Your Health Care Benefit Program

BlueEdge℠

A Preferred Provider Option (PPO) Plan

to be used in conjuction with the BlueEdge HSA 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 standalone dental insurance product.

Underwritten by:

BlueCross BlueShield of New Mexico

Experience. Wellness. Everywhere.℠

M642_GFD NGF (rev 02/14)

CUSTOMER ASSISTANCE

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

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

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

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

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

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

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 Benefits.*

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

A message from

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO

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

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

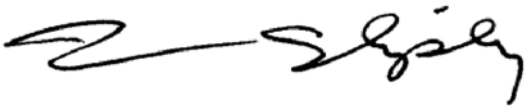
Please take some time to get to know your BlueEdge health care benefit plan coverage, including its benefit limits and exclusions, by reviewing this important document and any enclosures. This Plan is designed to be used along with the BlueEdge Health Savings Account (HSA) program. Learning how this Plan works can help make the best use of your health care benefits.

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

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

Welcome to Blue Cross and Blue Shield of New Mexico! We are very happy to have you as a member and pledge you our best service.

Sincerely,



Kurt Shipley
President
Blue Cross and Blue Shield of New Mexico

For Grandfathered Plans: (Contact your benefits administrator if you are unsure of the type of plan you have.)

Disclosure of Grandfather Status

The health care plan believes this coverage is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on essential benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the employer or to the Plan Administrator. For groups that are subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

For nonfederal governmental plans and church plans, which are not subject to ERISA, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Revision History: Revised as of 2/14 and includes all approved endorsements effective through 2/14.

ENDORSEMENT UPDATES FOR 2014 AND 1/1//15

The following Endorsements were issued for 2014 and 1/1/15 and are made a part of your benefit booklet.

2014 Changes: Summary of Benefits and Coverage (SBC), Late Applicant, Disabled Children Continued Coverage & General Provisions for Insured Group Plans

2015 BlueCard Program and Member Data Share Rider (for all HMO Blue Group Plans)

2015 BlueCard Program and Member Data Share Rider (for all EPO BlueNet Plans)

2015 BlueCard Program and Member Data Share Rider (for all PPO Group Plans)

The following disclaimer will appear on all booklet covers per mandate by the New Mexico Office of the Superintendent of Insurance:

"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."

Blue Cross and Blue Shield of New Mexico

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

Endorsement:

2014 Changes: Summary of Benefits and Coverage (SBC), Late Applicant, Disabled Children Continued Coverage & General Provisions for Insured Group Plans

(for BlueEdge℠ HSA and BlueEdge HSA 100, BluePPO Evolution℠, Blue PPO Options℠, BlueNet® EPO, BlueNet "H", HMO Blue® Traditional and HMO Blue Alternatives)

This endorsement for insured group health plans is made a part of your Blue Cross and Blue Shield of New Mexico (BCBSNM) health care plan benefit booklet. These changes apply to all fully insured group health plans *(BlueEdge HSA and BlueEdge HSA 100, BluePPO Evolution, Blue PPO Options, BlueNet EPO, BlueNet "H", HMO Blue Traditional and HMO Blue Alternatives),whether your health plan is considered a "grandfathered" or "non-grandfathered" health plan,* **unless noted otherwise**. The effective date of these changes depends upon your group's annual renewal date and whether or not your health plan is considered a "grandfathered" or "non-grandfathered" health plan. (See below for information regarding "grandfathered" and "non-grandfathered" health plans. If you do not know which type of plan you are under, ask your benefits administrator.)

BY:

Kurt Shipley
President, Blue Cross and Blue Shield of New Mexico

GRANDFATHERED PLANS

Your health plan is a grandfathered health plan if no changes were made to it that would cause it to lose its "grandfathered" status described in the "Disclosure of Grandfathered Status" provision of your benefit booklet. The "Disclosure of Grandfathered Status" provision was added to your benefit booklet in form no. "NM475509_2014 Benefit Changes for Insured Group Plans," of the Endorsement entitled, "2014 Benefit Changes: Insured Group Plans." If you are unsure as to whether or not your Plan is "grandfathered," please contact your benefits administrator.

NON-GRANDFATHERED PLANS

If your Plan was initiated on or after March 23, 2010 or if your Plan was in effect prior to March 23, 2010 and your group: i) makes changes that would cause your health plan to lose its grandfathered status or ii) elects not to continue your health plan's grandfathered status, your health plan may be considered a non-grandfathered health plan. Non-grandfathered health plans are subject to all of the new insurance reforms effective as of September 23, 2010 under the Affordable Care Act.

EFFECTIVE DATE:

This endorsement is effective on the later of your group's annual renewal date in 2014.

As of the applicable effective date described above, the following changes are made to your insured group health plan:

A. Summary of Benefits and Coverage (SBC) change to all plans: The "Summary of Benefits" provision in Section 1 "How To Use This Benefit Booklet" is replaced in its entirety with the following:

SUMMARY OF BENEFITS AND COVERAGE (SBC)

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

B. Disabled Children Continued Coverage change to all plans: The third bullet under "Eligible family members" in Section 2 "Enrollment and Termination Information" of your benefit booklet is replaced with the bullet shown below. The bullet below revises the notification of written notice for the disabling condition to 31 days to match the "Disabled Children Continued Coverage" provision being added to the "General Provisions" section of your benefit booklet in section C.3. below of this endorsement.

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

C. Late Applicant change to all plans*: The following text is added to the end of the "Late Applicant" provision under Section 2 "Enrollment and Termination Information" of your benefit booklet.

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

**If your insured group health plan is an HMO Blue Traditional or HMO Blue Alternatives plan, the text added above already appears in your booklet and the condition(s) set forth in the text above already applies to the coverage under your HMO Blue Traditional or HMO Blue Alternatives plan.*

D. General Provisions (changes apply to all plans unless noted otherwise): The following changes are made to Section 9 "General Provisions" of your benefit booklet.

1. This provision is moved from Section 8 "Claims Payments and Appeals" to the General Provisions section of your benefit booklet:

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.

2. This provision is revised to change 30 days' prior written notice in the first paragraph to 60 days' prior written notice:

CHANGES TO THE BENEFIT BOOKLET

BCBSNM may amend this benefit booklet when authorized by an officer of BCBSNM. BCBSNM will give you 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.

3. The following provision is added:

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.

4. The following paragraph is added to the **"DISCLAIMER OF LIABILITY"** provision:

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.

5. The following provisions are added:

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.

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.

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.

6. The following provision is removed:

RESEARCH FEES

BCBSNM reserves the right to charge you an administrative fee when extensive research is necessary to reconstruct information that has already been provided to you in explanations of benefits, letters, or other forms. If BCBSNM requires an independent medical examination (IME) before authorizing a service or processing a Claim, BCBSNM will cover the cost of the

IME. In the unlikely event that BCBSNM requires an autopsy before paying a Claim, BCBSNM will pay the cost of the autopsy.

7. ***Applicable to non-grandfathered plans only:*** The provision shown below is added. It replaces provisions entitled "TEMPORARY ENFORCEMENT SAFE HARBOR DISCLOSURE" and "RELIGIOUS EMPLOYER EXEMPTION DISCLOSURE" previously added to Section 9 "General Provisions" of your benefit booklet via prior endorsement form no. "NM82373_women's preventive services_grp."

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 contraceptives 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 contraceptives 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.

E. **Section 10: Definitions change to all plans:** The Summary of Benefits definition is replaced in its entirety with the following:

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.

F. **Benefit Booklet / back inside cover change to all plans:** The last sentence of the last paragraph in the information noted on the back inside cover of your benefit booklet is revised to reflect a 60-day notification instead of 30 days as follows:

You will be notified of any changes to this benefit booklet at least **60** days before the changes become effective.

2015 BlueCard® Program and Member Data Share Rider

(for all HMO Blue® Group Plans)

Blue Cross and Blue Shield of New Mexico

This 2015 *BlueCard Program and Member Data Share Rider (for all HMO Blue Group Plans)* is made part of and replaces any information you may have in your Blue Cross and Blue Shield of New Mexico (BCBSNM) member benefit booklet.

BY:

Kurt Shipley, President
Blue Cross and Blue Shield of New Mexico

The following language replaces the provision entitled "BlueCard Program," in the *Claims Payments and Appeals section* of your member benefit booklet.

Effective: January 1, 2015

INTER-PLAN PROGRAMS

Blue Cross and Blue Shield of New Mexico (BCBSNM) has relationships with other Blue Cross and/or Blue Shield Licensees under their Licensed Controlled Affiliates ("Licensees"), referred to generally as "Inter-Plan Program Arrangements." Whenever you obtain healthcare services outside of the BCBSNM Service Area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard program.

Typically, when accessing care outside of the BCBSNM Service Area, you will obtain care from healthcare providers that have a contractual agreement (i.e. are "Contracted Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from Noncontracted Providers. BCBSNM payment practices in both instances are described below. (**Note**: Under HMO plans, "Contracted Providers" are referred to as HMO-Participating Providers and "Noncontracted Providers" are referred to as Nonparticipating Providers. Also note that the definition of Nonparticipating Provider in the *Definitions* section is revised to read: "An appropriately licensed health care provider that has **not** contracted directly with a BCBS Plan.")

As used in this section, "Out-of-Area Covered Services" for HMO plans refers to emergency care obtained outside the geographic area of the BCBSNM Service Area. Any other services will not be covered when processing through any Inter-Plan Program Arrangements, unless authorized by your Primary Care Provider ("PCP") or BCBSNM.

Inter-Plan Program Arrangements link the BCBSNM provider network with other individual Blue Cross Blue Shield networks across the country to provide you broad access to Contracted Providers. Contracted Providers may be contracted with either BCBSNM or the Host Blue. Noncontracted Providers are not contracted with either BCBSNM or the Host Blue.

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

When services are received by you outside of the State of New Mexico for either Contracted or Noncontracted Providers, the Host Blue will provide BCBSNM with a Covered Charge based on what it uses for its own local members for services received from either Contracted or Noncontracted Providers in the state where the Host Blue is located.

For purposes of the Inter-Plan Arrangements described in this section, "Covered Charge" means the amount that BCBSNM determines is fair and reasonable for a particular covered and medically necessary service, as provided to BCBSNM by a Host Blue. After the member's share of the Covered Charge is calculated, BCBSNM will pay the remaining amount of the Covered Charge up to the maximum benefit limitation, if any. For services received in foreign countries, BCBSNM will use the exchange rate in effect on the date of service in order to determine the Covered Charge.

A. Services Received from Contracted Providers Outside New Mexico:

BlueCard Program

Under the BlueCard Program, when you obtain Out-of-Area Covered Services within the geographic area served by a Host Blue, BCBSNM will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Contracted Providers.

Whenever you access Out-of-Area Covered Services outside of the Service Area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar Copayment, is based on the lower of:

- The billed charges for your Covered Services;
- The negotiated price that the Host Blue makes available to BCBSNM.

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

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your liability calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

B. Services Received from a Noncontracted Provider Outside of New Mexico

"Out-of-Area Covered Services" for HMO plans refers to emergency care obtained outside the geographic area of the BCBSNM Service Area. Any other services will not be covered when processing through any Inter-Plan Program Arrangements, unless authorized by your Primary Care Physician ("PCP") or BCBSNM.

If services are provided by a Noncontracted Provider, the provider may, but is not required to, submit claims on your behalf. If the Noncontracted Provider does not submit claims on your behalf, you will be required to submit the claims directly to the Host Blue.

Member Liability Calculation

1. In General

Under Inter-Plan Program Arrangements, when services are received outside the state of New Mexico from a Noncontracted Provider, the Covered Charge will be determined by the Host Blue servicing area or by applicable law and will be passed on to BCBSNM. BCBSNM will use the Host Blue's Covered Charge as its Covered Charge so that your claim can be processed timely. BCBSNM's Covered Charge will be an amount up to but not in excess of the Covered Charge the Host Blue has passed on to BCBSNM.

2. Exceptions

In certain situations, BCBSNM may use other payment bases, such as billed charges for Covered Services, as the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment, as permitted under Inter-Plan Program Arrangements policies, to determine the amount BCBSNM will pay for services.

C. Emergency Care Services:

If you experience an Emergency while traveling outside the BCBSNM Service Area, go to the nearest emergency medical facility or trauma center.

The following "Member Data Share" section is added to your member benefit booklet:

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Blue Cross and Blue Shield of New Mexico ("BCBSNM"), a division of Health Care Service Corporation, or, if you do not reside in the BCBSNM service area, by the Host Blue whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise in various circumstances, such as from involuntary termination of your health coverage sponsored by the Subscriber. As part of the overall plan of benefits that BCBSNM offers to, you, if you do not reside in the BCBSNM service area, BCBSNM may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which you reside. To do this, BCBSNM may (1) communicate directly with you and/or (2) provide the Host Blues whose service area covers the geographic area in which you reside, with your personal information and may also provide other general information relating to your coverage under the Plan the Subscriber has with BCBSNM to the extent reasonably necessary to enable the relevant Host Blues to offer you coverage continuity through replacement coverage.

2015 BlueCard® Program and Member Data Share Rider

(for all EPO BlueNet® Plans)

Blue Cross and Blue Shield of New Mexico

This *2015 BlueCard Program and Member Data Share Rider (for all EPO BlueNet Plans)* is a made part of and replaces any information you may have in your Blue Cross and Blue Shield of New Mexico (BCBSNM) BlueNet member benefit booklet.

BY:

Kurt Shipley, President
Blue Cross and Blue Shield of New Mexico

The following language replaces the provision entitled, "BlueCard Program," in the *Claims Payments and Appeals* section of your member benefit booklet.

