardian for children or incapacitated adults, a representative as stated in writing, an attorney, or a provider acting on the member's behalf with the member's written permission, can file a grievance on behalf of a member. All grievances are kept confidential. You may ask for a copy of your grievance. You can call the Centennial Care Appeals/Grievance Coordinator or Member Services for help in getting a copy. No negative action will be taken against you or your provider for filing.

A Grievance is Not an Appeal

You can file a grievance even if you do not request an appeal. However, a grievance alone will not work to dispute a benefit decision. You must file an appeal to dispute a benefit decision. You can file both a grievance and an appeal at the same time.

Appeal

An appeal is defined by the State as a request for review of an Adverse Benefit Determination taken by BCBSNM about a service. For example, you can request an appeal when a service is denied, delayed, limited, or stopped. An appeal is a request for review of a BCBSNM Adverse Benefit Determination. An adverse benefit determination is the denial, reduction, limited authorization, suspension, or termination of a newly requested benefit or benefit currently being provided to a member including determinations based on the type or level of service, medical necessity criteria or requirements, appropriateness of setting, or effectiveness of a service.

We will tell you when we make a decision or action in writing. We will send you a letter to let you know when a service is denied, delayed, limited, or stopped. It will also give you the instructions for filing an appeal.

Appeals and HSD administrative hearings are not available if BCBSNM limits, reduces, denies or stops any value-added service.

Time Limits for Filing an Appeal

You have to appeal within 60 calendar days from the date of the Adverse Benefit Determination letter. You can start an appeal verbally or in writing. You must also mail in your written request for an appeal within 13 calendar days from calling. You can call Member Services and get help with submitting your written appeal request. The Centennial Care Appeals/Grievance Coordinator will also send you an appeal form to fill out and return within 13 calendar days. BCBSNM then has 30 calendar days from the day of your initial request to resolve the appeal. If you do not file an appeal within 60 calendar days from the date of the Adverse Benefit Determination letter, you may lose your right to appeal.

Filing an Appeal

You can send your written appeal to the Centennial Care Appeals/Grievance Coordinator to the following address or fax a copy of your appeal to the fax number. Appeals forms are available at *https://www.bcbsnm.com/community-centennial/member-resources/forms.html*.

Types of Appeal Helpers

There are different types of helpers who can help you with your appeal and go by different names. You can get help with your appeal from an "Authorized Provider," "Authorized Representative," and/or a "Spokesperson." Each type of helper can do some things for you but may not be able to do other things. To use each type of helper, you need to give BCBSNM the form for that helper and make sure the helper agrees to help you.

The types of helpers, the forms, and what the helpers can and cannot do for you is in the following table:

Type of Appeal Helper	Who Can be the Appeal Helper	Form Needed	Support You and Advocate for You	Access Case Information	File Appeal for You	Ask to Continue Your Benefits	Make Medical Decisions for You*
Authorized Provider	Your healthcare provider	Authorized Provider Form	Yes	Yes	Yes	Yes	Yes
Authorized Representative	Friend, relative, attorney healthcare provider, or anyone else	Authorized Representative Form	Yes	Yes	Yes	Yes	Yes**
Spokesperson	Friend, relative, or anyone else	Standard Authorization Form - HIPAA	Yes	Yes	No	No	No

*Only in the context of a Medicaid appeal, not applicable in a clinical setting (e.g., at a hospital).

**An Authorized Representative for a Medicaid appeal is not the same as an agent who you make your power of attorney for health care. A power of attorney for health care lets you name another person as agent to make health care decisions for you in a clinical setting (e.g., at a hospital) if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. If you want to make someone your power of attorney for health care, please use the health care power of attorney form available at *https://www.bcbsnm.com/community-centennial/member-resources/forms.html.*

After your appeal is filed, you can give more information to BCBSNM before your appeal is decided. The information can be written comments, documents, or verbal testimony. The information can also be written or verbal arguments of law or facts. You or your Authorized Provider, Authorized Representative, or Spokesperson can give this information to us. To give us more information before your appeal is decided, you must ask us right away because BCBSNM has limited time to finish your appeal. After you ask to give us more information, BCBSNM will schedule a time for you to give us the information before we decide your appeal. If you need more time to gather your information, you can request an extension of the appeal up to 14 more calendar days. When you ask for an extension, please tell us why.

