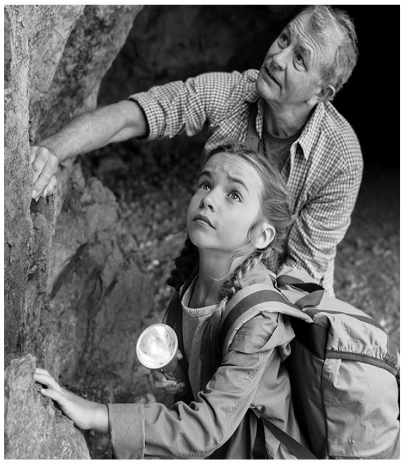
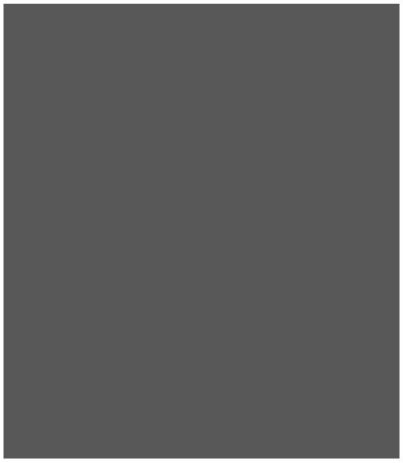
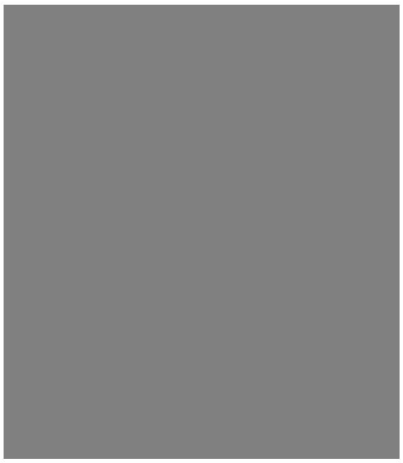
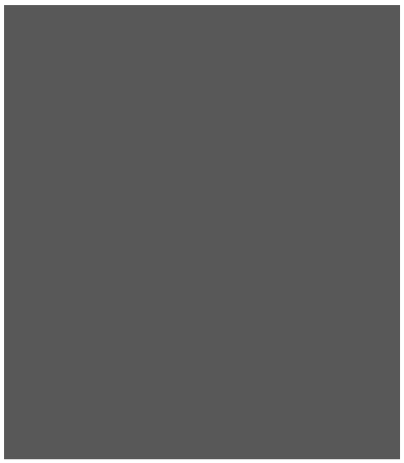
BlueCross BlueShield of New Mexico



Your Health Care Benefits Program

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

State of New Mexico

Account #:266000

HMO Blue Group

A Guide To Your Group HMO Blue Care Health Care Plan

(July 1, 2024)

IMPORTANT NOTICE

For all plans with an effective date of January 1, 2020, or later:

1. Cost-sharing and benefits limitations for an Emergency Health Care Service rendered by a Nonparticipating Provider shall be the same as if rendered by a Participating Provider. Prior authorization shall not be required for Emergency Health Care Services.

2. Cost-sharing and benefits limitations for a Medically Necessary, non-emergent Health Care Service rendered by a Nonparticipating Provider at a Participating facility where the covered person had no ability or opportunity to choose to receive the service from a Participating Provider shall be the same as if the service was rendered by a Participating Provider.

3. Cost-sharing and benefits limitations for a Medically Necessary, non-emergent Health Care Service where no Participating Provider is available to render the service shall be the same as if the service was rendered by a Participating Provider.

CUSTOMER ASSISTANCE

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

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

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

Street address: 4373 Alexander Blvd. NE
Toll-free telephone number: 1-877-994-2583

Send all **written inquiries/Prior Authorization requests** and submit **medical/surgical C**laims* to:

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

Prior Authorizations: Medical/Surgical Services—For Prior Authorization requests, call a Health Services representative at 505-291-3585 or toll-free at 1-800-325-8334, 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 Prior Authorization 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 Disorder and Chemical Dependency—For inquiries or Prior Authorizations related to Mental Disorder 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, Claim forms, and other information, or to e-mail your question to BCBSNM, visit the BCBSNM website at:

www.bcbsnm.com/bluehmo

***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

State of New Mexico

Welcome to the Managed Care Plan (HMO) for eligible employees of **State of New Mexico** (SONM) and their Eligible Family Members. Blue Cross and Blue Shield of New Mexico (BCBSNM), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, and an Independent Licensee of the Blue Cross and Blue Shield Association is pleased to serve as the Claims Administrator for the **State of New Mexico** self-insured managed care health plan (also referred to as "the Plan"). By encouraging physicians, hospitals, other providers, and members to work together, BCBSNM works to manage health care costs under this comprehensive health care plan offered by **State of New Mexico** to its employees and their eligible family members.

Please take some time to get to know your Health Care Benefit Plan coverage, including its benefit limits and exclusions, by reviewing this important document and any enclosures. Learning how this Plan works can help make the best use of your Health Care Benefits.

Note: The Plan's benefit administrator and **State of New Mexico** (your group) may change the benefits described in this Benefit Booklet. If that happens, your benefit administrator or **State of New Mexico** 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.

Thank you for selecting BCBSNM for your health care coverage. We look forward to working with you to provide personalized and affordable health care now and in the future.

Sincerely,

State of New Mexico

If You Live Outside New Mexico

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

NOTE:

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

Table of Contents

SECTION 1: HOW TO USE THIS BENEFIT BOOKLET 1
SECTION 2: ENROLLMENT AND TERMINATION INFORMATION 8
SECTION 3: HOW YOUR PLAN WORKS 16
SECTION 4: UTILIZATION MANAGEMENT 21
SECTION 5: COVERED SERVICES 29
SECTION 6: GENERAL LIMITATIONS AND EXCLUSIONS 57
SECTION 7: COORDINATION OF BENEFITS (COB) AND REIMBURSEMENT 66
SECTION 8: CLAIMS PAYMENTS AND APPEALS 68
SECTION 9: GENERAL PROVISIONS 77
SECTION 10: DEFINITIONS 80
APPENDIX A: CONTINUATION COVERAGE RIGHTS UNDER COBRA 94
SUMMARY OF HEALTH INSURANCE GRIEVANCE PROCEDURES 97
BENEFIT BOOKLET NO SURPRISES ACT AMENDMENT 107

SECTION 1: HOW TO USE THIS BENEFIT BOOKLET

This Benefit Booklet describes the medical/surgical, and Mental Disorder/Chemical Dependency coverage available to Members of this Managed Care Medical 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. You may be required to pay Copayments or other estimated amounts due at the time of your visit.
- 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 Prior Authorization, if necessary. The phone numbers are on your Plan ID Card. See *Section 4: Utilization Management* for details about the Prior Authorization process.
- Please read this Benefit Booklet and familiarize yourself with the details of your Plan *before* you need services. Doing so could save you time and money.
- **In an Emergency, call 911 or go directly to the nearest Hospital.**

DEFINITIONS

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

SUMMARY OF BENEFITS AND COVERAGE (SBC)

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

IDENTIFICATION (ID) CARD

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

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

PROVIDER NETWORK DIRECTORY

In order to receive benefits for non-Emergency services, you need to use Providers who are in the BCBSNM HMO-Participating Provider network. (You have coverage for Nonparticipating Provider services only during an Emergency. However, when referred to a Nonparticipating Provider by BCBSNM, because it has been determined that medically necessary covered services are not reasonably available, or otherwise when Prior Authorization has been obtained due to Medical Necessity.)

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

ACCESS PLAN

If required by applicable law, BCBSNM's access plan is available upon request, free of charge electronically, but printed copies are subject to charges for reasonable production and, if applicable, delivery costs.

BLUECARD® PROGRAM

As a Member of an HMO health plan administered by BCBSNM, you take your health plan benefits with you for Urgent Care Services across the country and around the world. You do not need to see a BlueCard® Participating Provider to obtain Out-of-Network Emergency Care Services. 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 Card 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. Instructions for locating a Preferred Provider outside of New Mexico can be found on the BCBSNM website.

DRUG PLAN BENEFITS

SONM 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.