Effective: January 1, 2015

INTER-PLAN PROGRAMS

Blue Cross and Blue Shield of New Mexico (BCBSNM) has relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Program Arrangements." Whenever you obtain healthcare services outside of the BCBSNM Service Area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard program.

Typically, when accessing care outside of the BCBSNM Service Area, you will obtain care from healthcare providers that have a contractual agreement (i.e. are "Contracted Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from Noncontracted Providers. BCBSNM payment practices in both instances are described below. (Note: Under EPO plans, "Contracted Providers" are referred to as Preferred Providers and "Noncontracted Providers" are referred to as Nonpreferred Providers.)

As used in this section, "Out-of-Area Covered Services" for EPO plans refers to emergency care obtained outside the geographic area of the BCBSNM service area. Any other services will not be covered when processing through any Inter-Plan Program Arrangements unless authorized by BCBSNM.

Inter-Plan Program Arrangements link the BCBSNM provider network with other individual Blue Cross Blue Shield networks across the country to provide you broad access to Contracted Providers. Contracted Providers may be contracted with either BCBSNM or the Host Blue. Noncontracted Providers are not contracted with either BCBSNM or the Host Blue.

When services are received by you outside of the State of New Mexico for either Contracted or Noncontracted Providers, the Host Blue will provide BCBSNM with a Covered Charge based on what it uses for its own local members for services received from either Contracted or Noncontracted Providers in the state where the Host Blue is located.

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

For purposes of the Inter-Plan Arrangements described in this section, "Covered Charge" means the amount that BCBSNM determines is fair and reasonable for a particular covered and medically necessary service, as provided to BCBSNM by a Host Blue. After the member's share of the Covered Charge is calculated, BCBSNM will pay the remaining amount of the Covered Charge up to the maximum benefit limitation, if any. For services received in foreign countries, BCBSNM will use the exchange rate in effect on the date of service in order to determine the Covered Charge.

A. Services Received from Contracted Providers Outside New Mexico:

BlueCard Program

Under the BlueCard Program, when you obtain Out-of-Area Covered Services within the geographic area served by a Host Blue, BCBSNM will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Contracted Providers.

Whenever you access Out-of-Area Covered Services outside of the Service Area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar Copayment, is based on the lower of:

- The billed charges for your Covered Services;
- The negotiated price that the Host Blue makes available to BCBSNM.

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

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your liability calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

B. Services Received from a Noncontracted Provider Outside of New Mexico

"Out-of-Area Covered Services" for EPO plans refers to **emergency care** obtained outside the geographic area of the BCBSNM Service Area. Any other services will not be covered when processing through any Inter-Plan Program Arrangements unless authorized by BCBSNM.

If services are provided by a Noncontracted Provider, the provider may, but is not required to, submit claims on your behalf. If the Noncontracted Provider does not submit claims on your behalf, you will be required to submit the claims directly to the Host Blue.

Member Liability Calculation

1. In General

Under Inter-Plan Program Arrangements, when services are received outside the state of New Mexico from a Noncontracted Provider, the Covered Charge will be determined by the Host Blue servicing area or by applicable law and will be passed on to BCBSNM. BCBSNM will use the Host Blue's Covered Charge as its Covered Charge so that your claim can be processed timely. BCBSNM's Covered Charge will be an amount up to but not in excess of the Covered Charge the Host Blue has passed on to BCBSNM.

2. Exceptions

In certain situations, BCBSNM may use other payment bases, such as billed charges for Covered Services, as the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment, as permitted under Inter-Plan Program Arrangements policies, to determine the amount BCBSNM will pay for services.

C. Emergency Care Services:

If you experience an Emergency while traveling outside the BCBSNM Service Area, go to the nearest emergency medical facility or trauma center.

The following "Member Data Share" section is added to your member benefit booklet:

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Blue Cross and Blue Shield of New Mexico ("BCBSNM"), a division of Health Care Service Corporation, or, if you do not reside in the BCBSNM service area, by the Host Blue whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise in various circumstances, such as from involuntary termination of your health coverage sponsored by the Subscriber. As part of the overall plan of benefits that BCBSNM offers to, you, if you do not reside in the BCBSNM service area, BCBSNM may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which you reside. To do this, BCBSNM may (1) communicate directly with you and/or (2) provide the Host Blues whose service area covers the geographic area in which you reside, with your personal information and may also provide other general information relating to your coverage under the Plan the Subscriber has with BCBSNM to the extent reasonably necessary to enable the relevant Host Blues to offer you coverage continuity through replacement coverage.

2015 BlueCard® Program and Member Data Share Rider

(for all PPO Group Plans)

Blue Cross and Blue Shield of New Mexico

This *2015 BlueCard Program and Member Data Share Rider (for all PPO Group Plans)* is made part of and replaces any information you may have in your Blue Cross and Blue Shield of New Mexico (BCBSNM) member benefit booklet.

BY:

Kurt Shipley, President
Blue Cross and Blue Shield of New Mexico

The following language replaces the provision entitled "BlueCard Program," in the *Claims Payments and Appeals* section of your member benefit booklet.

Effective: January 1, 2015

Inter-Plan Programs

Blue Cross and Blue Shield of New Mexico (BCBSNM) has relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Program Arrangements." Whenever you obtain healthcare services outside of the BCBSNM service area, the claims for these services may be processed through one of these arrangements, which includes the BlueCard Program.

Typically, when accessing care outside of the BCBSNM Service Area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "Contracted Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from Noncontracted Providers. BCBSNM payment practices in both instances are described below. (Note: Under PPO plans, "Contracted Providers" are referred to as Preferred Providers and "Noncontracted Providers" are referred to as Nonpreferred Providers.)

Inter-Plan Program Arrangements link the BCBSNM provider network with other individual Blue Cross Blue Shield networks across the country to provide you broad access to Contracted Providers. Contracted Providers may be contracted with either BCBSNM or the Host Blue. Noncontracted Providers are not contracted with either BCBSNM or the Host Blue.

You always have the choice to receive services from Contracted or Noncontracted Providers in New Mexico or outside New Mexico, but the difference in the amount you pay may be substantial. When services are received by you outside of the State of New Mexico from either Contracted or Noncontracted Providers, the Host Blue will provide BCBSNM with a Covered Charge based on what it uses for its own local members for services received from either Contracted or Noncontracted Providers in the state where the Host Blue is located.

For purposes of the Inter-Plan Program arrangements described in this section, "Covered Charge" means the amount that BCBSNM determines is fair and reasonable for a particular covered and medically necessary service, as provided to BCBSNM by a Host Blue. After the member's share of the Covered

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

Charge is calculated, BCBSNM will pay the remaining amount of the Covered Charge up to the maximum benefit limitation, if any. For services received in foreign countries, BCBSNM will use the exchange rate in effect on the date of service in order to determine the Covered Charge.

A. Services Received from Contracted Providers Outside of New Mexico:

BlueCard Program

Under the BlueCard Program, when you access Covered Services within the geographic area served by a Host Blue, BCBSNM will remain responsible for fulfilling BCBSNM contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Contracted Providers.

Whenever you access Covered Services outside the BCBSNM service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

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

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

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price BCBSNM uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your liability calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

B. Services Received from a Noncontracted Provider Outside of New Mexico

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

behalf, you will be required to submit the claims directly to the Host Blue. You will be subject to balance billing when you receive services from a Noncontracted Provider. This amount may be significant. "Balance Billing" means that the Noncontracted Provider may require you to pay any amount that the provider bills that exceeds the sum of what BCBSNM pays toward the Covered Charge and your Member Share of the Covered Charge.

Member Liability Calculation

1. **In General**

   Under Inter-Plan Program Arrangements, when services are received outside the State of New Mexico from a Noncontracted Provider, the Covered Charge will be determined by the Host Blue servicing the area or by applicable law and will be passed on to BCBSNM. BCBSNM will use the Host Blue's Covered Charge as its Covered Charge so that your claim can be processed timely. BCBSNM's Covered Charge will be an amount up to but not in excess of the Covered Charge the Host Blue has passed on to BCBSNM. In addition to being responsible to pay your Member Share, you may be subject to Balance Billing by the Noncontracted Provider who provided services to you. Before you receive services from a Noncontracted Provider, you should ask for a written breakdown of all amounts that you will have to pay, including Member Share and Balance Billing amounts, for the services you will receive.

2. **Exceptions**

   In certain situations, BCBSNM may use other payment bases, such as billed charges for Covered Services, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs policies, to determine the amount BCBSNM will pay for services rendered by Noncontracted healthcare providers. In these situations, you may be liable for the difference between the amount that the Noncontracted healthcare provider bills and the payment BCBSNM will make for the Covered Services as set forth in this paragraph.

The following "Member Data Share" section is added to your member benefit booklet:

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Blue Cross and Blue Shield of New Mexico ("BCBSNM"), a division of Health Care Service Corporation, or, if you do not reside in the BCBSNM service area, by the Host Blue whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise in various circumstances, such as from involuntary termination of your health coverage sponsored by the Subscriber. As part of the overall plan of benefits that BCBSNM offers to, you, if you do not reside in the BCBSNM service area, BCBSNM may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which you reside. To do this, BCBSNM may (1) communicate directly with you and/or (2) provide the Host Blues whose service area covers the geographic area in which you reside, with your personal information and may also provide other general information relating to your coverage under the Plan the Subscriber has with BCBSNM to the extent reasonably necessary to enable the relevant Host Blues to offer you coverage continuity through replacement coverage.

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SECTION 1: HOW TO USE THIS BENEFIT BOOKLET

This benefit booklet describes the medical/surgical, prescription drug, and mental health/chemical dependency coverage available to members of this health care plan and the Plan's benefit limitations and exclusions.

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

DEFINITIONS

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

SUMMARY OF BENEFITS

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

The provider network directory is available through the BCBSNM website at www.bcbsnm.com. It lists all providers in the BCBSNM preferred provider (PPO) network and participating pharmacies. It also provides links to the listings of preferred providers in other states. (If you want a paper copy of a directory, you may request one from Customer Service. 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® BROCHURE

As a member of a PPO health plan administered by BCBSNM, you take your health plan benefits with you – across the country and around the world. The BlueCard Program gives you access to preferred providers almost everywhere you travel or live. Almost 90 percent of physicians in the United States contract with Blue Cross and Blue Shield (BCBS) Plans. You and your eligible family members can receive the Preferred Provider level of benefits – even when traveling

or living outside New Mexico – by using health care providers that contract as preferred providers with their local BCBS Plan. You should have received a brochure describing this program in more detail. It's a valuable addition to your health care plan coverage. Instructions for locating a preferred provider outside New Mexico are in the brochure or can be found on the BCBSNM website at www.bcbsnm.com.

HSA BROCHURE

As a participant in the Health Savings Account (HSA) program, you will receive additional materials describing how the "Health Savings Account" (HSA) works with this Preferred Provider coverage. Your identification card will indicate the HSA program under which you are enrolled.

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.

PREFERRED PROVIDER BENEFIT ONLY

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

PREAUTHORIZATION REQUIRED

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

Emergency/Maternity Admission Notification

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

Written Request Required

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

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

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

PREAUTHORIZATION OF BEHAVIORAL HEALTH CARE

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

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

CUSTOMER SERVICE

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

Customer Service representatives can help with the following:

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

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

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

Website: www.bcbsnm.com

Behavioral Health Customer Service

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

Toll-free: 1-888-898-0070

Deaf and Speech Disabled Assistance

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

Translation Assistance

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

After Hours Help

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

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

24/7 Nurseline

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

Toll-free: 1-800-973-6329

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

Special Beginnings®

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

Toll-free: 1-888-421-7781

BLUE ACCESS FOR MEMBERS SM

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

If you need help accessing the BAM site, call:

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

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

HEALTH CARE FRAUD INFORMATION

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

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

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

SECTION 2: ENROLLMENT AND TERMINATION INFORMATION

WHO IS ELIGIBLE

Unless otherwise specified in the Group Master Contract, all active employees who have completed the employee probationary period and who are regularly working the minimum number of hours specified in the Group Master Contract and their eligible family members are eligible for coverage. (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 benefits administrator.)

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

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

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

ELIGIBLE FAMILY MEMBERS

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

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

- the subscriber's legal **spouse**
- the subscriber's eligible **child** through the end of the month in which the child reaches **age 26** (Once a covered child reaches age 26, the child is automatically removed from coverage and rates adjusted accordingly - unless the child is an eligible family member under this Plan due to a disability as described below.)
- the subscriber's **unmarried** child age 26 or older who was enrolled as the subscriber's covered child in this health plan at the time of reaching the age limit, and who is medically certified as **disabled,** chiefly dependent upon the subscriber for support and maintenance, and incapable of self-sustaining employment by reason of his/her disability (Such condition must be certified by a physician and BCBSNM. Also, a child may continue to be eligible for coverage 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 before the end of the month during which the child's coverage would otherwise end.)

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

- natural or legally adopted child of the subscriber
- child placed in the subscriber's home for purposes of adoption (including a child for whom the subscriber is a party in a suit in which the adoption of the child by the subscriber is being sought)
- stepchild of the subscriber

- child for whom the subscriber must provide coverage because of a court order or administrative order pursuant to state law
- eligible foster child of the subscriber

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

- once the subscriber is no longer a legal guardian of a child or there is no longer a court order to provide coverage to a child, the child must be eligible as a natural child, legally adopted child, foster child, or stepchild of the subscriber in order to retain eligibility as a family member under this health plan.

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.

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.

