Your Health Care Benefit Booklet



HMO GROUP

For Use With Your Group HMO Plan

This policy does not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent or the New Mexico Health Insurance Exchange (www.nmhix.com) if you wish to purchase pediatric dental coverage or a stand-alone dental insurance product.

Underwritten by:

BlueCross BlueShield of New Mexico

NM82869_G_H_OE (01/15)

On Exchange (SHOP)

CUSTOMER ASSISTANCE

Customer Service:—The 24/7 Nurseline can help when you have a **health** problem or concern. The 24/7 Nurseline is staffed by Registered Nurses who are available 24 hours a day, 7 days a week.

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

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

Street address: 4373 Alexander Blvd. NE
Toll-free telephone number: 1-800-432-1630

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

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

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

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

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

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

Send Claims* to:

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

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

www.bcbsnm.com

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

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

A message from

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO AND YOUR GROUP

This Plan is underwritten by Blue Cross and Blue Shield of New Mexico (BCBSNM), your partner in health care, for the "Exchange" (also known as the "Health Insurance Marketplace"). Like most people, you probably have many questions about your coverage. This Benefit Booklet contains a great deal of information about the services and supplies for which benefits will be provided under your Plan. Please read your entire Benefit Booklet very carefully. We hope that most of the questions you have about your coverage will be answered.

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

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

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

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

Welcome to Blue Cross and Blue Shield of New Mexico! We are very happy to have you as a member and pledge you our best service. This Plan is currently certified by the Exchange as a Qualified Health Plan.

Sincerely,

Kurt Shipley
President
Blue Cross and Blue Shield of New Mexico

If You Live Outside New Mexico

HMO- Participating Providers outside New Mexico and Nonparticipating Providers do not know what services need Preauthorization under this Medical Plan, which is administered by BCBSNM. In these cases, it is your responsibility to make sure Preauthorization is obtained when needed. **Please make sure you are aware of Preauthorization requirements in *Section 4.*** You may be responsible for all charges if you or your Provider do not receive authorization from **BCBSNM** for certain services. **All questions about your Plan benefits should be directed to BCBSNM - not to the BCBS Plan in your state of residency.**

NOTE:

This is a Managed Care Medical Plan that generally provides benefits ONLY for services received from a BCBS "HMO" (or HMO- Participating) Provider. Under the Managed Care Plan, if you obtain nonemergency services from a Nonparticipating (non- HMO) Provider, the services will usually NOT be covered. Exceptions to this requirement are listed in *Section 3: How Your Plan Works.* It is YOUR responsibility to determine if a Provider is in the national BCBS HMO- Participating Provider network.

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SECTION 1: HOW TO USE THIS BENEFIT BOOKLET

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

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

DEFINITIONS

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

SUMMARY OF BENEFITS AND COVERAGE (SBC)

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

IDENTIFICATION (ID) CARD

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

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

PROVIDER NETWORK DIRECTORY

In order to receive benefits for non-Emergency services, you need to use Providers who are in the BCBSNM HMO-Participating Provider network. (You have coverage for Nonparticipating Provider services only during an Emergency or when **preauthorized** due to Medical Necessity.)

The Provider network directory is available through the BCBSNM website at www.bcbsnm.com. It lists all Providers in the BCBSNM HMO-Participating Provider network and Participating Pharmacies. (If you want a paper copy of a directory, you may request one from Customer Service. It will be mailed to you free of charge.) **Note:** Although Provider directories are current as of the date shown at the bottom of each page, they can change without notice. To verify a Provider's status or if you have any questions about the directory, contact a Customer Service Advocate or visit the BCBSNM website.

DRUG PLAN BENEFITS

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

BLUECARD® PROGRAM

As a Member of an HMO health plan administered by BCBSNM, you take your health plan benefits with you for Emergency services – across the country and around the world. The BlueCard Program gives you access to HMO- Participating Providers almost everywhere you travel or live. More than 90 percent of all Hospitals and 80 percent of doctors in the United States contract with Blue Cross and Blue Shield (BCBS) Plans. You and your Eligible Family Members can receive the HMO- Participating Provider level of benefits – even when traveling or living outside of New Mexico – by using health care Providers that contract as HMO- Participating Providers with their local BCBS Plan. Instructions for locating an HMO- Participating Provider outside of New Mexico can be found on the BCBSNM website at www.bcbsnm.com.

LIMITATIONS AND EXCLUSIONS

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

PREAUTHORIZATION REQUIRED

To receive benefits for some services, you or your Provider must call the BCBSNM Health Services department **before** you receive treatment. Call Monday through Friday, 8 A.M. to 5 P.M., Mountain Standard Time. **Note:** Call Customer Service if you need Preauthorization assistance after 5 P.M.

Emergency/Maternity Admission Notification

To receive benefits for Emergency Hospital Admissions, you (or your Provider) should notify BCBSNM **as soon as reasonably possible** following Admission. Call BCBSNM's Health Services department, Monday through Friday, 8 A.M. to 5 P.M., Mountain Standard Time. Also, if you have a routine delivery and stay in the Hospital **more than 48 hours**, or if you have a C-section delivery and stay in the Hospital **more than 96 hours**, you must call BCBSNM for Preauthorization before you are discharged.

Written Request Required

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

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

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

PREAUTHORIZATION OF BEHAVIORAL HEALTH CARE

All Inpatient and specified Outpatient mental health and Chemical Dependency services must be preauthorized by the Behavioral Health Unit (BHU) at the phone number below (also listed on the back of your ID Card). For services requiring Preauthorization, you or your Physician should call the BHU before you schedule treatment. The BHU will coordinate Covered Services with an In- network Provider near you. **If you do not call and receive Preauthorization before receiving non- Emergency services, benefits for services may be denied**. Call 7 days a week, 24 hours a day:

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

CUSTOMER SERVICE

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

Customer Service representatives can help with the following:

- answer questions about your benefits
- assist with Preauthorization requests
- check on a Claim's status
- help you change your PCP selection
- order a replacement ID Card, Provider directory, Benefit Booklet, or forms

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

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

Website: www.bcbsnm.com

Behavioral Health Customer Service

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

Toll-free: 1-888-898-0070

Deaf and Speech Disabled Assistance

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

Translation Assistance

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

After Hours Help

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

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

24/7 Nurseline

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

Toll-free: 1-800-973-6329

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

BLUE ACCESS FOR MEMBERS SM

To help Members track Claim payments, make health care choices, and reduce health care costs, BCBSNM maintains a flexible array of online programs and tools for health care plan Members. The online "Blue Access for Members"

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

If you need help accessing the BAM site, call:

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

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

HEALTH CARE FRAUD INFORMATION

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

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

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

SECTION 2: ENROLLMENT AND TERMINATION INFORMATION

WHO IS ELIGIBLE

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

- Are active employees who have completed the Employee Probationary Period, if any, and who are regularly working the minimum number of hours specified in the Group Administration Document and their Eligible Family Members (No such probationary period may exceed 90 days unless permitted by applicable law. If BCBSNM records show that your Group has a probationary period that exceeds the time period permitted by applicable law, then BCBSNM reserves the right to begin your coverage on a date that BCBSNM believes is within the required period. Regardless of whether BCBSNM exercises that right, your Group is responsible for your probationary period. If you have questions about your probationary period or the number of hours you must work per week or to learn of any other eligibility criteria specified by your Group, contact your Group's benefits administrator.);
- Meet the definition of a Qualified Employee as determined by the Exchange (also known as the Health Insurance Marketplace) and the Plan, as appropriate;
- Have applied for this coverage, through the Exchange and the Plan, as appropriate, and received an eligibility determination from the Exchange;
- Have received a Blue Cross and Blue Shield identification card; and
- Reside or work in the geographic area ("Network Service Area") served by the Plan network for this Benefit Booklet. You may call customer service at the number shown on the back of your identification card to determine if you reside or work in the Network Service Area or log on to the web site at *www.bcbsnm.com*.

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

BCBSNM may request proof that a valid employer-employee relationship exists, if applicable, and/or that the applicant meets the eligibility requirements stated above and/or in the Group Administration Document and the Member's application.

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

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

IF YOUR EMPLOYER OFFERS RETIREE BENEFITS

If your employer's Plan also covers retirees, retirees under the age of 65 who meet the employer's eligibility requirements for Plan participation are also eligible. To be eligible for continued coverage in this Plan, the retiree must also be residing within the BCBSNM HMO Plan Service Area at least six months out of the year. **Note:** If you are a retiree covered under this Plan, please contact your employer's benefits administrator for eligibility criteria applicable to you.

ELIGIBLE FAMILY MEMBERS

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

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

- the Subscriber's legal **spouse**

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

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

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

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

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

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

- has signed jointly with you, a notarized affidavit which can be made available to BCBSNM on request.

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

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

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

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

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

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

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

Information for Noncustodial Parents

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

- provide such information to the custodial parent as may be necessary for the Child to obtain benefits through the Plan;
- permit the custodial parent or the Provider (with the custodial parent's approval) to submit Claims for Covered Services with the approval of the noncustodial parent; and
- make payments on Claims submitted in accordance with the above provision directly to the custodial parent, the Provider, or the state Medicaid agency as applicable.

MEDICARE-ELIGIBLE MEMBERS

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

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

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

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

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

If Medicare is Primary

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

CHILD-ONLY COVERAGE

Eligible Children that have not attained age 21 may enroll as the sole Subscriber under this health care plan. In such event, this health care plan is considered child-only coverage and the following restrictions apply:

- Each child is enrolled individually as the sole Subscriber; the parent or legal guardian is not covered and is not eligible for benefits under this health care Plan.
- No additional dependents may be added to the enrolled Child's coverage. Each Child must be enrolled in his/her own Plan. (Note: If a Child covered under this Plan acquires a new Eligible Child of his/her own, the new Eligible Child may be enrolled in his/her own Plan coverage if application for coverage is made within 30 days.
- If a child is under the age of 18, his/her parent, legal guardian, or other responsible party must submit the application for child-only insurance form, along with any exhibits, appendices, addenda and /or other required information to the Plan or the Exchange, as appropriate. For any Child under 18 covered under this health care Plan, any obligations set forth in this Plan, any exhibits, appendices, addenda and/or other required information will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the child's behalf. Application for a child-only coverage will not be accepted for an adult Child that has attained age 21 as of the beginning of the Plan year. Adult children (at least 18 years of age but who have not attained age 21) who are applying as the sole Subscriber under this Plan must apply for their own individual plan and must sign or authorize the applications(s).

APPLYING FOR COVERAGE

You may apply for coverage in a Qualified Health Plan (QHP) through the Exchange for yourself and/or your eligible spouse and/or dependents (see below) by submitting the application(s) for medical insurance to the Plan or the Exchange, as appropriate. The Application(s) for coverage may or may not be accepted. (BCBSNM cannot use genetic information or require genetic testing in order to limit or deny coverage.)

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

The Plan or the Exchange, as appropriate, may require acceptable proof (such as copies of legal adoption or legal guardianship papers, or court orders) that an individual qualifies as an Eligible Family Member under this Plan.

[INITIAL AND ANNUAL OPEN ENROLLMENT PERIODS / EFFECTIVE DATES OF COVERAGE

The Exchange and your Group will designate initial and annual open enrollment periods during which you may apply for or change coverage in a QHP through the Exchange for yourself and/or your eligible spouse and/or dependents.

An employee of the Group that becomes a Qualified Employee outside of the initial or annual open enrollment period will be given a QHP enrollment period that begins on the first day of becoming a Qualified Employee. If the Application is accepted, the Qualified Employee's effective date will be as determined by the Exchange and the Plan, as appropriate.

You and/or your Eligible Family Members' Effective Date of Coverage will be determined by the Plan or the Exchange, as appropriate, in accordance with this section, "Initial and Annual Open Enrollment Periods/Effective Dates of Coverage" and "Special Enrollment Periods/Effective Dates of Coverage" section below. Your Effective Date of Coverage will depend upon the date your application is received and other determining factors. Please contact your employer to determine your Effective Date of Coverage.

This section "Initial and Annual Open Enrollment Periods/Effective Dates of Coverage" is subject to change by the Exchange, the Plan, and/or applicable law, as appropriate.]

[SPECIAL ENROLLMENT PERIODS / EFFECTIVE DATES OF COVERAGE

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

Special Enrollment Events:

- You experience a loss of Minimum Essential Coverage. New coverage for you and/or your Eligible Family Members will be effective no later than the 1st day of the month following the loss.

  A loss of Minimum Essential Coverage does not include failure to pay premiums on a timely basis, including COBRA premiums prior to the expiration of COBRA coverage, or situations allowing for a Rescission, as determined by the Exchange and the Plan, as appropriate.

  For purposes of this Special Enrollment Periods/Effective Dates of Coverage section, **"Minimum Essential Coverage"** means health insurance coverage that is recognized as coverage that meets substantially all requirements under federal law pertaining to adequate individual, group or government health insurance coverage. For additional information on whether particular coverage is recognized as "Minimum Essential Coverage", please call the customer service number on the back of your ID card or visit www.cms.gov.
- You gain a dependent or become a dependent through marriage or establishment of a domestic partnership, provided your employer covers Domestic Partners. New coverage for you and/or your eligible spouse or Domestic Partner, provided your employer covers Domestic Partners, and/or dependents will be effective no later than the first day of the following month. (This Special Enrollment Event does not apply to you if you are enrolled in Child-Only Coverage. For information related to child-only plans, please refer to the "Child-Only Coverage" provision of this section.)
- You gain a dependent through birth, adoption or placement for adoption, assumption of eligible foster child care, or court-ordered dependent coverage. New coverage for you and/or your eligible spouse or Domestic Partner, provided your employer covers Domestic Partners, and/or dependents will be effective on the date of the birth, adoption or placement for adoption, or placement for eligible foster child care. However, the effective date for court-ordered Eligible Child coverage will be determined by the Plan in accordance with the provisions of the court order. (This Special Enrollment Event does not apply to you if you are enrolled in Child-Only Coverage. For information related to child-only plans, please refer to the "Child-Only Coverage" provision of this section.)
- Your enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous as evaluated and determined by the Exchange, the Group, and/or the Plan, as appropriate.
- You adequately demonstrate to the Exchange that the QHP in which you are enrolled substantially violated a material provision of its contract in relation to you.
- You gain access to new QHPs as a result of a permanent move.
- You are an Indian, as defined by section 4 of the Indian Health Care Improvement Act. You may enroll yourself and/or your eligible spouse and/or dependents' in a QHP or change from one QHP to another one time per month.
- You demonstrate to the Exchange, in accordance with the guidelines issued by the Department of Health and Human Services (HHS), that you meet other exceptional circumstances as the Exchange may provide.

- You or your Eligible Family Member lose eligibility for coverage under a Medicaid plan or a state child health plan under title XXI of the Social Security Act. You must request coverage within 60 days of loss of coverage.
- You or your Eligible Family Member become eligible for assistance, with respect to coverage through the SHOP, under such Medicaid plan or state child health plan. You must request coverage within 60 days of such eligibility.

Other Special Enrollment Events / Effective Dates of Coverage:

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

- Loss of eligibility as a result of:
  - — Legal separation, divorce, or dissolution of a domestic partnership, provided your employer covers Domestic Partners;
  - — Cessation of dependent status (such as attaining the limiting age to be eligible as a dependent child under the Plan);
  - — Death of an Employee;
  - — Termination of employment, reduction in the number of hours of employment.
- You incur a Claim that would meet or exceed a lifetime limit on all benefits.
- Loss of coverage due to a plan no longer offering benefits to the class of similarly situated individuals that include you.
- Your employer ceases to contribute towards your or/your dependent's coverage (excluding COBRA continuation coverage).
- COBRA continuation coverage is exhausted.

Coverage resulting from any of the special enrollment events outlined above is contingent upon timely completion of the application and remittance of the appropriate premiums in accordance with the guidelines as established by the Exchange and the Plan, as appropriate.]

WHO IS NOT ELIGIBLE

Eligibility for this coverage will be determined by the Exchange in accordance with applicable law. For questions reagarding eligibility, refer to www.healthcare.gov.

WHEN COVERAGE BEGINS

You and/or your Eligible Family Members' Effective Date of Coverage will be determined by the Plan or the Exchange, as appropriate, in accordance with the sections above entitled "Initial and Annual Open Enrollment Periods/Effective Dates of Coverage" and "Special Enrollment Periods/Effective Dates of Coverage." Your Effective Date of Coverage will depend upon the date your application is received and other determining factors. Please contact your employer to determine your Effective Date of Coverage.

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

CHANGES TO COVERAGE

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

Your ability to change coverage types (e.g., from Family to Individual coverage, etc.) will depend on the rules and regulations set forth by your employer or the Exchange, including those described in the sections above entitled "Initial

and Annual Open Enrollment Periods/Effective Dates of Coverage" and "Special Enrollment Periods/Effective Dates of Coverage." Please contact your employer for further information on when you can change your coverage type or remove a person from your coverage.

ADDING A FAMILY MEMBER TO COVERAGE

A Subscriber may apply for coverage of an Eligible Family Member (such as a new spouse or a newborn Child) as provided under the "Special Enrollment Events/Effective Dates of Coverage" section above. **Within 30 days** of acquiring the newly Eligible Family Member, the Subscriber must:

- request that the employer notify BCBSNM of the change,
- complete and submit all necessary enrollment/change forms and legal documentation of proof of dependency, and
- pay any additional premium or other employee contribution for coverage, which may mean changing, for example, from Individual to Family Coverage.

Adding a Spouse or a Domestic Partner

If a Subscriber adds coverage for a spouse or Domestic Partner, provided Domestic Partners are covered under the Plan, **within 30 days** of marriage or establishment of a domestic partnership, the effective date of the new Eligible Family Member's coverage will as described under the "Special Enrollment Events/Effective Dates of Coverage" section above provided BCBSNM receives the completed and signed enrollment/change application form on a timely basis. If the Subscriber does not submit a completed and signed enrollment/change application form to his/her benefits administrator or to BCBSNM (or to the COBRA administrator), along with necessary documentation and, if required, change from Individual (or Employee + Child(ren) coverage, if applicable) to Family Coverage **within 30 days** of marriage, the spouse may not be added to coverage except as a Late Applicant. You may also have the option of applying for a Two- Person (Employee + Spouse) coverage type. Ask your employer which coverage types are available to you. For example, if you are applying for coverage for a new spouse and his/her Eligible Child(ren), you will have to change to Family Coverage. See "Adding an Eligible Child," below.

Adding an Eligible Child

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

Newborn Children

If Family Coverage (or Employee/Children coverage, if available) is in effect, a newborn, natural Child is covered from birth. (You should, however, submit an application to add the newborn as an Eligible Child as soon as possible after birth.) If, for example, Family Coverage is not in effect, you must add coverage for the newborn **within 31** days of the birth in order for newborn care to be covered beyond day 31, (e.g., If an Employee + Child(ren) coverage type is not available to your group, you would need to switch to Family Coverage.). In any case, if the application is not received **within 31** days and additional premium or other employee contributions for coverage, if any, are not paid, the newborn is considered a Late Applicant.

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

Adopted Children/Foster Children

A Child placed in the Subscriber's home for the purposes of adoption or foster care may be added to coverage as soon as the Child is placed in the home. However, application for coverage for adopted children can be made as late as **30 days** following legal adoption without being considered late. Although a Child over the age of 18 is not eligible for adoption, an adopted Child (or a foster child) is covered as any other Child, subject to the same Eligible Child age limitations and restrictions. **Note:** An adopted Child or foster child who is not enrolled within 30 days of adoption or placement in the home for adoption or foster care will be considered a Late Applicant unless the Child was previously enrolled in a group health plan or other creditable coverage within 30 days of his/her adoption or placement for adoption or foster care and has had prior creditable coverage since that date with no significant lapse (i.e., 95 or more days).

Legal Guardianship

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

Stepchild

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

Court Ordered Coverage for Children

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

LATE APPLICANT

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

- anyone not enrolled **within 30 days** of becoming eligible for coverage under this Plan (e.g., a newborn Child added to coverage more than 30 days after birth when, for example, Family Coverage (or Employee/Children coverage, if available) is not already in effect, a Child added more than 30 days after legal adoption, or a new spouse or stepchild added more than 30 days after marriage)
- anyone enrolling on the Group's initial BCBSNM enrollment date who was not covered under the Group's prior plan (but who was eligible for such coverage)
- anyone eligible but not enrolled during the Group's initial enrollment
- anyone who voluntarily terminates his/her coverage and applies for reinstatement of such coverage at a later date (except as a provider under USERRA of 1994)

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

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

RE-ENROLLMENT

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

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

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

NOTIFICATION OF ELIGIBILITY AND ADDRESS CHANGES

The Subscriber must notify the Exchange **within 30 days** following any changes that may affect his/her or a family member's eligibility, including a change to a covered family member's name or address, by indicating such changes on an enrollment/change form and submitting it to the BCBSNM. You can obtain this form from the Exchange or at BCBSNM's website at www.bcbsnm.com, from your benefits administrator, or by calling the BCBSNM Customer

Service department. (Members covered under federal continuation must submit enrollment/change forms directly to the COBRA administrator.)

Employees and Their Eligible Family Members

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

State Continuation Coverage

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

COBRA Continuation Policy Members

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

COVERAGE TERMINATION

Except for nonpayment of premium or termination of the Group Administration Document, BCBSNM will not terminate your coverage without giving you 30 days' written notice. Also, if the employer or group administrator fails to submit premium payments to BCBSNM on a timely basis, coverage will terminate for all affected Members as of the end of the last- paid billing period. The affected Members and the employer or group administrator will not be notified of such a termination.

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

If your coverage in a QHP is terminated for any reason, the Plan will provide you and the Exchange with a notice of termination of coverage that includes the termination effective date and reason for termination at least 30 days prior to the last day of coverage. Unless stated otherwise, if you do not elect or do not qualify for continuation coverage (see "How to Continue Coverage"), your and your Eligible Family Members' coverage will be terminated due to the following events and will end on the dates specified below:

- You terminate your coverage in a QHP, including as a result of your obtaining other Minimum Essential Coverage, with reasonable, appropriate notice to the Exchange and the Plan. For the purposes of this section, reasonable notice is defined as 14 days from the requested effective date of termination.

  The last day of coverage will be:

  - The termination date specified by you, if you provide reasonable notice;
  - 14 days after the termination is requested by you, if you do not provide reasonable notice; or
  - On a date determined by the Plan, if the Plan is able to effectuate termination in fewer than 14 days and you request an earlier termination effective date.
- When you are no longer eligible for QHP coverage through the Exchange. The last day of coverage is the last day of the month following the month in which the notice is sent by the Exchange unless you request and earlier termination effective date.
- When the plan does not receive the premium payment on time or when there is a bank draft failure of premiums for your and/or your Eligible Family Members' coverage.
- Your coverage has been rescinded.
- The QHP terminates or is decertified.
- You change from one QHP to another during an Annual Open Enrollment Period or Special Enrollment Period. The last day of coverage in your prior QHP is the day before the effective date of coverage in your new QHP.