BLUECARD® BROCHURE

As a Member of an HMO health plan administered by BCBSNM, you take your health plan benefits with you for Emergency services – across the country and around the world. The BlueCard Program gives you access to 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. Additional information is available regarding BlueCard Program in *Section 8: Claims Payment and Appeals*. Also Guest Membership information is available in *Section 2: Enrollment and Termination Information* for Subscribers who are temporarily working or residing out of state at least 90 days.

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.

PRIOR AUTHORIZATION

Prior Authorization Requirement

Certain types of care require Prior Authorization by us. This means that you or your Provider must ask us to approve the care before you receive it.

A complete and current list of the services and prescription drugs that are subject to a Prior Authorization requirement can be found in you Plan Benefit Booklet or by contacting Customer Services at the number on the back of your ID card.

We may decline payment for unauthorized care. If your Provider is in-network, and you did not agree to receive unauthorized care, your Provider cannot bill you for the care. If you received unauthorized care from a Provider who is not in-network, you may be fully responsible for the resulting bills.

We do not require Prior Authorization for:

- Emergency services
- Contraception services that are not subject to any cost-sharing; or
- An obstetrical or gynecological ultrasound

However, we require authorization for continued in-patient care if you are admitted to a hospital for emergency treatment, but your condition is stabilized. You or your Provider must notify us within 48 hours from when you begin receiving emergency in-patient treatment. If you condition makes it impossible to call within 48 hours, call as soon as possible after the emergency ends and your condition stabilizes.

Prior Authorization Process

Your in-network Provider is responsible for knowing what care requires Prior Authorization, and for submitting a Prior Authorization request to us.

We will give any Provider access to all necessary forms and instructions for making the request. An out-of-network Provider is not required to submit a Prior Authorization request for you. If you visit one of these Providers, and that Provider will not submit a Prior Authorization request, you may submit a Prior Authorization request on your behalf, or on behalf of a dependent. We will help you obtain required documents and show you the guidelines that apply to the request. However, because your Provider should be able to gather required information and submit it sooner, we encourage you to have your Provider request Prior Authorization whenever possible.

Prior Authorization Review Timelines

If we do not deny a complete Prior Authorization request withing these time frames the request is automatically approved:

- Urgent Care or Prescription Drugs – If you require urgent medical care, behavioral health care or a prescription drug, we will resolve the request within 24 hours.
- Non-Urgent Medicine – if you do not have an urgent need for a prescription drug, we will resolve the request within three business days if your Provider:
    - Uses the Prior Authorization request form approved by the New Mexico Office of Superintendent of Insurance.
    - Requests an exception from an established step therapy process; or
    - Requests to prescribe a drug that we do not usually cover.
    - Other Requests – We will resolve all requests withing seven (7) business days.

Meeting these time frames depends on our receipt of sufficient information to evaluate the request. Our utilization management staff can answer questions your Provider might have concerning required information or any aspect of the request submission process. If we require additional information to evaluate a request, we will request if rom your Provider. Your Provider will have at least 4 hours to provider requested information in connection with an urgent Prior Authorization request, and at least two calendar days for any other type of request.

Why We Review

Our review of a Prior Authorization request will determine if the proposed care involved a covered service, is Medically Necessary and whether an alternative type of care should be pursued instead of, or before, the requested care. Our decisions concerning medically necessity and care alternatives will be guided by current clinical care standard and will be made by an appropriate medical professional.

Prior Authorization does not guarantee payment. We are not required to pay for an authorized service if your coverage ends before you receive the service.

After Care Review

If you received care without a required Prior Authorization, we may allow your Provider to request authorization retrospectively. Our utilization management team will assist your Provider in the submission of a retrospective

authorization request. However, we do not routinely authorize care retrospectively. To avoid uncertainty, it is always best to request Prior Authorization.

Behavioral Health Care

Requests for behavioral health care and prescriptions are subject to the same prior and retroactive authorization processes and timelines as requests for medical care and prescriptions.

Authorization Denial

We will inform you in writing if we deny a prior or retroactive authorization request. Our notice to you will explain why we denied the request and will provide you with instructions for disputing our decision if you disagree. A summary of the dispute resolution process can be found in the Claims Payments and Appeals section of your Plan Benefit Booklet. You have a right to request information about the guidance we followed to deny your request, even if you do not dispute our decision.

PRIOR AUTHORIZATION REQUIRED

To receive full benefits for some non-Emergency Admissions and certain medical/surgical services, you or your Provider must call the BCBSNM Health Services department at 505-291-3585 or toll-free at 1-800-325-8334 **before** you receive treatment. Prior Authorization for non-emergent services performed in an emergency room may be obtained within 48 hours of Admission or, if the patient's condition makes it impossible to call within 48 hours, as soon as possible. **If you do not call and receive Prior Authorization before receiving non-Emergency services, benefits for services may be denied.** Call Monday through Friday, 8 A.M. to 5 P.M., Mountain Standard Time. See *Section 4: Utilization Management* for details. **Note:** Call Customer Service if you need Prior Authorization assistance after 5 P.M.

Emergency/Maternity Admission Notification

To receive 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, at 505-291-3585 or toll-free at 1-800-325-8334, 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 Prior Authorization before you are discharged.

Written Request Required

For services subject to Prior Authorization 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.

PRIOR AUTHORIZATION OF BEHAVIORAL HEALTH CARE

To receive full benefits for some non-Emergency inpatient and specified outpatient Mental Disorder and Chemical Dependency services you or your Provider must call the Behavioral Health Unit (BHU) at the phone number below (also listed on the back of your ID card) before you receive treatment. Services performed in an Emergency room may be approved through Prior Authorization within 48 hours of Admission or, if the patient's condition makes it impossible to call within 48 hours, as soon as possible. The BHU will coordinate Covered Services with an In-Network Provider near you. If you do not call and receive Prior Authorization before receiving non-Emergency services, benefits for services may be denied. Call 7 days a week, 24 hours a day:

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

For Standards and Requirements surrounding Prior Authorizations obtained by BHU, please visit:

Bcbsnm/com/provider/standards-requirements/standards/provider-reference-manual

PRIOR AUTHORIZATION AND COMPLAINT/APPEAL PROCEDURES

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

HEALTH AND WELLNESS MAINTENANCE AND IMPROVEMENT PROGRAMS

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

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

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

TELEMEDICINE MEDICAL SERVICES

Covered Services provided via consultation with a contracted Provider through information and telecommunication technology. Telemedicine provides access to Providers who can provide diagnosis and treatment of non-Emergency medical conditions, Mental Disorders and Chemical Dependency in situations that may be handled without a traditional office visit, Urgent Care visit or Emergency Care visit.

See your *Summary of Benefits* for the member cost share for Telemedicine for primary care office visits and for Mental Disorder and Chemical Dependency visits delivered via Telemedicine.

IDENTITY THEFT PROTECTION SERVICES

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

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 Prior Authorization requests
- check on a Claim's status
- help you change your PCP selection
- order a replacement ID Card, Provider directory, Benefit Booklet, or forms

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

In addition to accepting e-mail inquiries, the BCBSNM website contains valuable information about BCBSNM Provider networks, 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 Mental Disorder and Chemical Dependency benefits, call the BCBSNM Behavioral Health Unit (BHU) 24 hours/day, 7 days/week 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, BCBSNM offers multilingual interpreters for Members. If you need multi-lingual services, call the Customer Service phone number on the back of your ID Card.

After Hours Help

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

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

24/7 Nurseline

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

Toll-free: 1-800-973-6329

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

BLUE ACCESS FOR MEMBERS [SM]

To help Members track Claim payments, make health care choices, and reduce health care costs, BCBSNM maintains a flexible array of online programs and tools for health care plan Members. The online "Blue Access for Members" (BAM) tool provides convenient and secure access to Claim information and account management features and the Cost Estimator tool. While online, Members can also access a wide range of health and wellness programs and tools, including a health assessment and personalized health updates. 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 Representatives are available 24 hours a day, 7 days a week.

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.

You can also contact the Office of Superintendent of Insurance if you suspect fraud.

SECTION 2: ENROLLMENT AND TERMINATION INFORMATION

WHO IS ELIGIBLE

Unless otherwise specified in the Professional Services Agreement, all active employees who have completed the Employee Probationary Period and who are regularly working the minimum number of hours specified in the Professional Services Agreement and their Eligible Family Members are eligible for coverage. To find out the number of hours you must work per week and to learn of any other eligibility criteria specified by your group refer to the SONM Administrative Guide or contact your benefits administrator or your Human Resources office.