Appeals Address and Phone Number

Centennial Care Appeal/Grievance Coordinator
P.O. Box 27838
Albuquerque, NM 87125-5520
Telephone (toll-free): 1-877-232-5520
Fax: 1-888-240-3004
Email: Go to **bcbsnm.com/medicaid** and complete the email form

Telephone hours are Monday through Friday from 8:00 a.m. to 5:00 p.m.
Closed Saturdays and Sundays.

If you want to leave us a message about your appeal after normal business hours, you may call **1-877-232-5520** (TTY: **711**). We will return your message by 5:00 p.m. the next business day.

How Your Appeal is Handled

Within five business days of receiving your appeal request, BCBSNM will send you a notice confirming we have received it. The notice will also tell you when BCBSNM expects to have an answer for you. If you or your provider believes an answer is needed more quickly from BCBSNM, you can request an "expedited" review and response.

If applicable, a provider who was not involved in the initial denial decision will review your case when you request an appeal. This provider can give another opinion about whether the request will be approved or denied again. An answer to your appeal will be provided within 30 calendar days. The resolution letter will explain the appeal decision. If we need more time to answer your appeal and believe it is in your best interest to take more time, we will ask the State if they will approve an extension of up to 14 calendar days. You may also ask for an extension. If we ask for an extension, we will call to let you know and also follow up in writing within two calendar days.

Keeping Your Services During an Appeal and HSD Administrative Hearing

You, your Authorized Provider, and your Authorized Representative may have the right to request that BCBSNM continue to cover (pay for) the services in question while your appeal is in process. You, your Authorized Provider, and your Authorized Representative may have the right to request that BCBSNM continue to pay for the services in question while your HSD administrative hearing is in process. Your Spokesperson does not have this right. The request to continue your benefits must be made prior to the date the initial denial goes into effect or within 10 calendar days after BCBSNM mails an appeal decision to you, whichever is later. You may request continued benefits by calling Member Services at **1-866-689-1523** (TTY: **711**). You can also send written requests to the mailing address, email address, or fax number listed below.

Blue Cross and Blue Shield of New Mexico
Attention: Blue Cross Community Centennial, Appeals Coordinator
P.O. Box 27838
4411 The 25 Way NE
Albuquerque NM 87125-7838
Toll-Free: **1-877-232-5520**
Fax Number: **1-888-240-3004** TTY: **711**
Email: Go to
bcbsnm.com/community-centennial
and click on Contact Us

You have the right to receive continued benefits only under certain conditions:

- Benefits for the services at issue will be continued during the process of your appeal to BCBSNM if: (1) you, your Authorized Provider, or your Authorized Representative request an appeal within 60 calendar days from the date of the denial letter; (2) the appeal is of the termination, suspension, or reduction of a previously authorized course of treatment; (3) the services were ordered by an authorized provider; (4) the original period covered by the original authorization has not expired; and (5) you, your Authorized Provider, or your Authorized Representative ask for your benefits to continue any time prior to the date the denial goes into effect or within 10 calendar days from the date of the denial letter, whichever is later.
- If your request to continue benefits for the appealed service has been approved by BCBSNM, you will continue to receive the disputed benefit during the appeal process unless: (1) you, your Authorized Provider or your Authorized Representative withdraw the appeal; (2) you or your Authorized Representative fail to request an HSD administrative hearing and continuation of benefits within 10 calendar days after BCBSNM mails an appeal decision to you; (3) the Human Services Department Medical Assistance Division Director issues a hearing decision against you; (4) the time period or service limits of a previously authorized service has been met; or (5) you, your Authorized Provider, or your Authorized Representative choose to end continued benefits.
- If you or your Authorized Representative have asked for benefits to continue within 10 calendar days from the date of the denial letter, BCBSNM may still deny your appeal. You can file for an HSD administrative hearing at that time. However, it will be too late to ask for your benefits to continue if you wait until the HSD administrative hearing process to make such a request.
- The result of the appeal or the HSD administrative hearing could be the same as BCBSNM's first decision to terminate, modify, suspend, reduce, or deny a service. In this event, you are responsible for paying for the services used. BCBSNM may recover the cost of the services furnished to you (request payment back from the provider or member).
- If BCBSNM started an expedited appeal on your behalf, you are not responsible to pay for the continued benefits during the appeal even if BCBSNM's initial decision is upheld.
- If the result of the appeal to BCBSNM or of the HSD administrative hearing is in your favor, BCBSNM will continue to pay for the services through the authorized time frame.