- When a **Member materially fails to abide by the rules,** policies, or procedures of this Plan or fraudulently provides or materially misrepresents information affecting coverage. If a Member knowingly gave false material information in connection with the eligibility or enrollment of the Subscriber or any of his/her eligible family members, the Exchange may terminate the coverage of the Subscriber and his/her Eligible Family Members retroactively to the date of initial enrollment. The Subscriber is liable for any benefit payments made as a result of such improper actions.
- When the Subscriber **dies**. (Surviving Eligible Family Members remain covered through the last-paid billing period.)
- If this Plan is primary over **Medicare** due to federal laws and regulations, when the Medicare-eligible member *chooses* Medicare as his/her primary coverage. (See "Medicare-Eligible Members" for information on coverage options for Members who are entitled to Medicare.)
- When the Member acts in a **disruptive** manner that prevents the orderly business operation of any network Provider or dishonestly attempts to gain a financial or material advantage.
- When **group coverage is discontinued** for the entire group or for the employee's or Subscriber's enrollment classification due to BCBSNM terminating such coverage.
- When the **Group Name** gives BCBSNM or BCBSNM gives the **Group Name** a minimum **30 days' advance written notice**.
- When an employee **retires.** (The retiree and his/her Eligible Family Members may be eligible for continuation coverage through federal law. See "How to Continue Coverage." Certain retirees who were covered under the Plan after retirement are allowed to remain covered under this Plan.)
- When the Subscriber moves to a primary residence or place of employment **outside the geographic area** serviced by BCBSNM. (See "How to Continue Coverage," later in this section.)

If you believe your coverage was cancelled due to health status or health requirements, race, gender, age, or sexual orientation, you may appeal such termination to the Office of Superintendent of Insurance (OSI). BCBSNM will not terminate your coverage when you become eligible for Medicare unless otherwise required or permitted under applicable law. Also, BCBSNM will not cancel your coverage for nonpayment of copayments if such a cancellation would constitute abandonment of a Member who is hospitalized and receiving treatment for a life- threatening condition. In addition, BCBSNM will not cancel your coverage if you refuse to follow a prescribed course of treatment. Before terminating your coverage for reasons other than nonpayment of premium, BCBSNM must provide you written notice at least 30 calendar days in advance. The notice must be in writing and dated, state the reason for cancellation and the date on which it becomes effective, provide you the list of circumstances under which your coverage cannot be cancelled, and provide you information about appealing your termination to the Office of Superintendent of Insurance. You will not receive a notice of cancellation if there is no renewal provision in your contract.

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

Additional Family Member Termination Reasons

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

- at the end of the **last-paid billing period** for Family Coverage;
- at the end of the month when a Child **no longer qualifies as an Eligible Child** under the terms set by the Exchange (e.g., a Child is removed from placement in the home or reaches the Eligible Child age limit);
- at the end of the month following the date of a final **divorce** decree or **legal separation** for a spouse;
- at the end of the month when the Subscriber gives a minimum **30 days' advance notice** in writing to end coverage for a covered family member(s), according to the rules set by the Exchange.
- at the end of the month following the dissolution of a domestic partnership, provided your employer covers Domestic Partners.

If a family member is being removed from coverage because of losing his/her eligibility under the terms set by the Exchange (for reasons other than reaching the Eligible Child age limit), the enrollment/change form must be re-

ceived by the Exchange **within 30 days** following the effective date of the change. In these cases, the Member will be removed from coverage as of the end of the month following the change in his/her eligibility status and payroll deductions will be properly adjusted, if necessary. BCBSNM and the Providers of care may recover benefits erroneously paid on behalf of the removed member.

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

Voluntary Termination of Coverage

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

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

Termination of Continuation Coverage or Extension of Benefits

See "How to Continue Coverage" for more information.

Leave of Absence

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

NOTIFICATION

If the Group Administration Document is terminated or premiums are not submitted, coverage will terminate for all affected Members as of the end of the last-paid billing period. The affected Members and the Group will **not** be notified of such terminations. (If your Group fails to submit premium payments to BCBSNM, it is your group's responsibility to advise Members of BCBSNM Plan termination.)

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

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

PREMIUM REFUNDS

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

- the enrollment/change form is not received **within 30 days** of the change in eligibility status; or
- any claims or capitation amounts have been paid on behalf of the terminated Member during the period for which premiums have been paid.

HOW TO CONTINUE COVERAGE

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

Continuation Coverage

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

You are not eligible to enroll for continuation coverage if:

- the employer stops offering this coverage to its employees, *or*
- you do not elect continuation coverage within the applicable time periods as specified by law for federal continuation (COBRA), state continuation, Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) continuation, and/or extension of benefits due to total disability.

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

Continuation Benefits

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

Federal Continuation (COBRA)

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

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

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

- the first of the month when you become entitled to Medicare
- when the employer discontinues offering this Plan to employees (If this Plan is replaced by another health care plan, continuation coverage will also be replaced by the new Plan.) **Exception:** If your Group declares bankruptcy and you are covered under this Plan as a retiree, you and your Eligible Family Members may be eligible for continued coverage.
- when you become covered under another group health care plan
- when the continuation period expires (If this employer's Plan is still being administered by BCBSNM, you will have the option of changing to the conversion coverage provided by BCBSNM and described under "Conversion to Individual Coverage.")

State Continuation Coverage

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

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

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

Call a Customer Service Advocate for more information.

Premium Payments

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

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

USERRA Continuation Coverage

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

Extension of Benefits

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

An extension of benefits is available if you:

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

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

CONVERSION TO INDIVIDUAL COVERAGE

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

- termination of employment
- a Member no longer meets the eligibility requirements of the Exchange
- the period of continuation coverage expires
- a covered family member loses coverage for one of the following reasons:
  - — divorce or legal separation from the Subscriber
  - — disqualification of the member under the definition of a Eligible Family Member
  - — death of the Subscriber
  - — an employee becomes primary under Medicare — leaving Eligible Family Members without coverage

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

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

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

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

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

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

SECTION 3: HOW YOUR PLAN WORKS

PCPS AND OTHER HMO- PARTICIPATING PROVIDERS

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

Your Primary Care Provider (PCP)

In order to receive coverage under your health plan, each Member must choose a PCP at the time of enrollment. If you do not select a PCP during enrollment, you will be assigned to a PCP in your area. You may choose a different one for each family member.

A PCP should be chosen for an eligible newborn before the child's birth, but no later than **31 days** following birth, to ensure continuous coverage from birth.

Check your Provider directory or visit the "Provider Finder®" section of the BCBSNM website (www.bcbsnm.- com) for a list of PCPs and other HMO- Participating Providers.

Changing PCPs

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

Visiting Your PCP

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

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

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

Cancelling an Appointment

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

HMO- Participating Specialists and Hospitals

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

Keep Your PCP Informed

Although you do not need a PCP referral before arranging to receive Covered Services from another HMO- Participating Provider, you should consult with your PCP if possible. Your PCP knows you and your medical history and may be able to suggest a course of treatment or a particular specialist that is more appropriate than

the one you may be considering. Also, many specialists and facilities will not take patients who have not been referred to them by a Physician.

Preauthorization Needed for Some Services

Your PCP is also aware of the types of services that require **Preauthorization** from BCBSNM and is familiar with the kind of medical information BCBSNM needs in such cases. While you may call BCBSNM for Preauthorization (**before** you incur costs that may not be covered), you may be told that your PCP or other Provider must call BCBSNM to obtain the Preauthorization for you.

Before seeking specialist services, **you need to be aware of Preauthorization requirements,** which are described in *Section 4: Preauthorizations.*

Important: If you choose to see a Physician for non-Emergency Care and find that you have received services needing Preauthorization - and did not get the authorization - benefits for the service may be denied. In such cases, **you will be responsible for the entire cost of the services** - even if you were not aware of the Preauthorization requirements.

Non-Emergency Hospital Admissions

This Plan will cover a Medically Necessary inpatient stay for a Covered Service if you are admitted to an HMO-Participating Provider Facility by your PCP or by an HMO-Participating Specialist. To be covered, you must obtain **Preauthorization** from BCBSNM **before** being admitted.

Selecting an HMO-Participating Provider

Check your Provider directory or visit the "Provider Finder®" section of the BCBSNM website (www.bcbsnm.com) for a list of HMO-Participating Providers. **Note:** Although Provider directories are current as of the date shown at the bottom of each page, they can change without notice. To verify a Provider's status or if you have any questions about how to use the directory, contact a BCBSNM Customer Service Advocate.

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

Nonparticipating Provider Services

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

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

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

Exceptions for Nonparticipating Providers

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

- may bill you for any amounts in excess of the BCBSNM Covered Charge, in addition to your Copayment; and
- is not responsible for obtaining any necessary approvals on your behalf; and
- may or may not file Claims for you.

Emergency Care

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

All follow-up care (which is no longer considered Emergency Care) must be preauthorized by BCBSNM in order to be covered.

Urgent Care

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

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

Ancillary Providers in a Hospital

When you are admitted to an HMO-Participating Provider Hospital or other HMO-participating treatment Facility and the Admission is covered under the Plan, you will receive benefits for services received during the Admission from a Nonparticipating Provider anesthesiologist, radiologist, and/or pathologist. These are the only three specialists that are covered under this provision.

Transition of Care

If your health care Provider leaves the BCBSNM Provider network (for reasons other than medical competence or professional behavior) or if you are a new Member and your Provider is not in the Provider network when you enroll, BCBSNM may authorize you to continue an ongoing course of treatment with the Provider for a transitional period of time of not less than 30 days. (If necessary and ordered by the treating Provider, BCBSNM may also authorize transitional care from other out-of-network Providers.) The period will be sufficient to permit coordinated transition planning consistent with your condition and needs. Special provisions may apply if the required transitional period exceeds 30 days. If you have entered the third trimester of pregnancy at the effective date of enrollment, the transitional period shall include post-partum care directly related to the delivery. Call the BCBSNM Customer Service department for details.

Out-of-Country Services

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

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

CALENDAR YEAR

A Calendar Year is a period of one year which begins on January 1 and ends on December 31 of the same year. The initial Calendar Year is from a Member's Effective Date of Coverage through December 31 of the same year, which may be less than 12 months.

BENEFIT LIMITS

There is no general lifetime maximum benefit under this Plan. However, certain services have separate benefit limits per Admission or per Calendar Year.

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

COST-SHARING FEATURES

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

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

COPAYMENTS

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

Other Fixed Dollar Copayments

Besides office visits, other services may also be subject to a fixed Copayment amount that may also require Coinsurance and a Deductible. See the *Summary of Benefits* for more information.

Drug Plan Copayment

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

DEDUCTIBLE

The Deductible is the amount of Covered Charges incurred by a Member that the Member must pay in a Calendar Year before this Plan begins to pay its percentage of that Member's Covered Charges incurred during that same Calendar Year. If the Deductible amount remains the same during the Calendar Year, the Member pays it only once each Calendar Year, and it applies to Covered Services received by that Member during that Calendar Year.

If the Calendar Year Deductible has been met while you are an Inpatient and the Admission continues into a new Calendar Year, no additional Deductible is applied to that Admission's Covered Services. However, all other Covered Services received during the new Calendar Year are subject to the Deductible for the new Calendar Year.

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

Individual Deductible

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

Family Deductible

For double or family coverage, with two enrolled Members, the Calendar Year Deductible requirement is fulfilled when both covered Members have each met their applicable individual Deductible, listed in the Summary of Benefits, during the Calendar Year. For Family coverage with three or more Members, the family Deductible

is met when three or more enrolled Members in aggregate have satisfied the total family Deductible, listed in the Summary of Benefits, during the Calendar Year.

Deductibles per Occurrence

The per Occurrence Deductibles below are charged in addition to your Calendar Year Deductible.

Inpatient Admission Deductible

Depending upon the Plan you chose, in addition to your Calendar Year Deductible, you may have an Inpatient Admission Deductible applicable to Covered Charges billed by a Hospital for Inpatient Services received during a Hospital stay. This Inpatient Admission Deductible applies each time you are admitted to a Hospital for Inpatient Services, including any Admissions occurring after formally being discharged from any previous hospitalization for treatment of the same condition. This Deductible is the amount of Covered Charges that you must pay, in addition to your Calendar Year Deductible, for Inpatient Services billed by a Hospital before this Plan begins to pay its percentage of Covered Charges billed by that Hospital for Inpatient Services you receive during that Hospital stay.

The following Inpatient Hospital/Facility services are subject to the Inpatient Admission Deductible: Medical/Surgical, Mental Health/Chemical Dependency (including Partial Hospitalization), Maternity Services (including Routine Nursery/Pediatrician Care for Covered Newborns) and covered Ancillaries. Please refer to your *Summary of Benefits* for additional information regarding cost-sharing.

Outpatient Surgery Deductible

Depending upon the Plan you chose, in addition to your Calendar Year Deductible, you may also have an Outpatient Surgery Deductible applicable to Covered Charges billed by a Facility for outpatient surgical services received. This Outpatient Surgery Deductible applies each time you are admitted to a Facility for outpatient surgical services. This Deductible is the amount of Covered Charges that you must pay, in addition to your Calendar Year Deductible, for outpatient surgical services billed by a Facility before this Plan begins to pay its percentage of Covered Charges billed by that Facility for outpatient surgical services you receive during that Facility stay.

Emergency Room Deductible

You may also have an Emergency Room (ER) Deductible. This ER Deductible is applicable to Covered Charges billed by a Hospital for emergency room services if you were not admitted to the Hospital for further treatment. This ER Deductible is the amount of Covered Charges that you must pay, in addition to your Calendar Year Deductible, for emergency room services. Should you be admitted, the Emergency Room Deductible is waived and you pay only the Calendar Year Deductible and if applicable, your Coinsurance.

What Is Subject to the Deductible

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

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

COINSURANCE

For most Covered Services, you must pay a percentage of Covered Charges (Coinsurance) after you have met your Calendar Year Deductible and, depending on your Plan, any Deductibles per Occurrence applicable according to the type of Covered Services received as specified on your *Summary of Benefits*. After your share has been calculated, this Plan pays the rest of the Covered Charge, up to maximum benefit limits, if any.

Drug Plan Coinsurance

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

OUT-OF-POCKET LIMIT

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

Individual Limit

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

Family Limits

For double or family coverage, with two enrolled Members, the annual Out-of-Pocket requirement is fulfilled when both covered Members have each met their respective individual Out-of-Pocket amount listed on the Summary of Benefits during the Calendar Year. For Family coverage with three or more Members, the family Out-of-Pocket is met when three or more enrolled Members in aggregate have satisfied the total family Out-of-Pocket amount listed on the Summary of Benefits during the Calendar Year.

What Is Included in the Out-of-Pocket Limits

The following amounts are applied to the out-of-pocket limits:

- fixed-dollar Copayments
- Coinsurance amounts
- Calendar Year Deductible
- Deductibles per Occurrence (Inpatient Admission Deductible, Outpatient Surgery Deductible, Emergency Room Deductible)
- *Drug Plan Rider* Copayments and/or Coinsurance amounts
- charges covered under your *Drug Plan Rider*

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

CHANGES TO THE COST-SHARING AMOUNTS

Copayments, Coinsurance percentage amounts, Deductibles, and Out-of-Pocket Limits are subject to change or increase as directed or permitted by law. If changes are made, the change applies only to services received after the change goes into effect (for Inpatient Services, benefits are determined based on the date you are admitted to the Facility). You will be notified if changes are made to this Plan. If any benefit changes result in a premium increase, you will be given 60 days' notice of such changes.

If your Group increases the Deductible or Out-of-Pocket Limit amounts during a Calendar Year, the new amounts must be met during the same Calendar Year. For example, if you have met your Deductible and your Group changes to a higher Deductible, you will not receive benefit payments for services received after the change went into effect until the increased Deductible is met.

If your Group decreases the Deductible or Out-of-Pocket Limit amounts, you will not receive a refund for amounts applied to the higher Deductible or Out-of-Pocket Limit.

SECTION 4: PREAUTHORIZATIONS

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

In order to receive benefits:

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

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

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

Please note:

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

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

Most preauthorization requests will be evaluated and you and/or the Provider notified of BCBSNM's decision **within 5 days** of receiving the request (**within 24 hours** for Urgent Care requests). If requested services are not approved, the notice will include: 1) the reasons for denial; 2) a reference to the health care plan provisions on which the denial is based; and 3) an explanation of how you may appeal the decision if you do not agree with the denial (see *Section 8: Claims Payments and Appeals*) and "If Your Preauthorization Request is Denied" later in this section).

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

How the Preauthorization Procedure Works

When you or your Provider call, BCBSNM's Health Services representative will ask for information about your medical condition, the proposed treatment plan, and the estimated length of stay (if you are being admitted). The Health Services representative will evaluate the information and notify the requesting Provider (usually at the time of the call) if benefits for the proposed hospitalization or other services are preauthorized. If the Admission or other services are not preauthorized, you may appeal the decision as explained in *Section 8: Claims Payments and Appeals* and in "If Your Preauthorization Request is Denied" later in this section).

SERVICES OF HMO-PARTICIPATING PROVIDERS

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

- when recommending any non-Emergency Admission, re-Admission, or transfer
- when a covered newborn stays in the Hospital longer than the mother
- before providing or recommending a service listed under "Other Preauthorizations," later in this section

- before recommending that you go to a Nonparticipating Provider for whose services you expect to receive benefits (Such requests may be denied.)

BCBSNM will advise you if a Preauthorization request is denied.

NONPARTICIPATING PROVIDERS OR PROVIDERS OUTSIDE THE NETWORK

Except in emergencies, BCBSNM must **preauthorize** a visit to a Nonparticipating Provider. If Preauthorization is not obtained **before** a visit to a Nonparticipating Provider, benefits will **not** be available for the services.

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

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

Most Preauthorizations may be requested over the telephone. If a *written* request is needed, have your Provider call a Health Services representative for instructions for filing a written request for Preauthorization. The Provider may call on your behalf, but it is **your responsibility** to ensure that BCBSNM is called when receiving out-of-network services.

If a Nonparticipating Provider or Provider Outside the Network Recommends Services

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

OTHER PREAUTHORIZATIONS

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

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

No Preauthorization Received	Claim Disposition: HMO Participating	Claim Disposition: Nonparticipating
Service is Medically Necessary	Claim is paid based on Member's benefit plan	Claim is paid based on Member's benefit plan
Service is **not** Medically Necessary	Claim is denied; Member is held harmless	Claim is denied; Member responsible for payment

- **air Ambulance** services (unless during a medical Emergency)
- Applied Behavioral Analysis (ABA)
- **Enteral Nutritional Products, Special Medical Foods,** and **certain drugs** covered under your Drug Plan Rider, if applicable to your Plan.
- **home infusion therapy (HIT),** excluding antibiotics

- certain **injections,** including but not limited to intravenous immunoglobulin (**IVIG**)
- Non-Emergency or **elective Hospital** or other Facility Admissions
- **Transplant procedures** including pre-Transplant evaluations

All services, including those for which Preauthorization is required, must meet the standards of Medical Necessity criteria described in *Section 5: Covered Services,* "Medically Necessary Services," and will not be covered, if excluded, for any reason. **Some services requiring Preauthorization may not be approved for payment** (for example, due to being Experimental, Investigational, Unproven, or not Medically Necessary). Services requiring Preauthorization are subject to review and change by BCBSNM.

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

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

Preauthorization of Mental Health/Chemical Dependency Services

All inpatient mental health and Chemical Dependency services must be preauthorized by the BCBSNM Behavioral Health Unit (BHU) at the phone number listed on the back of your ID Card. Preauthorization is also required for the following services for treatment of Mental Disorder and/or Chemical Dependency.

- outpatient psychological testing
- neuropsychological testing
- Intensive Outpatient Program (IOP) treatment
- electroconvulsive therapy (ECT)

Preauthorization is **not** required for group, individual, or family therapy outpatient office visits to a Physician or other Professional Provider licensed to perform Covered Services under this health plan.

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

If you or your Provider do not call for Preauthorization of non-Emergency **Inpatient Service**s, benefits for covered, Medically Necessary inpatient Facility care may be denied. If Inpatient Services received without Preauthorization are determined to be not Medically Necessary or not eligible for coverage under your Plan for any other reason, the Admission and all related services will be denied. In such cases, **you may be responsible for all charges.**

If preauthorization is **not** obtained before you receive psychological testing, IOP treatment, neuropsychological testing, or electroconvulsive therapy, your Claims may be denied as being **not Medically Necessary.** In such cases, **you may be responsible for all charges.** Therefore, you should make sure that you (or your Provider) have obtained preauthorization for Outpatient Services *before* you start treatment.

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

Summary of Contact Information for Preauthorization, Customer Service, Claim Submission, and Appeal (or Reconsideration) Processes for Medical/Surgical and Behavioral Health Services:			
Process:	**Type of Service:**	**Phone:**	**Send to:**
Request preauthorization	Medical/surgical	1-800-325-8334	BCBSNM, P.O. Box 27630, Albuquerque, NM 87125-7630
	Mental health/Chemical Dependency	1-888-898-0070	BH Unit, P.O. Box 27630, Albuquerque, NM 87125-7630
Customer Service Inquiry	Medical/surgical	1-800-432-0750	BCBSNM, P.O. Box 3235, Naperville, IL 60566-7235
	Mental health/Chemical Dependency	1-888-898-0070	BH Unit, P.O. Box 27630, Albuquerque, NM 87125-7630
Submit Claim (post-service)	Medical/surgical		BCBSNM, P.O. Box 3235, Naperville, IL 60566-7235
	Mental health/Chemical Dependency		Send Claim to BH Unit, P.O. Box 27630, Albuquerque, NM 87125-7630
Request **appeal** or reconsideration of **Claim** or **preauthorization** decision	Medical/surgical	1-800-205-9926	BCBSNM Appeals Unit, P.O. Box 27630, Albuquerque, NM 87125-9815
	Mental health/Chemical Dependency	1-888-898-0070	BCBSNM Appeals Unit, P.O. Box 27630, Albuquerque, NM 87125-9815
Grievance Assistance - Office of Superintendent of Insurance (OSI), Managed Health Care Bureau	Medical/surgical; Mental health/Chemical Dependency	1-855-427-5674	Office of Superintendent of Insurance; P.O. Box 1689, Santa Fe, NM 87504-1689

ADVANCE BENEFIT INFORMATION/PREDETERMINATION

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

UTILIZATION REVIEW/QUALITY MANAGEMENT

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

SECTION 5: COVERED SERVICES

This section describes the services and supplies covered by this health care plan, subject to the limitations and exclusions in *Section 3: How Your Plan Works* and *Section 6: General Limitations and Exclusions*. All payments are based on Covered Charges as determined by BCBSNM. **To be covered, services must be Medically Necessary or listed as a Covered Service below. If a service is not listed as a Covered Service below, it will be covered as long as that service is Medically Necessary and is not specifically excluded in this Benefit Booklet.** Services of a Nonparticipating Provider are covered only in an Emergency or if Preauthorization is given by BCBSNM.