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 Professional Services Agreement and the Member's application.

No eligibility rules or variations in premium will be imposed on you based on your specific health status, medical condition, Claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status-related factor. You will not be discriminated against for coverage under this Plan on the basis of race, color, national origin, disability, or perceived disability, blindness, partial blindness, limb loss or absence, 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.

An eligible employee includes anyone hired as classified, Governor-exempt, probationary, temporary, term or hourly, if the employee works an average of at least 20 hours per week over the course of a pay period and whose length of employment, when hired, is for at least six months. Elected Officials, if part of the SONM or a participating LPB, are considered eligible and do not need to meet the work schedule of at least 20 hours per week. Independent contractors are not eligible under the SONM benefit plan.

Note: Annualized salary is based upon a 40 hour work week and should be calculated on base pay (do not include multiple components of pay). This must be used to determine insurance premiums for those hired as temporary, term, or hourly even if they are scheduled to work less than 40 hours per week.

Temporary employees whose original term of employment was to be less than six months, but is later determined will be longer than six months, may be eligible for coverage if they are scheduled to work at least 20 hours per week. Employees will be eligible for benefits, as long as the employee has met the required eligibility waiting period, upon the offer of extended employment (the two pay period wait is not required for SONM employees.)

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.

Dual coverage is not allowed. If both an employee and their spouse/domestic partner are eligible employees, they cannot enroll each other as a spouse/domestic partner, nor can they both cover their children.

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 they turn 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 child beyond age 26 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. You must provide proof of the child's incapacity and dependency within 31 days of the child reaching age 26, and every year after that upon request by the plan. During initial enrollment, proof of incapacity and dependency must be furnished by you to your agency Group representative. Thereafter, proof of incapacity and dependency may be requested periodically by the claim administrator.

- the Subscriber's D**omestic Partner** (NOTE: Not all governing bodies of the entities have approved allowing an employee's Domestic Partner and his/her children to be eligible for insurance coverage. Check with your benefits administrator for more information.)

Eligible Child - The following family Members of the Subscriber through age 25:

- An eligible employee's child(ren) and legal dependent(s), under the age of 26, regardless of dependents marital status, residence, student status or tax filing, may be enrolled as dependents upon submission of a birth certificate, legal documentation of adoption/placement/foster placement, and/or legal guardianship order.
- Disabled legal dependents that are incapable of self support are eligible beyond age 26. Evidence of legal guardianship and disability is required upon enrollment. Medical enrollment is allowed if the disabled dependent is over age 26 years of age. To apply for continued coverage, disabled dependents must complete and file required forms and documentation. See the SONM benefits department for further assistance.
- A court order directing that an employee and/or employee's dependent provide insurance for someone else does not require the State to grant eligibility. Individual coverage may need to be purchased separately. Note: A Power of Attorney is not considered a court order to establish State Plan eligibility or otherwise extend coverage under the State Plan.

Note: If an employee's spouse has step-children from a previous marriage, and neither the employee nor spouse has adopted them or obtained legal guardianship, the step-children are not eligible for coverage.

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

- in an exclusive and committed relationship for the benefit of each other, and our relationship is the same as, or similar to, a marriage relationship in the State of New Mexico
- share and have shared together for 12 or more consecutive months a common, primary residence
- jointly responsible for each other's common welfare and share financial obligations
- neither are married or a member of another Domestic Partnership; nor have either been so during the past 12 months
- both at least 18 years of age
- both legally competent to sign an Affidavit of Domestic Partnership
- not related by blood to a degree of closeness that would prevent them from being married to each other

The federal government does not recognize Domestic Partners as qualified Eligible Family Members and therefore, the premium paid for their coverage cannot be pre-tax. In addition, the employee must pay tax on the portion of the premium paid by the employer for the Domestic Partner and his/her covered children.

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

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

Information for Noncustodial Parents

When a child is covered by the Plan through the child's noncustodial parent, then **State of New Mexico** will:

- provide such information to the custodial parent as may be necessary for the child to obtain benefits through the **State of New Mexico** 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 or coverage terminates.

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 your benefits administrator **within 31 days** after meeting the employers required wait period. **Note:** Your benefits administrator cannot use genetic information or require genetic testing in order to determine if a condition to be limited or deny coverage.

WHEN COVERAGE BEGINS

Your benefits administrator will determine the State of New Mexico employee's Effective Date of Coverage according to the provisions of the Professional Service Agreement and the SONM's Administrative Guide. If you work for a Local Public Body, the Human Resources Department will advise.

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 or a Domestic Partner

If a Subscriber adds coverage for a spouse **within 31 days** of marriage, the effective date of the new Eligible Family Member's coverage will be the date of the event. If the Subscriber does not submit a completed and signed enrollment/change application form to his/her benefits administrator (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 until the next open enrollment period (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 can not be added until the next open enrollment period.

Newborn Children

You should submit an application to add the newborn as an eligible Child as soon as possible after birth. If Family coverage (or Employee/Children coverage, if available) is in effect, a newborn, natural child is covered from birth. If, for example, Family coverage is not in effect, you must add coverage for the newborn **within 31** days of the birth in order for newborn care to be covered beyond day 31, (e.g., If an Employee + Child(ren) coverage type is not available to your Group, you would need to switch to Family coverage.). If the application is not received **within 31** days the newborn can not be added until the next open enrollment period.

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.)

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 within 31 days to enroll. (If the Subscriber has Individual or Two-Person coverage, he/she may be required to pay additional premium in order for the Eligible Child to be added.) If not specified in the court or administrative order, the Eligible Child's Effective Date of Coverage will be the date the order has been filed as public record with the State or the effective date of Family Coverage, or Employee/Children coverage, if available, whichever is later. **State of New Mexico** must receive a copy of the court or administrative order.

OPEN/SWITCH ENROLLMENT

Open/switch enrollment is the period established by the Plan Administrator prior to the Group's anniversary date (ask your employer when your Group's open enrollment period is held). During the annual open/switch enrollment period, any eligible employee and his/her Eligible Family Members may enroll or switch to a different medical carrier as

Members under this Plan. There is no penalty, benefit reduction, or pre-existing conditions waiting period for taking this action.

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 qualifying event), an enrollment/change form must be submitted to **State of New Mexico** 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 qualifying event, the effective date of change is explained below.

QUALIFYING EVENTS FOR ACTIVE EMPLOYEES AND THEIR COVERED FAMILY MEMBERS

There are instances ("qualifying events") in which an eligible person can make changes to coverage as needed. You have a limited amount of time during which you may request a qualifying event change. If you do not request changes during a qualifying event **within the time period specified of 31 days,** you will have to wait for the next open enrollment.

Qualifying Events

The instances of a qualifying event are:

- Change in job status of spouse/Domestic Partner resulting in loss of Group coverage or gain of other coverage for new employment.
- Change in job status of employee (such as reduction in hours due to FMLA, leave without pay and disability).
- Marriage or a change in marital status, such as divorce or legal separation, resulting in a loss of coverage. This includes satisfying requirements for Domestic Partnership eligibility.
- Death of the employee.
- Death of a spouse or eligible dependent, resulting in a loss of group coverage.
- Birth of a child, a court approved adoption or legal guardianship.
- Any other circumstance where the individual had other coverage and loses it due to circumstances beyond their control must be evaluated by the **STATE OF NEW MEXICO** for eligibility.

NOTIFICATION OF ELIGIBILITY AND ADDRESS CHANGES

The Subscriber must notify your benefits administrator **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 your benefits administrator. You can obtain this form from your human resources 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.

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 the date of the event listed below:

- The employee **terminates employment** or **otherwise loses eligibility** according to the terms of the Professional Service Agreement. If the Group or Subscriber fails to notify SONM **within 30 days** to remove an ineligible person from coverage, SONM 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 for Medically Necessary services received during the 30-day grace period will be covered.)
- 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 M**ember 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, **State of New Mexico** may terminate the coverage of the Subscriber and his/her Eligible Family Members retroactively to the date of initial enrollment. The Subscriber is liable for any benefit payments made as a result of such improper actions.
- When the Subscriber **dies**. (Surviving Eligible Family Members remain covered through the last-paid billing period.)
- If this Plan is primary over **Medicare** due to federal laws and regulations, when the Medicare-Eligible Member *chooses* Medicare as his/her primary coverage. (See "Medicare-Eligible Members" for information on coverage options for Members who are entitled to Medicare.)
- When the Member acts in a **disruptive** manner that prevents the orderly business operation of any Network Provider or dishonestly attempts to gain a financial or material advantage.
- When **Group coverage is discontinued** for the entire Group or for the employee's enrollment classification.
- When **State of New Mexico** gives BCBSNM or BCBSNM gives **State of New Mexico** a minimum **30 days' advance written notice**.