APPLYING FOR COVERAGE

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

WHEN COVERAGE BEGINS

BCBSNM will determine your effective date of coverage according to the provisions of the Group Master Contract. 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 that are covered under the prior benefit plan.

CHANGES TO COVERAGE

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

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

ADDING A FAMILY MEMBER TO COVERAGE

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

- request that the employer notify BCBSNM of the change,
- complete and submit all necessary enrollment/change forms and legal documentation of proof of dependency, 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

If a subscriber adds coverage for a spouse **within 31 days** of marriage, the effective date of the new eligible family member's coverage will be no later than the first of the month following the date BCBSNM received the completed and signed enrollment/change application form. If the subscriber does not submit a completed and signed enrollment/change application form to 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 31 days** of marriage, the spouse may not be added to coverage except as a late applicant (or as specified under "Special Enrollment" later in this section). You may also have the option of applying for a Two-Person (Employee + Spouse) coverage type. Ask your employer which coverage types are available to you. For example, if you are applying for coverage for a new spouse and 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 specified under "Special Enrollment."

Newborn Children

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

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

Adopted Children

A child placed in the subscriber's home for the purposes of adoption may be added to coverage as soon as the child is placed in the home. However, application for coverage can be made as late as **31 days** following legal adoption without being considered late. (Although a child over the age of 18 is not eligible for adoption, an adopted child

is covered as any other child, subject to the same eligible child age limitations and restrictions.) **Note:** An adopted child who is not enrolled within 31 days of adoption or placement in the home will be considered a late applicant unless the child was previously enrolled in a group health plan or other creditable coverage within 30 days of his/her adoption or placement for adoption and has had prior creditable coverage since that date with no significant lapse (i.e., 95 or more days).

Eligible Foster Children

Application for coverage must be made for an eligible foster child **within 31 days** from the date care is assumed by the subscriber for such foster child.

Legal Guardianship

Application for coverage must be made for a child for whom the subscriber or the subscriber's spouse becomes the legal guardian **within 31 days** of the court or administrative order granting guardianship.

Stepchild

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

Court Ordered Coverage for Children

When an employee or employer is required by a court or administrative order to provide coverage for an eligible child, the eligible child may be enrolled in the subscriber's Family coverage, or Employee/Children coverage, if available and will **not** be considered a late applicant. (If the subscriber has Individual coverage, 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 for a special enrollment, applications from the following enrollees will be considered late:

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

OPEN ENROLLMENT

Open enrollment is the period prior to the group's anniversary date (ask your employer when your group's open enrollment period is held). During the annual open enrollment period, any eligible employee and his/her eligible family members may enroll as members under this Plan.

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

SWITCH ENROLLMENT AND CHANGES IN PLAN

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

During an Open Enrollment Period

During an open enrollment period, the subscriber and his/her eligible family members may change coverage to one of the other health care plans for which the subscriber meets eligibility requirements. This is the only period of time during which a member may "voluntarily" change from one health care plan to another for which he/she is eligible.

Outside the Open Enrollment Period

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

SPECIAL ENROLLMENT FOR ACTIVE EMPLOYEES AND THEIR COVERED FAMILY MEMBERS

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

Note: There are no special enrollments for persons applying for any continuation, conversion coverage, or extension of benefits due to disability if offered under your Plan. You must enroll in these coverages timely.

Qualifying Events

The four instances of special enrollment are:

Loss of Prior Coverage

An eligible employee who declined coverage when initially eligible because of having other comprehensive medical coverage and who later *involuntarily* loses the other coverage (or who reaches a lifetime maximum under the prior benefit plan), may apply for coverage for himself/herself and eligible family members. (The eligible family members need not have been covered under the prior benefit plan when the employee has been granted a special enrollment under this provision.) Currently enrolled employees may also add eligible family members to coverage under this provision if the eligible family member had prior creditable coverage that was involuntarily lost or had reached lifetime benefit maximum under the other carrier's benefit plan. (See definition of "involuntary loss of coverage" in *Section 10: Definitions.")*

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

Documentation from the prior carrier – supporting the fact that the person had prior creditable coverage that was lost involuntarily – may be submitted at a later date with the employer's approval, but the employee must submit the completed and signed enrollment/change form **within 31 days** of the loss of coverage (or denial notice). **Note:** Enrollment changes cannot be processed until **all documentation** is provided to the employer.

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

special enrollment for self only, eligible family member(s) only, or both, BCBSNM requires proof of loss of coverage or proof of the date of the event.

Change in Family Status

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

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

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

Loss of Medicaid/SCHIP Eligibility

If an eligible employee or his/her eligible family member is not currently enrolled in the Plan and loses eligibility under Medicaid or under a state child health plan (SCHIP), the person losing such coverage may enroll in the Plan without being considered a late applicant. To be eligible for special enrollment, the person must apply for coverage under the group health plan no later than **60 days** after the date of termination of Medicaid or SCHIP coverage. (In order for an eligible family member to be eligible for special enrollment, the employee must be covered under the employer group health plan. If the employee is not enrolled in the Plan when the eligible family member becomes eligible for assistance, the employee must enroll into the Plan at the same time as the eligible family member.) Documentation from the state – supporting the fact that the person had Medicaid/SCHIP coverage that was lost involuntarily – may be submitted at a later date with the employer's approval, but the employee must submit the completed and signed enrollment/change form within **60 days** of the loss of coverage. **Note:** Enrollment changes cannot be processed until **all documentation** is provided to the employer.

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

Medicaid/SCHIP Group Health Plan Premium Assistance Eligibility

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

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

assistance eligibility date. **Note**: Enrollment changes cannot be processed until **all documentation** is provided to the employer.

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

Applying for Special Enrollment

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

Waiving Coverage

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

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

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

Coverage Effective Date

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

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

RE-ENROLLMENT

If a previously covered employee and/or eligible family member is re-enrolled in this group Plan, he/she will usually be considered a late applicant. See "Leave of Absence or Military Service" and "Special Enrollment" for exceptions and details.

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

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

NOTIFICATION OF ELIGIBILITY AND ADDRESS CHANGES

The subscriber must notify BCBSNM **within 31 days** following any changes that may affect his/her or a family member's eligibility, including a change to a covered family member's name or address, by indicating such changes on an enrollment/change form and submitting it to BCBSNM. You can obtain this form 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 your employer.

State Continuation Coverage

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

COBRA Continuation Policy Members

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

COVERAGE TERMINATION

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

- The employee **terminates employment** or **otherwise loses eligibility** according to the terms of the Group Master Contract. If the group or subscriber fails to notify BCBSNM **within 30 days** to remove an ineligible person from coverage, BCBSNM may recover any payment made on the ineligible person's behalf.
- When the **premium payment** or other employee contribution for coverage is not received on time. (Coverage will be suspended if premium is not paid when it is due. If premium is not received **within 30 days** after its due date, the group or affected member(s) will be terminated at the end of the last-paid billing period. Any claims received and paid for during the 30-day grace period will be billed both to the subscriber and to the group or, in the case of continuation coverage, to the subscriber.)
- When the member begins a **leave of absence** or enters the **armed forces** for **more than 30 days** or as provided by law. (See "Leave of Absence or Military Service.")
- When the **member materially fails to abide by the rules,** policies, or procedures of this Plan or fraudulently provides or materially misrepresents information affecting coverage. If a member knowingly gave false material information in connection with the eligibility or enrollment of the subscriber or any of his/her eligible family members, BCBSNM 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.)
- At the *beginning* of the month when the member becomes **age 65** (excepting any laws to the contrary that apply to certain large group employer health plans). See "How to Continue Coverage" for more information regarding continued coverage options in these cases.
- When the member acts in a **disruptive** manner that prevents the orderly business operation of any network provider or dishonestly attempts to gain a financial or material advantage.

- When **group coverage is discontinued** for the entire group or for the employee's enrollment classification.
- When the group gives BCBSNM or BCBSNM gives the group a minimum **30 days' advance written notice**.

If you believe your coverage was cancelled due to health status or health requirements, race, gender, age, or sexual orientation, you may appeal such termination to the Office of Superintendent of Insurance. Also, BCBSNM will not cancel your coverage for nonpayment 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 Plan (e.g., a child is removed from placement in the home or reaches the eligible child age limit);
- at the end of the month following the date of a final **divorce** decree or **legal separation** for a spouse;
- at the end of the month when the subscriber gives a minimum **30 days' advance notice** in writing to end coverage for a covered family member(s), according to the rules of your Plan as established by your employer.

If a family member is being removed from coverage because of losing his/her eligibility under the Plan (for reasons other than reaching the eligible child age limit), the enrollment/change form must be received by BCBSNM **within 31 days** following the effective date of the change. In these cases, the member will be removed from coverage as of the end of the month following the change in his/her eligibility status and payroll deductions will be properly adjusted, if necessary. BCBSNM and the providers of care may recover benefits erroneously paid on behalf of the removed member.

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

Voluntary Termination of Coverage

To remove a 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 his/her benefits administrator. If voluntary termination is allowed under your Plan outside the annual renewal period, coverage will end the first of the month following receipt of the enrollment/change form. Voluntarily terminated members may re-enroll under the Plan only as late applicants (except as provided under "Special Enrollment"). Also, these members are **not** eligible for any extension of benefits or federal 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 or Military Service

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

NOTIFICATION

If the Group Master Contract is terminated or premiums are not submitted, coverage will terminate for all affected members as of the end of the last-paid billing period. The affected members and the 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. The percentage of the total premium that you pay is established by your group. BCBSNM may change premium amounts according to any of the following:

- changes in federal and state law; 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 31 days** of the change in eligibility status; or
- any claims or capitation amounts have been paid on behalf of the terminated member during the period for which premiums have been paid.

HOW TO CONTINUE COVERAGE

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

Continuation Coverage

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

You are not eligible to enroll for continuation coverage if:

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

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

Continuation Benefits

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

Federal Continuation (COBRA)

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

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

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

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

If you are entitled to both Parts A and B of Medicare, your state continuation coverage option is limited to a Medicare Supplement Plan administered by BCBSNM. (The options for members under age 65 are limited.) 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 31 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 Group Master Contract
- 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.)

If you are entitled to Medicare, your conversion coverage option is limited to a Medicare Supplement Plan administered by BCBSNM. (The options for members under age 65 are limited.) 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

BENEFIT CHOICES

This health care plan is a Preferred Provider Option (PPO) health care plan that gives you the opportunity to save money, while providing you choice and flexibility when you need medical/surgical care and preventive services. When you need health care, you have the choice of obtaining benefits from either a preferred provider or a nonpreferred provider. It's important to understand the differences between them. When you receive treatment or schedule a surgery or admission, ask each of your providers if he/she is a BCBSNM preferred provider. (A physician's or other provider's contract may be separate from the facility's contract.) Your choice can make a difference in the amount you pay and the benefits available to you.

Your Choices

Preferred Provider Services	Nonpreferred Provider Services
•You pay an annual deductible and a lower percentage of covered charges (coinsurance) after the deductible is met. •You have a lower annual out-of-pocket limit. •The provider files claims for you. •The provider will not bill you for amounts above the covered charge.* •Preferred providers that contract directly with BCBSNM will obtain necessary preauthorizations for you.	•You pay a higher annual percentage of covered charges after the deductible is met. •You have a higher annual out-of-pocket limit to meet for Nonpreferred Provider benefit level. •You may need to file claims. •You may have to pay amounts above the covered charge.* •You are responsible for admission review and other preauthorizations. •Some benefits are not available unless services are received from a preferred provider. See your *Summary of Benefits* for those services not covered at the Nonpreferred Provider benefit level.

***Note:** The "covered charge" is the amount that BCBSNM determines is a fair and reasonable allowance for a particular covered service. After your share of a covered charge (e.g., deductible, coinsurance, penalty amount) has been calculated, BCBSNM pays the remaining amount of the covered charge, up to maximum benefit limits, if any. **The covered charge may be less than the billed charge.** Your choice of provider will determine if you will also have to pay the difference between the covered charge and the billed charge.

Although you can go to the hospital or physician of your choice, benefits under the PPO program will be greater when you use the services of a preferred provider.

PREFERRED PROVIDERS VERSUS NONPREFERRED PROVIDERS

Preferred Providers are health care professionals and facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, or another BCBS Plan as "preferred" or "PPO" providers. These providers have agreed to provide health care for **PPO** plan members and accept the Plan's payment for a covered service plus the member's share of the covered charge (i.e., deductible, coinsurance and/or penalty amount, if any) as payment in full.

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

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

Covered Charges
*For covered charges related to claims from providers that contract directly with BCBSNM, see "Covered Charges" in *Section 8: Claims Payments and Appeals.*
*For covered charges related to claims from out-of-network providers, see "Exceptions for Non-preferred Providers" later in this *Section 3: How Your Plan Works.*
*For covered charges related to claims from providers outside New Mexico, see "BlueCard" in *Section 8: Claims Payments and Appeals.*

PROVIDER DIRECTORY AND ONLINE PROVIDER FINDER®

When you need medical care, there are a variety of ways you can choose a preferred provider in your area. You can also access mental health providers (including those specializing in chemical dependency) and participating pharmacies.

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

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

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

Web-Based BCBSNM Provider Finder

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

www.bcbsnm.com

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

Paper Provider Network Directory

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

Finding a Pharmacy

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

www.MyPrime.com

Click on *Find a Pharmacy.* You will then be asked to select from a list of BCBS Plans. **You must select "Blue Cross and Blue Shield of New Mexico"** and then select **"Other BCBSNM Plans"** in order to get the correct list

of participating pharmacies for this health plan. After you have selected "Blue Cross and Blue Shield of New Mexico" as your health plan administrator, you will be able to locate participating pharmacies throughout the United States based on zip code or state name. You may also request a paper copy of the list of participating pharmacies by calling a Customer Service Advocate at BCBSNM.