MEDICALLY NECESSARY SERVICES

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

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

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

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

If Medicare is Primary

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

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

In order to receive benefits:

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

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

AMBULANCE SERVICES

This Plan covers Ambulance services in an Emergency (e.g., cardiac arrest, stroke). When you cannot be safely transported by any other means in a non-Emergency situation, this Plan also covers Medically Necessary Ambulance transportation to a Hospital with appropriate facilities, or from one Hospital to another.

Outside the Service Area

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

Air Ambulance

Ground Ambulance is usually the approved method of transportation. This Plan covers air Ambulance only when terrain, distance, or your physical condition requires the use of air Ambulance services or for high-risk Maternity and newborn transport to tertiary care facilities. To be covered, non-Emergency air Ambulance services require **Preauthorization** from BCBSNM.

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

Exclusions

This Plan does **not** cover:

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

AUTISM SPECTRUM DISORDERS

For a Member **19 years old or younger** (or, if enrolled in high school, 22 years old or younger), this Plan covers the Habilitative Treatment and rehabilitative treatment of Autism Spectrum Disorder through Speech Therapy, Occupational Therapy, Physical Therapy, and Applied Behavioral Analysis (ABA). Providers must be credentialed to provide such therapy.

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

Services not Preauthorized by BCBSNM must be performed in accordance with a treatment plan and must be Medically Necessary or benefits for such services will be denied. **Note:** Habilitative treatment is defined as treatment programs that are necessary to: 1) develop, 2) maintain, and 3) restore to the maximum extent practicable the functioning of an individual. All three conditions must be met in order to be considered habilitative.

Services are subject to usual Member cost-sharing features such as Deductible, Coinsurance, Copayments, and Out-of-Pocket Limits - based on place of treatment and type of service. All services are subject to the *General Limitations and Exclusions* except where explicitly mentioned as being an exception. This benefit is subject to the other general provisions of the health plan, including but not limited to: coordination of benefits, Participating Provider agreements, restrictions on Health Care Services, including review of Medical Necessity, case management, and other Managed Care provisions.

Regardless of the type of therapy received, Claims for services related to Autism Spectrum Disorder should be mailed to BCBSNM - **not** to the behavioral health services administrator.

Exclusions

This Plan does **not** cover:

- any Experimental, long-term, or maintenance treatments not required under state law unless listed above
- any services that are not Medically Necessary
- any services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children 3 to 22 years old who have Autism Spectrum Disorder
- services in accordance with a treatment plan that has not been preauthorized by BCBSNM
- respite services or care

- Sensory Integration Therapy (SIT) or Auditory Integration Therapy (AIT)
- music therapy, vision therapy, or touch or massage therapy
- floor time
- facilitated communication
- elimination diets; nutritional supplements; intravenous immune globulin infusion; secretin infusion
- chelation therapy
- hippotherapy, animal therapy, or art therapy

DENTAL-RELATED SERVICES AND ORAL SURGERY

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

Dental and Facial Accidents

Benefits for Covered Services for the treatment of Accidental Injuries to the jaw, mouth, face or Sound Natural Teeth are generally subject to the same limitations, exclusions and Member cost-sharing provisions that would apply to similar services when not dental-related (e.g., x-rays, Medical Supplies, Surgical Services).

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

Facility Charges and General Anesthesia for Dental-Related Services

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

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

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

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

Oral Surgery

This Plan covers the following oral surgical procedures only:

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

- lingual frenectomy
- removal or biopsy of tumors or cysts of the jaws, cheeks, lips, tongue, roof or floor of mouth when pathological examination is required
- removal of exostoses or bony impacted teeth

TMJ/CMJ Services

This Plan covers standard diagnostic, therapeutic, surgical and nonsurgical treatments of temporomandibular joint (TMJ)/craniomandibular joint (CMJ) disorders or Accidental Injuries. Treatment may include orthodontic Appliances and treatment, crowns, bridges, or dentures **only if** required because of an Accidental Injury to Sound Natural Teeth involving the temporomandibular/craniomandibular joint.

Exclusions

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

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

DIABETIC SERVICES

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

Diabetes Self-Management Education

This Plan covers diabetes self-management training including if you have elevated blood glucose levels induced by pregnancy. Training must be prescribed by a health care Provider and given by a certified, registered, or licensed health care professional with recent education in diabetes management. Covered Services are limited to:

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

Diabetic Supplies and Equipment

This Plan covers the following supplies and equipment for diabetic Members and individuals with elevated glucose levels due to pregnancy (supplies are not to exceed a **30-day supply** purchased during any 30-day period):

- injection aids, including those adaptable to meet the needs of the legally blind
- insulin pumps and insulin pump supplies
- blood glucose monitors, including those for the legally blind
- Medically Necessary podiatric Appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices, and shoe modifications

Reminder: See your *Drug Plan Rider* for additional diabetic supply coverage of the following supplies: insulin; insulin needle and syringes; visual reading urine and ketone strips; lancets and lancet devices; prescriptive oral agents for controlling blood sugar levels; test strips for glucose monitors, and glucagon Emergency kits.

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

EMERGENCY CARE AND URGENT CARE

Acute medical Emergency Care is available 24 hours per day, 7 days a week. If services are received in an Emergency room or other trauma center, the condition must meet the definition of an "Emergency" in order to be covered.

Emergency Care

This Plan covers medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to his/her health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part, or disfigurement. (In addition, services must be received in an Emergency room, trauma center, or Ambulance to qualify as an Emergency.) Examples of Emergency conditions include, but are not limited to: heart attack or suspected heart attack, coma, loss of respiration, stroke, acute appendicitis, severe allergic reaction, or poisoning.

Emergency Room and Ambulance Services

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

You do not need BCBSNM authorization before seeking **Emergency room or Emergency Ambulance** services from either an HMO-Participating or a Nonparticipating Provider. **Nonparticipating Provider care received without a Preauthorization in any other setting (e.g., Physician's office or Urgent Care center) will not be covered.** (See *Section 4: Preauthorizations* for more information about Preauthorization requirements.) Emergency room and Ambulance services for a condition that meets the definition of "Emergency Care" will be covered within the limits of the health care plan. Services for conditions that do *not* meet the definition of "Emergency Care" and have not been preauthorized will **not** be covered.

What to Do

In an Emergency:

- If cardiopulmonary resuscitation (CPR) is necessary or if there is an immediate threat to life or limb, **call 911.**
- If you do not call 911, and you are:

- In the Network Service Area (i.e., New Mexico): **Either call your PCP** or **go directly to an HMO-participating Hospital.** If due to the severity of the medical problem, you are unable to reach an HMO-participating Hospital, **go to the nearest medical Facility or trauma center.**

Emergency Notification

You do not need BCBSNM authorization before seeking **Emergency room** services or being hospitalized as an inpatient from the Emergency room for Emergency Care. However, you should call BCBSNM for Preauthorization of Nonparticipating Provider Facility services or in order to notify BCBSNM of any Emergency inpatient Admission as soon as reasonably possible. Such services, when received without Preauthorization, may be reviewed for Medical Necessity/appropriateness and you may be responsible for all charges.

Follow-Up Care

Once you are discharged from the Emergency room or inpatient setting, follow-up care from a Nonparticipating Provider **must** be preauthorized by BCBSNM in order to be covered. You should notify your PCP and/or BCBSNM as soon as possible after receiving the Emergency room care or of being admitted as an inpatient in order to arrange for follow-up care.

Filing Claims for Services of a Nonparticipating Provider

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

Member Deductible

If you are directly admitted as an inpatient, the Emergency Room Deductible, if any, for Emergency room services is waived. The inpatient Hospital benefit will apply in such cases.

Urgent Care

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

Urgent Care Center Copayments or Coinsurance

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

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

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

Exclusions

This Plan does **not** cover:

- the follow-up care received outside the Network Service Area as a result of an Emergency or an urgent condition, if you could have returned to the Network Service Area to receive care without medically harmful results
- services received outside the Network Service Area if you could have foreseen the need for this care before leaving the Network Service Area
- Urgent Care or follow-up care received from a Nonparticipating Provider if it is not authorized in advance by BCBSNM.

RETAIL HEALTH CLINIC CARE

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

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

HEARING AIDS/RELATED SERVICES FOR CHILDREN UP TO AGE 21

This Plan covers the cost of hearing aids, the fitting and dispensing fees for hearing aids and ear molds for Members up to 21 years old.

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

HOME HEALTH CARE/HOME I.V. SERVICES

Conditions and Limitations of Coverage

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

Preauthorization Required

Before you receive home I.V. therapy, your Physician or Home Health Care Agency must obtain **Preauthorization** from BCBSNM. **This Plan does not cover home I.V. services without Preauthorization.**

Covered Services

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

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

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

Exclusions

This Plan does **not** cover:

- care provided primarily for your or your family's convenience
- homemaking services or care that consists mostly of bathing, feeding, exercising, preparing meals for, moving, giving medications to, or acting as a sitter for the patient
- services provided by a nurse who ordinarily resides in your home or is a Member of your immediate family
- private duty nursing

HOSPICE CARE SERVICES

Conditions and Limitations

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

Covered Services

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

- visits from Hospice Physicians
- Skilled Nursing Care by a Registered Nurse or Licensed Practical Nurse
- physical and Occupational Therapy by licensed or certified physical or Occupational Therapists
- Speech Therapy provided by an American Speech and Hearing Association certified therapist
- Medical Supplies
- drugs and medications for the Terminally Ill Patient
- medical social services provided by a qualified individual with a degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training and experience (Such services must be recommended by a Physician to help the Member or his/her family deal with a specified medical condition.)
- services of a home health aide under the supervision of a Registered Nurse and in conjunction with Skilled Nursing Care
- nutritional guidance and support, such as intravenous feeding and hyperalimentation
- respite care for a period **not to exceed five continuous days** for **every 60 days** of Hospice Care and **no more than two respite care periods** during each Hospice Benefit Period (*Respite care* provides a brief break from total care-giving by the family.)

Exclusions

This Plan does **not** cover:

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

- supportive services provided to the family of a Terminally Ill Patient when the patient is not a Member of this Plan
- care or services received after the Member's coverage terminates

HOSPITAL/OTHER FACILITY SERVICES

Blood Services

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

Inpatient Services

Preauthorization Required

To be covered, **Preauthorization** from BCBSNM must be received for all inpatient Admissions. Also, Nonparticipating Provider Facility services are covered only for **Emergency Care** or if **Preauthorization** for such services is received from BCBSNM. (You may be required to travel to another city to receive services from an HMO- Participating Provider Facility.)

Covered Services

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

Medical Detoxification

This Plan also covers Medically Necessary services related to Medical Detoxification from the effects of Alcohol or Drug Abuse. Detoxification is the treatment in an acute care Facility for withdrawal from the physiological effects of Alcohol or Drug Abuse, which usually takes about three days in an acute care Facility. Benefits for detoxification services are the same as for any other acute medical/surgical condition. Preauthorization is required for all inpatient hospitalizations. See "Psychotherapy (Mental Health and Chemical Dependency)" for information about benefits for Chemical Dependency rehabilitation.

Exclusions

This Plan does **not** cover:

- transplants or related services when transplant received at a facility that does not contract directly with a BCBSNM participating provider or through a BCBS transplant network. (See "Transplant Services" for more information.)
- Admissions related to non- Covered Services or procedures
- Custodial Care Facility Admissions

Outpatient or Observation Services

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

LAB, X-RAY, OTHER DIAGNOSTIC SERVICES

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

- x-ray and radiology services, ultrasound, and imaging studies
- laboratory and pathology tests
- EKG, EEG, and other electronic diagnostic medical procedures
- genetic testing (Tests such as amniocentesis or ultrasound to determine the gender of an unborn child are not covered.)

- infertility-related testing
- PET (Positron Emission Tomography) scans, cardiac CT scans
- MRIs
- psychological or neuropsychological testing
- audiometric (hearing) and vision tests for the diagnosis and/or treatment of an Accidental Injury or an illness

Note: All services, including those for which Preauthorization is required, must meet the standards of Medical Necessity criteria established by BCBSNM and will not be covered if excluded for any reason under this Plan. The Medical Necessity requirements do not apply to mandated benefits, unless permitted by law.

MATERNITY/REPRODUCTIVE SERVICES AND NEWBORN CARE

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

Family Planning and Infertility-Related Services

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

Family Planning

Covered family planning services include:

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

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

- over-the-counter female contraceptive devices with a written prescription by a health care Provider
- FDA-approved contraceptive drugs and devices listed on the *contraceptive drugs and devices list* posted to the BCBSNM website (http://bcbsnm.com/affordable_care_act/provisions.html), or available by contacting your Customer Service Advocate at the toll-free number on your ID-Card.
- outpatient contraceptive services such as consultations, examinations, procedures (including follow-up care for trouble you may have from using a birth control method that a family planning Provider gave you) and medical services provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy
- female surgical sterilization procedures (other than hysterectomy), including tubal ligations

When obtaining the items noted above, you may be required to pay the full cost and then submit a Claim form with itemized receipts to BCBSNM for reimbursement. Please refer to the **CLAIM PAYMENTS AND APPEALS** section of your Benefit Booklet for information regarding submitting Claims.

Infertility-Related Services

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

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

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

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

Exclusions

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

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

Pregnancy-Related/Maternity Services

Like any other service, Maternity care must be received from a PCP or other women's health care HMO-Participating Provider. Therefore, once your pregnancy is confirmed, you may choose either your PCP or another women's health care HMO-Participating Provider to provide Maternity care and receive benefits for Covered Services. The Provider is then responsible for notifying BCBSNM of any Admissions. If you are pregnant, you or your Physician should call BCBSNM for Admission notification before your Maternity due date, soon after your pregnancy is confirmed. BCBSNM must be notified if the mother's stay is greater than **48 hours** for a routine delivery or greater than **96 hours** for a C-section delivery as soon as possible. If not notified, benefits for covered Facility services may be **denied**. (If you are out-of-area and need Emergency services, also notify BCBSNM, your PCP, or HMO-Participating Provider **within 48 hours** or as soon as possible.)

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

If you are pregnant on the date you enroll in the BCBSNM-administered Managed Care Medical Plan and you are already seeing a Provider, please call Customer Service so that BCBSNM can approve your visits to the Provider if he/she is outside the HMO-Participating Provider network. If you are in your first or second trimester, in most cases you will be allowed to continue your care with that doctor for at least 30 days. If you are six or more months pregnant, you can continue seeing your doctor for the rest of your pregnancy.

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

Covered Services

Covered Pregnancy-Related Services include:

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

- routine or complicated delivery, including prenatal and postnatal medical care of an Obstetrician, Certified Nurse-Midwife or Licensed Midwife (Expenses for prenatal and postnatal care are included in the total Covered Charge for the actual delivery or completion of pregnancy. **Note:** Home births are not covered unless the Provider has an HMO- Participating Provider contract with his/her local BCBS Plan and is credentialed to provide the service.
- pregnancy-related diagnostic tests, including genetic testing or counseling if **preauthorized** by BCBSNM (Services must be sought due to a family history of a gender-linked genetic disorder or to diagnose a possible congenital defect caused by a present, external factor that increases risk, such as advanced maternal age or Alcohol Abuse. For example, tests such as amniocentesis or ultrasound to determine the gender of an unborn child are **not** covered.) See *Section 4: Preauthorizations* for more information about Preauthorization requirements.
- necessary anesthesia services by a Provider qualified to perform such services, including Acupuncture used as an anesthetic during a covered surgical procedure and administered by a Physician, a licensed Doctor of Oriental Medicine, or other practitioner as required by law
- when necessary to protect the life of the infant or mother, coverage for transportation, including air transport, for the medically high-risk pregnant woman with an impending delivery of a potentially viable infant to the nearest available Tertiary Care Facility for newly born infants
- services of a Physician who actively assists the operating surgeon in performing a covered surgical procedure when the procedure requires an assistant
- spontaneous, or therapeutic termination of pregnancy prior to full term (Copayment or Coinsurance will be based on the place of treatment at the time of pregnancy termination.)
- termination of pregnancy prior to full term for rape, incest, or life endangerment (Copayment or Coinsurance will be based on the place of treatment at the time of pregnancy termination.)

This Plan does **not** cover care for planned deliveries or planned C- sections outside the BCBSNM Network Service Area, unless you made a reasonable effort to be in the Network Service Area during the six weeks preceding your anticipated delivery date or your PCP arranges out- of- area care for you by obtaining **Preauthorization** from BCBSNM (which will direct you to a Contracted Provider in the area you will be visiting). See *Section 4: Preauthorizations* for more information about Preauthorization requirements.

Newborn Care

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

Newborn Eligibility

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

Routine Newborn Care

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

Covered Services

Covered Services for initial Routine Newborn Care include:

- routine Hospital nursery services, including alpha-fetoprotein IV screening
- routine medical care in the Hospital after delivery

- pediatrician standby care at a C-section procedure
- services related to circumcision of a male newborn

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

Extended Stay Newborn Care

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

If the pediatrician is a Nonparticipating Provider or you are in a Nonparticipating Provider Hospital and services are eligible for coverage, you must ensure that BCBSNM is called **before** the mother is discharged from the Hospital. If you do not, benefits for the newborn's covered Facility services will be paid at the Nonparticipating Provider benefit level. The baby's services will be subject to a separate Deductible(s), Copayment and/or Coinsurance and Out-of-Pocket Limit.

PHYSICIAN VISITS/MEDICAL CARE

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

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

Office Visits and Consultations

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

Allergy Care

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

Breastfeeding Support and Services

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

Genetic Inborn Errors of Metabolism

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

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

Special Medical Foods

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

Injections and Injectable Drugs

This Plan covers most FDA-approved therapeutic injections administered in a Provider's office. However, this Plan covers some injectable drugs only when **Preauthorization** is received from BCBSNM. Your BCBSNM-Contracted Provider has a list of those injectable drugs that require Preauthorization. If you need a copy of the list, call a BCBSNM Customer Service Advocate. (When you request Preauthorization, you may be directed to purchase the self-injectable medication through your drug plan.)

BCBSNM and the Plan reserves the right to exclude any injectable drug currently being used by a Member. Proposed new uses for injectable drugs previously approved by the FDA will be evaluated on a medication-by-medication basis. Note: Certain drugs that have not been FDA-approved could be excluded. Call a BCBSNM Customer Service Advocate if you have any questions about this policy.

Mental Health Evaluation Services

This Plan covers medication checks and intake evaluations for Mental Disorders, Alcohol, and Drug Abuse.

Inpatient Medical Visits

With the exception of Dental-Related Services (see "Dental-Related Services and Oral Surgery"), this Plan covers the following services when received on a covered inpatient Hospital day:

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

PREVENTIVE SERVICES

The services listed under this provision are not limited as to the number of times you may receive the service in any given period or as to the age of the patient (except when a service is inappropriate for the patient's age group, such as providing a pediatric immunization to an adult). You and your Physician are encouraged to determine how often and at what time you should receive preventive tests and examinations and you will receive coverage according to the benefits and limitations of your health care plan.

This Plan covers the following Preventive Services, not subject to Coinsurance, Deductible, Copayment, or benefit maximums when received from an In-network Provider (out-of-network services are subject to the usual out-of-network Deductible, Coinsurance, and Out-of-Pocket Limit):

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

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

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

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

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

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

Covered Preventive Services **not** described in items "a" through "d" above may be subject to Deductibles, Coinsurance, Copayments, and/or dollar maximums. Allergy injections are **not** considered immunizations under the "Preventive Services" benefit. If a recommendation or guideline for a particular preventive health service does not specify the frequency, method, treatment, or setting in which it must be provided, BCBSNM may use reasonable medical management techniques to apply coverage. If a covered preventive health service is provided during an office visit and is billed separately from the office visit, you may be responsible for any applicable Deductible, Coinsurance, Copayments, for the office visit only. If an office visit and the preventive health service are not billed separately and the primary purpose of the visit was not the preventive health service, you may be responsible for any applicable Deductible, Coinsurance, Copayments, for the office visit, including the preventive health service.

Examples of Covered Services include, but are not limited to:

- routine physical, breast, and pelvic examinations
- routine adult and pediatric immunizations
- an annual routine gynecological or pelvic examination and low-dose mammogram screenings
- one baseline mammogram to women age thirty-five (35) through thirty-nine (39); one mammogram biannually to women age forty (40) through forty-nine (49); and one mammogram annually to women age fifty (50) or older
- papilloma virus screening and Cytologic Screening (a Pap test or liquid-based cervical cytopathology) to determine the presence of precancerous or cancerous conditions and other health problems (These tests are available for women age thirteen and older; and for women who are at risk for cancer, or at risk for other health conditions that can be identified through a Cytologic Screening.)
- human papillomavirus vaccine (HPV) for Members ages 9 - 26 years old
- periodic blood hemoglobin, blood pressure and blood glucose level tests
- periodic colorectal screening tests
- periodic blood cholesterol or periodic fractionated cholesterol level including a low-density lipoprotein (LDL) and a high-density lipoprotein (HDL) level; periodic stool examination for the presence of blood
- periodic left-sided colon examination of 35 to 60 centimeters or colonoscopy
- Well-Child Care, including well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorder (This routine service is not limited by the annual and lifetime maximum benefits for Applied Behavioral Analysis; see "Autism Spectrum Disorders" for additional Covered Services.)
- periodic glaucoma eye tests
- vision and hearing screenings in order to detect the need for additional vision or hearing testing for Members when received as part of a routine physical examination (A screening does *not* include an eye examination, refraction or other test to determine the amount and kind of correction needed.)
- health education and counseling services if recommended by your Physician, including an annual consultation to discuss lifestyle behaviors that promote health and well-being, including smoking/tobacco use Cessation Counseling and obesity screening and counseling

Exclusions

This Plan does **not** cover:

- employment physicals, insurance examinations, or examinations at the request of a third party (the requesting party may be responsible for payment); premarital examinations; sports or camp physicals; any other nonpreventive physical examination
- hepatitis B immunizations when required due to possible exposure during the Member's work

- routine eye examinations; eye refractions; or any related service or supply
- routine hearing examinations; hearing aids; or any related service or supply, unless otherwise specified in this section

NOTE: Routine screening mammography does **not** include "diagnostic mammography" which is a mammogram done after an abnormal finding has first been detected, or screening the opposite breast when the other breast has cancer. Routine colonoscopy does **not** include colonoscopy done for follow- - up of colon cancer. A colonoscopy is still considered screening if, during the colonoscopy, **previously unknown** polyps were removed. Colonoscopies performed to remove **known** polyps are not routine screening colonoscopies. Routine screening colonoscopy does not include upper endoscopy (esophagogastroduodenal endoscopy), sigmoidoscopy, or computerized tomographic colongraphy (sometimes referred to as "virtual colonoscopy").