Additional Family Member Termination Reasons

In addition, coverage will end for any family member on the date of the event listed above or the date of the event listed below:

- at the end of the **last-paid billing period** for 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);
- the date of a final **divorce** decree or **affidavit of termination for domestic partnership**;
- 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 SONM **within 31 days** following the effective date of the change. In these cases, the Member will be removed from coverage as of the date of the qualifying event and payroll deductions will be properly adjusted, if necessary. SONM and the Providers of care may recover benefits erroneously paid on behalf of the removed Member.

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, the coverage termination date will be provided by the SONM benefits department following receipt of the enrollment/change form. Also, these Members are **not** eligible for any extension of benefits or federal or state continuation coverage. Voluntarily terminated Members may apply for individual coverage offered by BCBSNM; a health statement will be required and the application may be denied.

Termination and Continuation of Coverage

See "How to Continue Coverage" for more information.

Leave of Absence or Military Service

Coverage will end for the Subscriber and his/her Eligible Family Members on the qualifying event date. During a leave of absence covered by the Family and Medical Leave Act (FMLA) contact your Human Resources department for details and further information.

If you have any questions or circumstances not listed above, contact the SONM's benefit department for further information, instructions, and needed actions.

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 qualifying event 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 including Domestic Partners who lose eligibility under this Group Health Care Plan may be able to continue as Members, without a health statement, for a limited period of time by purchasing the continuation coverage described below. You must pay premiums from the date of loss of Group coverage.

You are not eligible to enroll for continuation coverage if:

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

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 SONM, the following persons may **not** enroll in this continued coverage option:

- *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

Premium Payments

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

USERRA Continuation Coverage

Active duty benefit coverage with the SONM is waived and reinstated upon return. Contact the SONM benefits department for details about the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

GUEST MEMBERSHIP (THE AWAY FROM HOME CARE PROGRAM)

Subscribers who are temporarily working or residing out of state for at least 90 days may be eligible for Guest Membership for up to 180 days of membership in one of the many participating Blue Cross and Blue Shield HMOs. Also, Eligible Family Members residing in another state for at least 90 days may also enroll for coverage in the out-of-state, host HMO Plan for as long as this Group participates with BCBSNM, or until the Eligible Family Member is no longer eligible (e.g., reaches dependent age limit or Subscriber terminates coverage). Under either option, the local HMO provides all of the services and access available through their Plan. For more information, call a BCBSNM Customer Service Advocate.

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

SECTION 3: HOW YOUR PLAN WORKS

PCPS AND OTHER HMO-PARTICIPATING PROVIDERS

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

You do not need to select a primary care physician (PCP) to coordinate your health care, but are encouraged to visit your PCP before seeking specialist care. You pay a lower Copayment for the office visits of a PCP.

Visiting Your PCP

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

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

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

Cancelling an Appointment

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

HMO-Participating Specialists and Hospitals

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

Keep Your PCP Informed

Although you do not need a PCP referral before arranging to receive Covered Services from another HMO-Participating Provider, you should consult with your PCP if possible. Your PCP knows you and your medical history and may be able to suggest a course of treatment or a particular specialist that is more appropriate than the one you may be considering. Also, many specialists and facilities will not take patients who have not been referred to them by a Physician.

Prior Authorization Needed for Some Services

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

Before seeking specialist services, **you need to be aware of Prior Authorization requirements,** which are described in *Section 4: Utilization Management.*

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

Non-Emergency Hospital Admissions

This Plan will cover a Medically Necessary inpatient stay for a Covered Service if you are admitted to an HMO-Participating Facility by your PCP or by an HMO-Participating Specialist. To be covered, you must obtain **Prior Authorization** from BCBSNM **before** being admitted. See "Prior Authorizations," later in this section, for details.

Selecting an HMO-Participating Provider

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

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

Nonparticipating Provider Services

If you visit a **Nonparticipating P**rovider for non-Emergency care without first obtaining Prior Authorization from BCBSNM, **the services will not be covered except in the limited circumstances outlined in this section.**

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

Out-of-Country Services

This Plan does **not** cover service received outside the United States unless there is an Emergency. See *Section 8: Claims Payments and Appeals* for more information about filing Claims for out-of-country services.

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 "Benefit Level Exceptions" 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.*

Benefit Level Exceptions

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

- may bill you for any amounts in excess of the BCBSNM Covered Charge, in addition to your Copayment; and
- is not responsible for obtaining any necessary approvals on your behalf (see "Prior Authorizations," in *Section 4*); and
- may or may not file Claims for you.

Emergency Care

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

Prior Authorization must be obtained from BCBSNM for all follow-up care (which is no longer considered Emergency Care) in order to be covered. (See "Emergency and Urgent Care" in *Section 5: Covered Services* for more information.)

Urgent Care

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

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

Ancillary Providers in a Hospital

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

Transition of Care

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

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

CALENDAR YEAR

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

BENEFIT LIMITS

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

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

COST-SHARING FEATURES

In order to receive a specific service or benefit covered under this Plan, you must pay a Copayment (fixed dollar-amount) to the Health Care Provider (or in some cases, the percentage of Covered Charges). Copayments for specific services are listed on your *Summary of Benefits*.

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 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 covered services you receive during that Calendar Year.

Individual and Two-Person Deductible

The individual Deductible amounts are indicated on your *Summary of Benefits.* Once a member's Deductible payments for HMO-Participating Provider services reach the applicable Deductible amount, this Plan will begin paying its share of that member's covered HMO-Participating Provider charges.

Family Deductible

An entire family meets when the total Deductible amount for all family members reaches the amount specified on your separately issued *Summary of Benefits. **Note:** If a member's Individual* D*eductible is met, no more charges incurred by that member may be used to satisfy the Family* D*eductible.*

What Is Not Subject to the Deductible

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

- preventive services
- fixed-dollar copayments or services with no charge
- hearing aids and ear molds
- CAC tests

Admissions Spanning Two Calendar Years

If 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 Deductible 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. HMO-Participating Providers that have Provider agreements with BCBSNM will file Claims for you and must submit

them within a specified amount of time (usually 180 days). See *Section 8: Claim Payments and Appeals* for more information.

COPAYMENTS

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

You must make Copayments directly to Providers at the time of service. You are always responsible for paying a Provider's full charges for Noncovered Services and for services received without a necessary Prior Authorization.

COINSURANCE

For some Covered Services, you must pay a percentage of Covered Charges (Coinsurance). After your share has been calculated, this Plan pays the rest of the Covered Charge, up to maximum benefit limits, if any. You pay a lower percentage of Covered Charges when you visit an HMO-Participating Provider.

Remember: The Covered Charge may be less than the billed charge for a Covered Service. HMO-Participating Providers may not bill you more than the Covered Charge. **Note:** If you receive Covered Services from an "unsolicited" Provider, as defined in this section, you will be responsible for amounts over the Covered Charge.

OUT-OF-POCKET LIMIT

The maximum total that any one *member* will pay for basic health care services (as defined in federal and state regulations) in any Calendar Year will not exceed twice the total annual premium that is normally charged for a single member under this Plan.

Any Coinsurance amounts and Copayments over the Out-of-Pocket Limit will be refunded to the Subscriber if the refund is requested **within 45 days** after the end of the Calendar Year. It is your responsibility to determine when the Out-of-Pocket Limit has been reached; therefore, you should maintain accurate records of amounts.

Call a BCBSNM Customer Service Advocate if you have any questions about your Out-of-Pocket Limit.

CHANGES TO THE COST-SHARING AMOUNTS

Coinsurance, Copayments and Out-of-Pocket Limits may change during a Calendar Year. If changes are made, the change applies only to services received after the change goes into effect (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.