Expedited Appeal

If you think the normal 30 calendar day appeal time will put your health at risk, you can ask us to "expedite" your appeal (review it faster). Your Centennial Care plan automatically provides an expedited review for all requests related to a continued hospital stay or other health care services for a member who has received emergency services and is still in the hospital. You or your provider can file an expedited appeal by calling Member Services. We will tell you within one working day if we agree to expedite your appeal. If we agree, we will tell you and/or your provider the outcome over the phone within 72 hours after we receive your appeal. We will send a follow-up letter within two (2) calendar days telling you and your provider the outcome.

You or your authorized representative may ask for up to a 14 calendar day extension to submit additional information to BCBSNM that supports your request for an expedited appeal.

If we need more time to answer your expedited appeal to collect and review additional documentation, we can extend the 72-hour time frame up to 14 calendar days. We will write you a letter to explain why we extended the 72-hour time frame.

If BCBSNM decides that taking the time for a standard appeal puts your health at serious risk, BCBSNM will start an expedited appeal on your behalf. BCBSNM will contact you if we have started the expedited appeal. We will continue your benefits without cost to you during an expedited appeal started by BCBSNM. We will give you an expedited appeal decision in 72 hours.

BCBSNM or the New Mexico HSD are not responsible for any fees or cost you incur during the regular or expedited appeals process.

Expedited Appeal Request Denials

If an expedited appeal request is denied, it goes through the normal appeal process. It will be resolved within 30 calendar days. BCBSNM will call you within one working day to tell you the appeal is not going to be expedited. We will also follow up in writing within two (2) calendar days. If we deny your expedited request, you can request a standard or expedited HSD administrative hearing.

HSD Administrative Hearing

You have the right to ask for a hearing with the HSD Fair Hearings Bureau if after exhausting BCBSNM's internal appeal process, you do not agree with the final decision. You also have the right to ask for an HSD administrative hearing if we denied your request for an expedited appeal. You or your representative must ask for an HSD administrative hearing from the HSD Fair Hearings Bureau within 90 calendar days of BCBSNM's final appeal decision. You have the right to have someone represent you at the hearing. The parties who may attend the HSD administrative hearing include representatives from BCBSNM, as well as you and/or your representative, or attorney, or the representative of a deceased member's estate. You will receive a summary of evidence (SOE) packet for the HSD administrative hearing. The SOE provides information regarding your appeal. Your case may be dismissed if you do not go to your scheduled hearing without a good reason. If you requested continuation of benefits, and the result of the HSD administrative hearing is not in your favor, you will have to pay for the services received.

You can ask for an HSD administrative hearing by calling or writing:

New Mexico Human Services Department
HSD Fair Hearings Bureau
P.O. Box 2348
Santa Fe, NM 87504-2348
Telephone: 1-800-432-6217, then press 6; or (505) 476-6213 TTY: **711**
Fax: (505) 476-6215
Email: HSD-FairHearings@state.nm.us

Annual Choice Period

During the first three months after your effective date of Centennial Care, you are given one chance to change to another managed care plan. If you do not change during this time, you will have to wait 12 more months.