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

www.bcbsnm.com/health/know_your_numbers

PSYCHOTHERAPY (MENTAL HEALTH AND CHEMICAL DEPENDENCY)

Note: You do not receive a separate mental health/Chemical Dependency ID Card; use your BCBSNM ID Card to receive all medical/surgical and mental health/Chemical Dependency services covered under this Plan.

Medical Necessity

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

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

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

Preauthorization Requirements

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

In order to receive benefits:

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

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

Services Requiring Preauthorization

All inpatient mental health and Chemical Dependency services must be Preauthorized by the Behavioral Health Unit at the phone number listed on the back of your ID card. Preauthorization is also required for the following outpatient services for treatment of mental illness and/or Chemical Dependency:

- outpatient psychological testing

- neuropsychological testing
- Intensive Outpatient Program (IOP) treatment
- electroconvulsive therapy (ECT)
- repetitive transcranial magnetic stimulation

You or your Physician should call the Behavioral Health Unit **before** you schedule treatment. If you do not call before receiving non-Emergency services, **benefits for Covered Services may be reduced or denied** as explained in the *Preauthorizations* section, earlier. In such cases, you may be responsible for all charges, so please ensure that you or your Provider have received Preauthorization for any services you plan to receive. The BHU Call Center is open 24/7 to assist Members and Providers with Emergency admission inquiries and to respond to crisis calls.

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

Preauthorization is **not** required for group, individual, or family therapy office visits to a Physician or other Professional Provider licensed to perform Covered Services under this Plan.

Covered Services/Providers

Covered Services include solution-focused evaluative and therapeutic mental health services (including individual and group psychotherapy) received in a Psychiatric Hospital, an IOP (Intensive Outpatient Program), or an alcoholism treatment program that complies with applicable state laws and regulations, and services rendered by psychiatrists, licensed psychologists, and Other Providers as defined in *Section 10: Definitions*. Mental Disorders that respond to and require long-term treatment with medications and/or therapeutic treatment including schizophrenia, bi-polar disorder, and chronic depression are also covered.

Residential Treatment Centers

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

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

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

Exclusions

This Plan does **not** cover:

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

- hospitalization or admission to a Skilled Nursing Facility (SNF), nursing home, or other Facility for the primary purposes of providing Custodial Care service, convalescent care, rest cures, or domiciliary care to the patient
- services or supplies received during an Inpatient stay when the stay is solely related to behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness. Note: This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- any care that is patient-elected and is not considered Medically Necessary
- care that is mandated by court order or as a legal alternative, and lacks clinical necessity as diagnosed by a licensed Provider; services rendered as a condition of parole or probation
- special education, school testing and evaluations, counseling, therapy, or care for learning deficiencies or educational and developmental disorders; behavioral problems unless associated with manifest Mental Disorders or other disturbances
- non-national standard therapies, including those that are Experimental as determined by the mental health professional practice
- the cost of any damages to a treatment Facility

REHABILITATION AND OTHER THERAPY

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

Acupuncture and Chiropractic Services

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

Cardiac and Pulmonary Rehabilitation

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

Chemotherapy and Radiation Therapy

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

Cancer Clinical Trials

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

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

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

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

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

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

Dialysis

This Plan covers the following services:

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

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

Preauthorization Required

To be covered, all inpatient short-term rehabilitation treatments, including Skilled Nursing Facility and physical rehabilitation Facility Admissions, must receive **Preauthorization** from BCBSNM.

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

Covered Services

This Plan covers the following short-term rehabilitation services for the Medically Necessary treatment of Accidental Injury or illness:

- Occupational Therapy performed by a licensed Occupational Therapist
- Physical Therapy performed by a Physician, licensed Physical Therapist, or other Professional Provider licensed as a Physical Therapist (such as a Doctor of Oriental Medicine)
- Speech Therapy, including audio diagnostic testing, performed by a properly accredited Speech Therapist for the treatment of communication impairment or swallowing disorders caused by disease, trauma, congenital anomaly, or a previous treatment or therapy
- inpatient physical rehabilitation and Skilled Nursing Facility services when **preauthorized** by BCBSNM

Benefit Limits

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

Exclusions

This Plan does **not** cover:

- maintenance therapy or care provided after you have reached your rehabilitative potential except as required under New Mexico State law.
- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay, except as required by law and described in this *Covered Services* section under "Autism Spectrum Disorders"
- services provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered Provider
- therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights)
- private room expenses unless your medical condition requires isolation for protection from exposure to bacteria and diseases (e.g., severe burns or conditions that require isolation according to public health laws)
- Speech Therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic; other speech services that can be carried out by the patient, the family, or caregiver/teacher
- herbs, homeopathic preparations, or nutritional supplements
- services of a massage therapist or rolfing

SUPPLIES, EQUIPMENT AND PROSTHETICS

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

To be covered, items must be Medically Necessary and ordered by a health care Provider. If you have a question about Durable Medical Equipment, Medical Supplies, Prosthetics or Appliances not listed, please call the BCBSNM Health Services Department.

Breast Pumps

This Plan covers the rental (but not to exceed the total cost) or, at its option, the purchase, of manual, electric and Hospital-grade breast pumps and supplies with a written prescription from a health care Provider. The rental or purchase cost of manual, electric or Hospital-grade breast pumps and supplies is not subject to Coinsurance, Deductible, Copayment, or benefit maximums when received from an HMO-Participating Provider.

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

Durable Medical Equipment and Appliances

This Plan covers the following item**:**

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

placement is covered only if a Physician or Optometrist recommends a change in prescription due to a change in your medical condition.)

- cardiac pacemakers

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

Medical Supplies

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

- colostomy bags, catheters
- gastrostomy tubes
- hollister supplies
- tracheostomy kits, masks
- lamb's wool or sheepskin pads
- ace bandages, elastic supports when billed by a Physician or other Provider during a covered office visit
- slings
- support hose prescribed by a Physician for treatment of varicose veins (6 pairs per Calendar Year)..

Orthotics and Prosthetic Devices

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

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

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

Exclusions

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

- air conditioners, biofeedback equipment, humidifiers, purifiers, self-help devices, or whirlpools
- items that are primarily nonmedical in nature such as Jacuzzi units, hot tubs, exercise equipment, heating pads, hot water bottles, or diapers
- nonstandard or deluxe equipment, such as motor-driven wheelchairs, chairlifts or beds; external Prosthetics that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing
- repairs to items that you do not own

- comfort items such as bedboards, beds or mattresses of any kind, bathtub lifts, overbed tables, or telephone arms
- repair or rental costs that exceeds the purchase price of a new unit
- dental Appliances
- accommodative orthotics (deal with structural abnormalities of the foot, accommodate such abnormalities, and provide comfort, but do not alter function)
- orthopedic shoes, unless joined to braces (Diabetic Members should refer to "Diabetic Supplies and Equipment" earlier in this section for information about covered podiatric equipment and orthopedic shoes.)
- equipment or supplies not ordered by a health care Provider, including items used for comfort, convenience, or personal hygiene
- duplicate items; repairs to duplicate items; or the replacement of items because of loss, theft, or destruction
- stethoscopes or blood pressure monitors
- voice synthesizers or other communication devices
- eyeglasses or contact lenses or the costs related to prescribing or fitting of glasses or contact lenses, unless listed as covered; sunglasses, special tints, or other extra features for eyeglasses or contact lenses
- hearing aids or ear molds, fitting of hearing aids or ear molds, or related services or supplies for persons 21 or older
- syringes or needles for self-administering drugs (Coverage for insulin needles and syringes and other diabetic supplies not listed as covered in this section is described under your separately issued *Drug Plan Rider.*
- items that can be purchased over-the-counter, including but not limited to dressings for wounds (i.e., bed sores) and burns, gauze, and bandages
- male contraceptive devices, including over-the-counter contraceptive products such as condoms; female contraceptive devices, including over-the-counter contraceptive products such as spermicide, when not prescribed by a health care Provider
- items not listed as covered

SURGERY AND RELATED SERVICES

To be covered, Preauthorization from BCBSNM must be received for all inpatient surgical procedures.

Surgeon's Services

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

Cochlear Implants

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

Mastectomy Services

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

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

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

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

Obesity (Bariatric) Surgery

Surgical treatment of Morbid Obesity is covered only if it is Medically Necessary and Preauthorization has been obtained from BCBSNM before treatment begins. There is a lifetime limit of one surgical procedure for the treatment of Morbid Obesity.

Reconstructive Surgery

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

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

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

Exclusions

This Plan does **not** cover:

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

Anesthesia Services

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

Exclusions

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

Assistant Surgeon Services

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

Exclusions

This Plan does **not** cover:

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

TRANSPLANT SERVICES

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

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

Facility Must Be in Transplant Network

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

Effect of Medicare Eligibility on Coverage

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

Organ Procurement or Donor Expenses

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

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

Bone Marrow, Cornea or Kidney

This Plan covers the following Transplant procedures if **Preauthorization** is received from BCBSNM:

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

Cost-Sharing Provisions

Covered Services related to the above Transplants are subject to the usual cost-sharing features and benefit limits of this Plan (e.g., Deductible, Coinsurance, Copayments and Out-of-Pocket Limits; and annual home health care maximums).

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

This Plan covers Transplant-Related Services for a **heart, heart-lung, liver, lung or pancreas-kidney** Transplant. Services must be **preauthorized** in order to be covered. All other limitations, requirements, and exclusions of this "Transplant Services" provision apply to these Transplant-Related Services.

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

Recipient Travel and Per Diem Expenses

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

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

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

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

Transplant Exclusions

This Plan does **not** cover:

- Transplant-Related Services for a Transplant that did not receive **Preauthorization** from BCBSNM
- any Transplant or organ-combination Transplant not listed as covered
- implantation of artificial organs or devices (mechanical heart, unless covered under BCBSNM Medical Necessity Guidelines)
- nonhuman organ Transplants
- care for complications of noncovered Transplants or follow-up care related to such Transplants
- services related to a transplant performed in a Facility not contracted directly or indirectly with BCBSNM to provide the required transplant (except cornea, kidney, or bone marrow)
- expenses incurred by a Member of this plan for the donation of an organ to another person
- drugs that are self-administered or for use while at home unless specifically covered under this Plan
- donor expenses after the donor has been discharged from the Transplant Facility
- lodging expenses in excess of the per diem allowance, if available, and food, beverage, or meal expenses
- travel or per diem expenses:
  - incurred **more than five days before** or **more than one year following** the date of transplantation
  - if the recipient's case manager indicates that travel is not Medically Necessary
  - related to a kidney Transplant (unless services are not reasonably available within your community without travel)
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; telephone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)

- expenses charged only because benefits are available under this provision (such as transportation received from a member of your family, or from any other person charging for transportation that does not ordinarily do so)

SECTION 6: GENERAL LIMITATIONS AND EXCLUSIONS

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

Before Effective Date of Coverage

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

Biofeedback

This Plan does not cover services related to biofeedback.

Blood Services

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

Complications of Non-Covered Services

This Plan does not cover any services, treatments, or procedures required as the result of complications of a non-Covered Service, treatment, or procedure (e.g., due to a noncovered sex change operation, Cosmetic surgery, or Experimental procedure).

Convalescent Care or Rest Cures

This Plan does not cover convalescent care or rest cures.

Cosmetic Services

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

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

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

Custodial Care

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

Dental-Related Services and Oral Surgery

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

Domiciliary Care

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

Duplicate (Double) Coverage

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

Duplicate Testing

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

Experimental, Investigational, or Unproven Services

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

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

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

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

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

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

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

Food or Lodging Expenses

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

Genetic Testing or Counseling

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

Hair Loss Treatments

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

Hearing Examinations, Procedures and Aids

This Plan does not cover audiometric (hearing) tests **unless** 1) required for the diagnosis and/or treatment of an Accidental Injury or an illness, or 2) covered as a preventive *screening* service (a preventive screening does *not* include a hearing test to determine the amount and kind of correction needed), or 3) covered as part of the hearing aid benefit for Members up to age 21 and described under "Hearing Aids/Related Services for Children Up To Age 21" in *Section 5: Covered Services.* **This Plan does not cover** hearing aids or ear molds, fitting of hearing aids or ear molds, or any related service or supply for **Members age 21 and older.** For **Members up to age 21**, see "Hearing Aids/Related Services for Children Up To Age 21" in *Section 5.*

Home Health, Home I.V. and Hospice Services

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

Hypnotherapy

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

Infertility Services/Artificial Conception

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

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

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

Late Claim Filing

This Plan does not cover services of a Nonparticipating Provider if the Claim for such services is received by BCBSNM **more than 12 months** after the date of service. (HMO- Participating Providers contracting directly

with BCBSNM and Providers that have a "participating" Provider agreement with BCBSNM will file Claims for you and must submit them within a specified period of time, usually 180 days.) If a Claim is returned for further information, resubmit it **within 45 days. Note:** If there is a change in the Claims Administrator, the length of the timely filing period may also change.

Learning Deficiencies/Behavioral Problems

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

Limited Services/Covered Charges

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

Local Anesthesia

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

Long-Term and Maintenance Therapy

This Plan does not cover long-term therapy whether for physical or for mental conditions, even if Medically Necessary and even if any applicable benefit maximum has not yet been reached, except that medication management for chronic conditions is covered. Therapies are considered long-term if measurable improvement is not possible **within two months** of beginning therapy. Long- term therapy includes treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Treatment of chronic conditions is not covered. (Chronic conditions include, but are not limited to, muscular dystrophy, Down's syndrome, and cerebral palsy.) **Note:** This exclusion does **not** apply to benefits for medication or medication management or to certain services required to be covered under New Mexico state law for children with Autism Spectrum Disorders.

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

Medical Necessity Guidelines Determinations

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

Medical Tourism

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

Medically Unnecessary Services

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

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

No Legal Payment Obligation

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

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

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

Noncovered Providers of Service

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

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

Nonmedical Expenses

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

- adoption or surrogate expenses
- educational programs such as behavior modification, cardiac classes that are received outside of a covered Cardiac Rehabilitation session, or arthritis classes
- vocational or training services and supplies
- mailing and/or shipping and handling

- missed appointments; “get-acquainted” visits without physical assessment or medical care; telephone consultations; charges for medical records furnished by your Provider; filling out of Claim forms; copies of medical records; interest expenses
- modifications to home, vehicle, or workplace to accommodate medical conditions; voice synthesizers; other communication devices
- membership at spas, health clubs, or other such facilities
- personal convenience items such as air conditioners, humidifiers, exercise equipment, or personal services such as haircuts, shampoos, guest meals, and television rentals, Internet services
- personal comfort services, including homemaker and housekeeping services, except in association with respite care covered during a Hospice Admission
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; phone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- physicals or screening examinations and immunizations given primarily for insurance, licensing, employment, camp, medical research programs, sports, or for any nonpreventive purpose
- hepatitis B immunizations when required due to possible exposure during the Member’s work
- court- or police-ordered services unless the services would otherwise be covered or services rendered as a condition of parole or probation
- the cost of any damages to a treatment Facility that are caused by the Member

Nonparticipating Provider Services

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

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

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

Members who extend coverage under an extension of benefits due to disability after the Group Administration Document is terminated are not eligible to receive Preauthorization for services of a Nonparticipating Provider. Services of a Nonparticipating Provider are not covered in such instances of extended coverage.

Nonprescription Drugs

This Plan does not cover nonprescription or over-the-counter drugs, medications, ointments, or creams, including herbal or homeopathic preparations, or prescription drugs that have over-the-counter equivalents, except for

those products specifically listed as covered in your separately issued *Drug Plan Rider* This exclusion includes nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum.

Nutritional Supplements

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

Post-Termination Services

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

Prescription Drugs

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

Preauthorization Not Obtained When Required

This Plan may not cover certain services if you do not obtain Preauthorization from BCBSNM before those services are received.

Private Duty Nursing Services

This Plan does not cover private duty nursing services.

Sex-Change Operations and Services

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

Sexual Dysfunction Treatment

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

Supplies, Equipment and Prosthetics

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

Surgery and Related Services

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

Therapy and Counseling Services

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

- recreational, sleep, crystal, primal scream, sex, and Z therapies
- self-help, stress management and codependency programs
- smoking/tobacco use Cessation Counseling programs that do not meet the standards described under "Cessation Counseling" in *Section 10: Definitions*

- Speech Therapy or diagnostic testing related to the following conditions: learning disorders, whether or not they accompany mental retardation; deafness; personality, developmental, voice, or rhythm disorders when these conditions are not the direct result of a diagnosed neurological, muscular, or structural abnormality involving the speech organs; or stuttering at any age (Note: Does not apply to Autism Spectrum Disorder.)
- services of a massage therapist or rolfing
- transactional analysis, encounter groups, and transcendental meditation (TM); moxibustion; sensitivity or assertiveness training
- vision therapy; orthoptics
- pastoral, spiritual, or religious counseling
- supportive services provided to the family of a Terminally Ill Patient when the patient is not a Member of this Plan
- therapy for chronic conditions such as, but not limited to, cerebral palsy or developmental delay, except as required by law and described in *Section 5* under "Autism Spectrum Disorders" (See "Early Developmental Delay and Disability" in *Section 8: Claim Payments and Appeals* for coverage of certain services provided to eligible children by the Department of Health.)
- any therapeutic exercise equipment for home use (e.g., treadmill, weights)

Thermography

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

Transplant Services

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

Travel or Transportation

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

Veteran's Administration Facility

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

Vision Services

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

War-Related Conditions

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

Work-Related Conditions

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

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

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

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

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

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

SECTION 7: COORDINATION OF BENEFITS (COB) AND REIMBURSEMENT

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

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

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

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

The following rules determine which coverage pays first:

No COB Provision — If the Other Valid Coverage does not include a COB provision, that coverage pays first.

Medicare — If the Other Valid Coverage is Medicare and Medicare is not secondary according to federal law, Medicare pays first.

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

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

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

Child — For a child whose parents are not separated or divorced, the coverage of the parent whose birthday falls earlier in the Calendar Year pays first. If the Other Valid Coverage does not follow this rule, the father's coverage pays first.

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

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

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

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

Responsibility For Timely Notice

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

Facility of Payment

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

Overpayments - Right of Recovery

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

REIMBURSEMENT

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

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

— BCBSNM is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits BCBSNM provided for that sickness or injury.

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

SECTION 8: CLAIMS PAYMENTS AND APPEALS

IMPORTANT NOTE ABOUT FILING CLAIMS

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

CLAIM FORMS AND PROOF OF LOSS

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

IF YOU HAVE OTHER VALID COVERAGE

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

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

HMO- PARTICIPATING PROVIDERS

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

PROVIDER NETWORK

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

NONPARTICIPATING PROVIDERS

A Nonparticipating Provider is one that does not have an HMO- Participating Provider agreement. If your Nonparticipating Provider does not file a Claim for you for Emergency Care, submit a separate Claim form for each family member as the services are received. Attach itemized bills and, if applicable, your Other Valid Coverage's payment explanation, to a *Member Claim Form.* (Forms can be printed from the BCBSNM website at www.bcbsnm.com or requested from a Customer Service Advocate.) Complete the claim form using the instructions on the form. (See special Claim filing instructions for out-of-country Claims under "Where to Send Claim Forms" later in this section.)

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

ITEMIZED BILLS

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

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

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

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

WHERE TO SEND CLAIM FORMS

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

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

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

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

Mental Health/Chemical Dependency Claims

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

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

Drug Plan Claims

If you purchase a prescription drug or other item covered under the drug plan from a non- Participating Pharmacy or other Provider in an Emergency, or if you do not have your ID Card with you when purchasing a prescription or

other covered item, you must pay for the prescription in full and then submit a Claim to BCBSNM's pharmacy benefit manager. **Do not send these Claims to BCBSNM.** The bills or receipts must be issued by the pharmacy and must include the pharmacy name and address, drug name, prescription number, and amount charged. If not included in your enrollment materials, you can obtain the name and address of the pharmacy benefit manager and the necessary Claim forms from a Customer Service Advocate or on the BCBSNM website at www.bcbsnm.com.

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

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

You will need to pay up front for care received from a **doctor,** a **participating outpatient Hospital,** and/or a **non-participating Hospital.** Then, complete an *International Claim Form* and send it with the bill(s) to the BlueCard Worldwide Service Center (the address is on the form). The *International Claim Form* is available from BCBSNM, the BlueCard Worldwide Service Center, or on-line at:

www.bcbs.com/already-a-member/coverage-home-and-away.html

The BlueCard Worldwide *International Claim Form* is to be used to submit institutional and professional Claims for benefits for covered Emergency services received outside the United States, Puerto Rico, Jamaica and the U.S. Virgin Islands. For filing instructions for other Claim types (e.g., dental, prescription drugs, etc.) contact your Blue Cross and Blue Shield Plan. The *International Claim Form* must be completed for each patient in full, and accompanied by fully itemized bills. It is not necessary for you to provide an English translation or convert currency.

Since the Claim cannot be returned, please be sure to keep photocopies of all bills and supporting documentation for your personal records. The Member should submit an *International Claim Form* (available at www.bcbs.com), attach itemized bills, and mail to BlueCard Worldwide at the address below. BlueCard Worldwide will then translate the information, if necessary, and convert the charges to United States dollars. They also will contact BCBSNM for benefit information in order to process the Claim. Once the Claim is finalized, the *Explanation of Benefits* will be mailed to the Subscriber and payment, if applicable, will be made to the Subscriber via wire transfer or check. Mail international Claims to:

BlueCard Worldwide Service Center
P.O. Box 72017
Richmond, VA 23255-2017

IF YOU HAVE MEDICARE

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

Filing Claims if Medicare is Primary

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

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

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

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

Medicare- Covered Facility Services

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

After Medicare Part A has paid its portion of Covered Charges for services received in New Mexico, it is **not** necessary for you to file a Claim for a Claim for most Facility services with BCBSNM. These Claims are automatically submitted by the Medicare Part A intermediary to BCBSNM. An *Explanation of Benefits* will be sent to you by BCBSNM after Plan benefits have been determined. If you must file your own Claim after Medicare pays its portion (for example, because services were received outside New Mexico), you must file a Claim for services received from the Hospital, along with Medicare's EOMB, **to the local BCBS Plan.** (See instructions in this section.)

Medicare- Covered Non- Facility Services

A Claim for Physician and other Professional Provider services must be filed **first** with Medicare Part B Medical Insurance. (All Medicare Providers must file Claims for you to Medicare.)

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

Services Not Covered by Medicare

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

When an EOMB is Not Required

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

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

benefits for covered mental health and Chemical Dependency services received from LPCC and LMFT Providers.)

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

Services Outside Medicare Territorial Limits

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

If you receive Covered Services while outside the United States, call the BlueCard Worldwide Service Center, collect, at 804- 673- 1177 for assistance with Claims filing. Or visit the Blue Cross and Blue Shield Association website to locate nearby participating Physicians and Hospitals.