Providers Outside New Mexico

Out-of-state providers that contract with their local Blue Cross and/or Blue Shield Plan and international providers that contract with the Blue Cross and Blue Shield Association as **Preferred Providers** are also eligible for the "Preferred Provider" level of benefits for covered services, listed on the *Summary of Benefits.* **Note:** Providers who have a "participating-only" contract are **not** preferred providers and you will not receive the Preferred Provider benefit level when receiving services from participating-only providers. You must use **preferred providers** in order to obtain the higher benefit (unless listed under **"Benefit Level Exceptions,"** later in this section).

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

BCBSNM Website

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

BCBSNM website: www.bcbsnm.com

National Website

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

Blue Cross and Blue Shield Association website:

www.bcbs.com (or www.bluecares.com)

National Phone Number

Call BlueCard Access® at the phone number below for the names and addresses of doctors and hospitals in the area where you or an eligible family member need care. When you call, a BlueCard representative will give you the name and telephone number of a local provider (you will be asked for the zip code in the area of your search) who will be able to call Customer Service for eligibility information and will submit a claim for the services provided to the local BCBS Plan. Call:

1-800-810-BLUE (2583)

International Assistance

Call the BlueCard Worldwide Service Center at one of the phone numbers **below**, 24 hours a day, 7 days a week, for information on doctors, hospitals, and other health care professionals or to receive medical assistance services around the world. An assistance coordinator, in conjunction with a medical professional, will help arrange a doctor's appointment or hospitalization, if necessary. If you need to be hospitalized, call BCBSNM for preauthorization. You can find the preauthorization phone number on your ID card. **Note:** The phone number for preauthorization is different from the following phone numbers, which are strictly for locating a Preferred Provider while outside the United States:

1-800-810-BLUE (2583) or call collect: 1-804-673-1177

CALENDAR YEAR

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

BENEFIT LIMITS

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

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

COST-SHARING FEATURES

For some services, you will pay only a fixed-dollar amount copayment for covered charges. In other cases, you will have to meet a deductible and pay a percentage of the covered charge (preferred providers will not bill you for amounts in excess of the covered charge). When you receive a number of services during a single visit or procedure, you may have to pay both a copayment and a deductible (if applicable) plus a percentage of the covered charges that are not included in the copayment. Refer to your *Summary of Benefits* for details.

YOUR DEDUCTIBLE

Your deductible (if applicable) is the amount of covered charges that you must pay in a calendar year before this Plan begins to pay its share of the applicable (preferred or nonpreferred provider) covered charges you incur during the same calendar year. If the deductible amount remains the same during the calendar year, you pay it only once each calendar year, and it applies to all preferred or nonpreferred provider covered services you receive during that calendar year.

Family Deductible

The deductible amount you must satisfy depends on whether you have Individual or Family coverage. An Individual Coverage member must meet the "Individual Coverage" deductible before this Plan begins to pay your covered charges, including for items covered under you *Drug Plan Rider.*

An entire family must meet the "Family Coverage" deductible before this Plan begins to pay benefits for covered services for any covered family member. The deductible is met when the total deductible amounts paid by all family members combined reach the amount specified in the *Summary of Benefits*. **Note:** There is no "Individual" deductible to meet for a member under "Family Coverage." An entire family must first meet the Family Coverage deductible and one family member may satisfy the entire amount for the whole family.

What Is Not Subject to the Deductible

The following are **not applied** to the annual deductible:

- the first **$400** you incur in covered adult Preventive Services for **Grandfathered** plans
- preventive services from preferred providers for eligible children through age 17 for **Grandfathered** plans
- preventive services from preferred providers for **Nongrandfathered** plans

Admissions Spanning Two Calendar Years

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

Timely Filing Reminder

Most benefits are payable only after BCBSNM's records show that the applicable deductible has been met. Preferred providers and providers that have "participating-only" provider agreements with BCBSNM will file claims for you and must submit them within a specified amount of time (usually 180 days). If you file your own claims for covered services from nonparticipating providers, you must file them **within 12 months** of the date of service. If a claim is returned for further information, resubmit it **within 45 days.** See *Section 8: Claim Payments and Appeals* for details.

COPAYMENTS

Drug Plan Coinsurance and Copayments

Drugs and other items purchased through the drug plan are subject to the annual deductible, coinsurance and/or copayment amounts you pay for covered items under the drug plan and are also applied to the preferred provider out-of-pocket limit each calendar year. See your *Drug Plan Rider* for more information about the amounts you pay under the drug plan.

COINSURANCE

For some covered services, you must pay a percentage of covered charges as (coinsurance) after you have met your annual deductible. After your share has been calculated, this Plan pays the rest of the covered charge, up to maximum benefit limits, if any. You pay a lower percentage of covered charges when you visit a preferred provider.

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

Preferred Providers

When you receive covered services from a preferred provider, you pay an annual deductible and, after meeting the deductible, you pay a percentage of covered charges (coinsurance). Preferred provider office visit charges are not subject to the coinsurance or deductible unless listed as otherwise on your summary.

Nonpreferred Providers

When you receive covered services from a nonpreferred provider, you have a higher deductible amount to meet each year and you must pay a higher percentage of covered charges for nonpreferred provider services. If the covered charge is less than the billed charge, you will also be responsible for paying the difference when you receive services from a nonpreferred provider. See *Section 8: Claims and Appeals,* "Provider Payment Example," for more information.

OUT-OF-POCKET LIMIT

For **Grandfathered** plans, the out-of-pocket limit is the maximum amount of deductible and coinsurance that you pay for most covered services in a calendar year.

For **Nongrandfathered** plans, the out-of-pocket limit is the maximum amount of deductible, coinsurance, and copayments, if applicable, that you pay for most covered services in a calendar year.

The out-of-pocket limit amount that a member must meet depends on whether you have Individual or Family Coverage. Unlike the deductible provision, there are **two** separate out-of-pocket limits for Preferred Provider and Nonpreferred provider services. An Individual Coverage member must meet the applicable "Individual Coverage" out-of-pocket limit before this Plan begins to pay **100 percent** of his/her covered charges for Preferred Provider or Nonpreferred Provider services, as applicable, for the rest of the calendar year. The higher Nonpreferred Provider limit must be met before this Plan pays **100 percent** of most of the member's covered charges for Nonpreferred Provider services.

The out-of-pocket amounts for preferred provider services are **not** applied to the Nonpreferred Provider out-of-pocket limit. In addition, the out-of-pocket amounts for nonpreferred provider services are not applied to the Preferred Provider out-of-pocket limit.

Individual Limits

Once your coinsurance amounts for preferred provider services in a calendar year reaches the individual preferred provider amount indicated on the *Summary of Benefits,* this Plan pays 100 percent of most of your covered preferred provider charges for the rest of the calendar year.

Once your coinsurance amounts for nonpreferred provider services in a calendar year reaches the higher individual nonpreferred provider amount indicated on the *Summary of Benefits*, this Plan pays 100 percent of most of your covered nonpreferred provider charges for the rest of the calendar year.

Family Limits

An entire family must meet the "Family Coverage" out-of-pocket limits indicated in the *Summary of Benefits* before this Plan begins to pay **100 percent** of preferred provider or nonpreferred provider covered charges for any covered family member. The applicable limit is met when the total deductible and coinsurance for all family members reaches the amount specified in the *Summary of Benefits*. **Note:** There are no "individual" limits to meet for a member under "Family Coverage." An entire family must first meet the out-of-pocket limit(s) and one family member may satisfy an entire preferred provider or nonpreferred provider limit for the whole family.

What Is Not Included in the Out-of-Pocket Limits

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

- penalty amounts
- amounts in excess of covered charges (including amounts in excess of annual or lifetime benefit limits, if applicable)
- noncovered expenses (including services in excess of annual or lifetime day/visit limits)

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

CHANGES TO THE COST-SHARING AMOUNTS

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

If you must change from Individual Coverage to Family Coverage because you must add an eligible family member to your coverage, you and your new eligible family member must meet the higher Family Coverage deductible and out-of-pocket limit. **Exception:** If you must switch to Family Coverage because of adding an eligible newborn child within the time limits specified in *Enrollment and Termination,* you will not be required to meet the Family Coverage deductible and out-of-pocket limits for covered hospital services related to routine newborn nursery care. However, the newborn's pediatrician services for routine newborn care *will* be subject to Family Coverage deductible and out-of-pocket provisions.

If you lose an eligible family member and must switch from Family to Individual Coverage, you will be given credit for all amounts applied to both the Family Coverage deductible and the Family Coverage out-of-pocket limit. However, you will not be given a refund for any amounts that are in excess of the new individual coverage amount.

If your employer provided a choice of **two or more** benefit plan options and you wish to change to a lower or higher deductible (and out-of-pocket limit), you may do so only during your group's annual renewal period.

BENEFIT LEVEL EXCEPTIONS

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

Emergency Care

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

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

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.

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

Unsolicited Providers

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

Ancillary Provider

Once you have obtained preauthorization for an inpatient admission to a preferred hospital or treatment facility, your preferred physician or hospital will make every effort to ensure that you receive ancillary services from other preferred providers. If you receive covered services from a **preferred** physician for outpatient surgery or inpatient medical/surgical care in a preferred hospital or treatment facility, services of a nonpreferred radiologist, anesthesiologist, or pathologist will be paid at the preferred provider level and you will not be responsible for any amounts over the covered charge (these are the only three specialties covered under this provision).

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

Note: Except as described above, the preferred provider benefit level will not apply to nonemergency services when received from a nonpreferred provider — even if a preferred provider is not available in your area to perform the services.

SECTION 4: PREAUTHORIZATIONS

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

In order to receive benefits:

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

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

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

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

Most preauthorization requests will be evaluated and you and/or the provider notified of BCBSNM's decision **within 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*).

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*.

BCBSNM PREFERRED PROVIDERS

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

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

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

NONPREFERRED PROVIDERS OR PROVIDERS OUTSIDE NEW MEXICO

If any provider outside New Mexico (except for those contracting as preferred providers directly with BCBSNM) or any Nonpreferred Provider recommends an admission or a service that requires preauthorization, the provider is **not** obligated to obtain the preauthorization for you. In such cases, it is **your** responsibility to ensure that preauthorization is obtained. If authorization is **not** obtained **before** services are received, **your benefits for covered services will be reduced for some services or you will be entirely responsible for the charges.** The provider may call on your behalf, but it is **your responsibility** to ensure that BCBSNM is called.

INPATIENT PREAUTHORIZATION

Preauthorization is required for all admissions **before** you are admitted to the hospital or other inpatient treatment facility (e.g., skilled nursing facility, physical rehabilitation facility, long-term acute care (LTAC). If you are receiving services at an out-of-network facility (or from an in-network facility outside New Mexico) and you do not obtain authorization within the time limits indicated in the table below, benefits for covered facility services will be **reduced or denied** as explained under "Penalty for Not Obtaining Inpatient Preauthorization," below.

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

Penalty for Not Obtaining Inpatient Preauthorization

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

If, based on a review of the claim:	Then:
The admission was **not for a covered service**.	Benefits for the facility and all related services will be **denied.***
The admission was for an item listed under **"Other Preauthorizations,"** (e.g.,air ambulance).	Benefits for the facility and all related services will be **denied.***
The admission was for any other covered service but hospitalization was **not medically necessary**.	Benefits will be **denied** for **room, board,** and **other charges** that are not medically necessary.*
The admission was for a **medically necessary covered service.**	Benefits for the facility's covered services will be **reduced by $300 .***

*The admission review penalty of $300 and charges for noncovered and denied services are **not applied** to any deductible or out-of-pocket limit. You are responsible for paying this amount for out-of-network services.

Inpatient preauthorization requirements may affect the amounts that this Plan pays for inpatient services, but they do not deny your right to be admitted to any facility and to choose your services.

OTHER PREAUTHORIZATIONS

In addition to preauthorization review for all nonemergency inpatient services, preauthorization is required for the services listed below. Most preauthorizations may be requested over the telephone. If a *written* request is needed, have your provider call a Health Services representative for instructions for filing a written request for preauthorization. An out-of-network provider, or an out-of-state network provider may call on your behalf, but it is **your responsibility** to

ensure that BCBSNM is called. Preferred providers that contract **directly** with BCBSNM are responsible for requesting all necessary preauthorizations for you. (See "Inpatient Preauthorization" for further information regarding inpatient preauthorization requirements.)

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

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

- **air ambulance** services (unless during a medical emergency)
- **Applied Behavioral Analysis (ABA)**
- **PET scans**; **cardiac CT scans**; **MRIs**
- **enteral nutritional products, special medical foods,** and **certain drugs** covered under the *Drug Plan Rider;*"Prescription Drugs and Other Items;"
- **home infusion therapy (HIT),** excluding antibiotics
- certain **injections,** including but not limited to **intravenous immunoglobulin** (**IVIG**)
- **psychological testing; neuropsychological testing; electroconvulsive therapy (ECT);** and **intensive outpatient program (IOP)** treatment
- **smoking/tobacco use cessation** drug therapy
- **transplant procedures** including pretransplant evaluations

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

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

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

Preauthorization of Mental Health/Chemical Dependency Services

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

For services needing preauthorization, you or your health care provider should call the BHU **before** you schedule treatment. **NOTE:** Your provider may be asked to submit clinical information in order to obtain preauthorization for the services you are planning to receive. Services may be authorized or may be denied based on the clinical

information received. (*Clinical information* is information based on actual observation and treatment of a particular patient.)