Moving out of State

If you move out of state, you are no longer eligible for Centennial Care coverage. It is very important to let your local ISD office know if you move out of state right away.

Member Disenrollment Requests

You can switch to another managed care plan at any time if there is "good cause." You or your representative must make the request in writing and send it to HSD. If you do not receive approval from HSD, you may ask for an HSD administrative hearing. See **Section 7: Grievances & Appeals** for details about requesting an HSD administrative hearing. Below are examples of when you may make a special request:

- Centennial Care does not cover the service because of moral or religious reasons
- Centennial Care has been given penalties by HSD
- In-network providers are not available to perform multiple services at the same time
- You do not have access to in-network providers for your health care needs
- Moved out of state
- Poor quality of care

HSD Reasons for Disenrolling Members

HSD can also ask a member to disenroll from the Managed Care program. These reasons include:

- Loss of Medicaid eligibility
- At any time during the HSD administrative hearing process, HSD finds it would be best for the member or HSD for the member to disenroll

BCBSNM Reasons for Disenrolling Members

BCBSNM can also request a member disenrollment request from HSD. This can be done when the member's continued enrollment could harm the Centennial Care plan's ability to offer services to its members.

Long-Term Care Residential or Employment Support Provider Leaving Network

If your long-term care residential or employment support provider leaves our network, you may switch to another MCO at any time within 90 calendar days from the date you were notified that the provider was leaving the network.

Disenrolling During a Hospital Stay or While in a Nursing Facility

If you change to another managed care plan while you are hospitalized, BCBSNM will be responsible for payment of all covered inpatient facility and related professional services until your discharge date. Once you are discharged, all services will be handled by your new managed care plan under Centennial Care.

If you change managed care plans while in a nursing facility, BCBSNM is responsible for payment of covered services until the discharge date or the date you change managed care plans, whichever comes first.

If your coverage ends as a result of being not eligible for Centennial Care while you are hospitalized or in a nursing facility, BCBSNM will be responsible for payment of all covered inpatient facility and related professional services until the end of the month in which you were determined not eligible.

After the end of that month, you are responsible for all charges even if you continue to be hospitalized or in a nursing facility.

How to Disenroll

To send a request to disenroll, call the NM Medicaid Call Center at **1-888-997-2583** or go to YESNM at **www.yes.nm.state.us**.

You need to contact ISD if you:

- Change your name
- Move to another address
- Change your phone number
- Get married or get divorced
- Know of a Centennial Care member who has died
- Have a new child, adopt a child, or place your child for adoption
- Get other health insurance, including Medicare
- Think you lost eligibility or must change your eligibility with HSD/MAD
- Move out of New Mexico
- Need a referral for community resources through Centennial Care
- Have any questions about your eligibility with Centennial Care

Section 9: General Information

Changes to Handbook or Benefits

HSD/MAD reserves the right to add or delete benefits to the Centennial Care program.

Disclosure and Release of Information

BCBSNM will only disclose information, including medical records, as permitted or required under state and federal law.

Accessing your Medical Records

Your health information may be available online through your patient portal. This is a secure website through your doctor's office or health care system. Using a secure user name and password, you can log in and view some of your health information such as:

- Recent doctor visit notes
- Discharge summaries
- Lab and test results
- Medications
- Immunizations
- Allergies
- Online prescription refills
- Online appointment scheduling
- Secure messaging with your provider

Your patient portal may allow you to download this information or share it with others. If this information is not available, you can request it from your doctor's office. You may have more than one patient portal for all the places you receive care. Like your primary care physician, a hospital, your specialists, your pharmacy, laboratories, or your insurance provider.