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

CLAIMS PAYMENT PROVISIONS

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

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

If A Claim or Preauthorization Is Denied

If benefits are denied or only partially paid, BCBSNM will notify you of the determination. The notice to you will include: 1) the reasons for denial; 2) a reference to the health care plan provisions on which the denial is based; and 3) an explanation of how you may appeal the decision if you do not agree with the denial. (See "Complaints/Appeals Summary," later in this section.) **You also have 180 days** following request of notification of an adverse benefit determination in which to appeal a decision to BCBSNM; however, you may exceed the 180- day limit when appealing to the Managed Health Care Bureau of the Office of Superintendent of Insurance**.**

Covered Charge

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

HMO- Participating Providers

Payments for Covered Services usually are sent directly to network (HMO- Participating) Providers. The EOB you receive explains the payment.

Nonparticipating Providers

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

Accident-Related Hospital Services

If services are administered as a result of an accident, a Hospital or treatment Facility may place a lien upon a compromise, settlement, or judgement obtained by you when the Facility has not been paid its total billed charges from all other sources.

Assignment of Benefits

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

Early Developmental Delay and Disability

For covered children **under age four** who are also eligible for services under the New Mexico Department of Health's (DOH) "Family, Infant and Toddler" (FIT) program, as defined in 7.30.8, NMAC, your BCBSNM Plan will reimburse the DOH for certain medically necessary early intervention services that are provided as part of an individualized family service plan under the FIT program by personnel who are licensed and certified for the DOH's FIT program. The maximum reimbursement under the BCBSNM Plan is **limited to $3,500** per year. However, amounts paid to DOH for such services are not included in any annual or lifetime benefit maximums under the Plan. Claims for services payable to the DOH under this provision will be honored only if submitted to BCBSNM by the New Mexico DOH.

Medicaid

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

Medicare

If you are 65 years of age or older, BCBSNM will suspend your Claims until it receives (a) an *Explanation of Medicare Benefits (EOMB)* for each Claim (if you are entitled to Medicare), or (b) Social Security Administration documentation showing that you are not entitled to Medicare.

Overpayments

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

Pricing of Noncontracted Provider Claims

The BCBSNM Covered Charge for some Covered Services received from Noncontracted Providers is the lesser of the Provider's billed charges or the BCBSNM "Noncontracting Allowable Amount." The BCBSNM Noncontracting Allowable Amount is based on the **Medicare Allowable** amount for a particular service, which is determined by the Centers for Medicaid and Medicare Services (CMS). The Medicare Allowable is determined for a service covered under your BCBSNM health plan using information on each specific Claim and, based on place of treatment and date of service, is multiplied by an "Adjustment Factor" to calculate the BCBSNM Noncontracting Allowable Amount. The Adjustment Factor for non-Emergency services are:

- 100% of the base Medicare Allowable for inpatient Facility Claims
- 300% of the base Medicare Allowable for outpatient Facility Claims

- 200% of the base Medicare Allowable for freestanding ambulatory surgical center Claims
- 100% of the base Medicare Allowable for Physician, other Professional Provider Claims, and other ancillary Providers of covered Health Care Services and supplies

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

- services for which a Medicare Allowable cannot be determined based on the information submitted on the Claim (in such cases, the Covered Charge is 50 percent of the billed charge)
- home health Claims (the Covered Charge is 50 percent of the billed charge)
- services administered and priced by any subcontractor of BCBSNM or by the Blue Cross and Blue Shield Association
- Claims paid by Medicare as primary coverage and submitted to your health plan for secondary payment
- New Mexico ground Ambulance Claims (for which the New Mexico Public Regulation Commission sets fares)
- covered Claims priced by a non-New Mexico BCBS Plan through BlueCard using local pricing methods

NOTE: Non-Emergency services are generally **not covered** under HMO or EPO plans when received out-of-network from Noncontracted Providers. The pricing methods above apply **only** when the Claim for out-of-network services has been authorized for payment and does not satisfy any of the conditions below:

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

- Covered Services required during an Emergency and received in a Hospital, trauma center, or Ambulance
- for HMO health plans, services from Noncontracted Providers that satisfy at least one of the three conditions below and, as a result, are eligible for coverage under HMO and EPO health plans

  -Covered Services from Noncontracted Providers within the United States that are classified as "Unsolicited Providers" as determined by the Member's Host Plan while outside the Network Service Area of BCBSNM

  -**preauthorized** transition of care services received from Noncontracted Providers

  -Covered Services received from a Noncontracted anesthesiologist, pathologist, or radiologist while you are a patient at a **Contracted** Facility receiving Covered Services or procedures that have been preauthorized, if needed

BCBSNM will use essentially the same Claims processing rules and/or edits for Noncontracted Provider Claims that are used for Contracted Provider Claims, which may change the Covered Charge for a particular service. If BCBSNM does not have any Claim edits or rules for a particular Covered Service, BCBSNM may use the rules or edits used by Medicare in processing the Claims. Changes made by CMS to the way services or Claims are priced for Medicare will be applied by BCBSNM within 90-145 days of the date that such change is implemented by CMS or its successor.

IMPORTANT: Regardless of the pricing method used, the BCBSNM Covered Charge will usually be less than the Provider's billed charge and **you will be responsible** for paying to the Provider the difference between the BCBSNM Covered Charge and the Noncontracted Provider's billed charge for a Covered Service. **This difference may be considerable.** The difference is **not** applied to any Deductible or Out-of-Pocket limit. In the case of a non-Covered Service, you are responsible for paying the Provider's full billed charge directly to the Provider. **Reminder:** Contracted Providers will **not** charge you the difference between the BCBSNM Covered Charge and the billed charge for a Covered Service.

BLUECARD® PROGRAM

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

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

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

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

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

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

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

GRIEVANCE PROCEDURES

Please refer to the following grievance procedures in bold for information regarding what action(s) to take if you have a grievance. Please call Customer Service for assistance if you have any questions regarding the grievance procedures.

Request for internal review of an Adverse Determination must be submitted within 180 days from the date of the Adverse Determination. If you do not submit the request for internal review within the 180-day period, you waive your right to internal review, unless you can satisfy BCBSNM that matters beyond your control prevented you from timely filing the request.

Definitions

As used in this section:

administrative grievance **means an oral or written complaint submitted by, or on behalf of, you regarding any aspect of a health benefits plan other than a request for Health Care Services, including but not limited to:**

(1) administrative practices of BCBSNM that affect the availability, delivery, or quality of Health Care Services;

(2) claims payment, handling, or reimbursement for Health Care Services; and

(3) terminations of coverage;

adverse determination **means any of the following: any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time), a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit including any such denial, reduction, termination, or failure to provide or make payments that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational, or not medically necessary or appropriate;**

adverse determination grievance **means an oral or written complaint submitted by, or on your behalf, regarding an adverse determination;**

certification **means a decision by BCBSNM that a health care service requested by a provider or you has been reviewed and, based upon the information available, meets BCBSNM's requirements for coverage and medical necessity, and the requested health care service is therefore approved;**

culturally and linguistically appropriate manner of notice **means;**

(1) notice that meets the following requirements:

(a.) BCBSNM must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language;

(b.) BCBSNM must provide, upon request, a notice in any applicable non-English language;

(c.) BCBSNM must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by BCBSNM; and

(2) for purposes of this definition, with respect to an address in any New Mexico county to which a notice is sent, a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county is literate only in the same non-English language, as determined by the department of health and human services (HHS); the counties that meet this ten percent (10%) standard, as determined by HHS, are found at http://cciio.cms.gov/resources/factsheets/clas-data.html and any necessary changes to this list are posted by HHS annually;

grievant **means any of the following:**

(1) a policyholder, subscriber, enrollee, or other individual, or that person's authorized representative or provider, acting on behalf of that person with that person's consent, entitled to receive health care benefits provided by BCBSNM;

(2) an individual, or that person's authorized representative, who may be entitled to receive health care benefits provided by BCBSNM;

(3) Medicaid recipients enrolled in BCBSNM's Medicaid plan;

(4) individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act;

health benefits plan **means a policy, contract, certificate or agreement offered or issued by BCBSNM or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of Health Care Services; this includes a health benefits plan as defined under NMSA 1978 Section 59A-22A-3(D) as "the health insurance policy or subscriber agreement between you or the policyholder and BCBSNM which defines the covered services and benefit levels available";**

health care insurer **means a person that has a valid certificate of authority in good standing issued pursuant to the Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan, fraternal benefit society, vision plan, or pre-paid dental plan;**

health care professional **means a physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide Health Care Services consistent with state law;**

health care services **means services, supplies, and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the health benefits plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay;**

hearing officer, independent co-hearing officer or ICO **means a health care or other professional licensed to practice medicine or another profession who is willing to assist the superintendent as a hearing officer in understanding and analyzing medical necessity and coverage issues that arise in external review hearings;**

medical necessity or medically necessary **means Health Care Services determined by a provider, in consultation with BCBSNM, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by BCBSNM consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease;**

provider **means a duly licensed hospital or other licensed facility, physician, or other health care professional authorized to furnish Health Care Services within the scope of their license;**

rescission of coverage means **a cancellation or discontinuance of coverage that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if:**

(1) the cancellation or discontinuance of coverage has only a prospective effect; or

(2) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage;

summary of benefits **means the written materials required by NMSA 1978 Section 59A-57-4 to be given to you by BCBSNM or group contract holder;**

termination of coverage **means the cancellation or non-renewal of coverage provided by BCBSNM to you but does not include a voluntary termination by you or termination of a health benefits plan that does not contain a renewal provision;**

traditional fee-for-service indemnity benefit **means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage you to utilize HMO Participating Providers, to follow preauthorization rules, to utilize prescription drug formularies or other cost-saving procedures to obtain prescription drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services;**

uniform standards **means all generally accepted practice guidelines, evidence-based practice guidelines or practice guidelines developed by the federal government or national and professional medical societies, boards and associations, and any applicable clinical review criteria, policies, practice guidelines, or protocols developed by BCBSNM consistent with the federal, national, and professional practice guidelines that are used by BCBSNM in determining whether to certify or deny a requested health care service.**

Computation of Time

Whenever these procedures require that an action be taken within a certain period of time from receipt of a request or document, the request or document shall be deemed to have been received within three (3) working days of the date it was mailed.

General Requirements Regarding Grievance Procedures

Written grievance procedures required. **BCBSNM shall establish and maintain separate written procedures to provide for the presentation, review, and resolution of:**

(1) ***adverse determination grievances*****; BCBSNM shall establish procedures for both standard and expedited review of adverse determination grievances that comply with the requirements of 13.10.17.17 NMAC through 13.10.17.22 NMAC;**

(2) ***administrative grievances*****; BCBSNM shall establish procedures for reviewing administrative grievances that comply with the requirements of 13.10.17.33 NMAC through 13.10.17.36 NMAC; and**

(3) if a grievance contains clearly divisible administrative and adverse decision issues, then BCBSNM shall initiate separate complaints for each issue; with an explanation of the insurer's actions contained in one acknowledgement letter.

Assistance to grievants. **In those instances where you make an oral grievance or request for internal review to BCBSNM, or expresses interest in pursuing a written grievance, BCBSNM shall assist you to complete all the forms required to pursue internal review and shall advise you that the Managed Health Care Bureau of the Office of Superintendent of Insurance is available for assistance.**

Retaliatory action prohibited. **No person shall be subject to retaliatory action by BCBSNM for any reason related to a grievance.**

Information about Grievance Procedures

For grievants. **BCBSNM shall:**

(1) include a clear and concise description of all grievance procedures, both internal and external, in boldface type in the enrollment materials, including in member handbooks or evidences of coverage, issued to you;

(2) for a person who has been denied coverage, provide him or her with a copy of the grievance procedures;

(3) notify you that a representative of BCBSNM and the Managed Health Care Bureau of the Office of Superintendent of Insurance are available upon request to assist you with grievance procedures by including such information, and a toll-free telephone number for obtaining such assistance, in the enrollment materials and ***summary of benefits*** **issued to you;**

(4) provide a copy of its grievance procedures and all necessary grievance forms at each decision point in the grievance process and immediately upon request, at any time, to you, your provider or other interested person;

(5) provide a detailed written explanation of the appropriate grievance procedure and a copy of the grievance form to you or your provider when BCBSNM makes either an adverse determination or adverse administrative decision; the written explanation shall describe how BCBSNM reviews and resolves grievances and provide a toll-free telephone number, facsimile number, e-mail address, and mailing address of BCBSNM's consumer assistance office;

(6) provide consumer education brochures and materials developed and approved by the superintendent, annually or as directed by the superintendent in consultation with the insurer for distribution;

(7) provide notice to enrollees in a culturally and linguistically appropriate manner;

(8) provide continued coverage for an ongoing course of treatment pending the outcome of an internal appeal;

(9) not reduce or terminate an ongoing course of treatment without first notifying you and sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of the proposed reduction or termination; and

(10) allow individuals in urgent care situations and receiving an ongoing course of treatment to proceed with an expedited external review at the same time as the internal review process.

***For providers*. BCBSNM shall inform all providers of the grievance procedures available to you and providers acting on your behalf, and shall make all necessary forms available to providers, including consumer education brochures and materials developed and approved by the superintendent, annually or as directed by the superintendent in consultation with the insurer for distribution.**

***Special needs*. Information about grievance procedures must be provided in accordance with the Americans with Disabilities Act, 42 U.S.C. Sections 12101 et seq., and 13.10.13 NMAC, Managed Health Care, particularly 13.10.13.29 NMAC, Cultural and Linguistic Diversity.**

Confidentiality of a Grievant's Records and Medical Information

***Confidentiality.* BCBSNM, the superintendent, independent co- hearing officers, and all others who acquire access to identifiable medical records and information of yours when reviewing grievances shall treat and maintain such records and information as confidential except as otherwise provided by federal and New Mexico law.**

***Procedures required*. The superintendent and BCBSNM shall establish procedures to ensure the confidential treatment and maintenance of identifiable medical records and information of yours submitted as part of any grievance.**

Record of Grievances

***Record required*. BCBSNM shall maintain a grievance register to record all grievances received and handled during the calendar year. The register shall be maintained in a manner that is reasonably clear and accessible to the superintendent.**

***Contents*. For each grievance received, the grievance register shall:**

(1) assign a grievance number;

(2) indicate whether the grievance is an adverse determination or administrative grievance, or a combination of both;

(3) state the date, and for an expedited review the time, the grievance was received;

(4) state the name and address of the grievant, if different from yours;

(5) identify by name and member number the covered person making the grievance or for whom the grievance was made;

(6) indicate whether your coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act, the medicaid program, or a commercial Health Care Insurer;

(7) identify the health insurance policy number and the group if the policy is a group policy;

(8) identify the individual employee of BCBSNM to whom the grievance was made;

(9) describe the grievance;

(10) for adverse determination grievances, indicate whether the grievance received expedited or standard review;

(11) indicate at what level the grievance was resolved and what the actual outcome was; and

(12) state the date the grievance was resolved and the date you were notified of the outcome.

Annual report. **Each year, the superintendent shall issue a data call for information based on the grievances received and handled by BCBSNM during the prior calendar year. The data call will be based on the information contained in the grievance register.**

Retention. **BCBSNM shall maintain such records for at least six (6) years.**

Submittal. **BCBSNM shall submit information regarding all grievances involving quality of care issues to BCBSNM's Continuous Quality Improvement committee and to the superintendent and shall document the qualifications and background of the Continuous Quality Improvement committee members.**

Examination. **BCBSNM shall make such record available for examination upon request and provide such documents free of charge to you, or state or federal agency officials, subject to any applicable federal or state law regarding disclosure of personally identifiable health information.**

Preliminary Determination

Upon receipt of a grievance, BCBSNM shall first determine the type of grievance at hand.

If the grievance seeks review of an adverse determination of a pre- or post- health care service, it is an adverse determination grievance and BCBSNM shall review the grievance in accordance with its procedures for adverse determination grievances and the requirements of 13.10.17.17 NMAC through 13.10.17.22 NMAC.

If the grievance is not based on an adverse determination of a pre- or post- health care service, it is an administrative grievance and BCBSNM shall review the grievance in accordance with its procedures for administrative grievances and the requirements of 13.10.17.33 NMAC through 13.10.17.36 NMAC.

Timeframes for Initial Determinations

Expedited decision. **BCBSNM shall make its initial certification or adverse determination decision in accordance with the medical exigencies of the case. BCBSNM shall make decisions within twenty- four (24) hours of the written or verbal receipt of the request for an expedited decision whenever:**

(1) your life or health would be jeopardized;

(2) your ability to regain maximum function would be jeopardized;

(3) the provider reasonably requests an expedited decision; or

(4) in the opinion of the physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim;

(5) the medical exigencies of the case require an expedited decision;

(6) your claim involves urgent care.

Standard decision. **BCBSNM shall make all other initial utilization management decisions within five (5) working days. BCBSNM may extend the review period for a maximum of ten (10) working days if it:**

(1) can demonstrate reasonable cause beyond its control for the delay;

(2) can demonstrate that the delay will not result in increased medical risk to you; and

(3) provides a written progress report and explanation for the delay to you and provider within the original five (5) working day review period.

Initial Determination

Coverage. **When considering whether to certify a health care service requested by a provider or by you, BCBSNM shall determine whether the requested health care service is covered by the health benefits plan. Before denying a health care service requested by a provider or by you on grounds of a lack of coverage, BCBSNM shall determine that there is no provision of the health benefits plan under which the requested**

health care service could be covered. If BCBSNM finds that the requested health care service is not covered by the health benefits plan, BCBSNM need not address the issue of medical necessity.

Medical Necessity.

(1) If BCBSNM finds that the requested health care service is covered by the health benefits plan, then when considering whether to certify a health care service requested by a provider or you, a physician, registered nurse, or other health care professional shall, within the timeframe required by the medical exigencies of the case, determine whether the requested health care service is medically necessary.

(2) Before BCBSNM denies a health care service requested by a provider or you on grounds of a lack of medical necessity, a physician shall render an opinion as to medical necessity, either after consultation with specialists who are experts in the area that is the subject of review, or after application of uniform standards used by BCBSNM. The physician shall be under the clinical authority of the medical director responsible for Health Care Services provided to you.

Notice of Initial Determination

***Certification*. BCBSNM shall notify you and provider of the certification by written or electronic communication within two (2) working days of the date the health care service was certified, unless earlier notice is required by the medical exigencies of the case.**

***24- hour notice of adverse determination*. BCBSNM shall notify you and your provider of an adverse determination by telephone or as required by the medical exigencies of the case, but in no case later than twenty- four (24) hours after making the adverse determination, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or have insurance coverage. If you fail to provide such information, you must be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty- eight (48) hours, to provide the specified information. Additionally, BCBSNM shall notify you and provider of the adverse determination by written or electronic communication sent within one (1) working day of the telephone notice.**

***Contents of notice of adverse determination*.**

(1) if the adverse determination is based on a lack of medical necessity, clearly and completely explain why the requested health care service is not medically necessary. A statement that the health care service is not medically necessary will not be sufficient;

(2) if the adverse determination is based on a lack of coverage, identify all health benefits plan provisions relied on in making the adverse determination, and clearly and completely explain why the requested health care service is not covered by any provision of the health benefits plan. A statement that the requested health care service is not covered by the health benefits plan will not be sufficient;

(3) the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code and corresponding meaning of these codes, the denial code and its corresponding meaning;

(4) include a description of the BCBSM standard that was used in denying the claim;

(5) provide a summary of the discussion which triggered the final determination;

(6) advise you that he or she may request internal review of BCBSNM's adverse determination; and

(7) describe the procedures and provide all necessary forms to you for requesting internal review.

Rights Regarding Internal Review of Adverse Determinations

***Right to internal review.* If you are dissatisfied with an adverse determination, you shall have the right to request internal review of the adverse determination by BCBSNM.**

***Acknowledgement of request.* Upon receipt of a request for internal review of an adverse determination, BCBSNM shall date and time stamp the request and, within one (1) working day from receipt, send you an acknowledgment that the request has been received. The acknowledgment shall contain the name, address,**

and direct telephone number of an individual representative of BCBSNM who may be contacted regarding the grievance.

***Full and fair hearing*. To ensure that you receive a full and fair internal review, BCBSNM must, in addition to allowing you to review the claim file and to present evidence and testimony as part of the internal claims and appeals process, provide you, free of charge, with any new or additional evidence, and new or additional rationale, considered, relied upon, or generated by BCBSNM, as soon as possible and sufficiently in advance of the date of the notice of final internal adverse benefit determination to allow you a reasonable opportunity to respond before the final internal adverse benefit determination is made.**

***Conflict of interest.* BCBSNM must ensure that all internal claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions in a way that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.**

Timeframes for Internal Review of Adverse Determinations

Upon receipt of a request for internal review of an adverse determination, BCBSNM shall conduct either a standard or expedited review, as appropriate.

***Expedited review.* BCBSNM shall complete its internal review as required by the medical exigencies of the case but in no case later than seventy-two (72) hours from the time the internal review request was received whenever:**

(1) your life or health would be jeopardized;

(2) your ability to regain maximum function would be jeopardized;

(3) the provider reasonably requests an expedited decision;

(4) in the opinion of the physician, with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim; or

(5) the medical exigencies of the case require an expedited decision.

***Standard review.* BCBSNM shall complete a standard review of both internal reviews as described in 13.10.17.19 NMAC and 13.10.17.20 NMAC within twenty (20) working days of receipt of the request for internal review in all cases in which the request for review is made prior to the service requested, and does not require expedited review, and within forty (40) working days of receipt of the request in all post-service requests for internal review. BCBSNM may extend the review period for a maximum of ten (10) working days in pre-service cases, and twenty (20) working days for post-service cases if it:**

(1) can demonstrate reasonable cause beyond its control for the delay;

(2) can demonstrate that the delay will not result in increased medical risk to you; and

(3) provides a written progress report and explanation for the delay to you and provider within the original thirty (30) day for pre-service or sixty (60) day for post-service review period;

(4) if the grievance contains clearly divisible administrative and adverse decision issues, then BCBSNM shall initiate separate complaints for each decision.

***Failure to comply with deadline*. If BCBSNM fails to comply with the deadline for completion of an internal review, the requested health care service shall be deemed approved unless you, after being fully informed of your rights, have agreed in writing to extend the deadline.**

First and Second Internal Review of Adverse Determinations for Group Health Plans

Scope of review. **Health Care Insurers that offer group health care benefits plans and entities subject to the Health Care Purchasing Act shall complete the review of the adverse determination within the timeframes above.**

(1) *Coverage*. If the initial adverse determination was based on a lack of coverage, BCBSNM shall review the health benefits plan and determine whether there is any provision in the plan under which the requested health care service could be certified.

(2) *Medical necessity.* If the initial adverse determination was based on a lack of medical necessity, BCBSNM shall render an opinion as to medical necessity, either after consultation with specialists who are experts in the area that is the subject of review, or after application of uniform standards used by BCBSNM.