SECTION 4: UTILIZATION MANAGEMENT

Utilization Management may be referred to as Medical Necessity reviews, utilization review (UR), or medical management reviews. A Medical Necessity reviews for a procedure/service, inpatient admission, and length of stay is based on BCBSNM Medical policy and/or level of care review criteria. Medical Necessity reviews may occur prior to services rendered, during the course of care, or after care has been completed for a Post-Service Medical Necessity Review. Some services may require a Prior Authorization before the start of services, while other services will be subject to a concurrent or Post-Service Medical Necessity review. If requested, services normally subject to a Post-Service Medical Necessity review may be reviewed for Medical Necessity prior to the service through a Recommended Clinical Review as defined below.

Refer to the definition of Medically Necessary/Medical Necessity in ***Section 10: Definitions*** in this Benefit Booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

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

In order to receive benefits:

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

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

Medically Necessary/Medical Necessity is defined as Health Care Services determined by a health care Provider, in consultation with the health insurance carrier, to be appropriate or necessary, according to:

a. any applicable generally accepted principles and practices of good medical care;

b. practice guidelines developed by the federal government, national or professional medical societies, boards and associations; or

c. Any applicable clinical protocols or practice guidelines developed by the health insurance carrier consistent with such federal, national and professional practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical or Mental Disorder, or Chemical Dependency condition, illness, injury or disease.

Please note:

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

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

Most Prior Authorization requests will be evaluated and you and/or the Provider notified of BCBSNM's decision within 15 days of receiving the request (within 24 hours for Urgent Care requests). If requested services are not approved, the notice will include: 1) the reasons for denial; 2) a reference to the health care plan provisions on which the denial is based; and 3) an explanation of how you may appeal the decision if you do not agree with the denial (see ***Section 8: Claims Payments and Appeals***) and "If Your Prior Authorization Request is Denied" later in this section).

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

HOW THE PRIOR AUTHORIZATION 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 have been approved through Prior Authorization. If the Admission or other services are not approved through Prior Authorization, 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 Prior Authorization is not your responsibility — it is the Provider's. Preferred Providers must obtain Prior Authorization from BCBSNM (or from the Behavioral Health Unit (BHU), when applicable) in the following circumstances:

- when recommending any non-Emergency Admission, re-Admission, or transfer
- when a covered newborn stays in the Hospital longer than the mother
- before providing or recommending a service listed under "Other Prior Authorizations," later in this section
- before recommending that you go to a Nonparticipating Provider for whose services you expect to receive benefits (Such requests may be denied.)

BCBSNM will advise you if a Prior Authorization request is denied.

Note: Providers that contract with other Blue Cross and Blue Shield plans are not familiar with the Prior Authorization 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 Prior Authorization 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 Prior Authorization, the Provider is not obligated to obtain the Prior Authorization for you. In such cases, it is your responsibility to ensure that Prior Authorization is obtained. If authorization is not obtained before services are received, your benefits for covered services may be denied for some services or you may 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 PRIOR AUTHORIZATION

Prior Authorization is required for all Admissions before you are admitted to the Hospital or other inpatient treatment Facility (e.g., Skilled Nursing Facility, Residential Treatment Center, Physical Rehabilitation Facility, long-term acute care (LTAC). If you are receiving services at an Out-of-Network Facility (or from an In-Network Facility outside New Mexico) and you do not obtain authorization within the time limits indicated in the table below, benefits for covered Facility services will be denied as explained under *"Not Obtaining Inpatient Prior Authorization"* below.

Type of inpatient Admission, re-Admission, or transfer:	When to obtain inpatient Admission Prior Authorization:
Non-Emergency	**Before** the patient is admitted.
Emergency, nonmaternity, or Emergency Room services to treat Mental Disorders or Chemical Dependency	**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.**

NOT OBTAINING INPATIENT PRIOR AUTHORIZATION

If you or your Provider do not receive Prior Authorization for inpatient benefits, but you choose to be hospitalized anyway, no benefits may be paid 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 Prior Authorizations,"** (e.g., elective Admissions).	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 **may be denied.***

*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 Prior Authorization 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 PRIOR AUTHORIZATIONS

In addition to Prior Authorization review for all non-Emergency Inpatient Services, Prior Authorization is required for certain other services listed below. Most Prior Authorization 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 Prior Authorization. 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 Prior Authorizations for you. (See *"Inpatient Prior Authorization"* (or similar heading) for further information regarding inpatient Prior Authorization requirements.)

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

No Prior Authorization Received:	Claim Disposition: Preferred	Claim Disposition: Nonpreferred
Service is Medically Necessary	Claim is paid based on Member's benefit plan	Claim is paid based on Member's benefit plan
Service is not Medically Necessary	Claim is denied; Member is held harmless	Claim is denied; Member is held harmless

Services that require Prior Authorization:

- Non-Emergency Air Ambulance transportation
- All inpatient Hospital Admissions
- The following Outpatient Services and procedures:
  - Home Health Care Services and home I.V. services
  - Home infusion therapy (HIT), excluding antibiotics
  - Outpatient infusion drugs
  - Home Hospice services
  - Transitional care benefits
  - Certain injections, including but not limited to intravenous immunoglobulin (IVIG)
  - Outpatient Surgery performed at a Hospital or Ambulatory Surgical Facility for Out-of-Network services only

— Transplant Evaluations and Transplants
— Dialysis (home only)
— Cardiac and pulmonary rehabilitation
— **Ear, Nose and Throat (ENT):**
  - Bone Conduction Hearing Aids
  - Cochlear Implant
  - Nasal and Sinus Surgery
— **Gastroenterology (Stomach):**
  - Gastric Electrical Stimulation (GES)
— **Neurological:**
  - Deep Brain Stimulation
  - Sacral Nerve Neuromodulation/Stimulation
  - Vagus Nerve Stimulation (VNS)
— **Orthopedic Musculoskeletal:**
  - Artificial Intervertebral Disc
  - Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions
  - Femoroacetabular Impingement (FAI) Syndrome
  - Lumbar Spinal Fusion
  - Meniscal Allografts and Other Meniscal Implants
  - Orthopedic Applications of Stem-Cell Therapy
— **Specialty Pharmacy:**
  - Medical Benefit Specialty Drugs (Specialty drugs administered by your Provider)

Surgical Procedures:
  - Orthognathic Surgery
  - Mastopexy
  - Reduction Mammoplasty; Breast Reduction
— **Wound Care:**
  - Hyperbaric Oxygen (HBO2) Therapy-Systemic

For specific details about the Prior Authorization requirement for the above referenced Outpatient Services, please call Customer Service at the number on the back of your Identification Card. BCBSNM reserves the right to no longer require Prior Authorization during the Calendar Year. Updates to the list of services requiring Prior Authorization may be confirmed by calling Customer Service.

BCBSNM will send a letter to you, your Physician and the Hospital or Facility with a determination of your Prior Authorization review no later than five (5) calendar days after BCBSNM receives the request for Prior Authorization review. However, in some instances depending on the timing of the request for review, these letters may not be received prior to your scheduled date of service or procedure.

All services, including those for which Prior Authorization 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 Prior Authorization may not be approved for payment (for example, due to being Experimental, Investigational or Unproven, or not Medically Necessary). Services requiring Prior Authorization are subject to review and change by BCBSNM.

The Prior Authorization requirements noted above do not apply to mandated benefits, unless permitted by law and stated in the provisions of a specific mandated benefit. Gynecological or obstetrical ultrasounds do not require Prior Authorization. The Medical Necessity requirements noted above do not apply to mandated benefits, unless permitted by law.

It is strongly recommended that you request a Recommended Clinical Review for benefits for high-cost services in order to reduce the likelihood of benefits being denied after charges are incurred. See "Recommended Clinical Review" later in this section for further information.

PRIOR AUTHORIZATION OF MENTAL DISORDER/CHEMICAL DEPENDENCY SERVICES

Prior Authorization for all inpatient Mental Disorder and Chemical Dependency services must be obtained from the BCBSNM Behavioral Health Unit (BHU) at the phone number listed on the back of your ID Card. Prior Authorization is also required for the following Outpatient Services for treatment of Mental Disorder and/or Chemical Dependency:

- psychological testing
- neuropsychological testing
- Intensive Outpatient Program (IOP) treatment
- electroconvulsive therapy (ECT)
- repetitive transcranial magnetic stimulation
- Applied Behavior Analysis (ABA) therapies

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

For services needing Prior Authorization, 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 Prior Authorization 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 Prior Authorization of non-Emergency Inpatient Services, benefits for covered, Medically Necessary inpatient Facility care may be denied. If Inpatient Services received without Prior Authorization 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 Prior Authorization is not obtained before you receive psychological testing, IOP treatment, neuropsychological testing, electroconvulsive therapy repetitive transcranial magnetic stimulation or Applied Behavior Analysis (ABA) therapies, your Claims may be denied if it is 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 Prior Authorization for Outpatient Services before you start treatment.