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

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

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

Summary of Contact Information for Preauthorization, Customer Service, Claim Submission, and Appeal (or Reconsideration) Processes for Medical/Surgical and Behavioral Health Services:			
Process:	**Type of Service:**	**Phone:**	**Send to:**
Request preauthorization	Medical/surgical	1-800-325-8334	Send to P.O. number listed on inside cover.
	Mental health/chemical dependency	1-888-898-0070	BH Unit, P.O. Box 27630, Albuquerque, NM 87125-7630
Customer Service Inquiry	Medical/surgical	1-800-432-0750	Send to P.O. number listed on inside cover.
	Mental health/chemical dependency	1-888-898-0070	BH Unit, P.O. Box 27630, Albuquerque, NM 87125-7630
Submit claim (post-service)	Medical/surgical		Send claim to P.O. number listed on inside cover.
	Mental health/chemical dependency		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	OSI; 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 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.

Reminder: It is to your financial advantage to receive care from preferred providers.

MEDICALLY NECESSARY SERVICES

A service or supply is medically necessary when it is provided to diagnose or treat a covered medical condition, is a service or supply that is covered under this Plan, and is determined by BCBSNM's medical director (in consultation with your provider) to meet all of the following conditions:

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

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

Note: Because a health care provider prescribes, orders, recommends, or approves a service does not make it medically necessary or make it a covered service, even if it is not specifically listed as an exclusion. BCBSNM, will determine medical necessity based on the criteria above.

AMBULANCE SERVICES

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

Air Ambulance

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

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 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. Treatment 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. Once maximum functionality has been reached and no additional improvement is expected, no therapies are covered unless required to maintain that member's current functionality (that is, in the absence of additional treatment, the patient would suffer a setback). **No benefits are available for any treatments not shown to be habilitative or rehabilitative.** See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Services are subject to usual member cost-sharing features such as deductible, coinsurance, copayments, and out-of-pocket limits - based on place of treatment, type of service, and whether preauthorization was obtained from BCBSNM. 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
- medically unnecessary or nonhabilitative services under any circumstance
- 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 not in accordance with a treatment plan
- 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 must be sought **within 72 hours** of the accident and any services required after the initial treatment must be associated with the initial accident in order to be covered. (For treatment of TMJ or CMJ injuries, see "TMJ/CMJ Services.")

Facility Charges and General Anesthesia for Dental-Related Services

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

- Because of the **patient's** physical, intellectual or medical condition(s), local anesthesia is not the best choice.
- Local anesthesia is ineffective because of acute infection, anatomic variation, or allergy to local anesthesia.
- The patient is a member age 19 or younger who is extremely uncooperative, fearful or uncommunicative; his/her dental needs are too significant to be postponed; and lack of treatment would be detrimental to the child's dental health.
- Because oral-facial or dental trauma is so extensive, local anesthesia would be ineffective.
- There is a medically necessary dental procedure – not excluded by any general limitation or exclusion listed in this benefit booklet such as for work-related 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. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Reminder: If hospital covered services are recommended by a nonpreferred (out-of-network) provider, you are responsible for assuring that your provider obtains preauthorization for outpatient covered services or benefits may be reduced or denied.

Oral Surgery

This Plan covers the following oral surgical procedures only:

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

TMJ/CMJ Services

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

Exclusions

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

- surgeon's or dentist's charges for noncovered dental services
- hospitalization or general anesthesia for the patient's or provider's convenience
- any service related to a dental procedure that is not medically necessary

- any service related to a dental procedure that is excluded under this Plan for reasons other than being dental-related, even if hospitalization and/or general anesthesia is medically necessary for the procedure being received (e.g., cosmetic procedures, experimental procedures, services received after coverage termination, work-related injuries, etc.)
- nonstandard services (diagnostic, therapeutic, or surgical)
- removal of tori, exostoses, or impacted teeth
- dental-related services that may be related to, or required as the result of, a medical condition or procedure (e.g., chemotherapy or radiation therapy)
- procedures involving orthodontic care, the teeth, dental implants, periodontal disease, noncovered services, or preparing the mouth for dentures
- duplicate or "spare" appliances
- personalized restorations, cosmetic replacement of serviceable restorations, or materials (such as precious metals) that are more expensive than necessary to restore damaged teeth
- dental treatment or surgery, such as extraction of teeth or application or cost of devices or splints, unless required due to an accidental injury and covered under "Dental and Facial Accidents" or "TMJ/CMJ Services"
- dentures, artificial devices and/or bone grafts for denture wear, including implants

DIABETIC SERVICES

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

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

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

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

EMERGENCY CARE AND URGENT CARE

Emergency Care

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

Emergency Room Services

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

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

If you visit a nonpreferred provider for emergency care, the preferred provider benefit is applied only to the initial treatment, which includes emergency room services and, if you are hospitalized **within 48 hours** of an

emergency, the related inpatient hospitalization. Once you are discharged, covered follow-up care from a nonpreferred provider is paid at the nonpreferred provider benefit level. (Services received in an office or urgent care facility are not considered emergency care for purposes of this provision.)

Emergency Admission Notification

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

Follow-Up Care

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

Urgent Care

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

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

HEARING AIDS/RELATED SERVICES FOR CHILDREN UNDER AGE 21

This Plan covers the cost of hearing aids, the fitting and dispensing fees for hearing aids and ear molds, **limited to two hearing aids every 36 months** for members under 21 years old. This 36-month benefit period begins on the date the first covered hearing aid-related service is received and payable under this provision and ends 36 months later. The next benefit period begins 36 months after the first hearing aid-related service (e.g., fitting cost, ear mold, etc.) OR on the date the next hearing aid-related service, whichever length of time is greater.

Benefits for hearing aid-related services payable under this provision are not subject to any coinsurance amount. Benefits for hearing aid-related services will be provided at **100 percent** of the covered charges. (Other covered services, such as hearing examinations and audiometric testing related to a hearing aid need for members under 21 years old are subject to the usual plan coinsurance provisions for office services and diagnostic testing. Benefits for these additional services are not applied to the 36-month maximum benefit available for hearing aids.) **Routine hearing examinations and related services are not covered for members age 21 and older.**

HOME HEALTH CARE/HOME I.V. SERVICES

Conditions and Limitations of Coverage

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

Preauthorization Required

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

Covered Services

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

- skilled nursing care provided on an intermittent basis by a registered nurse or licensed practical nurse
- physical, occupational, or respiratory therapy provided by licensed or certified physical, occupational, or respiratory therapists

- speech therapy provided by a speech pathologist or an American Speech and Hearing Association certified therapist
- intravenous medications and other prescription drugs ordinarily not available through a retail pharmacy if **preauthorization** is received from BCBSNM (If drugs are not provided by the home health care agency, see your separately issued *Drug Plan Rider.*)
- drugs, medicines, or laboratory services that would have been covered during an inpatient admission
- enteral nutritional supplies (e.g., bags, tubing) (For enteral nutritional formulas, see your 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 (See the "Custodial Care" exclusion in *Section 6: General Limitations and Exclusions*.)
- services provided by a nurse who ordinarily resides in your home or is a member of your immediate family
- private duty nursing

HOSPICE CARE SERVICES

Conditions and Limitations

This Plan covers inpatient and home hospice services for a terminally ill member received during a hospice benefit period when provided by a hospice program approved by BCBSNM. If you need an extension of the hospice benefit period, the hospice agency must provide a new treatment plan and the attending physician must recertify your condition to BCBSNM. (See definition of a hospice benefit period in *Section 10* for more information.)

Covered Services

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

- visits from hospice physicians
- skilled nursing care by a registered nurse or licensed practical nurse
- physical and occupational therapy by licensed or certified physical or occupational therapists
- speech therapy provided by an American Speech and Hearing Association certified therapist
- medical supplies (If supplies are *not* provided by the hospice agency, see "Supplies, Equipment and Prosthetics.")
- drugs and medications for the terminally ill patient (If drugs are *not* provided by the hospice agency, see your separately issued *Drug Plan Rider.*)
- medical social services provided by a qualified individual with a degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training and experience (Such services must be recommended by a physician to help the member or his/her family deal with a specified medical condition.)
- services of a home health aide under the supervision of a registered nurse and in conjunction with skilled nursing care
- nutritional guidance and support, such as intravenous feeding and hyperalimentation

- respite care for a period **not to exceed five continuous days** for **every 60 days** of hospice care and **no more than two respite care periods** during each hospice benefit period (*Respite care* provides a brief break from total care-giving by the family.)

Exclusions

This Plan does **not** cover:

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

HOSPITAL/OTHER FACILITY SERVICES

Blood Services

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

Inpatient Services

Preauthorization Required

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

Covered Services

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

Medical Detoxification

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

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 noncovered services or procedures
- custodial care facility admissions

Outpatient or Observation Services

Coverage for outpatient or observation services and related physician or other professional provider services for the treatment of illness or accidental injury depends on the type of service received.

LAB, X-RAY, OTHER DIAGNOSTIC SERVICES

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

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

- x-ray and radiology services, 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 with **preauthorization** from BCBSNM
- MRIs
- psychological or neuropsychological testing with **preauthorization** from BCBSNM
- audiometric (hearing) and vision tests for the diagnosis and/or treatment of an accidental injury or an illness

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

MATERNITY/REPRODUCTIVE SERVICES AND NEWBORN CARE

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

Family Planning and Infertility-Related Services

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

Family Planning for Grandfathered Plans

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

- health education and family planning counseling
- follow-up care for trouble you may have from using a birth control method that a family planning provider gave you
- birth control pills (covered under the drug plan provision)
- pregnancy testing and counseling
- injection of Depo-Provera for birth control purposes
- diaphragm, including fitting
- IUDs or cervical caps, including fitting, insertion, and removal
- surgical sterilization procedures such as vasectomies and tubal ligations

Family Planning for Nongrandfathered Plans

Covered family planning services include:

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

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

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

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

Infertility-Related Services

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

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

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:

- contraceptive devices that do not require a prescription, including over-the-counter contraceptive products such as condoms and spermicide (for **Grandfathered** plans)
- male contraceptive devices, including over-the-counter contraceptive products such as condoms (for **Nongrandfathered** plans)
- 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

If you are pregnant, you should call BCBSNM before your maternity due date, soon after your pregnancy is confirmed. BCBSNM must be notified as soon as possible if the mother's stay is greater than **48 hours** for a routine delivery or greater than **96 hours** for a C-section delivery. If not notified, benefits for covered facility services may be reduced by **$300**.

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 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 a preferred provider contract with his/her local BCBS Plan and is credentialed to provide the service.
- pregnancy-related diagnostic tests, including genetic testing or counseling (Services must be sought due to a family history of a gender-linked genetic disorder or to diagnose a possible congenital defect caused by a present, external factor that increases risk, such as advanced maternal age or alcohol abuse. For example, tests such as amniocentesis or ultrasound to determine the gender of an unborn child are **not** covered.)
- necessary anesthesia services by a provider qualified to perform such services, including acupuncture used as an anesthetic during a covered surgical procedure and administered by a physician, a licensed doctor of oriental medicine, or other practitioner as required by law
- when necessary to protect the life of the infant or mother, coverage for transportation, including air transport, for the medically high-risk pregnant woman with an impending delivery of a potentially viable infant to the nearest available tertiary care facility for newly born infants (See "Ambulance Services" for details.)
- services of a physician who actively assists the operating surgeon in performing a covered surgical procedure when the procedure requires an assistant
- elective, spontaneous, or therapeutic termination of pregnancy prior to full term

Special Beginnings

This is a maternity program for BCBSNM members that is available whenever you need it. It can help you better understand and manage your pregnancy. To take full advantage of the program, you should enroll within three months of becoming pregnant. When you enroll, you will receive a questionnaire to find out if there may be any problems with your pregnancy to watch out for, information on nutrition, newborn care, and other topics helpful

to new parents. You will also receive personal and private phone calls from an experienced nurse – all the way from pregnancy to six weeks after your child is born. To learn more, or to enroll, call toll-free at:

1-888-421-7781

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 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 you are in a nonpreferred facility, you must ensure that BCBSNM is called **before** the mother is discharged from the hospital. If you do not, benefits for the newborn's covered facility services will be reduced by **$300**. The baby's services will be subject to a separate deductible, coinsurance and out-of-pocket limit.

PHYSICIAN VISITS/MEDICAL CARE

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

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

Office Visits and Consultations

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

Allergy Care

This 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

If you have a **Nongrandfathered** plan, it covers counseling and support services rendered by a lactation consultant such as a certified nurse practitioner, certified nurse midwife or midwife, not subject to coinsurance, deductible, copayment, or benefit maximums when received from a provider in the preferred or participating provider network.

Diabetes Self-Management Education

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

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

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

Genetic Inborn Errors of Metabolism

This Plan covers medically necessary expenses related to the diagnosis, monitoring and control of genetic inborn errors of metabolism as defined in *Section 10: Definitions.* Covered services include medical assessment, including clinical services, biochemical analysis, medical supplies, prescription drugs (see your *Drug Plan Rider*), corrective lenses for conditions related to the genetic inborn error of metabolism, nutritional management and **preauthorized** special medical foods (as defined and described in your *Drug Plan Rider*). In order to be covered, services cannot be excluded under any other provision of this benefit booklet and are paid according to the provisions of the Plan that apply to that particular type of service (e.g., special medical foods are covered under your *Drug Plan Rider,* medical assessments under "Physician Visits/Medical Care" and corrective lenses under "Supplies, Equipment and Prosthetics").