Decision to reverse. **If BCBSNM reverses the initial adverse determination and certifies the requested health care service, BCBSNM shall notify you and provider as discussed above.**

Decision to uphold. **If BCBSNM upholds the initial adverse determination to deny the requested health care service, BCBSNM shall notify you and your provider as discussed above and shall ascertain whether you wish to pursue the grievance.**

(1) If you do not wish to pursue the grievance, BCBSNM shall mail written notification of the medical director's decision, and confirmation of your decision not to pursue the matter further, to you within three (3) working days of the medical director's decision.

(2) If BCBSNM is unable to contact you by telephone within seventy- two (72) hours of making the decision to uphold the determination, BCBSNM shall notify you by mail of the medical director's decision and shall include in the notification a self- addressed stamped response form which asks you whether you wish to pursue the grievance further and provides a box for checking "yes" and a box for checking "no." If you do not return the response form within ten (10) working days, BCBSNM shall again contact you by telephone. If BCBSNM is still unable to contact you, your grievance file shall be closed.

(3) If you respond affirmatively to the telephone inquiry or by response form, BCBSNM will select a medical panel to further review the adverse determination.

(4) If you do not respond to BCBSNM's telephone inquiries or return the response form, BCBSNM shall select a medical panel to further review the adverse determination when the review is an expedited review.

Extending the Timeframe for Standard Review. **If you do not make an immediate decision to pursue the grievance, or you have requested additional time to supply supporting documents or information, or postponement, the timeframe for completing the review shall be extended to include the additional time required by you.**

Internal Panel Review of Adverse Determinations

Note: If you are insured under an individual health plan, you will have one level of internal review.

Selection of an internal review panel. **In cases of appeal from an adverse determination or from a third party administrator's decision to uphold an adverse determination, BCBSNM shall select an internal review panel to review the adverse determination or the decision to uphold the adverse determination.**

Notice of review. **Unless you choose not to pursue the grievance, BCBSNM shall notify you of the date, time, and place of the internal panel review. The notice shall advise you of the rights specified in the "Information to grievant" section on the next page. If BCBSNM indicates that it will have an attorney represent its interests, the notice shall advise you that an attorney will represent BCBSNM and that you may wish to obtain legal representation of you own.**

Panel membership. **BCBSNM shall select one or more representatives of BCBSNM and one or more health care or other professionals who have not been previously involved in the adverse determination being re-**

viewed to serve on the internal panel. At least one of the health care professionals selected shall practice in a specialty that would typically manage the case that is the subject of the grievance or be mutually agreed upon by you and BCBSNM.

Scope of Review.

(1) *Coverage*. The internal review panel shall review the health benefits plan and determine whether there is any provision in the plan under which the requested health care service could be certified.

(2) *Medical necessity.* The internal review panel shall render an opinion as to medical necessity, either after consultation with specialists who are experts in the area that is the subject of review, or after application of uniform standards used by BCBSNM.

***Information to grievant*. No fewer than three (3) working days prior to the internal panel review, BCBSNM shall provide to you copies of:**

(1) your pertinent medical records;

(2) the treating provider's recommendation;

(3) your health benefits plan;

(4) BCBSNM's notice of adverse determination;

(5) uniform standards relevant to your medical condition that is used by the internal panel in reviewing the adverse determination;

(6) questions sent to or reports received from any medical consultants retained by BCBSNM; and

(7) all other evidence or documentation relevant to reviewing the adverse determination.

***Request for postponement.* BCBSNM shall not unreasonably deny a request for postponement of the internal panel review made by you. The timeframes for internal panel review shall be extended during the period of any postponement.**

***Rights of grievant.* You have the right to:**

(1) attend and participate in the internal panel review;

(2) present your case to the internal panel;

(3) submit supporting material both before and at the internal panel review;

(4) ask questions of any representative of BCBSNM;

(5) ask questions of any health care professionals on the internal panel;

(6) be assisted or represented by a person of your choice, including legal representation;

(7) hire a specialist to participate in the internal panel review at his or her own expense, but such specialist may not participate in making the decision.

***Timeframe for review; attendance*. The internal panel will complete its review of the adverse determination as required by the medical exigencies of the case and within the applicable timeframes above. Internal panel review members must be present physically or by video or telephone conferencing to hear the grievance. An internal review panel member who is not present to hear the grievance either physically or by video or telephone conferencing shall not participate in the decision.**

Additional Requirements for Expedited Internal Review of Adverse Determinations

In an expedited review, all information shall be transmitted between BCBSNM and you by the most expeditious method available.

If an expedited review is conducted during your hospital stay or course of treatment, Health Care Services shall be continued without cost (except for applicable co- payments and deductibles) to you until BCBSNM makes a final decision and notifies you.

BCBSNM shall not conduct an expedited review of an adverse determination made after Health Care Services have been provided to you.

Notice of Internal Panel Decision

Notice required. **Within the time period allotted for completion of its internal review, BCBSNM shall notify you and your provider of the internal panel's decision by telephone within twenty- four (24) hours of the panel's decision and in writing or by electronic means within one (1) working day of the telephone notice.**

Contents of notice**. The written notice shall contain:**

(1) the names, titles, and qualifying credentials of the persons on the internal review panel;

(2) a statement of the internal panel's understanding of the nature of the grievance and all pertinent facts;

(3) a description of the evidence relied on by the internal review panel in reaching its decision;

(4) a clear and complete explanation of the rationale for the internal review panel's decision;

(a.) the notice shall identify every provision of your health benefits plan relevant to the issue of coverage in the case under review, and explain why each provision did or did not support the panel's decision regarding coverage of the requested health care service;

(b.)the notice shall cite the uniform standards relevant to your medical condition and explain whether each supported or did not support the panel's decision regarding the medical necessity of the requested health care service;

(5) notice of your right to request external review by the superintendent, including the address and telephone number of the managed health care bureau of the Office of the Superintendent of Insurance, a description of all procedures and time deadlines necessary to pursue external review, and copies of any forms required to initiate external review; this notice of your right to request external review is in addition to the same notice provided to you in the *summary of benefits* and health benefits plan.

External Review of Adverse Determinations

Right to external review. **If you are dissatisfied with the results of a medical panel review of an adverse determination by BCBSNM and where applicable, with the results of a grievance review by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act, you may request external review by the superintendent at no cost to you. There shall be no minimum dollar amount of a claim before you may exercise this right to external review.**

Exhaustion of internal appeals process. **The superintendent may require you to exhaust any grievance procedures adopted by BCBSNM or the entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act, as appropriate, before accepting a grievance for external review.**

Deemed exhaustion**. If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary and the internal appeals process will be deemed exhausted if*:***

(1) BCBSNM waives the exhaustion requirement;

(2) BCBSNM is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process; or

(3) you simultaneously request an expedited internal appeal and an expedited external review.

Exception to exhaustion requirement.

The internal claims and appeals process will not be deemed exhausted based on violations by BCBSNM that are *de minimus* and do not cause, and are not likely to cause, prejudice or harm to you, so long as BCBSNM

demonstrates that the violation was for good cause or due to matters beyond the control of BCBSNM, and that the violation occurred in the context of an ongoing, good faith exchange of information between BCBSNM and you. This exception is not available if the violation is part of a pattern or practice of violations by BCBSNM.

You may request a written explanation of the violation from BCBSNM and BCBSNM must provide such explanation within ten (10) days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review on the basis that BCBSNM met the standards for the *de minimus* exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), BCBSNM shall provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of the notice.

Filing Requirements for External Review of Adverse Determinations

Deadline for filing request.

(1) *When required by the medical exigencies of the case.* If required by the medical exigencies of the case, you or your provider may telephonically request an expedited review by calling the managed health care bureau at 1-(855) 427-5674.

(2) *In all other cases.* To initiate an external review, you must file a written request for external review with the superintendent within one hundred twenty (120) calendar days from receipt of the written notice of internal review decision unless extended by the superintendent for good cause shown. The request shall be:

(a.) mailed to the Office of Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, Post Office Box 1689, Santa Fe, New Mexico 87504-1689; or

(b.) e-mailed to mhcb.grievance@state.nm.us, subject External Review Request;

(c.) faxed to the Office of Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request at (505) 827-4734; or

(d.) completed on-line with an Office of Superintendent of Insurance Complaint Form available at http://www.osi.state.nm.us.

Documents required to be filed by the grievant. **You shall file the request for external review on the forms provided to you by BCBSNM or entity that purchases health care benefits and shall also file:**

(1) a copy of the notice of internal review decision;

(2) a fully executed release form authorizing the superintendent to obtain any necessary medical records from BCBSNM or any other relevant provider; and

(3) if the grievance involves an experimental or investigational treatment adverse determination, the provider's certification and recommendation as described in the section for "Additional Criteria for Initial External Review of Experimental or Investigational Treatment Adverse Determinations by Office of Superintendent of Insurance Staff" later in this section.

Other filings. **You may also file any other supporting documents or information you wish to submit to the superintendent for review.**

Extending timeframes for external review. **If you wish to supply supporting documents or information subsequent to the filing of the request for external review, the timeframes for external review shall be extended up to ninety (90) days from the receipt of the complaint form, or until you submit all supporting documents, whichever occurs first.**

Acknowledgement of Request for External Review of Adverse Determination and Copy to BCBSNM

Upon receipt of a request for external review, the superintendent shall immediately send:

(1) an acknowledgment to you that the request has been received;

(2) BCBSNM a copy of the request for external review.

Upon receipt of the copy of the request for external review, BCBSNM shall, within five (5) working days for standard review or the time limit set by the superintendent for expedited review, provide to the superintendent and you by any available expeditious method:

(1) the *summary of benefits*;

(2) the complete health benefits plan, which may be in the form of a member handbook/Evidence of Coverage;

(3) all pertinent medical records, internal review decisions and rationales, consulting physician reports, and documents and information submitted by you and BCBSNM;

(4) uniform standards relevant to your medical condition that were used by the internal panel in reviewing the adverse determination; and

(5) any other documents, records, and information relevant to the adverse determination and the internal review decision or intended to be relied on at the external review hearing.

If BCBSNM fails to comply with the requirements listed immediately above, the superintendent may reverse the adverse determination.

The superintendent may waive the requirements of this section if necessitated by the medical exigencies of the case.

Timeframes for External Review of Adverse Determinations

The superintendent shall conduct either a standard or expedited external review of the adverse determination, as required by the medical exigencies of the case.

Expedited review. **The superintendent shall complete an external review as required by the medical exigencies of the case but in no case later than seventy-two (72) hours of receipt of the external review request whenever:**

(1) your life or health would be jeopardized; or

(2) your ability to regain maximum function would be jeopardized.

If the superintendent's initial decision is made orally, written notice of the decision must be provided within forty-eight (48) hours of the oral notification.

Standard review. **The superintendent shall conduct a standard review in all cases not requiring expedited review. Office of Superintendent of Insurance staff shall complete the initial review within ten (10) working days from receipt of the request for external review and the information required of you and BCBSNM in Subsection B of 13.10.17.24 and Subsection B of 13.10.17.25 NMAC respectively. If a hearing is held in accordance with 13.10.17.30 NMAC, the superintendent shall complete the external review within forty-five (45) working days from receipt of the complete request for external review in compliance with 13.10.17.24 NMAC. The superintendent may extend the external review period for up to an additional ten (10) working days when the superintendent has been unable to schedule the hearing within the required timeframe and the delay will not result in increased medical risk to you.**

Criteria for External Review of Adverse Determination by Office of Superintendent of Insurance Staff

Upon receipt of the request for external review, Office of Superintendent of Insurance staff shall review the request to determine whether:

(1) you have provided the documents required;

(2) you are or were a grievant of BCBSNM at the time the health care service was requested or provided;

(3) you have exhausted BCBSNM's internal review procedure and any applicable grievance review procedure of an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act; and

(4) the health care service that is the subject of the grievance reasonably appears to be a covered benefit under the health benefits plan.

Additional Criteria for Initial External Review of Experimental or Investigational Treatment Adverse Determinations by Office of Superintendent of Insurance Staff

If the request is for external review of an experimental or investigational treatment adverse determination, Office of Superintendent of Insurance staff shall also consider whether:

coverage; **the recommended or requested health care service:**

(1) reasonably appears to be a covered benefit under your health benefit plan except for BCBSNM's determination that the health care service is experimental or investigational for a particular medical condition; and

(2) is not explicitly listed as an excluded benefit under your health benefit plan; and

medical necessity; **your treating provider has certified that:**

(1) standard Health Care Services have not been effective in improving your condition; or

(2) standard Health Care Services are not medically appropriate for you; or

(3) there is no standard health care service covered by BCBSNM that is as beneficial or more beneficial than the health care service:

(a.) recommended by your treating provider that the treating provider certifies in writing is likely to be more beneficial to you, in the treating provider's opinion, than standard Health Care Services; or

(b.) requested by you regarding which your treating provider, who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service requested by you is likely to be more beneficial to you than available standard Health Care Services.

Initial External Review of Adverse Determinations by Office of Superintendent of Insurance Staff

Request incomplete. **If the request for external review is incomplete, the Office of Superintendent of Insurance staff shall immediately notify you and require you to submit the required information within a specified period of time.**

Request does not meet criteria. **If the request for external review does not meet the applicable criteria, Office of Superintendent of Insurance staff shall so inform the superintendent. The superintendent shall notify you and BCBSNM that the request does not meet the criteria for external review and is thereby denied, and that you have the right to request a hearing within thirty-three (33) days from the date the notice was mailed.**

Request meets criteria. **If the request for external review is complete and meets the applicable criteria, Office of Superintendent of Insurance staff shall so inform the superintendent. The superintendent shall notify you and BCBSNM that the request meets the criteria for external review and that an informal hearing has been**

set to determine whether, as a result of BCBSNM's adverse determination, you were deprived of medically necessary covered services. Prior to the hearing, Office of Superintendent of Insurance staff shall attempt to informally resolve the grievance.

***Notice of hearing*. The notice of hearing shall be mailed no later than eight (8) working days prior to the hearing date. The notice shall state the date, time, and place of the hearing and the matters to be considered and shall advise you and BCBSNM of the rights of the parties. The superintendent shall not unreasonably deny a request for postponement of the hearing made by you or BCBSNM.**

Hearing Procedures for External Review of Adverse Determinations

***Conduct of hearing*. The superintendent may designate a hearing officer who shall be an attorney licensed to practice in New Mexico. The hearing may be conducted by telephone conference call, video conferencing, or other appropriate technology at the Office of Superintendent of Insurance's expense.**

***Co-hearing officers*. The superintendent may designate two (2) independent co-hearing officers who shall be licensed health care professionals. If the superintendent designates two (2) independent co-hearing officers, at least one of them shall practice in a specialty that would typically manage the case that is the subject of the grievance.**

***Powers*. The superintendent or attorney hearing officer shall regulate the proceedings and perform all acts and take all measures necessary or proper for the efficient conduct of the hearing. The superintendent or attorney hearing officer may:**

(1) require the production of additional records, documents, and writings relevant to the subject of the grievance;

(2) exclude any irrelevant, immaterial, or unduly repetitious evidence; and

(3) if you or BCBSNM fails to appear, proceed with the hearing or adjourn the proceedings to a future date, giving notice of the adjournment to the absent party.

***Staff participation*. Staff may attend the hearing, ask questions, and otherwise solicit evidence from the parties, but shall not be present during deliberations among the superintendent or his designated hearing officer and any independent co-hearing officers.**

***Testimony*. Testimony at the hearing shall be taken under oath. The superintendent or hearing officers may call and examine you, BCBSNM, and other witnesses.**

***Hearing recorded*. The hearing shall be stenographically recorded at the Office of Superintendent of Insurance's expense.**

***Rights of parties*. Both you and BCBSNM have the right to:**

(1) attend the hearing; BCBSNM shall designate a person to attend on its behalf and you may designate a person to attend on your behalf if you choose not to attend personally;

(2) be assisted or represented by an attorney or other person; and

(3) call, examine and cross-examine witnesses; and

(4) submit to the ICO, prior to the scheduled hearing, in writing, additional information that the ICO must consider when conducting the internal review hearing and require that the information be submitted to BCBSNM and the MHCB staff.

***Stipulation*. You and BCBSNM shall each stipulate on the record that the hearing officers shall be released from civil liability for all communications, findings, opinions, and conclusions made in the course and scope of the external review.**

Independent Co- Hearing Officers (ICOs)

***Identification of ICOs*. The superintendent shall consult with appropriate professional societies, organizations, or associations to identify licensed health care and other professionals who are willing to serve as independent co- hearing officers in external reviews who maintain independence and impartiality of the process.**

***Disclosure of interests*. Prior to accepting designation as an ICO, each potential ICO shall provide to the superintendent a list identifying all Health Care Insurers and providers with whom the potential ICO maintains any health care related or other professional business arrangements and briefly describe the nature of each arrangement. Each potential ICO shall disclose to the superintendent any other potential conflict of interest that may arise in hearing a particular case, including any personal or professional relationship to you or to BCBSNM or providers involved in a particular external review.**

***Compensation of Hearing Officers and ICOs*.**

(1) *Compensation schedule*. The superintendent shall consult with appropriate professional societies, organizations, or associations in New Mexico to determine reasonable compensation for health care and other professionals who are appointed as ICOs for external grievance reviews and shall annually publish a schedule of ICO compensation in a bulletin.

(2) *Statement of ICO compensation*. Upon completion of an external review, the attorney and co- hearing officers shall each complete a statement of ICO compensation form prescribed by the superintendent detailing the amount of time spent participating in the external review and submit it to the superintendent for approval. The superintendent shall send the approved statement of ICO compensation to BCBSNM.

(3) *Direct payment to ICOs*. Within thirty (30) days of receipt of the statement of ICO compensation, BCBSNM shall remit the approved compensation directly to the ICO.

(4) *No compensation with early settlement*. If the parties provide written notice of a settlement up to three (3) working days prior to the date set for external review hearing, compensation will be unavailable to the hearing officers or ICOs.

The hearing officer and ICOs must maintain written records for a period of three (3) years and make them available upon request to the state.

Superintendent's Decision on External Review of Adverse Determination

***Deliberation*. At the close of the hearing, the hearing officers shall review and consider the entire record and prepare findings of fact, conclusions of law, and a recommended decision. Any hearing officer may submit a supplementary or dissenting opinion to the recommended decision.**

***Order.* Within the time period allotted for external review, the superintendent shall issue an appropriate order. If the order requires action on the part of BCBSNM, the order shall specify the timeframe for compliance.**

(1) The order shall be binding on you and BCBSNM and shall state that you and BCBSNM have the right to judicial review and that state and federal law may provide other remedies.

(2) Neither you nor BCBSNM may file a subsequent request for external review of the same adverse determination that was the subject of the superintendent's order.

Internal Review of Administrative Grievances

***Request for internal review of grievance*. Any person dissatisfied with a decision, action or inaction of BCBSNM, including termination of coverage, has the right to request internal review of an administrative grievance orally or in writing.**

***Acknowledgement of grievance*. Within three (3) working days after receipt of an administrative grievance, BCBSNM shall send you a written acknowledgment that it has received the administrative grievance. The**

acknowledgment shall contain the name, address, and direct telephone number of an individual representative of BCBSNM who may be contacted regarding the administrative grievance.

Initial review. **BCBSNM shall promptly review the administrative grievance. The initial review shall:**

(1) be conducted by a BCBSNM representative authorized to take corrective action on the administrative grievance; and

(2) allow you to present any information pertinent to the administrative grievance.

Initial Internal Review Decision on Administrative Grievance

BCBSNM shall mail a written decision to you within fifteen (15) working days of receipt of the administrative grievance. The fifteen (15) working day period may be extended when there is a delay in obtaining documents or records necessary for the review of the administrative grievance, provided that BCBSNM notifies you in writing of the need and reasons for the extension and the expected date of resolution, or by mutual written agreement of BCBSNM and you. The written decision shall contain:

(1) the name, title, and qualifications of the person conducting the initial review;

(2) a statement of the reviewer's understanding of the nature of the administrative grievance and all pertinent facts;

(3) a clear and complete explanation of the rationale for the reviewer's decision;

(4) identification of the health benefits plan provisions relied upon in reaching the decision;

(5) reference to evidence or documentation considered by the reviewer in making the decision;

(6) a statement that the initial decision will be binding unless you submit a request for reconsideration within twenty (20) working days of receipt of the initial decision; and

(7) a description of the procedures and deadlines for requesting reconsideration of the initial decision, including any necessary forms.

Reconsideration of Internal Review of Administrative Grievance

Committee. **Upon receipt of a request for reconsideration, BCBSNM shall appoint a reconsideration committee consisting of one or more employees of BCBSNM who have not participated in the initial decision. BCBSNM may include one or more covered persons other than you to participate on the reconsideration committee.**

Hearing. **The reconsideration committee shall schedule and hold a hearing within fifteen (15) working days after receipt of a request for reconsideration. The hearing shall be held during regular business hours at a location reasonably accessible to you, and BCBSNM shall offer you the opportunity to communicate with the committee, at BCBSNM's expense, by conference call, video conferencing, or other appropriate technology. BCBSNM shall not unreasonably deny a request for postponement of the hearing made by you.**

Notice. **BCBSNM shall notify you in writing of the hearing date, time and place at least ten (10) working days in advance. The notice shall advise you of the rights specified in the Rights of grievant section below. If BCBSNM will have an attorney represent its interests, the notice shall advise you that BCBSNM will be represented by an attorney and that you may wish to obtain legal representation of your own.**

Information to grievant. **No fewer than three (3) working days prior to the hearing, BCBSNM shall provide to you all documents and information that the committee will rely on in reviewing the case.**

Rights of grievant. **You have the right to:**

(1) attend the reconsideration committee hearing;

(2) present your case to the reconsideration committee;

(3) submit supporting material both before and at the reconsideration committee hearing;

(4) ask questions of any representative of BCBSNM; and

(5) be assisted or represented by a person of your choice.

Decision of Reconsideration Committee

BCBSNM shall mail a written decision to you within seven (7) working days after the reconsideration committee hearing. The written decision shall include:

(1) the names, titles, and qualifications of the persons on the reconsideration committee;

(2) the reconsideration committee's statement of the issues involved in the administrative grievance;

(3) a clear and complete explanation of the rationale for the reconsideration committee's decision;

(4) the health benefits plan provision relied on in reaching the decision;

(5) references to the evidence or documentation relied on in reaching the decision;

(6) a statement that the initial decision will be binding unless you submit a request for external review by the superintendent within twenty (20) working days of receipt of the reconsideration decision; and

(7) a description of the procedures and deadlines for requesting external review by the superintendent, including any necessary forms. The notice shall contain the toll- free telephone number and address of the superintendent's office.

External Review of Administrative Grievances

Right to external review. **If you are dissatisfied with the results of the internal review of an administrative decision you shall have the right to request external review by the superintendent.**

Exhaustion of remedies**. The superintendent may require you to exhaust any grievance procedures adopted by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act or BCBSNM, as appropriate, before accepting an administrative grievance for external review.**

Deemed exhaustion**. If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary and the internal appeals process will be deemed exhausted if:**

(1) BCBSNM waives the exhaustion requirement;

(2) BCBSNM is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process; or

(3) you simultaneously request an expedited internal appeal and an expedited external review.