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

Summary of Contact Information for Prior Authorization, Customer Service, Claim Submission and Appeal (or Reconsideration) Processes for Medical/Surgical and Mental Disorders and Chemical Dependency Services:

Process:	Type of Service:	Phone:	Send to:
Request Prior Authorization	Medical/Surgical	1-800-325-8334	BCBSNM P.O. Box 27630 Albuquerque, NM 87125-7630
	Mental Disorder/Chemical Dependency	1-888-898-0070	BH Unit P.O. Box 27630 Albuquerque, NM 87125-7630

Customer Service Inquiry	Medical/Surgical	1-800-432-0750	BCBSNM P.O. Box 27630 Albuquerque, NM 87125-7630
	Mental Disorder/Chemical Dependency	1-888-898-0070	BH Unit P.O. Box 27630 Albuquerque, NM 87125-7630
Submit Claim (post-service)	Medical/Surgical		BCBSNM P.O. Box 27630 Albuquerque, NM 87125-7630
	Mental Disorder/Chemical Dependency		BH Unit P.O. Box 27630 Albuquerque, NM 87125-7630
Request appeal of Claim or Prior Authorization decision	Medical/Surgical	1-800-205-9926	BCBSNM Appeals Unit P.O. Box 27630 Albuquerque, NM 87125-7630
	Mental Disorder/Chemical Dependency	1-888-898-0070	BCBSNM Appeals Unit P.O. Box 27630 Albuquerque, NM 87125-7630
Grievance Assistance - Office of Superintendent of Insurance (OSI), Managed Health Care Bureau	Medical/Surgical; Mental Disorder/Chemical Dependency	1-855-427-5674	Office of Superintendent of Insurance P.O. Box 1689 Santa Fe, NM 87504-1689

IF YOUR PRIOR AUTHORIZATION REQUEST IS DENIED

BCBSNM has established written procedures for reviewing and resolving your concerns. There are two different procedures depending upon the type of issue involved - pre-service or post-service. This is a summary of the procedures that apply to Prior Authorization requests ("pre-service Claims"). For appeals involving post-service Claims payments or denials, see ***Section 8: Claims Payment and Appeals***.

If you are dissatisfied at any time during the process described below, you may file an appeal. You may designate a representative to act for you in the review and appeal procedures. Your designation of a representative must be in writing in order to protect against disclosure of information about you except to your authorized representative. If you make an inquiry or request an appeal under the following procedures, you will not be subject to retaliatory action by BCBSNM.

If you have an inquiry or a concern about any Prior Authorization request, call your Customer Service Advocate for assistance. Many complaints or problems can be handled informally by calling or writing BCBSNM Customer Service. If you make an oral complaint, a BCBSNM Customer Service Advocate will assist you.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions under this Benefit Booklet.

Upon completion of the preadmission or emergency Admission review, BCBSNM will send you a letter confirming that you or your representative called BCBSNM. A letter authorizing a length of service or length of stay will be sent to you, your Physician, Behavioral Health Practitioner and/or the Hospital or Facility.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care services are Medically Necessary. If the extension is determined not to be Medically Necessary, the coverage for the length of stay/service will not be extended, except as otherwise described in the *Appeal Procedure* section under this Benefit Booklet.

A length of stay/service review, also known as a concurrent Medical Necessity review, is when you, your Provider, or other authorized representative may submit a request to the plan for continued services. If you, your Provider or authorized representative requests to extend care beyond the approved time limit and it is a request involving urgent care or an ongoing course of treatment, the plan will make a determination on the request as soon as possible but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

RECOMMENDED CLINICAL REVIEW

Some services that do not require Prior Authorization may be subject to review for evidence of Medical Necessity for coverage determinations that may occur prior to services rendered, during the course of care or after care has been completed for a Post-Service Medical Necessity Review.

A Recommended Clinical Review is a Medical Necessity review for a Covered Service that occurs before services are completed and helps limit the situations where you have to pay for a non-approved service. BCBSNM will review the request to determine if it meets approved BCBSNM medical policy and/or level of care review criteria for medical and behavioral health services. Once a decision has been made on the services reviewed as part of the Recommended Clinical Review process, they will not be reviewed for Medical Necessity again on a retrospective basis. Submitted services (subject to Medical Necessity review) not included as part of Recommended Clinical Review may be reviewed retrospectively.

To determine if a Recommended Clinical Review is available for a specific service, visit our website at www.bcbsnm.com/find-care/where-you-go-matters/utilization-managment.com for the required Prior Authorization and Recommended Pre-Service Clinical Review list, which is updated when new services are added or when services are removed. You can also call BCBSNM Customer Service at the number on the back of your identification card.

Recommended Clinical Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions under this Benefit Booklet. Please coordinate with your Provider to submit a written request for Recommended Clinical Review.

General Provisions Applicable to All Recommended Clinical Reviews

a) No Guarantee of Payment

A Recommended Clinical Review is not a guarantee of benefits or payment of benefits by BCBSNM. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Benefit Booklet. Even if the service has been approved on a Recommended Clinical Review, coverage or payment can be affected for a variety of reasons. For example, the Member may have become ineligible as of the date of service or the Member's benefits may have changed as of the date of service.

b) Request for Additional Information

The Recommended Clinical Review process may require additional documentation from the Member's health care Provider or pharmacist. In addition to the written request for a Recommended Clinical Review, the health care Provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by BCBSNM to make a determination of coverage pursuant to the terms and conditions of this Plan.

Post-Service Medical Necessity Review

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or Post-Service Claims request, is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms Member eligibility, availability of benefits at the time

of service, and reviews necessary clinical documentation to ensure the service was Medically Necessary. Providers should submit appropriate documentation at the time of a Post-Service Medical Necessity Review request. A Post-Service Medical Necessity Review may be performed when a Prior Authorization or Recommended Clinical Review was not obtained prior to services being rendered under certain circumstances.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

a) No Guarantee of Payment

A Post-Service Medical Necessity Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Benefit Booklet. Post-Service Medical Necessity Reviews do not guarantee payment of benefits by BCBSNM, for instance a Member may become ineligible as of the date of service or the Member's benefits may have changed as of the date of service.

b) Request for Additional Information

The Post-Service Medical Necessity Review process may require additional documentation from the Member's health care Provider or pharmacist. In addition to the written request for Post-Service Review, the health care Provider or pharmacist may be required to include pertinent documentation explaining the services rendered, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by BCBSNM to make a determination of coverage pursuant to the terms and conditions of this Plan.

SECTION 5: COVERED SERVICES

This section describes the services and supplies covered by this Group Health Care Plan, subject to the limitations and exclusions in *Section 3: How Your Plan Works* and *Section 6: General Limitations and Exclusions*. All payments are based on Covered Charges as determined by BCBSNM. **To be covered, services must be Medically Necessary.** Services of a Nonparticipating Provider are covered only in an Emergency or if Prior Authorization is given by BCBSNM.

MEDICALLY NECESSARY SERVICES

A service or supply is Medically Necessary when it is provided to diagnose or treat a covered medical condition, is a service or supply that is covered under this Plan, and is determined by BCBSNM's medical director (in consultation with your Provider) to meet 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 "Medical Necessity" as defined above in order to be covered.

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

Certain services are covered pursuant to BCBSNM medical policies and clinical procedure and coding policies, which are updated throughout the plan year. The medical policies are guides considered by BCBSNM when making coverage determinations and lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Service or is Experimental/Investigational/Unproven, cosmetic, or a convenience item. The clinical procedure and coding policies provide information about what services are reimbursable under the Plan. The most up-to-date medical and clinical procedure and coding policies are available at www.bcbsnm.com or by contacting a Customer Service Representative at the number shown on your Identification Card.

AMBULANCE SERVICES

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

Outside the Service Area

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

Air Ambulance

Ground Ambulance is usually the approved method of transportation. This Plan covers Air Ambulance only when terrain, distance, or your physical condition requires the use of Air Ambulance services or for high-risk Maternity and newborn transport to Tertiary Care Facilities. To be covered, non-Emergency Air Ambulance services require **Prior Authorization** from BCBSNM.