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

Injections and Injectable Drugs

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

Mental Health Evaluation Services

This Plan covers medication checks and intake evaluations for mental disorders, alcohol, and drug abuse.

Inpatient Medical Visits

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

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

PREVENTIVE SERVICES

Claims filed under this provision must clearly show that the office visit and tests were for routine or preventive care.

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 if you have a **Nongrandfathered** plan; **Grandfathered** plans are subject to cost-sharing. (See your *Summary of Benefits* for specific cost-sharing details.)

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

b. immunizations for routine use that have in effect a recommendation by the Advisory Committee on 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 deductible, coinsurance, copayments, and/or dollar maximums. Allergy injections are **not** considered immunizations under the "Preventive Services" benefit. Examples of covered services include, but are not limited to:

- routine physical, breast, gynecological, and pelvic examinations
- routine adult and pediatric immunizations
- routine screening colonoscopies and mammograms at 100 percent of covered charges when received from an in-network provider, not subject to any annual maximum for preventive care
- papilloma virus screening and cytologic screening (a Pap test or liquid-based cervical cytopathology)
- human papillomavirus vaccine (HPV) for members ages 9 - 26 years old
- periodic blood hemoglobin, blood pressure and blood glucose level tests

- periodic colorectal screening tests
- periodic blood cholesterol or periodic fractionated cholesterol level including a low-density lipoprotein (LDL) and a high-density lipoprotein (HDL) level; periodic stool examination for the presence of blood
- periodic left-sided colon examination of 35 to 60 centimeters or colonoscopy
- well-child care, including well-baby and well-child screening for diagnosing the presence of autism spectrum disorder
- periodic glaucoma eye tests
- vision and hearing screenings in order to detect the need for additional vision or hearing testing for members (through age 17 for **Grandfathered** plans) 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 for **Nongrandfathered** plans

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
- immunizations or medications required for international travel (**Grandfathered** plans only)
- hepatitis B immunizations when required due to possible exposure during the member's work (**Grandfathered** plans only)
- routine eye examinations; eye refractions; visual screening (for members over age 17 on **Grandfathered** plans); or any related service or supply
- routine hearing examinations; hearing aids; hearing screening (for members over age 17 on **Grandfathered** plans); or any related service or supply, unless otherwise specified in this section (See "Hearing Aids/Related Services for Children Under Age 21.")

PSYCHOTHERAPY (MENTAL HEALTH AND CHEMICAL DEPENDENCY)

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

Medical Necessity

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

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

Covered Services/Providers

Covered services include solution-focused evaluative and therapeutic mental health services (including individual and group psychotherapy) received in a psychiatric hospital, an IOP (intensive outpatient program), or an alcoholism treatment program that complies with applicable state laws and regulations, and services rendered by

psychiatrists, licensed psychologists, and other providers as defined in *Section 10: Definitions*. See your BCBSNM *Provider Directory* for a list of contracting providers or check the BCBSNM website at www.bcbsnm.com.

Preauthorization Requirements

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

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.**

Benefit Limits Small Group (2 - 50) Grandfathered Plans

Benefits for inpatient and outpatient psychotherapy (whether required due to mental disorders and drug or alcohol abuse or any other covered condition) and related adjunctive services are limited as specified in the *Summary of Benefits.* If your services are limited, chemical dependency does not go towards your out-of-pocket limits.

Chemical Dependency Benefit Period Limitation for Small Group (2 - 50) Grandfathered Plans

If indicated on your *Summary of Benefits,* benefits for drug and alcohol abuse rehabilitation are limited to those treatments you receive during a maximum of **two 12-month benefit periods** for as long as you remain covered under the Plan. Even if you have not exhausted your annual benefit, you will not be extended coverage for chemical dependency rehabilitation beyond the two benefit periods to which you are entitled (except as provided for alcohol abuse rehabilitation, below). The benefit periods need not be consecutive in order to be covered (as long as you maintain eligibility). Benefits for psychotherapy services that are **not** related to chemical dependency renew annually and are not subject to a lifetime maximum of benefit periods.

Minimum Coverage for Alcohol Abuse Rehabilitation for Small Group (2 - 50) Grandfathered Plans

If you exhaust your maximum benefits when receiving services that are **not** related to alcohol abuse, you are still entitled to up to **30 inpatient days** and **35 outpatient office visits** for medically necessary alcohol abuse rehabilitation during each of **two 12-month benefit periods**. However, if you exhaust an *annual* maximum for psychotherapy services while receiving alcoholism treatment, benefits for mental disorders and drug abuse will not renew until the following benefit period. Likewise, if you are receiving alcohol abuse treatment and use up the two benefit periods, no further drug abuse rehabilitation benefits are available.

Exclusions

This Plan does **not** cover:

- care received from a nonpreferred provider on **Grandfathered** plans
- 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; residential treatment centers; or behavior modification services
- long-term therapy or therapy for the treatment of chronic mental disorders or incurable conditions for which treatment produces minimal or temporary change of relief - except that medication management for chronic conditions is covered (Chronic conditions are conditions such as, but not limited to, autism, Down's Syndrome

and developmental delays.) See "Early Developmental Delay and Disability" in *Section 8: Claims Payments and Appeals* for reimbursement of certain services provided to eligible children by the Department of Health.

- maintenance therapy or care provided after you have reached your rehabilitative potential (See the "Long-Term or Maintenance Therapy" exclusion in the *General Limitations and Exclusions* section.)
- biofeedback, hypnotherapy, or behavior modification services
- religious or pastoral counseling
- custodial care (See the "Custodial Care" exclusion in *Section 6: General Limitations and Exclusions*.)
- any care that is patient-elected and is not considered medically necessary
- care that is mandated by court order or as a legal alternative, and lacks clinical necessity as diagnosed by a licensed provider; services rendered as a condition of parole or probation
- special education, school testing and evaluations, counseling, therapy, or care for learning deficiencies or educational and developmental disorders; behavioral problems unless associated with manifest mental disorders or other disturbances (See "Early Developmental Delay and Disability" in *Section 8: Claim Payments and Appeals* for reimbursement of certain services provided to eligible children by the Department of Health.)
- non-national standard therapies, including those that are experimental as determined by the mental health professional practice
- the cost of any damages to a treatment facility

REHABILITATION AND OTHER THERAPY

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

Acupuncture and Spinal Manipulation

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

Cardiac and Pulmonary Rehabilitation

This Plan covers outpatient cardiac rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services. **Services must be received from a preferred provider in order to be covered.**

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 Services.

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

Dialysis

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

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

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

Preauthorization Required

To be covered, all **inpatient**, short-term rehabilitation treatments, including skilled nursing facility and physical rehabilitation facility admissions, must receive **preauthorization** from BCBSNM and be received from a **preferred provider**.

Covered Services

This Plan covers the following short-term rehabilitation services when rendered by a **preferred provider** for the medically necessary treatment of accidental injury or illness:

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

Benefit Limits

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

Exclusions

This Plan does **not** cover:

- maintenance therapy or care provided after you have reached your rehabilitative potential except as required under New Mexico State law (Even if you have not reached your rehabilitative potential, this Plan does not cover services that exceed maximum benefit limits, if any.)
- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay, except as required by law and described in this *Covered Services* section under "Autism Spectrum Disorders" (See "Early Developmental Delay and Disability" in *Section 8: Claim Payments and Appeals* for reimbursement of certain services provided to eligible children by the Department of Health.)
- services provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered provider
- therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights)
- speech therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic; other speech services that can be carried out by the patient, the family, or caregiver/teacher
- herbs, homeopathic preparations, or nutritional supplements
- services of a massage therapist or rolfing

SMOKING/TOBACCO USE CESSATION FOR GRANDFATHERED PLANS

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

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

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

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

Exclusions

This Plan does **not** cover the following services:

- cessation counseling or treatment received from nonpreferred providers or drug therapy that has not received preauthorization
- acupuncture, biofeedback, or hypnotherapy for smoking/tobacco use cessation

- over-the-counter tobacco cessation products, including but not limited to items such as nicotine patches or nicotine gum (See your separately issued *Drug Plan Rider* for copayments and other limitations that apply to prescription drugs.)

SUPPLIES, EQUIPMENT AND PROSTHETICS

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

If you have a **Nongrandfathered** plan, it covers the rental (but not to exceed the total cost) or purchase of manual, electric, or hospital grade breast pumps and supplies with a written prescription from a health care provider. The rental or purchase cost of manual, electric, or hospital grade breast pumps and supplies are not subject to coinsurance, deductible, copayment, or benefit maximums when received from an in-network provider.

Diabetic Supplies and Equipment

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

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

Reminder: For additional diabetic supply coverage, (e.g., insulin needle and syringes, autolet, glucose meters, test strips for glucose monitors, glucagon emergency kits), see your *Drug Plan Rider.*

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 Rider* within the limits of this Plan.

Durable Medical Equipment and Appliances

This Plan covers the following items**:**

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

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

Medical Supplies

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

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

Orthotics and Prosthetic Devices

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

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

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

Exclusions

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

- air conditioners, biofeedback equipment, humidifiers, purifiers, self-help devices, or whirlpools
- items that are primarily nonmedical in nature such as Jacuzzi units, hot tubs, exercise equipment, heating pads, hot water bottles, or diapers
- nonstandard or deluxe equipment, such as motor-driven wheelchairs, chairlifts or beds; external prosthetics that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing
- repairs to items that you do not own
- comfort items such as bedboards, beds or mattresses of any kind, bathtub lifts, overbed tables, or telephone arms
- repair or rental costs that exceeds the purchase price of a new unit

- dental appliances
- 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 and older or, if under age 21, in excess of the maximum benefit described in this section (For surgically implanted devices for the profoundly hearing impaired, see "Surgery and Related Services" below.)
- syringes or needles for self-administering drugs (Coverage for insulin needles and syringes and other diabetic supplies not listed as covered in this section is described 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. (See "Maternity/Reproductive Services and Newborn Care: Family Planning" for devices requiring a prescription.)
- items not listed as covered
- costs for items received from a nonpreferred provider that exceed the maximum benefit listed in the *Summary of Benefits,* if any

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.

Reconstructive Surgery

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

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

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

Exclusions

This Plan does **not** cover:

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

Anesthesia Services

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

Exclusions

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

Assistant Surgeon Services

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

Exclusions

This Plan does **not** cover:

- services of an assistant only because the hospital or other facility requires such services

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

TRANSPLANT SERVICES

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

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

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 and out-of-pocket limits; and annual home health care maximums, if applicable).

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

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

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

Recipient Travel and Per Diem Expenses

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

Travel expenses and standard per diem allowances are limited to a total combined lifetime maximum benefit of **$10,000** . 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 retransplant date.

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 policy)
- nonhuman organ transplants
- care for complications of noncovered transplants or follow-up care related to such transplants
- services related to a transplant performed in a facility not contracted directly or indirectly with BCBSNM to provide the required transplant (except cornea, kidney, or bone marrow)
- expenses incurred by a member of this plan for the donation of an organ to another person
- drugs that are self-administered or for use while at home (These services may be covered under your separately issued *Drug Plan Rider*.)
- donor expenses after the donor has been discharged from the transplant facility
- lodging expenses in excess of the per diem allowance, if available, and food, beverage, or meal expenses
- travel or per diem expenses:
  - incurred **more than five days before** or **more than one year following** the date of transplantation
  - if the recipient's case manager indicates that travel is not medically necessary
  - related to a bone marrow or kidney transplant
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; telephone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- expenses charged only because benefits are available under this provision (such as transportation received from a member of your family, or from any other person charging for transportation that does not ordinarily do so)

SECTION 6: GENERAL LIMITATIONS AND EXCLUSIONS

These general limitations and exclusions apply to **all** services listed in this benefit booklet and your *Drug Plan Rider*.

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

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

— Before Effective Date of Coverage

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

— Biofeedback

This Plan does not cover services related to biofeedback.

— Blood Services

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

— Complications of Noncovered Services

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

— Convalescent Care or Rest Cures

This Plan does not cover convalescent care or rest cures.

— Cosmetic Services

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

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

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

— Custodial Care

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

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

— Dental-Related 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 tests such as amniocentesis or ultrasound to determine the gender of an unborn child.

— 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 for children through age 17 on **Grandfathered** plans, or 3) covered as part of the hearing aid benefit for members under age 21 and described under "Hearing Aids/Related Services for Children Under Age 21" in *Section 5: Covered Services.* (A screening does *not* include a hearing test to determine the amount and kind of correction needed.) **This Plan does not cover** hearing aids or ear molds, fitting of hearing aids or ear molds, or any related service or supply for **members age 21 and older.** For **members under age 21**, see "Hearing Aids/Related Services for Children Under Age 21" in *Section 5.* (For surgically implanted devices, see "Surgery and Related Services" in *Section 5: Covered Services.*)

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

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

— Hypnotherapy

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

— Indian Health Services

This Plan does not cover services provided at Indian Health Services (IHS) facilities pursuant to the Indian Health Care Improvement Act (IHCIA).

— 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. (Preferred providers contracting directly with BCBSNM and providers that have a "participating" provider agreement with BCBSNM will file claims for you and must submit them within a specified period of time, usually 180 days.) If a claim is returned for further information, resubmit it **within 45 days.**

— Learning Deficiencies/Behavioral Problems

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

— Limited Services/Covered Charges

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

— Local Anesthesia

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

— Long-Term and Maintenance Therapy

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

— Medical Policy Determinations

Any technologies, procedures, or services for which medical policies have been developed by BCBSNM are either limited or excluded as defined in the medical policy. (See "Medical Policy" in *Section 10: Definitions)*. **Exception:** The fact that this Plan covers certain services that are excluded under BCBSNM medical policy and certain services defined as experimental or as maintenance therapy but which must be covered under New Mexico state law (such as cancer clinical trials and applied behavioral analysis) does not mean that any other services will be or should be

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

— Medically Unnecessary Services

This 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.