Exception to exhaustion requirement.

Notwithstanding the *Exhaustion of remedies* section above, the internal claims and appeals process will not be deemed exhausted based on violations by BCBSNM that are *de minimus* and do not cause, and are not likely to cause, prejudice or harm to you, so long as BCBSNM demonstrates that the violation was for good cause or due to matters beyond the control of BCBSNM, and that the violation occurred in the context of an ongoing, good faith exchange of information between BCBSNM and you. This exception is not available if the violation is part of a pattern or practice of violations by BCBSNM.

You may request a written explanation of the violation from BCBSNM and BCBSNM must provide such explanation within ten (10) days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review under the *Exhaustion of remedies* section on the previous page on the basis that BCBSNM met the standards for the exception under Paragraph (1) of the *Exception to exhaustion requirement* above, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), BCBSNM shall provide you with notice of the opportunity to re-submit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of the notice.

Filing Requirements for External Review of Administrative Grievance

Deadline for filing request. **To initiate an external review, you must file a written request for external review with the superintendent within twenty (20) working days from receipt of the written notice of reconsideration decision. The request shall either be:**

(1) mailed to the Office of Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, Post Office Box 1689, Santa Fe, New Mexico 87504-1689; or

(2) e-mailed to mhcb.grievance@state.nm.us, subject External Review Request; or

(3) faxed to the Office of Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, (505) 827-4734; or

(4) completed on-line using an Office of Superintendent of Insurance Complaint Form available at http://www.osi.state.nm.us.

Documents required to be filed by the grievant. **You shall file the request for external review on the forms provided to you by BCBSNM pursuant to Subsection G of 13.10.17.36 NMAC.**

Other filings. **You may also file any other supporting documents or information you wish to submit to the superintendent for review.**

Extending timeframes for external review. **If you wish to supply supporting documents or information subsequent to the filing of the request for external review, the timeframes for external review shall be extended up to ninety (90) days from the receipt of the complaint form, or until you submit all supporting documents, whichever occurs first.**

Acknowledgement of Request for External Review of Administrative Grievance and Copy to BCBSNM

Upon receipt of a request for external review, the superintendent shall immediately send:

(1) an acknowledgment to you that the request has been received;

(2) BCBSNM a copy of the request for external review.

Upon receipt of the copy of the request for external review, BCBSNM shall provide to the superintendent and you by any available expeditious method within five (5) working days all necessary documents and information considered in arriving at the administrative grievance decision.

Review of Administrative Grievance by Superintendent

The superintendent shall review the documents submitted by BCBSNM and you, and may conduct an investigation or inquiry or consult with you, as appropriate. The superintendent shall issue a written decision on the administrative grievance within twenty (20) working days of receipt of the complete request for external review.

SECTION 9: GENERAL PROVISIONS

ADVANCE DIRECTIVES

Advance directives are written documents (such as a Living Will, Health Care Treatment Directives, and Durable Power of Attorney) that designate a person with the responsibility for making your health care decisions if you are incapable of expressing your own wishes. They also describe the kind of treatment you do and do not want. Members over age 18 have the right to refuse or accept medical care or surgical treatments and to execute advance directives.

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

APPLICATION STATEMENT

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

AVAILABILITY OF PROVIDER SERVICES

BCBSNM does not guarantee that a certain type of room or service will be available at any Hospital or other Facility within the BCBSNM network, nor that the services of a particular Hospital, Physician, or other Provider will be available.

CATASTROPHIC EVENTS

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

CHANGES TO THE BENEFIT BOOKLET

BCBSNM may amend this Benefit Booklet when authorized by an officer of BCBSNM. BCBSNM will give your Group at least 60 days prior written notice of an amendment to this Benefit Booklet. No employee of BCBSNM may change this Benefit Booklet by giving incomplete or incorrect information, or by contradicting the terms of this Benefit Booklet. Any such situation will not prevent BCBSNM from administering this Benefit Booklet in strict accordance with its terms. See the inside back cover for further information.

CONSUMER ADVISORY BOARD

BCBSNM has established a Consumer Advisory Board to provide input from the member's point-of-view about BCBSNM's general operations and internal policies and to identify areas that need improvement.

DISABLED CHILDREN CONTINUED COVERAGE

BCBSNM, which provides for coverage of an Eligible Child of the Subscriber until the attainment of the limiting age of 26 for Eligible Children, shall not terminate the coverage of a Child while the Child is, and continues to be both incapable of self-sustaining employment, by reason of mental retardation or physical disability, and chiefly dependent upon the Subscriber for support and maintenance. However, proof of the incapacity and dependency of the Child must be furnished to BCBSNM by the Subscriber within 31 days of the Child's attainment of the limiting age and subsequently, as may be required by BCBSNM, but not more frequently than annually after the two-year period following the Child's attainment of the limiting age of 26.

DISCLAIMER OF LIABILITY

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

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

DISCLOSURE AND RELEASE OF INFORMATION

BCBSNM will only disclose information as permitted or required under state and federal law. If this Plan is purchased through the Exchange, in no event shall BCBSNM be considered the agent of the Exchange or be responsible for the Exchange. All information you provide to the Exchange that is received by BCBSNM from the Exchange will be relied upon as accurate and complete. You must promptly notify the Exchange and BCBSNM of any changes to such information.

ENTIRE CONTRACT

This Benefit Booklet (and any amendments, riders, endorsements, and the *Summary of Benefits*), your Group enrollment/change application which is incorporated by reference into this Plan, and your Identification (ID) Card shall constitute the entire contract. All statements, in the absence of fraud, made by any applicant shall be deemed representations and not warranties. No such statements shall void coverage or reduce benefits unless contained in a written application for coverage.

EXECUTION OF PAPERS

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

FREEDOM OF CHOICE OF HOSPITAL AND PRACTITIONER

Within the area and limits of coverage offered to Subscribers and selected by the Subscriber in the application for insurance, the right of a person to exercise full freedom of choice in the selection of a hospital for hospital care or of a practitioner of the healing arts, or optometrist, psychologist, podiatrist, physician assistant, certified nurse-midwife, registered lay midwife, or registered nurse in expanded practice, for treatment of an illness or injury within that practitioner's scope of practice shall not be restricted under any new policy of health insurance, contract, or health care plan. Any person insured or claiming benefits under any such health insurance policy, contract, or health care plan providing within its coverage for payment of covered service benefits, or indemnity for hospital care or treatment of persons for the cure or correction of any physical or mental condition shall be deemed to have complied with the Plan requirements as to submission of proof of loss upon submitting written proof supported by the certificate of any hospital currently licensed by the department of health or any practitioner of the healing arts, or optometrist, psychologist, podiatrist, physician assistant, certified nurse--midwife, registered lay midwife or registered nurse in expanded practice.

FREEDOM OF CHOICE OF INDEPENDENT SOCIAL WORKER

Within the area and limits of coverage offered to Subscribers and selected by the Subscriber in the application for insurance, the right of a person to exercise full freedom of choice in the selection of any independent social worker for treatment within that practitioner's scope of practice shall not be restricted under any new policy of health insurance, contract, or health care plan in this state or in the processing of any Claim thereunder. Any person insured or claiming benefits under any such health insurance policy, contract, or health care plan providing within its coverage for payment of covered service benefits, or indemnity for treatment of persons for the cure or correction of any mental condition shall be deemed to have complied with the Plan requirements as to submission of proof of loss upon submitting written proof supported by any independent social worker.

HOLD-HARMLESS

The contracts between BCBSNM and its HMO-Participating Providers include a "hold harmless" clause which provides that an HMO plan Member cannot be liable to the Provider for monies owed by BCBSNM for Health Care Services covered under the HMO health plan.

INDEPENDENT CONTRACTORS

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

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

MEMBER RIGHTS

All members have these rights:

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

MEMBER RESPONSIBILITIES

As a member enrolled in a Managed Health Care Plan administered by BCBSNM, you have these responsibilities:

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

MEMBERSHIP RECORDS

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

PAYMENT OF CLAIMS

Claims submitted by a Member for Covered Services received by a deceased Member will be payable in accordance with the beneficiary designation and the provisions respecting such payments and effective at the time of payment. If no such designation or provision is then effective, Claims will be payable to the estate of the Subscriber. Any other Claims unpaid at the Member's death may, at our option, be paid to the beneficiary. All other Claims will be payable to the Subscriber.

PHYSICAL EXAMINATION AND AUTOPSY

If BCBSNM requires an independent medical examination before authorizing a service or processing a Claim, BCBSNM will cover the cost of the independent medical examination. In the unlikely event that BCBSNM requires an autopsy before paying a Claim, BCBSNM will pay the cost of the autopsy where it is not forbidden by law.

REFUSAL TO FOLLOW RECOMMENDED TREATMENT

A Member is allowed to refuse treatment that has been recommended by a participating Provider. The Provider may decide that the refusal compromises the Provider-patient relationship and obstructs the provision of proper medical care. If you refuse to follow the recommended treatment or procedure, you are entitled to see another Provider of the same specialty for a second opinion. You can also pursue the appeal process.

SENDING NOTICES

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

TIME PAYMENT OF CLAIMS

Claims payable under this Plan for any loss other than loss for which this Plan provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued Claims for loss for which this Plan provides periodic payment will be paid not less frequently than monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

TRANSFER OF BENEFITS

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

RELIGIOUS EMPLOYER EXEMPTION AND ELIGIBLE ORGANIZATION ACCOMMODATION

A certification(s) may have been provided to BCBSNM that your group health plan is established or maintained by an organization(s) that is a "religious employer(s)" as defined in 45 C.F.R. 147.131(a), as modified or replaced, and qualifies for a religious employer exemption from the Affordable Care Act requirement to cover certain contraceptive services without cost sharing under guidelines supported by the Health Resources and Services Administration ("Religious Employer Exemption"). Provided that the Religious Employer Exemption is satisfied for your group health plan, then coverage under your group health plan will not include coverage for some or all of such contraceptive services. Please call Customer Service at the number on the back of your ID card for more information. Questions regarding the Religious Employer Exemption should be directed to your Group.

In addition, a certification(s) may have been provided to BCBSNM that your group health plan is established or maintained by an organization(s) that is an "eligible organization(s)" as defined in 45 C.F.R. 147.131(b), as modified or replaced, and qualifies for an eligible organization accommodation with respect to the Affordable Care Act requirement to cover certain contraceptive services without cost sharing under guidelines supported by the Health Resources

and Services Administration (“Eligible Organization Accommodation"). Provided that the Eligible Organization Accommodation is satisfied, coverage under your group health plan will not include coverage for some or all of such contraceptive services. Please call Customer Service at the number on the back of your ID card for more information. If you have questions regarding the certification(s), you may contact your Group. For other questions about the Eligible Organization Accommodation, you may contact Customer Service at the number on the back of your ID card.

SECTION 10: DEFINITIONS

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

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

Adjustment Factor — The percentage by which the Medicare Allowable amount is multiplied in order to arrive at the "Noncontracting Allowable Amount." Adjustment Factors will be evaluated and updated no less than every two years.

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

Adverse Determination — A decision made either pre-service or post-service by BCBSNM that a Health Care Service requested by a Provider or Member has been reviewed and based upon the information available does not meet the requirements for coverage or Medical Necessity and the requested Health Care Service is either denied, reduced, or terminated.

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

Alcohol Abuse Treatment Facility, Alcohol Abuse Treatment Program — An appropriately licensed provider of Medical Detoxification and rehabilitation treatment for Alcohol Abuse.

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

Ambulatory Surgical Facility — An appropriately licensed provider, with an organized staff of Physicians, that meets all of the following criteria:

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient Basis; *and*
- provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the Facility; *and*
- does not provide inpatient accommodations; *and*
- is not a Facility used primarily as an office or clinic for the private practice of a Physician or other Provider.

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

Applied Behavioral Analysis (ABA) — Services that include behavior modification training programs that are based on the theory that behavior is learned through interaction between an individual and the environment. The goal of behavior management is to reinforce and increase desirable, functional behaviors while reducing undesirable, "maladaptive" behaviors.

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

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

Blue Access for Members (BAM) — On-line programs and tools that BCBSNM offers its Members to help track claims payments, make health care choices, and reduce health care costs.

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

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

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

Calendar Year — A Calendar Year is a benefit period of one year that begins on January 1 and ends on December 31 of the same year. The initial Calendar Year benefit period is from a Member's Effective Date of Coverage and ends on December 31, which may be less than 12 months.

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

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

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

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

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

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

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

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

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

Child — The following family members of the Subscriber or the Subscriber's spouse or Domestic Partner (provided your employer covers Domestic Partners) through the end of the month during which such family member turns age 26:

- natural or legally adopted child of the Subscriber or the Subscriber's spouse or Domestic Partner;
- child placed in the Subscriber's home for purposes of adoption (including a child for whom the Subscriber or the Subscriber's spouse or Domestic Partner is a party in a suit in which the adoption of the child by the Subscriber or the Subscriber's spouse or Domestic Partner is being sought);
- stepchild of the Subscriber or the Subscriber's spouse or Domestic Partner;
- eligible foster child of the Subscriber or the Subscriber's spouse or Domestic Partner;
- child for whom the Subscriber or the Subscriber's spouse or Domestic Partner must provide coverage because of a court order or administrative order pursuant to state law.

Child- Only Coverage — Coverage that is specifically designed and rated for children under age 21. Children are enrolled individually in the Plan; the parent or legal guardian is not covered and is not eligible for benefits under this Plan. If a Child is under the age of 18, his/her parent, legal guardian, or other responsible party must submit the *Application* for coverage on the Child's behalf. Also, for any Child covered under the Plan, any obligations of the Subscriber set forth in this Benefit Booklet or riders will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the Child's behalf. Applications for "Child- Only" coverage will not be accepted for an adult Child aged 21 or older. Adult children who are applying as the sole Member covered under the Plan must apply for his/her own coverage and must sign or authorize the *Application.*

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

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

Claim — Any request by a Subscriber for payment by a MHCP and/or any direct services provided to an individual.

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

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

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

Continuous Quality Improvement — An ongoing and systemic effort to measure, evaluate, and improve a Managed Health Care Plan's process in order to continually improve the quality of Health Care Services provided to its Members.

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

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

Cosmetic Surgery Services — Cosmetic Surgery Services is a beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic.

Cost Effective — A procedure, service, or supply that is an economically efficient use of resources with respect to cost, relative to the benefits and harms associated with the procedure, service, or supply. When determining Cost Effectiveness, the situation and characteristics of the individual patient are considered.

Covered Charge — The amount that BCBSNM allows for Covered Services using a variety of pricing methods and based on generally accepted claim coding rules. The Covered Charge for services from "Contracted Providers" is the amount the Provider, by contract with BCBSNM (or another entity, such as another BCBS Plan), will accept as payment in full under this health plan.

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

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

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

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

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

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

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

Deductible — An amount of Covered Charges that you must pay in a Calendar Year before this Plan begins to pay its share of Covered Charges you incur during that Calendar Year.

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

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

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

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

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

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

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

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

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

Drug Abuse — A condition defined by patterns of usage that continue despite occupational, marital, or physical problems related to compulsive use of drugs or other non-alcoholic substance. There may also be significant risk of severe withdrawal symptoms if the use of drugs is discontinued. Drug Abuse does not include nicotine addiction or Alcohol Abuse.

Drug Abuse Treatment Facility— An appropriately licensed provider primarily engaged in detoxification and rehabilitation treatment for Chemical Dependency.

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

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

Effective Date of Coverage — 12:01 a.m. of the date on which a Member's coverage under this Plan begins.

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

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

Emergency, Emergency Care — Medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to his/her health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part, or disfigurement. In addition, services must be received in an emergency room, trauma center, or Ambulance to qualify as an Emergency. Examples of Emergency conditions include, but are not limited to: heart attack or suspected heart attack, coma, loss of respiration, stroke, acute appendicitis, severe allergic reaction, or poisoning.

Emergency Room (ER) Deductible per Occurrence — You may also have an Emergency Room (ER) Deductible. This ER Deductible is applicable to Covered Charges billed by a Hospital for emergency room services if you were not admitted to the Hospital for further treatment. This ER Deductible is the amount of Covered Charges that you must pay, in addition to your Calendar Year Deductible, for emergency room services. Should you be admitted, the Emergency Room Deductible is waived and you pay only the Calendar Year Deductible and if applicable, your Coinsurance.

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

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

Exchange — A governmental agency or non-profit entity that meets the applicable standards of federal law and makes Qualified Health Plans available to Qualified Employees and Qualified Employers. Unless otherwise identified, "Exchange" refers to State Exchanges, regional Exchange, subsidiary Exchange, and a Federally-facilitated Exchange.

Experimental, Investigational or Unproven — Any treatment, procedure, facility, equipment, drug, device, or supply that is not accepted as standard medical practice in the state where services are provided. In addition, if a federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is Experimental. To be considered standard medical practice and not Experiment or Investigational, treatment must meet all five of the following criteria:

- a technology must have final approval from the appropriate regulatory government bodies;
- the scientific evidence as published in peer--reviewed literature must permit conclusions concerning the effect of the technology on health outcomes;

- the technology must improve the net health outcome;
- the technology must be as beneficial as any established alternatives; and
- the improvement must be attainable outside the Investigational settings.

Facility — A Hospital or other institution.

Family Coverage — Coverage for you and your Eligible Family Members under this Plan as described in this Benefit Booklet.

FDA — The United States Food and Drug Administration.

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

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

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

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

Group Administration Document — The contract between BCBSNM and the Group, any addenda, this Benefit Booklet, the Group's application to the Exchange and the Plan, as appropriate, along with any exhibits, appendices, addenda and/or other required information and the individual application(s) of the persons covered under the Group Administration Document which by its terms limits eligibility to Members of a specified group.

Habilitative or Rehabilitative Treatment — Treatment programs that are necessary to: 1) develop, 2) maintain, and 3) restore to the maximum extent practicable the functioning of an individual.

Health Care Benefits — Benefits for Medically Necessary services consisting of preventive care, Emergency care, inpatient and out- patient hospital and Physician care, diagnostic laboratory and diagnostic and therapeutic radiological services and does not include dental services, vision services for adults, or long- term rehabilitation treatment.

Health Care Facility — An institution providing Health Care Services, including a Hospital or other licensed inpatient center, an ambulatory surgical or treatment center, a Skilled Nursing Facility, a Residential Treatment Center, a Home Health Care Agency, a diagnostic laboratory or imaging center, and a rehabilitation or other therapeutic health setting.

Health Care Insurer — A person that has a valid certificate of authority in good standing under the New Mexico Insurance Code to act as an insurer, Health Maintenance Organization (HMO), nonprofit health care plan, prepaid dental plan, a multiple employer welfare arrangement or any other person providing a plan of health insurance or a Managed Health Care Plan subject to state insurance law and regulation.

Health Care Services — Services, supplies, and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the health plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay.

Health Maintenance Organization (HMO) — Any person who undertakes to provide or arrange for the delivery of basic Health Care Services to Subscribers on a prepaid basis, except for Subscriber responsibility for Copayments or Deductibles.

HMO- Participating Provider — Either a Facility (i.e., a Hospital) or a Professional Provider (i.e., a Physician) that, for the service being provided, contracts with BCBSNM as an HMO- Participating Provider, either directly or indirectly, or with the National BCBS Transplant Network to provide Health Care Services to Members with an expectation of receiving payment (other than Copayments, Coinsurance, or Deductibles) directly or indirectly from BCBSNM. An HMO- Participating Provider also agrees to bill BCBSNM and to accept this Plan's payment (provided in accordance with the provisions of the contract) plus the Member's Copayment, Coinsurance or Deductibles as payment in full for Covered Services. BCBSNM, as Claims Administrator, will pay the HMO- Participating Provider directly.

The contracts between BCBSNM and its Providers include a "hold harmless" clause so that an HMO Member cannot be liable to the provider for moneys owed by BCBSNM for services covered under this Plan.

BCBSNM may add, change, or terminate specific HMO- Participating Providers at its discretion or recommend a specific Provider for specialized care as Medical Necessity warrants. HMO- Participating Providers are not required by BCBSNM to comply with any specified numbers, targeted averages, or maximum durations of patient visits.

> **Nonparticipating Provider** — An appropriately licensed health care provider that has **not** contracted directly with a BCBS Plan to be a part of the BCBS HMO- Participating Provider Network.

HMO- Participating Specialist — A health care practitioner who has an HMO- Participating Provider contract with BCBSNM, but is **not** specially contracted as a "PCP." A specialist does not include Hospitals or other treatment facilities, Urgent Care Facilities, pharmacies, equipment suppliers, Ambulance companies, or similar ancillary health care Providers.

Home Health Care Agency — An appropriately licensed provider that both:

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

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

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

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

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

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

- diagnosis and treatment of illness, injury, deformity, abnormality or pregnancy
- clinical laboratory, diagnostic x-ray, and definitive medical treatment provided by an organized medical staff within the institution

- treatment facilities for Emergency Care and Surgical Services either within the institution or through a contractual arrangement with another licensed Hospital (These contracted services must be documented by a well-defined plan and related to community needs.).

Hospital Care — Hospital service provided by a hospital that is licensed as a hospital by the department of health and has accommodations for bed patients, a licensed professional registered nurse always on duty or call, a laboratory, and an operating room where surgical operations are performed. Hospital care does not include a convalescent, nursing, or rest home.

Host Blue — When you are outside New Mexico and receive Covered Services, the provider will submit Claims to the Blue Cross Blue Shield (BCBS) Plan in that state. That BCBS Plan (the "Host Blue" Plan) will then price the Claim according to local practice and contracting, if applicable, and then forward the Claim electronically to BCBSNM - your "Home" Plan - for completion of processing (e.g., benefits and eligibility determination).

Identification Card (ID Card) — The card BCBSNM issues to the Subscriber that identifies the cardholder as a Plan Member.

Independent Social Worker — A person licensed as an Independent Social Worker by the board of social work examiners.

Inpatient Admission Deductible per Occurrence — Depending upon the Plan you chose, in addition to your Calendar Year Deductible, you may have an Inpatient Admission Deductible applicable to Covered Charges billed by a Hospital for Inpatient Services received during a Hospital stay. This Inpatient Admission Deductible applies each time you are admitted to a Hospital for Inpatient Services, including any Admissions occurring after formally being discharged from any previous hospitalization for treatment of the same condition. This Deductible is the amount of Covered Charges that you must pay, in addition to your Calendar Year Deductible, for Inpatient Services billed by a Hospital before this Plan begins to pay its percentage of Covered Charges billed by that Hospital for Inpatient Services you receive during that Hospital stay.

Inpatient Services — Care provided while you are confined as an inpatient in a Hospital or treatment center for at least 24 hours. Inpatient care includes partial hospitalization (a nonresidential program that includes from 5-12 hours of continuous mental health or Chemical Dependency care during any 24- hour period in a treatment Facility). Inpatient Services include, but are not limited to, semi-private room accommodations, general nursing care, meals, and special diets or parenteral nutrition when Medically Necessary, Physician and surgeon services, use of all Hospital facilities when use of such facilities is determined to be Medically Necessary by your treating Physician, pharmaceuticals and other medications, anesthesia and oxygen services, special duty nursing when Medically Necessary, Radiation Therapy, inhalation therapy, and administration of whole blood and blood components when Medically Necessary.