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

Exclusions

This Plan does **not** cover:

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

AUTISM SPECTRUM DISORDERS

This Plan covers the Habilitative and Rehabilitative treatment of Autism Spectrum Disorder through Speech Therapy, Occupational Therapy, Physical Therapy, and Applied Behavioral Analysis (ABA) with no age restrictions or age limits for the Member. 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 approved through **Prior Authorization** 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 approved through Prior Authorization by BCBSNM must be performed in accordance with a treatment plan and must be Medically Necessary or benefits for such services may be denied. Examples include therapy for a child who isn't walking or talking at the expected age and includes therapy to enhance the ability of a child to function with a Congenital, Genetic or Early Acquired disorder. These services also may include Physical Therapy and Occupational Therapy, speech language pathology, or other services for people with disabilities in a variety of Inpatient and/or Outpatient settings, with coverage as described in this booklet. Please review the **Short-Term Rehabilitation: Occupational, Physical, Speech Therapy** section of this Policy.

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, except where prohibited by state or federal law. Applied Behavioral Analysis (ABA) therapies are not subject to Member cost-sharing, when received from a Network Provider. 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 unless listed above
- 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 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). This also includes services or supplies provided for the treatment of an Accidental Injury resulting from an act of domestic violence or a medical condition.

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

Facility Charges

This Plan covers inpatient and outpatient Hospital expenses for Dental-Related Services **only** if the patient is under age six or has a nondental, hazardous physical condition (e.g., heart disease or hemophilia) that makes hospitalization Medically Necessary. All Hospital Services for dental-related and oral surgery services must obtain **Prior Authorization** from BCBSNM. **Note:** The Dentist's services for the procedure will not be covered unless listed as eligible for coverage in this section.

Reminder: If Hospital Covered Services are recommended by a Nonpreferred (Out-of-Network) Provider, you are responsible for assuring that your Provider obtains Prior Authorization for outpatient Covered Services or benefits may be reduced or denied. (See *Section 4: Utilization Management*.)

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 non-Covered dental services
- hospitalization or general anesthesia for the patient's or Provider's convenience
- any service related to a dental procedure that is not Medically Necessary
- any service related to a dental procedure that is excluded under this Plan for reasons other than being dental-related, even if hospitalization and/or general anesthesia is Medically Necessary for the procedure being received (e.g., Cosmetic procedures, Experimental procedures, services received after coverage termination, work-related injuries, etc.)
- nonstandard services (diagnostic, therapeutic, or surgical)
- removal of tori, exostoses, or impacted teeth
- procedures involving orthodontic care, the teeth, dental implants, periodontal disease, non-Covered 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, and Appliance for the treatment and management of diabetes are approved by the U.S. Food and Drug Administration.

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

Acute Medical Emergency care is available 24 hours per day, 7 days a week. If services are received in an Emergency room or other trauma center, the condition must meet the definition of an "Emergency" in order to be covered. 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 disagree with the Claim Administrator's determination in processing your benefits as non-emergency care instead of Emergency Care, you may call the Claim Administrator at the number on the back of your Identification Card. Please review Section 8: Claims Payments and Appeals section of this Policy for specific information on your right to seek and obtain a full and fair review of your claim.

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. Non-Emergency services provided in an emergency room for treatment of Mental Disorders or Chemical Dependency will be paid the same as Emergency Care services.

Emergency Room and Ambulance Services

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

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 disagree with the Claim Administrator's determination in processing your benefits as non-Emergency Care instead of Emergency Care, you may call the Claim Administrator at the number on the back of your Identification Card. Please see *Section 8: Claims Payments and Appeals* section of this Policy for specific information on your right to seek and obtain a full and fair review of your Claim.

You do not need BCBSNM authorization before seeking E**mergency room or Emergency Ambulance** services from either an HMO-Participating or a Nonparticipating Provider. **Nonparticipating Provider care received without a Prior Authorization in any other setting (e.g., Physician's office or Urgent Care center) will not be covered.** (See *Section 4: Utilization Management* for more information about Prior Authorization requirements.) Emergency room and Ambulance services for a condition that meets the definition of "Emergency Care" will be covered within the limits of the health care plan. Non-Emergency services provided in an emergency room for treatment of Mental Disorders or Chemical Dependency will be paid the same as Emergency Care services. Services for conditions that do *not* meet the definition of "Emergency Care" and have not been approved through Prior Authorization will **not** be covered.

Services provided in an emergency room that are not Emergency Care may be excluded from emergency coverage, although these services may be covered under another benefit, if applicable. Emergency Care services – including non-Emergency services provided in an Emergency room for Mental Disorders or Chemical Dependency – performed by a Nonpreferred Provider will be paid at the Preferred Provider level.

What to Do

In an Emergency:

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

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

  - Outside the Service Area: **Go to the nearest medical Facility or trauma center.**

Emergency Notification

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

Follow-Up Care

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

Urgent Care

The Urgent Care Copayment will apply to care received in an Urgent Care Facility (including hospital-based Urgent Care Centers). Covered Services received in an Emergency room or other trauma center are subject to the Emergency room Copayment and your condition must meet the definition of "Emergency" in order to be covered.

Urgent Care Center Copayments

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

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

- Call your PCP and request an immediate appointment (if available).
- Visit the nearest BCBSNM HMO-Participating Urgent Care Center.
- If there is not a BCBSNM HMO-Participating center nearby, call your PCP and ask for BCBSNM Prior Authorization to visit another Facility or other appropriate Provider. If you do not receive Prior Authorization **before** receiving treatment from a Nonparticipating Provider, you are responsible for the entire cost of the service.
- If you are away from home and need Urgent Care, call a Customer Service Advocate, who will connect you with the BlueCard Program. If you prefer, you may contact a BlueCard representative directly at 1-800-810-BLUE (2583). The BlueCard representative will give you the name and telephone number of a local Provider who will be able to call BCBSNM Customer Service for eligibility information and will submit a Claim to the local affiliated HMO Plan. You will also need to call your PCP and have him/her call BCBSNM for Prior Authorization to visit an Out-of-Network Provider. **Urgent Care and follow-up carefrom Providers who do not participate with BCBSNM must always be approved through Prior Authorization by BCBSNM.** See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

Exclusions

This Plan does **not** cover:

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

HEARING AIDS/RELATED SERVICES

This Plan covers the cost of hearing aids, the fitting and dispensing fees for hearing aids and ear molds, **limited to one hearing aid per hearing impaired ear every 36 months**. For Members age 22 years old and older, there is a **maximum amount of $2,500 per hearing aid per hearing impaired ear every 36 months. 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 Copayment amount. Benefits for hearing aid-related services will be provided at **100 percent** of the Covered Charges. (Other Covered Services, such as hearing examinations and audiometric testing related to a hearing aid need for Members are subject to the usual plan Copayment provisions for office services and diagnostic testing. Benefits for these additional services are not applied to the 36-month maximum benefit available for hearing aids.)

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.

Prior Authorization Required

Before you receive Home Health Care Services or home I.V. therapy, you, your Physician or Home Health Care Agency must obtain **Prior Authorization** from BCBSNM. **This Plan does not cover H**ome **H**ealth **C**are **S**ervices or **home I.V. services without Prior Authorization.**

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 **Prior Authorization** is received from BCBSNM (If drugs are not provided by the Home Health Care Agency, contact CVS Caremark for information)
- 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, contact CVS Caremark for information)
- Medical Supplies
- skilled services by a qualified aide to do such things as change dressings and check blood pressure, pulse, and temperature

Cost Sharing

Your Copayment or Coinsurance and Deductible will be the same amount as shown on your *Summary of Benefits* under primary care visits for Covered Services aimed at maximizing level of function, returning to a prior level of function, or maintaining or slowing the decline of function when these services are provided by a licensed or certified Physical Therapist, Occupational Therapist or Speech Therapist. Other Covered Services are subject to usual Member cost-sharing features such as Copayment or Coinsurance or Deductible based on the type of Provider, service or supply.

Exclusions

This Plan does **not** cover:

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

HOSPICE CARE SERVICES

Conditions and Limitations

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

Prior Authorization Required

Before you receive hospice care, your attending physician or the Hospice agency must request **Prior Authorization** from BCBSNM. **Hospice care services are not covered without Prior Authorization.** See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

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, contact CVS Caremark.)
- 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.)