Advance Directives

Advance directives are written documents (such as a Living Will, Health Care Treatment Directives, and Durable Power of Attorney) that give a person you select the responsibility for making your health care decisions if you cannot express your own wishes. These documents also describe the kind of treatment you do and do not want. Talk with your provider about advance directives. Keep a copy of your advance directives in your medical record at your PCP's office. Members over age 18 or emancipated minors have the right to refuse or accept medical or surgical care and to make advance directives.

BCBSNM, in-network providers, and staff do not discriminate care based on whether you have signed any type of advance directive. If you have questions or concerns about advance directives, contact your PCP to discuss these issues.

Complaints about noncompliance with advance directive requirements may be filed with HSD/MAD Division of Health Improvement in the New Mexico Department of Health.

Federal law says hospitals, nursing homes, and other providers have to tell you about advance directives. They need to explain your legal choices about medical decisions. The law was made to give you more control during times when you may not be able to make health care decisions.

If you need help to get an advance directive, contact Member Services or your Care Coordinator. If you are speech or hearing impaired, call 711 for TTY service. You can also call the State of New Mexico Aging and Disability Resource Center at **1-800-432-2080**.

Mental Health Advance Directives

New Mexico's Mental Health Care Treatment Decisions Act allows you to put in writing your wishes for psychiatric treatment. This is called a Psychiatric Advance Directive (PAD). If you are unable to make a decision, mental health advance directives will describe your wishes. You can list a person you trust to make decisions for you. If you need help to get an advance directive, contact Member Services or your Care Coordinator.

Major Disasters

In the event of any major disaster, epidemic, or other circumstance beyond your control, BCBSNM will render or try to arrange covered services with in-network providers as much as possible. BCBSNM will do this according to its best judgment and within the limitations of facilities, supplies, pharmaceuticals, and personnel available. Such events include, complete or partial disruption of facilities, war, riot, civil uprising, disability of BCBSNM personnel, disability of Centennial Care providers, or an act of terrorism.

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, BCBSNM provides benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and treatment of complications resulting from a mastectomy (including lymphedema). If you have any questions, please call, write, or email Member Services.

Health Care Fraud and Abuse

Health care fraud, waste and abuse hurts everyone by causing higher costs, receiving inappropriate medical services and/or supplies, and creating distrust within the medical community.

Definitions:

- Fraud means an intentional deception or misrepresentation by a person or an entity, with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes Fraud under applicable federal or State law.
- Waste means the over-utilization of services or other practices that result in unnecessary costs
- Abuse means any intentional, knowing or reckless act or failure to act that produces or is likely to produce physical or great mental or emotional harm, unreasonable confinement, sexual abuse or sexual assault. Provider practices that are inconsistent with sound fiscal, business, medical or service-related practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary Services or that fail to meet professionally recognized standards for health care. Abuse also includes member practices that result in unnecessary cost to the Medicaid program

What you can do to prevent yourself from being a victim to health care fraud:

- Understand your treatment program; ask your physician to explain why a test or procedure is necessary
- Never use someone else's health insurance identification card
- Don't share your health insurance information with anyone over the phone

How You Can Help

Always review the bills from your providers. Make sure that you received all the services that were claimed. If you think there is a problem or that the Centennial Care program is being charged for services that you did not receive, call Member Services at **1-866-689-1523**.

- Be very careful about giving information about your health care insurance over the telephone
- Keep your Centennial Care ID card safe; do not let anyone else use it
- Report any suspicion of fraud and/or abuse to BCBSNM

Reporting Fraud and Abuse

If you feel health care fraud and abuse has happened, or will happen, report it right away. BCBSNM will look into the report and will work with any needed government, regulatory, or law enforcement agency for both member and provider cases.