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

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

Involuntary Loss of Coverage — A loss of other coverage due to legal separation, divorce, death, termination of employment, reduction in hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Involuntary Loss of Coverage does not include a loss of coverage due to the failure of the individual or Member to pay premiums on a timely basis or termination of coverage for Good Cause.

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

- anyone not enrolled **within 30 days** of becoming eligible for coverage under this health care plan (e.g.,a newborn child added to coverage **more than 30 days** after birth when Family Coverage (or Employee/Child(ren), if available, is not already in effect, a child added **more than 30 days** after legal adoption, a new spouse or stepchild added more than 30 days after marriage)

- anyone enrolling on the Group's initial BCBSNM enrollment date who was not covered under the Group's prior plan (but who was eligible for such coverage)
- anyone eligible but not enrolled during the Group's initial enrollment
- anyone who voluntarily terminates his/her coverage and applies for reinstatement of such coverage at a later date (except as provided under the USERRA of 1994)

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

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

Managed Care — A system or technique(s) generally used by third party payors or their agents to affect access to and control payment for Health Care Services. Managed Care techniques most often include one or more of the following:

- prior, concurrent, and retrospective review of the Medical Necessity and appropriateness of services or site of services;
- contracts with selected health care providers;
- financial incentives or disincentives for Members to use specific Providers, services, prescription drugs, or service sites;
- controlled access to and coordination of services by a case manager; and
- payor efforts to identify treatment alternatives and modify benefit restrictions for high cost patient care.

Managed Health Care Plan (MHCP) — A "Managed Health Care Plan" is a health plan that requires a member to use, or encourages a member to use, a "Network Provider" (your Provider network is determined by the type of health plan you have). Your health plan may require you to use Network Providers in order to receive benefits. Your health plan may provide a higher level of benefit for in- network services. Therefore, your choice of Provider under a Managed Health Care Plan determines the amount and kind of **benefits** you receive under your health care plan. **Your BCBSNM health plan does not prevent you from choosing to receive services from a Provider outside the network.** The choice of Provider is still up to you - but the health plan is not obligated to provide benefits for every service you seek to receive. You may receive no benefits or reduced benefits for services received outside the network.

Maternity/Pregnancy Related — Any condition that is related to pregnancy. Maternity care includes prenatal and postnatal care and care for the complications of pregnancy, such as ectopic pregnancy, spontaneous abortion (miscarriage), or C-section.

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

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

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

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

Medically Necessary, Medical Necessity — Health Care Services determined by a Provider, in consultation with BCBSNM, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical

societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by BCBSNM consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease.

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

Member — An enrollee (the Subscriber or any Eligible Family Member) who is enrolled for coverage and entitled to receive benefits under this Plan in accordance with the terms of the Group Administration Document. Throughout this Benefit Booklet, the terms "you" and "your" refer to each Member.

Mental Disorder — A clinically significant behavioral or psychological syndrome or condition that causes distress and disability and for which improvement can be expected with relatively short-term treatment. Mental Disorder does not include developmental disabilities, autism or Autism Spectrum Disorders, drug or Alcohol Abuse, or learning disabilities.

Minimum Essential Coverage — Health insurance coverage that is recognized as coverage that meets substantially all requirements under federal law pertaining to adequate individual, group, or government health insurance coverage.

Morbid Obesity — A serious health condition that can interfere with a person's basic physical functions such as breathing or walking and that meets the following criteria with respect to such person's weight and/or health:

- a body mass index (BMI) equal to or greater than 40 kg/meters^2;
- a BMI equal to or greater than 35kg/meters^2 with at least one (1) of the following clinically significant obesity-related diseases or complications that are not controlled by best practice medical management:
  - — hypertension
  - — dyslipidemia
  - — diabetes mellitus
  - — coronary heart disease
  - — sleep apnea
  - — osteoarthritis

Network Provider (In-network Provider) — A Contracted Provider that has agreed to provide services to Members in your *specific* type of health plan (e.g., PPO etc.).

Network Service Area — The geographic area designated by BCBSNM, within which the Benefits of this Plan are available to Members. A Member may call Customer Service at the number shown on the back of the Identification Card to determine if he/she resides or works in the Network Service Area or he/she may log on to the website at www.bcbsnm.com.

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

Noncontracting Allowable Amount— See definition of "Covered Charge" earlier in this section.

Obstetrician-Gynecologist — A Physician who is board-eligible or board-certified by the American Board of Obstetricians and Gynecologists or by the American College of Osteopathic Obstetricians and Gynecologists.

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

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

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

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

OSI — The Office of Superintendent of Insurance.

Other Valid Coverage — All other group and individual (or direct-pay) insurance policies or health care benefit plans (including Medicare, but excluding Indian Health Service and Medicaid coverages), that provide payments for medical services will be considered Other Valid Coverage for purposes of coordinating benefits under this Plan.

Other Providers — Clinical Psychologists and the following masters-degreed psychotherapists (an independently licensed Professional Provider with either an M.A. or M.S. degree in psychology or counseling): licensed independent social workers (L.I.S.W.); licensed professional clinical mental health counselors (L.P.C.C.); masters-level Registered Nurse certified in psychiatric counseling (R.N.C.S.); licensed marriage and family therapist (L.M.F.T.). For Chemical Dependency services, a Provider also includes a licensed Alcohol and Drug Abuse counselor (L.A.D.A.C.).

Out-of-Area Services — Covered services that are provided to you when outside the BCBSNM HMO Network Service Area.

Out-of-Pocket Limit — The maximum amount of Deductibles, Coinsurance, and Copayments for HMO- Participating Provider or for Nonparticipating Provider services that you pay for most Covered Services in a Calendar Year. After the applicable Out-of-Pocket Limit is reached, this Plan pays **100 percent** of your HMO- Participating Provider Covered Charges for the rest of that Calendar Year, not to exceed any benefit limits.

Outpatient Services — Medical/Surgical Services received in the outpatient department of a Hospital, observation room, Emergency room, Ambulatory Surgical Facility, freestanding Dialysis Facility, or other covered outpatient treatment Facility. Outpatient Services include those Hospital services that can reasonably be provided on an ambulatory basis and those preventive, Medically Necessary, diagnostic and treatment procedures prescribed by your attending Physician. Such services may be provided at a Hospital, a Physician's office, any other appropriate licensed Facility, or at any other appropriate Facility if the professional delivering the services is licensed to practice, is certified and is practicing under authority of the Health Care Insurer, a medical group, an independent practice association, or other authority authorized by applicable New Mexico law.

Outpatient Surgery — Any Surgical Services that is performed in an Ambulatory Surgical Facility or the outpatient department of a Hospital, but **not** including a procedure performed in an office or clinic. Outpatient Surgery includes any procedure that requires the use of an Ambulatory Surgical Facility or an outpatient Hospital operating or recovery room.

Outpatient Surgery Deductible per Occurrence — Depending upon the Plan you chose, in addition to your Calendar Year Deductible, you may also have an Outpatient Surgery Deductible applicable to Covered Charges billed by a Facility for outpatient surgical services received. This Outpatient Surgery Deductible applies each time you are admitted to the Facility for outpatient surgical services. This Deductible is the amount of Covered Charges that you must pay, in addition to your Calendar Year Deductible, for outpatient surgical services billed by a Facility before this Plan begins to pay its percentage of Covered Charges billed by that Facility for outpatient surgical services you receive during that Facility stay.

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

provide specialty drugs to Members; these pharmacies are called "Specialty Pharmacy Providers" and some drugs must be dispensed by these specially contracted pharmacy Providers in order to be covered

Participating Provider — See definition of "HMO- Participating Provider," earlier in this section.

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

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

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

Physician Assistant — A graduate of a physician assistant or surgeon assistant program approved by a nationally recognized accreditation body or a skilled person who is currently certified by the National Commission on Certification of Physician Assistants, who is licensed in the state of New Mexico (or by the appropriate state regulatory body) to practice medicine under the supervision of a licensed Physician.

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

Practitioner of the Healing Arts — Any person holding a license or certificate authorizing the licensee to offer or undertake to diagnose, treat, or operate on, or prescribe for any human pain, injury, disease, deformity, physical, or mental condition pursuant to:

- the Chiropractic Physician Practice Act
- the Dental Health Act
- the Medical Practice Act
- the Acupuncture and Oriental Medicine Practice Act

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

Predetermination — An advance confirmation, or "predetermination," of benefits for a requested Covered Service. Predetermination does not guarantee benefits if the actual circumstances of the case differ from those originally described.

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

Primary Care Provider (PCP) — HMO- Participating Providers who have signed special "Primary Care Provider" agreements with BCBSNM and are listed as "PCPs" in the Provider Directory or online Provider Finder. They include family and general practice, internal medicine, obstetrics/gynecology, oriental medicine, and pediatric health care Providers. See the definition of "Provider" for more information. Other health care professionals may also provide primary care.

Professional Provider (Health Care Professional) — A Physician or health care practitioner, including a pharmacist, who is licensed, certified, or otherwise authorized by the state to provide Health Care Services consistent with state law.

Prosthetics, Prostheses or Prosthetic Device — An externally attached or surgically implanted artificial substitute for an absent body part; for example, an artificial eye or limb.

Provider — A duly licensed Hospital, Physician, or other Practitioner of the Healing Arts authorized to furnish Health Care Services within the scope of licensure.

Psychiatric Hospital — A psychiatric Facility licensed as an acute care Facility or a psychiatric unit in a medical Facility that is licensed as an acute care Facility. Services are provided by or under the supervision of an organized staff of Physicians. Continuous 24-hour nursing services are provided under the supervision of a Registered Nurse.

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

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

Qualified Employee — An individual who is employed by a Qualified Employer who has been offered health insurance coverage by such Qualified Employer through the Small Business Health Options Program.

Qualified Employer — A Small Employer that elects to offer, at a minimum, all full- time employees of such employer coverage in one or more Qualified Health Plans offered through the SHOP.

Qualified Health Plan (QHP) — A health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of part 155.

Qualified Health Plan Issuer (QHP Issuer) — A health insurance issuer that offers a QHP in accordance with a certification from the Exchange.

QCMSO — A Qualified Child Medical Support Order.

Radiation Therapy — X-ray, radon, cobalt, betatron, telocobalt, and radioactive isotope treatment for malignant diseases and other medical conditions.

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

Registered Lay Midwife — Any person who practices lay midwifery and is registered as a lay midwife by the New Mexico Department of Health.

Registered Nurse (R.N.) — A nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by appropriate state authority.

Registered Nurse (R.N.) in an Expanded Practice — A person licensed by the board of nursing as a Registered Nurse for Expanded Practice as a certified nurse practitioner, certified registered nurse anesthetist, certified clinical nurse specialist in psychiatric mental health nursing or clinical nurse specialist in private practice and who has a master's degree or doctorate in a defined clinical nursing specialty and is certified by a national nursing organization.

Rehabilitation Hospital — An appropriately licensed Facility that provides rehabilitation care services on an Inpatient Services basis. Rehabilitation care services consist of the combined use of a multidisciplinary team of Physical, Occupational, Speech, and Respiratory Therapists, medical social workers, and rehabilitation nurses to enable patients disabled by illness or Accidental Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

Residential Treatment Center — A Facility offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, and structure and is licensed by the appropriate state and local authority to provide such service. It does not include half- way houses, supervised living, group homes, boarding houses, or other facilities that provide primarily a supportive environment and address long- term social needs, even if counseling is provided in such facilities. Patients in Residential Treatment Centers are

medically monitored with 24-hour medical availability and 24-hour on-site nursing service for patients with Mental Illness and/or Chemical Dependency disorders.

Rescission — A cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if:

- the cancellation or discontinuance of coverage has only a prospective effect; or
- the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

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

Retail Health Clinic — A health care clinic located in a retail setting, supermarket, or pharmacy which provides treatment of common illnesses and routine preventive Health Care Services by Certified Nurse Practitioners. A "Participating" Retail Health Clinic has a written agreement with BCBSNM or another Blue Cross and Blue Shield Plan to provide services. A "Nonparticipating" Retail Health Clinic does not have a written agreement with BCBSNM or another Blue Cross and Blue Shield Plan to provide services.

Routine Newborn Care — Care of a child immediately following his/her birth that includes:

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

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

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

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

www.bcbsnm.com/Members/Health and Wellness

SHOP — A Small Business Health Option Program ("SHOP") operated through an Exchange through which a Qualified Employer can provide its employees and their dependents with access to one or more QHPs.

Short-Term Rehabilitation — Inpatient, outpatient, office- and home-based occupational, physical, and Speech Therapy techniques that are medically necessary to restore and improve lost bodily functions following illness or Accidental Injury. (This does not include services provided as part of an approved home health or Hospice Admission,

which are subject to separate benefit limitations and exclusions, and does not include Alcohol or Drug Abuse rehabilitation.)

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

Skilled Nursing Facility — A Facility or part of a Facility that:

- is licensed in accordance with state or local law; *and*
- is a Medicare-participating Facility; *and*
- is primarily engaged in providing Skilled Nursing Care to inpatients under the supervision of a duly licensed Physician; *and*
- provides continuous 24-hour nursing service by or under the supervision of a Registered Nurse; *and*
- does **not** include any Facility that is primarily a rest home, a Facility for the care of the aged, or for treatment of tuberculosis, or for intermediate, Custodial Care or educational care.

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

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

Special Enrollment — When an otherwise eligible employee or Eligible Family Member did not enroll in the Plan when initially eligible, there are certain instances (or "qualifying events") during which the employee and his/her Eligible Family Members, if any, may enroll in the Plan at a later date - or more than 31 days after becoming eligible - and not considered Late Applicants. The "Special Enrollment" period is the period of time during which an otherwise Late Applicant may apply for coverage outside the annual open enrollment period.

Special Medical Foods — Nutritional substances in any form that are formulated to be consumed or administered internally under the supervision of a Physician, specifically processed or formulated to be distinct in one or more nutrients present in natural food; intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs, or certain nutrients contained in ordinary foodstuffs, or who have other specific nutrient requirements as established by medical evaluation; and essential to optimize growth, health, and metabolic homeostasis. Special Medical Foods are covered only when prescribed by a Physician for treatment of genetic orders of metabolism, and the member is under the Physician's ongoing care. Special Medical Foods are not for use by the general public and may not be available in stores or supermarkets. Special Medical Foods are not those foods included in a health diet intended to decrease the risk of disease, such as reduced-fat foods, low sodium foods, or weight loss products.

Specialty Pharmacy Provider — See definition of "Participating Pharmacy."

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

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

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

Summary of Benefits and Coverage (SBC) — The separately issued schedule that defines your Coinsurance requirements, Deductibles, Copayments, Out- of- Pocket Limits, and annual or lifetime benefits, and provides an overview of Covered Services. It is referred to as the *Summary of Benefits* throughout this Benefit Booklet.

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

Temporomandibular Joint (TMJ)/Craniomandibular Joint (CMJ) Disorder — A condition that may include painful temporomandibular joints, tenderness in the muscles that move the jaw, clicking of joints, and limitation of jaw movement.

Terminally Ill Patient (or Member) — A patient with a life expectancy of **six months or less**, as certified in writing by the attending Physician.

Tertiary Care Facility — A Hospital unit that provides complete perinatal care (occurring in the period shortly before and after birth) and intensive care of intrapartum (occurring during childbirth or delivery) and perinatal high-risk patients. This Hospital unit also has responsibilities for coordination of transport, communication and data analysis systems for the geographic area served.

Tobacco User — A person who is permitted under state and federal law to legally use tobacco, with tobacco use (other than religious or ceremonial use of tobacco), occurring on average four or more times per week that last occurred within the past six months (or such other meaning required or permitted by applicable law). Tobacco includes, but is not limited to, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, , etc. For additional information, please call the number on the back of your ID Card or visit our website at www.bcbsnm.com.

Totally Disabled — With respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

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

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

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

Utilization Management — A system for reviewing the appropriate and efficient allocation of medical services and Hospital resources given or proposed to be given to a patient or group of patients.

Well- Child Care — Periodic health and developmental assessments and screenings, immunizations, and physical exams provided to children who have no symptoms of current illness as recommended by the American Academy of Pediatrics, and the U.S. Preventive Services Task Force (USPSTF).

SECTION 11: CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

This notice generally explains:

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

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

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

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of health care plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the health care plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and eligible children of employees may be qualified beneficiaries. Under the Plan, generally most qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Contact the employer and/or COBRA administrator for specific information for your Plan.

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

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

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

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

Your eligible children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens and if your Group is subject to the provisions of COBRA:

- the parent-employee dies;
- the parent-employee's hours of employment are reduced;
- the parent-employee's employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes enrolled in Medicare (Part A, Part B or both);
- the parents become divorced or legally separated; or
- the child stops being eligible for coverage under the Plan as an "eligible child".

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage of any retiree covered under the Plan, the retiree is a qualified beneficiary with respect to the bankruptcy. The retiree's spouse, surviving spouse and eligible children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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

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

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

For the other qualifying events (divorce or legal separation of the employee and spouse or an eligible child losing eligibility for coverage as an eligible child), you must notify the Plan administrator. The Plan requires you to notify the Plan administrator **within 60 days** after the qualifying event occurs. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

Once the Plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

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

- the death of the employee;
- the enrollment of the employee in Medicare (Part A, Part B or both);
- your divorce or legal separation; or
- an eligible child losing eligibility as an eligible child.

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

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during **the first 60 days** of COBRA continuation coverage and you notify the Plan administrator in a timely fashion, you and your entire family can receive **up to an additional 11 months** of COBRA continuation coverage, **for a total maximum of 29 months**. You must make sure that your Plan administrator is notified of the Social Security Administration's determination **within 60 days** of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

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

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

In all of these cases, you must make sure that the Plan administrator is notified of the second qualifying event **within 60 days** of the second qualifying event. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

IF YOU HAVE QUESTIONS

If you have questions about COBRA continuation coverage, contact the Plan administrator or the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

In order to protect your family's rights, you should keep the Plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Plan administrator.

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

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

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

- this Benefit Booklet and any amendments, riders, or endorsements;
- the enrollment/change form(s) for the Subscriber and his/her dependents;
- the Members' Identification Cards; and
- the *Summary of Benefits.*

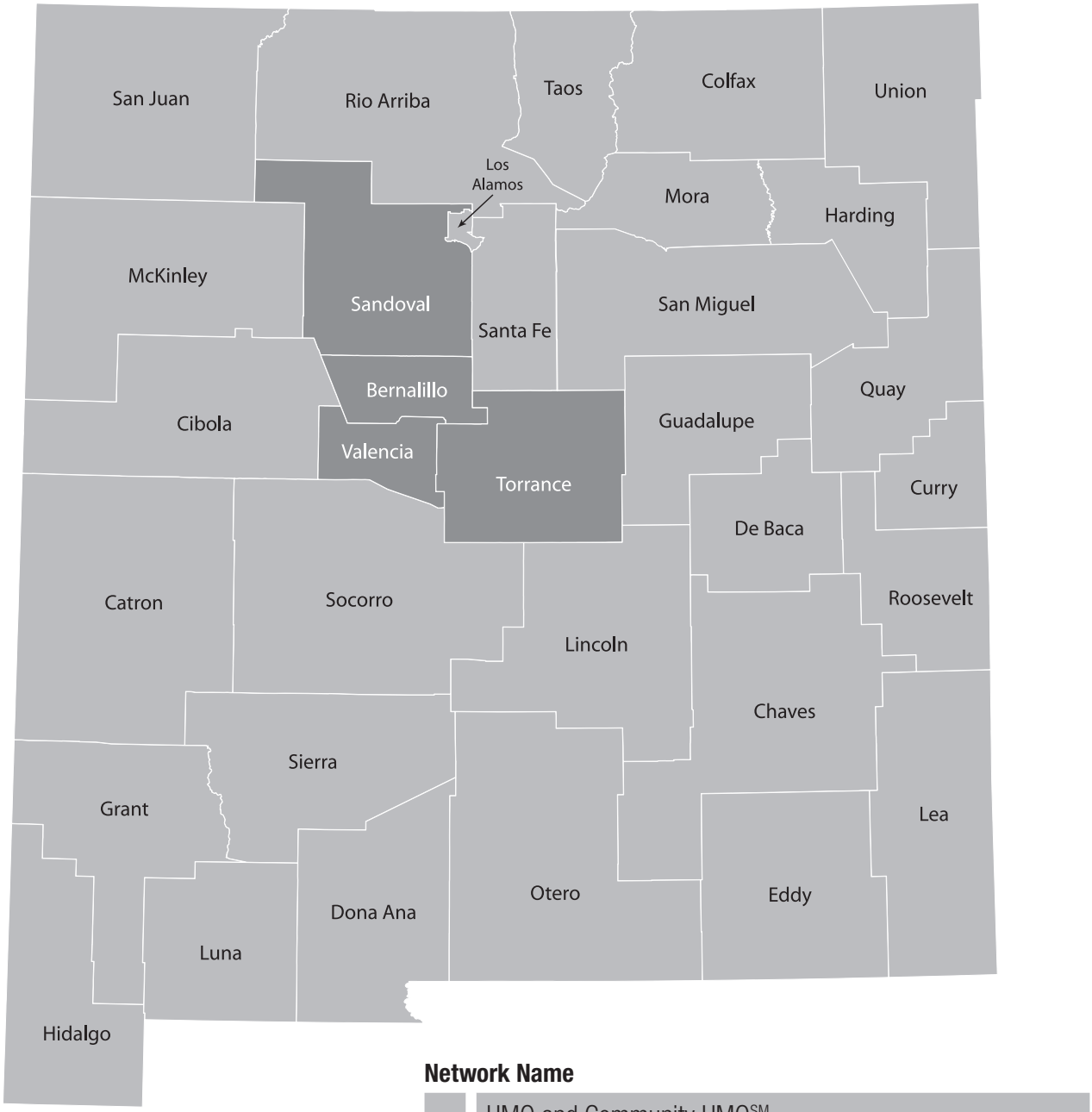
In addition, your Group has important documents that are part of the legal agreement:

- your Group's application for participation in the Exchange; and
- the Group Administration Document between BCBSNM and your Group.

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

BlueCross BlueShield of New Mexico

Appendix A
New Mexico HMO Networks by County

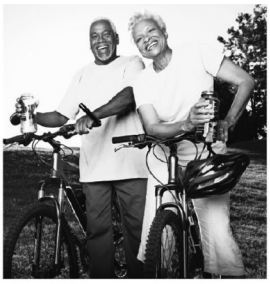


Network Name

HMO and Community HMO℠

HMO, Community HMO℠ and Blue Advantage HMO℠

BlueCross BlueShield of New Mexico



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