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 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
  - extended care facility or similar institution
  - residential treatment center (A residential treatment center is a facility where the primary services are the provision of room and board and constant supervision or a structured daily routine for a person who is impaired but whose condition does not require acute care hospitalization.)
  - dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group
  - 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 and arthritis classes (Some diabetic services and other educational programs may be covered; see "Physician Visits/Medical Care" and "Preventive Services" in *Section 5: Covered Services* for details.)
- vocational or training services and supplies
- mailing and/or shipping and handling
- missed appointments; "get-acquainted" visits without physical assessment or medical care; provision of medical information to perform admission review or other preauthorizations; filling out of claim forms; copies of medical records; interest expenses
- modifications to home, vehicle, or workplace to accommodate medical conditions; voice synthesizers; other communication devices
- membership at spas, health clubs, or other such facilities
- personal convenience items such as air conditioners, humidifiers, exercise equipment, or personal services such as haircuts, shampoos, guest meals, and television rentals, Internet services
- personal comfort services, including homemaker and housekeeping services, except in association with respite care covered during a hospice admission
- immunizations or medications required for international travel
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; phone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- physicals or screening examinations and immunizations given primarily for insurance, licensing, employment, camp, weight reduction programs, medical research programs, sports, or for any nonpreventive purpose
- hepatitis B immunizations when required due to possible exposure during the member's work
- court- or police-ordered services unless the services would otherwise be covered or services rendered as a condition of parole or probation
- the cost of any damages to a treatment facility that are caused by the member

— Nonpreferred Provider Services

This Plan does not cover some services when received from a nonpreferred provider. Refer to your *Summary of Benefits* for any applicable services that are not covered.

— 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.*

— Obesity Surgery

This Plan does not cover any and all surgical treatments of obesity including, without limitation, gastric bypass or other type of bariatric surgery, under any circumstance. This is true regardless of the presence or absence of other medical conditions that can be either directly or indirectly attributed to obesity. Obesity means any diagnosis of obesity including morbid obesity.

— Post-Termination Services

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

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

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

— Private Duty Nursing Services

This Plan does not cover private duty nursing services.

— Psychotherapy (Mental Health and Chemical Dependency)

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

— 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, weight-loss, and codependency programs
- smoking/tobacco use cessation counseling programs of providers that do not meet the standards described under "Cessation Counseling" in *Section 10: Definitions*
- services of a massage therapist or rolfing
- transactional analysis, encounter groups, and transcendental meditation (TM); moxibustion; sensitivity or assertiveness training
- vision therapy; orthoptics
- pastoral, spiritual, or religious counseling
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this Plan
- therapy for chronic conditions such as, but not limited to, cerebral palsy or developmental delay, 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)
- speech therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic, except as required by law and described in *Section 5* under "Autism Spectrum Disorders"; other speech services that can be carried out by the patient, the family, or caregiver/teacher

— Thermography

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

— Transplant Services

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

— Travel or Transportation

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

— Veteran's Administration Facility

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

— Vision Services

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

— War-Related Conditions

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

— Weight Management

This Plan does not cover weight-loss or other weight-management programs, dietary control, or medical obesity treatment, other than counseling programs as required under federal law for **Nongrandfathered** plans unless dietary advice and exercise are provided by a physician, nutritionist, or dietitian licensed by the appropriate agency. Call a Customer Service Advocate for assistance.

— 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.

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

The following rules determine which coverage pays first:

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

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

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 timely information is not provided.

Facility of Payment

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

Overpayments - Right of Recovery

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

REIMBURSEMENT

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

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

— BCBSNM is assigned the right to recover from the third party, or 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.

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

SECTION 8: CLAIMS PAYMENTS AND APPEALS

FILING CLAIMS

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

IMPORTANT NOTE ABOUT FILING CLAIMS

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

IF YOU HAVE OTHER VALID COVERAGE

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

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

PARTICIPATING AND PREFERRED PROVIDERS

Your "preferred" provider may have two agreements with the local BCBS Plan — a preferred provider contract and another participating provider contract. Some providers have **only** the participating provider contract and are **not** considered preferred providers. However, all participating and preferred providers file claims with their local BCBS Plan and payment is made directly to them. Be sure that these providers know you have health care coverage administered by BCBSNM. Do **not** file claims for these services yourself.

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

PROVIDER NETWORK

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

NONPARTICIPATING PROVIDERS

A nonparticipating provider is one that has neither a preferred or a participating provider agreement. If your nonparticipating provider does not file a claim for you, submit a separate claim form for each family member as the services are received. Attach itemized bills and, if applicable, your other valid coverage's payment explanation, to a *Member Claim Form.* (Forms can be printed from the BCBSNM website at 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:** Participating and preferred providers will file claims for you; these procedures are used only when you must file your own claim.

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

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

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

Mental Health/Chemical Dependency Claims

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

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

Drug Plan Claims

If you purchase a prescription drug or other item covered under the drug plan from a nonparticipating pharmacy or other provider in an emergency, or if you do not have your ID card with you when purchasing a prescription or other

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

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

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

You will need to pay up front for care received from a **doctor,** a **participating outpatient hospital,** and/or a **nonparticipating hospital.** Then, complete an *International Claim Form* and send it with the bill(s) to the 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/coverage/bluecard/bluecard-worldwide.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

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 in which to appeal a decision.**

Covered Charge

Provider payments are based upon preferred provider and participating provider agreements and covered charges as determined by BCBSNM. For services received outside of New Mexico, covered charges may be based on the local Plan practice (e.g., for out-of-state providers that contract with their local Blue Cross and Blue Shield Plan, the covered charge may be based upon the amount negotiated by the other Plan with its own contracted providers). You are responsible for paying copayments, deductibles, coinsurance, any penalty amounts, and noncovered expenses. For covered services received in foreign countries, BCBSNM will use the exchange rate in effect on the date of service in order to determine billed charges.

Participating and Preferred Providers

Payments for covered services usually are sent directly to network (preferred or participating) providers. The EOB you receive explains the payment.

Nonparticipating Providers

If covered services are received from a nonparticipating provider, payments are usually made to the subscriber (or to the applicable alternate payee when a QCMSO is in effect). The check will be attached to an EOB that explains BCBSNM's payment. In these cases, you are responsible for arranging payment to the provider and for paying any amounts greater than covered charges plus copayments, deductibles, coinsurance, any penalty amounts, and noncovered expenses.

Accident-Related Hospital Services

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

Assignment of Benefits

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

Early Developmental Delay and Disability

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

Medicaid

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

Overpayments

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

Pricing of Noncontracted Provider Claims

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

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

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

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

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

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

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

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

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

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

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

Provider Payment Example

The two examples below demonstrate the difference between your liability for services from a nonpreferred provider (when such services are **preauthorized** and **not** eligible for 100 percent coverage of billed charges, such as during an emergency) versus a preferred provider. Both examples are for a plan that pays 80 percent of covered charges with the remaining 20 percent of covered charges paid by the member.

Example 1. Preferred Provider Claim Payment (Plan pays 80 percent; deductible is met):

Provider's billed charge	$10,000
Covered charges (maximum amount that can be considered for benefit payment)	$8,000
BCBSNM payment to provider (80% of $8,000)	$6,400
Member coinsurance (20% of $8,000) applied to the out-of-pocket limit	$1,600
Amount over the covered charges - the preferred provider writes off the difference between billed amount and covered charge	$0
Total amount due from member (coinsurance only):	$1,600

Example 2. Nonpreferred Provider Claim Payment (Plan pays 80 percent; deductible is met):

Provider's billed charge	$10,000
Covered charges (maximum amount that can be considered for benefit payment)	$8,000
BCBSNM payment to provider (80% of $8,000)	$6,400
Member coinsurance (20% of $8,000) applied to the out-of-pocket limit	$1,600
Amount over the covered charges - the member is responsible for all costs incurred over the covered charges and these amounts do not apply to your out-of-pocket limits	$2,000
Total amount due from member (coinsurance only):	$3,600

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.

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

GRIEVANCE PROCEDURES

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

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 preferred 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 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.

(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 reviewed 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 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 twenty (20) working 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.nmOSI.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 Insurance Division 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. Insurance division 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 Insurance Division Staff

Upon receipt of the request for external review, insurance division 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 Insurance Division Staff

If the request is for external review of an experimental or investigational treatment adverse determination, insurance division 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, insurance division 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, insurance division 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, insurance division 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, insurance division 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 insurance division'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 insurance division'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 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 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;

(2) e-mailed to mhcb.grievance@state.nm.us, subject External Review Request;

(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.nmOSI.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

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 30 days prior written notice of an amendment to this benefit booklet. No employee of BCBSNM may change this benefit booklet by giving incomplete or incorrect information, or by contradicting the terms of this benefit booklet. Any such situation will not prevent BCBSNM from administering this benefit booklet in strict accordance with its terms. 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.

DISCLAIMER OF LIABILITY

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

DISCLOSURE AND RELEASE OF INFORMATION

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

ENTIRE CONTRACT

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

EXECUTION OF PAPERS

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

INDEPENDENT CONTRACTORS

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

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

MEMBER RIGHTS

All members have these rights:

- The right to available and accessible services, when medically necessary, as determined by your primary care or treating physician in consultation with BCBSNM, 24 hours per day, 7 days a week, or urgent or emergency care services, and for other health services as defined by your benefit booklet.
- The right to be treated with courtesy and consideration, and with respect for your dignity and your need for privacy.
- The right to have their privacy respected, including the privacy of medical and financial records maintained by BCBSNM and its health care providers as required by law.
- The right to be provided with information concerning BCBSNM's policies and procedures regarding products, services, providers, and appeals procedures and other information about the company and the benefits provided.
- The right to 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 preferred providers that may restrict referral or treatment options or limit the services offered to members.
- The right to adequate access to qualified health professionals near your work or home within the BCBSNM service area (the state of New Mexico).
- The right to affordable health care, with limits on out-of-pocket expenses, including the right to seek care from a nonpreferred provider, and an explanation of your financial responsibility when services are provided by a nonpreferred provider, or provided without required preauthorization.
- The right to detailed information about coverage, maximum benefits, and exclusions of specific conditions, ailments or disorders, including restricted prescription benefits, and all requirements that you must follow for preauthorization and utilization review.
- The right to make recommendations regarding BCBSNM's member rights and responsibilities policies.
- The right to 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 Superintendent of Insurance.

MEMBER RESPONSIBILITIES

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

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

MEMBERSHIP RECORDS

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

RELIGIOUS EMPLOYER EXEMPTION DISCLOSURE FOR NONGRANDFATHERED PLANS

If you have a **Nongrandfathered** plan, your group may certify that its group health plan is established or maintained by an organization that is a religious employer as defined in 45 C.F.R. 147.130(a)(1)(iv)(B) 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 your group is a religious employer that has certified it satisfies this Religious Employer Exemption, coverage under your group health plan will not include coverage of such contraceptive services. Questions regarding the Religious Employer Exemption should be directed to your group benefit administrator.

RESEARCH FEES

BCBSNM reserves the right to charge you an administrative fee when extensive research is necessary to reconstruct information that has already been provided to you in explanations of benefits, letters, or other forms. If BCBSNM requires an independent medical examination (IME) before authorizing a service or processing a claim. BCBSNM will cover the cost of the IME. In the unlikely event that BCBSNM requires an autopsy before paying a claim, BCBSNM will pay the cost of the autopsy.

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.

TEMPORARY ENFORCEMENT SAFE HARBOR DISCLOSURE FOR NONGRANDFATHERED PLANS

If you have a **Nongrandfathered** plan, your group may certify that its group health plan is established or maintained by an organization that satisfies all of the criteria for a one (1) year temporary enforcement Safe Harbor from the Affordable Care Act requirement to cover certain contraceptive services without cost-sharing under guidelines supported by the Health Resources and Services Administration. During this one-year period and provided your group certifies that it qualifies for the Safe Harbor, coverage under your group health plan will not include coverage of such contraceptive services. Questions regarding the Safe Harbor should be directed to your group benefit administrator.

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.

SECTION 10: DEFINITIONS

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

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

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

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

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.

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

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

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

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

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

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

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

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

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

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

- is designed to build positive behavior change practices and provides counseling at a minimum on: establishment of reasons for quitting, understanding nicotine addiction, techniques for quitting, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse prevention information, and follow-up;

- operates under a written program outline that meets minimum requirements established by the Office of Superintendent of Insurance;
- employs counselors who have formal training and experience in tobacco cessation programming and are active in relevant continuing education activities; and
- uses a formal evaluation process, including mechanisms for data collection and measuring participant rate and impact of the program.

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

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

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

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

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

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

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

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

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

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

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

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

Cost effective — A procedure, service, or supply that is an economically efficient use of resources with respect to cost, relative to the benefits and harms associated with the procedure, service, or supply. When determining cost effectiveness, the situation and characteristics of the individual patient are considered.

Covered charge — The amount that BCBSNM allows for covered services using a variety of pricing methods and based on generally accepted claim coding rules. The covered charge for services from "contracted providers" is the amount the provider, by contract with BCBSNM (or another entity, such as another BCBS Plan), will accept as

payment in full under this health plan. For information about pricing of noncontracted provider claims, see "Pricing of Noncontracted Provider Claims" in *Section 8: Claim Payments and Appeals*.