You can report fraud and abuse by doing the following:

- File a fraud and abuse report with BCBSNM's Special Investigations Department (SID). SID's toll-free Fraud and Abuse Hotline at **1-800-543-0867** is staffed and operational 24 hours a day, seven days a week. Call **711** for TTY service. The Fraud and Abuse Hotline has Spanish-speaking staff and is also capable of receiving complaints from the hearing impaired. All calls are confidential and you do not have to give your name.
- Go to BCBSNM's SID website at **bcbsnm.com/company-info/who-we-are/fraud-prevention**.
- Contact the New Mexico Attorney General's Office, which has a dedicated unit called the Medicaid Fraud & Elder Abuse Division (MFEAD). The MFEAD unit investigates and prosecutes providers who commit health care fraud and abuse, neglect, and exploitation of Medicaid recipients. It also reviews complaints about abuse and neglect for persons receiving services in long-term care Medicaid-funded facilities. You can report fraud to the MFEAD by filling out a Complaint Form at **nmag.gov/how-to-report-to-mfcd.aspx**. When the form is complete, please submit via fax, email, or mail.

Phone: 1-505-717-3585
Fax: 1-505-318-1006
Email: report.mfcd@nmag.gov
Mail: New Mexico Office of the
Attorney General
Attn: Medicaid Fraud Control Division
201 Third St. NW, Suite 300
Albuquerque, NM 87102

Medical Policy

A medical policy is a medical coverage position developed by BCBSNM. It summarizes the scientific knowledge currently available for new or existing technology, products, devices, procedures, treatment, services, supplies, or drugs and used by BCBSNM to process claims and provide benefits for covered services. BCBSNM's medical policies are based on scientific and medical research. They are often used as a guide to determine what is covered by a health plan. Policies can pertain to a medical procedure, treatment, drug or device. You can check to see if these are:

- Cosmetic
- Under investigation or experimental
- Medically necessary

Medical policies are posted on the BCBSNM website at **bcbsnm.com/medicaid** under Member Resources. Specific medical policies may be requested in writing from Member Services. Please note that these policies do not replace professional health care.

Privacy of Your Information

As a Centennial Care member, HSD is responsible for providing you with a notice. This notice explains how your Protected Health Information (PHI) can be used and shared. PHI includes medical information. It also includes information about your Centennial Care benefits. PHI can be communicated by spoken word, in writing, or electronically.

BCBSNM manages a contract with HSD to provide the Blue Cross Community Centennial health plan to BCBSNM's Centennial Care members. So that you may use the benefits of this plan, BCBSNM has access to your PHI in all its forms. Due to this fact, we wanted you to know how BCBSNM protects and secures your PHI.

How We Use or Share Your PHI

To operate the health plan and for you to receive services from your health care providers, BCBSNM uses your PHI. BCBSNM shares it with your providers and other organizations. We also share your PHI to help with the following:

- Public health
- Safety issues
- Other legal or law enforcement activities

Please know that BCBSNM only shares your PHI when allowed by law.

Your Rights

- Authorizations: There may be times when BCBSNM requires your authorization to release your PHI. Sometimes we need to share your PHI. This may be with your legal guardian, legal representative, or others involved in making decisions about your care.
- Access to your PHI: You have the right to ask BCBSNM for a copy of your health information, claims records, or other PHI.

How We Protect Your PHI

BCBSNM has policies, procedures and strong security controls in place. These are in place to protect your PHI. BCBSNM protects your PHI whether it is spoken, written, or maintained electronically. Employees at BCBSNM have to take privacy and security training at least once a year. Employees are also required to comply with all privacy and security policies and procedures.

Information

For more information about this notice or your rights, please call Member Services at **1-866-689-1523** (TTY: **711**) or contact HSD.

Independent Companies

Prime Therapeutics is a separate company that is the pharmacy benefit manager for the Blue Cross Community Centennial health plan. Davis Vision, DentaQuest, and LogistiCare are independent companies that provide certain administrative services for the Blue Cross Community Centennial health plan in the areas of vision, dental, and transportation, respectively. All of these companies are independent contractors that do not offer Blue Cross and Blue Shield products and services and are solely responsible for the products and services they provide.

Notes

Notes

BlueCross BlueShield of New Mexico

Such services are funded in part with the State of New Mexico.

Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

476935.0318