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

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

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

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

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

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

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

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

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

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

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

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

Drug abuse — A condition defined by patterns of usage that continue despite occupational, marital, or physical problems related to compulsive use of drugs or other non-alcoholic substance. There may also be significant risk of severe withdrawal symptoms if the use of drugs is discontinued. Drug abuse does not include nicotine addiction or alcohol abuse.

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

Drug List — A list of prescription drugs that are preferred for use by BCBSNM for retail and mail-order pharmacy benefits. The list is subject to periodic review and change by BCBSNM. BCBSNM-contracted providers should have received a copy of the list. If you need a list of commonly prescribed drugs on the BCBSNM Drug List, request it from a Customer Service Advocate or visit the BCBSNM website. Your drug plan may or may not use a Drug List. See your separately issued *Drug Plan Rider* for details.

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

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

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

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

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

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

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

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

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

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Initial enrollment eligibility date — A member's effective date of coverage or the first day of any employee probationary period imposed on the member by the employer, whichever is earlier. For a late applicant or for a person applying under a special enrollment provision, the initial enrollment eligibility date is his/her effective date of coverage.

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 hospital services include, but are not limited to, semi-private room accommodations, general nursing care, meals, and special diets or parenteral nutrition when medically necessary, physician and surgeon services, use of all hospital facilities when use of such facilities is determined to be medically necessary by your treating physician, pharmaceuticals and other medications, anesthesia and oxygen services, special duty nursing when medically necessary, radiation therapy, inhalation therapy, and administration of whole blood and blood components when medically necessary.

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

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

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

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

- anyone not enrolled **within 31 days** of becoming eligible for coverage under this health care plan (e.g., a child added **more than 31 days** after legal adoption, a new spouse or stepchild added more than 31 days after marriage)
- anyone enrolling on the group's initial BCBSNM enrollment date who was not covered under the group's prior plan (but who was eligible for such coverage)
- anyone eligible but not enrolled during the group's initial enrollment

- anyone who voluntarily terminates his/her coverage and applies for reinstatement of such coverage at a later date (except as provided under the USERRA of 1994)

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

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

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

Maternity — Any condition that is related to pregnancy. Maternity care includes prenatal and postnatal care and care for the complications of pregnancy, such as ectopic pregnancy, spontaneous abortion (miscarriage), elective abortion 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 policy — A coverage position developed by BCBSNM that summarizes the scientific knowledge currently available concerning new or existing technology, products, devices, procedures, treatment, services, supplies, or drugs and used by BCBSNM to adjudicate claims and provide benefits for covered Services. Medical policies are posted on the BCBSNM website for review or copies of specific medical policies may be requested in writing from a Customer Service Advocate.

Medical supplies — Expendable items (except prescription drugs) ordered by a physician or other professional provider, that are required for the treatment of an illness or accidental injury.

Medically necessary, medical necessity — See "Medically Necessary Services" in *Section 5: Covered Services.*

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

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

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

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

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

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

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

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

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

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

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

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

Other valid coverage — All other group and individual (or direct-pay) insurance policies or health care benefit plans (including Medicare, but excluding Indian Health Service and Medicaid coverages), that provide payments for medical services will be considered other valid coverage for purposes of coordinating benefits under this Plan.

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

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

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

Outpatient surgery — Any surgical services that is performed in an ambulatory surgical facility or the outpatient department of a hospital, but **not** including a procedure performed in an office or clinic. Outpatient surgery includes

any procedure that requires the use of an ambulatory surgical facility or an outpatient hospital operating or recovery room.

Participating pharmacy — See the definition of "Provider."

Participating provider — Any provider that, for the service being provided, contracts with BCBSNM, a BCBSNM contractor or subcontractor, another Blue Cross and Blue Shield (BCBS) Plan or the national BCBS transplant network. Your "preferred" provider may have two agreements with the local BCBS Plan — a preferred provider contract and another "participating" provider contract. Providers that have only the participating provider contract are **not** considered preferred providers. See definition of "Provider."

Pharmacy-related definitions — The definitions below are specifically related to pharmacy services.

Coinsurance — A **percentage** amount paid by you for each covered specialty pharmacy prescription order filled through a designated specialty pharmacy provider.

Copayment — The maximum fixed-dollar amount you pay for each covered prescription order filled or refilled or a covered supply purchased through a retail pharmacy, specialty pharmacy provider, or designated mail-order service vendor.

Compound drugs — Those drugs or inert ingredients that have been measured and fixed with United States Food and Drug Administration (FDA)-approved pharmaceutical ingredients by a pharmacist to produce a unique formulation that is medically necessary because commercial products either do not exist or do not exist in the correct dosage, size, or form.

Device — An instrument, apparatus, implement, machine, contrivance, implant, or similar or related article, including a component part or accessory, that is required by federal law to bear the label, **"Caution: federal law or state law requires dispensing by or on the order of a physician."**

Dispense — The evaluation and implementation of a prescription, including the preparation and delivery of a drug or device to a patient or patient's agent in a suitable container appropriately labeled for subsequent administration to or use by a patient.

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

Generic drug — A drug that has the same active ingredient as a brand-name drug and is allowed to be produced after the brand-name drug's patent has expired. In determining the brand or generic classification for covered drugs, BCBSNM uses the generic/brand status assigned by a nationally recognized provider of drug product database information.

Maintenance medications — Prescription drugs that are taken regularly to treat a chronic health condition such as high cholesterol, high blood pressure, or asthma.

Nonprescription drugs — Non-narcotic medicines or drugs that may be sold without a prescription and are prepackaged for use by a consumer and are labeled in accordance with the laws and regulations of the state and federal governments.

Patient counseling — The oral communication by the pharmacist of information to a patient or his agent or caregiver regarding proper use of a drug or device.

Pharmaceutical care — The provision of drug therapy and other patient care services related to drug therapy intended to achieve definite outcomes that improve a patient's quality of life, including identifying potential and actual drug-related problems, resolving actual drug-related problems, and preventing drug-related problems.

Pharmacy — A state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any provider's office, and where drugs and devices are dispensed under prescription orders to the general public by a pharmacist licensed to dispense such drugs and devices under the law of the state in which he/she practices.

Practice of pharmacy — The evaluation and implementation of a lawful order of a licensed practitioner: the dispensing of prescriptions; the participation in drug and device selection or drug administration that has

been ordered by a licensed practitioner; drug regimen reviews and drug or drug-related research; the administering or prescribing of dangerous drug therapy; the provision of patient counseling and pharmaceutical care; the responsibility for compounding and labeling of drugs and devices; the proper and safe storage of drugs and devices; and the maintenance of proper records.

Prescription — An order given individually for the person for whom prescribed, either directly from a licensed practitioner or his agent to the pharmacist, including electronic transmission or indirectly by means of a written order signed by the prescriber, that bears the name and address of the prescriber, his/her license classification, the name and address of the patient, the name and quantity of the drug prescribed, directions for use, and the date of the issue.

Prescription drugs, medicines and devices — Those that are taken at the direction and under the supervision of a provider, that require a prescription before being dispensed, and are labeled as such on their packages. All prescription drugs, medicines and devices must be approved by the FDA, and must not be experimental, investigational, or unproven. (See "Experimental, Investigational, or Unproven Service" in *Section 6: General Limitations and Exclusions*.)

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

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

Physician — See definition of "Provider," below.

Physician assistant — A graduate of a physician assistant or surgeon assistant program approved by a nationally recognized accreditation body or a skilled person who is currently certified by the National Commission on Certification of Physician Assistants, who is licensed in the state of New Mexico (or by the appropriate state regulatory body) to practice medicine under the supervision of a licensed physician.

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

Practitioner of the healing arts — See definition of "Provider," below.

Preauthorization — An advance confirmation to determine medical necessity, as may be required where permitted by law, for certain services to be eligible for benefits.

Predetermination — An advance confirmation, or "predetermination," of benefits for a requested covered service. Predetermination does not guarantee benefits if the actual circumstances of the case differ from those originally described.

Preferred provider — See definition of "Provider," below.

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

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

Probationary period — The amount of time an employee must work before becoming eligible for any health care coverage offered by the employer sponsoring this plan. Your employer determines the length of the probationary period.

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

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

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

Physician: A practitioner of the healing arts who is also a doctor of medicine (M.D.) or osteopathy (D.O.) and who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

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

Professional provider: A physician or health care practitioner, including a pharmacist, who is licensed, certified, or otherwise authorized by the state to provide health care services consistent with state law.

A provider may belong to one or more networks, but if you want to visit a network provider, you must choose the provider from the *appropriate* network:

Preferred (PPO) Provider: Health care professionals and facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, or another BCBS Plan, as "preferred" or "PPO" providers. These providers belong to the Preferred Provider Network.

Participating pharmacy: A retail supplier that has contracted with BCBSNM or its authorized representatives to dispense prescription drugs and medicines, insulin, diabetic supplies, and nutritional products to members covered under the drug plan portion of this Plan and that has contractually accepted the terms and conditions as set forth by BCBSNM and/or its authorized representatives. Some participating pharmacies are contracted with BCBSNM to provide specialty drugs to members; these pharmacies are called "Specialty Pharmacy Providers" and some drugs must be dispensed by these specially contracted pharmacy providers in order to be covered.

A network provider agrees to provide health care services to members with an expectation of receiving payment (other than coinsurance or deductibles) directly or indirectly from BCBSNM (or other entity with whom the provider has contracted). A network provider agrees to bill BCBSNM (or other contracting entity) directly and to accept this Plan's payment (provided in accordance with the provisions of the contract) plus the member's share (coinsurance, deductibles, copayments, etc.) as payment in full for covered services. BCBSNM (or other contracting entity) will pay the network provider directly. BCBSNM (or other contracting entity) may add, change, or terminate specific network providers at its discretion or recommend a specific provider for specialized care as medical necessity warrants.

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

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

Radiation therapy — X-ray, radon, cobalt, betatron, telocobalt, and radioactive isotope treatment for malignant diseases and other medical conditions.

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

Registered lay midwife — Any person who practices lay midwifery and is registered as a lay midwife by the New Mexico Department of Health.

Registered nurse (R.N.) — A nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by appropriate state authority.

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

Residential treatment center — A facility where the primary services are the provision of a room and board and constant supervision or a structured daily routine for a person who is impaired but whose condition does not require acute care hospitalization. **Services of a residential treatment center are not covered under this Plan.** See the "Noncovered Providers of Service" exclusion in *Section 6: General Limitations and Exclusions.*

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

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

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

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

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

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

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

www.bcbsnm.com/Members/Health and Wellness

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 drug abuse, mental disorder, tuberculosis, or for intermediate, custodial or educational care.

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

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

Special enrollment — When an otherwise eligible employee or eligible family member did not enroll in the Plan when initially eligible, there are certain instances (or "qualifying events") during which the employee and his/her eligible family members, if any, may enroll in the Plan at a later date – or more than 31 days after becoming eligible – and not considered late applicants. The "special enrollment" period is the period of time during which an otherwise late applicant may apply for coverage outside the annual open enrollment period.

Special medical foods — Nutritional substances in any form that are consumed or administered internally under the supervision of a physician, specifically processed or formulated to be distinct in one or more nutrients present in natural food; intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs, or certain nutrients contained in ordinary foodstuffs, or who have other specific nutrient requirements as established by medical evaluation; and essential to optimize growth, health, and metabolic homeostasis. Special medical foods are covered only when prescribed by a physician for treatment of genetic orders of metabolism, and the member is under the physician's ongoing care. Special medical foods are not for use by the general public and may not be available in stores or supermarkets. Special medical foods are not those foods included in a 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 Master Contract (e.g., COBRA members).

Summary of Benefits and/or Coverage— The separately issued schedule that defines your copayment and/or coinsurance requirements, deductible, out-of-pocket limit, and annual or lifetime benefits, and provides an overview of covered services. It is referred to as the *Summary of Benefits* throughout this benefit booklet.

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

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

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

Tertiary care facility — A hospital unit that provides complete perinatal care (occurring in the period shortly before and after birth) and intensive care of intrapartum (occurring during childbirth or delivery) and perinatal high-risk patients. This hospital unit also has responsibilities for coordination of transport, communication and data analysis systems for the geographic area served.

Totally disabled — A member (subscriber or eligible family member) who is prevented, solely because of illness or accidental injury, from engaging in substantial gainful employment or is incapable of doing most of the normal tasks and activities for that person's age and family status.

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

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

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

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

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).

APPENDIX A: CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

This notice generally explains:

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

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

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

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of health care plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the health care plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and eligible children of employees may be qualified beneficiaries. Under the Plan, generally most qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Contact the employer and/or COBRA administrator for specific information for your Plan.

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

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

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

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

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

- the parent-employee dies;
- the parent-employee's hours of employment are reduced;
- the parent-employee's employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes enrolled in Medicare (Part A, Part B or both);

- the parents become divorced or legally separated; or
- the child stops being eligible for coverage under the Plan as an "eligible child".

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 (or association) and Blue Cross and Blue Shield of New Mexico (BCBSNM) includes the following documents:

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

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

- the Group Master Application from the employer; and
- The Group Master Contract between BCBSNM and the employer or association.

The above documents constitute the entire legal agreement between BCBSNM and the employer. No change or modification to the agreement will be valid unless it is in writing and signed by an officer of BCBSNM. No agent or employee of BCBSNM has authority to change this benefit booklet or waive any of its provisions. You will be notified of any changes to this benefit booklet at least 30 days before the changes become effective.

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