Cost Sharing

Your Copayment or Coinsurance and Deductible will be the same amount as shown on your *Summary of Benefits* under primary care visits for Covered Services aimed at maximizing level of function, returning to a prior level of function, or maintaining or slowing the decline of function when these services are provided by a licensed or certified Physical Therapist, Occupational Therapist or Speech Therapist. Other Covered Services are subject to usual Member cost-sharing features such as Copayment or Coinsurance or Deductible based on the type of Provider, service or supply.

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

Prior Authorization Required

To be covered, **Prior Authorization** from BCBSNM must be received for all Inpatient Admissions. Also, Nonparticipating Facility services are covered only for E**mergency Care** or if **Prior Authorization** for such services is received from BCBSNM. (You may be required to travel to another city to receive services from a participating facility.)

Covered Services

For acute inpatient medical or surgical care received during a covered Hospital Admission, this Plan covers semiprivate room and board or special care unit (e.g., ICU, CCU) expenses and other Medically Necessary services provided by the Facility. If you have a private room for any reason other than isolation, covered room expenses are limited to the average semiprivate room rate, whether or not a semiprivate room is available. BCBSNM must give **Prior Authorization** for Medically Necessary private room charges to be covered. at full benefits. If you did not receive Prior Authorization, the covered charge for the additional cost of a medically necessary private room will be denied, which you will be responsible for paying, in addition to your Deductible and/or Coinsurance. Private room charges that are not Medically Necessary will be denied. See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

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. Prior Authorization is required for all inpatient hospitalizations. See "Psychotherapy (Mental Disorder and Chemical Dependency)" for information about benefits for Chemical Dependency rehabilitation. See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

Exclusions

This Plan does **not** cover:

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

Outpatient or Observation Services

Coverage for outpatient or observation services and related Physician or other Professional Provider services for the treatment of illness or Accidental Injury depends on the type of service received (for example, see "Lab, X-Ray, Other Diagnostic Services" or "Emergency and Urgent Care"). Observation and Emergency room services

are subject to the Copayment listed on the *Summary of Benefits.* The Copayment will be waived if you are admitted as an inpatient directly from the observation or Emergency room; inpatient Hospital benefit will apply.

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 Prior Authorization is received from BCBSNM. Your BCBSNM-Contracted Provider has a list of those injectable drugs that require Prior Authorization. If you need a copy of the list, call a BCBSNM Customer Service Advocate. (When you request Prior Authorization, 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.

Exclusions

This Plan does **not** cover:

- This plan does **not** cover any self-administered drugs dispensed or administered by a Physician in his/her office.

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, pre-Admission testing, that are related to an illness or Accidental Injury. Covered Services include:

- x-ray and radiology services, ultrasound, and imaging studies
- laboratory and pathology tests
- EKG, EEG, and other electronic diagnostic medical procedures
- genetic testing with **Prior Authorization** from BCBSNM (Tests such as amniocentesis or ultrasound to determine the gender of an unborn child are not covered; see "Maternity/Reproductive Services and Newborn Care.")
- infertility-related testing with **Prior Authorization** from BCBSNM (See "Maternity/Reproductive Services and Newborn Care.")
- PET (Positron Emission Tomography) scans, cardiac CT scans with **Prior Authorization** from BCBSNM
- MRIs
- psychological or neuropsychological testing with **Prior Authorization** from BCBSNM
- audiometric (hearing) and vision tests for the diagnosis and/or treatment of an Accidental Injury or an illness

Coronary Artery Calcification Tests

Early detection test for cardiovascular disease. This Plan covers a computed tomography (CT) scan measuring coronary artery calcifications (CAC) for Members between 45 and 65 years of age who have an intermediate risk of developing coronary heart disease. This Plan also covers scanning at five-year intervals for such Members who have previously received a CT scan measuring a CAC score of zero.

Note: All services, including those for which Prior Authorization 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. Gynecological or obstetrical ultrasounds do not require Prior Authorization. **Some services requiring Prior Authorization will not be approved for payment.**

Artery Calcification Tests

Early detection test for cardiovascular disease. Computed tomography (CT) scanning measuring coronary artery calcifications (CAC) tests are available to: (1) each covered Member who is between the ages of 45 and 65 years of

age or (2) covered Members at five-year intervals who have previously received a CT scan measuring CAC with a score of zero.

Diagnostic and Supplemental Breast Examinations

Benefits for Medically Necessary Diagnostic and Supplemental Breast Examinations will be provided without cost sharing when obtained from Participating Provider.

Biomarker Testing

This Plan provides benefits for Medically Necessary Biomarker Testing for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of a disease or condition.

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

Contact CVS Caremark for additional information regarding contraceptive drugs and devices purchased from a Pharmacy.

Family Planning

Covered family planning services include FDA-approved (if applicable) devices and other procedures such as:

- health education
- tubal ligation; sterilization implant; copper intrauterine device; intrauterine device with progestin; implantable rod; contraceptive shot or injection; combined oral contraceptives; extended or continuous use oral contraceptives; progestin-only oral contraceptives; patch; vaginal ring; diaphragm with spermicide; sponge with spermicide; cervical cap with spermicide; male and female condoms; spermicide alone; vasectomy; ulipristal acetate; levonorgestrel Emergency contraception; and any additional method categories of contraception approved by the FDA
- Pregnancy testing and counseling

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.

- over-the-counter female contraceptives and male contraceptives
- The contraceptive drugs and devices list posted on the BCBSNM website (www.bcbsnm.com) or available by contacting Customer Service at the toll-free number on your Identification Card
- outpatient contraceptive services such as consultations, examinations, procedures (including follow-up care for trouble you may have from using a birth control method that a family planning provider gave you) and medical services Provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended Pregnancy
- female surgical sterilization procedures (other than hysterectomy), including tubal ligations

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

If benefits for contraceptive coverage are denied, you or your representative may contact Customer Service at the toll-free number on your ID Card to request an expedited review.

Fertility-Related Services

Infertility means a disease, condition, or status characterized by 1) the inability to conceive a child or to carry a pregnancy to live birth after one year of regular unprotected sexual intercourse for a woman 35 years of age or younger, or after 6 months for a woman over 35 years of age (conceiving but having a miscarriage does not restart the 12 month or 6-month term for determining Infertility), 2) a person's inability to reproduce either as a single

individual or with a partner without medical intervention, or 3) a licensed Physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

Unprotected sexual intercourse means sexual union between a male and a female, without the use of any process, device or method that prevents conception, including but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

Diagnostic *testing*, when **Prior Authorization** is received from BCBSNM, is covered only to diagnose the cause of infertility. (See *Section 4: Utilization Management* for more information about Prior Authorization requirements.) Once the cause has been established and the treatment determined to be non-Covered, no further testing is covered.

Exclusions

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

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

Pregnancy-Related/Maternity Services

Like any other service, Maternity care must be received from a PCP or other HMO-Participating women's health care Provider. Therefore, once your Pregnancy is confirmed, you may choose either your PCP or another HMO-Participating women's Health Care Provider to provide Maternity care and receive benefits for covered ices. The Provider is then responsible for notifying BCBSNM of any Admissions. If you are pregnant, you or your Physician should call BCBSNM for Admission notification before your Maternity due date, soon after your Pregnancy is confirmed. BCBSNM must be notified if the mother's stay is greater than **48 hours** for a routine delivery or greater than **96 hours** for a C-section delivery as soon as possible. If not notified, benefits for covered Facility services may be **reduced** by **$300**. (If you are Out-of-Area and need Emergency services, also notify BCBSNM, your PCP, or HMO-Participating Provider **within 48 hours** or as soon as possible.)

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

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

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

Covered Services

Covered Pregnancy-Related Services include:

- hospital or other Facility charges for semiprivate room and board and ancillary services, including the use of labor, delivery, and recovery rooms (This Plan covers all Medically Necessary hospitalization, including at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a C-section delivery. **Note:** Newborns who are not eligible for coverage under this Plan will not be covered beyond the 48 or 96 hours required under federal law.)
- routine or complicated delivery, including prenatal and postnatal medical care of an Obstetrician, Certified Nurse-Midwife or Licensed Midwife (Expenses for prenatal and postnatal care are included in the total Covered Charge for the actual delivery or completion of Pregnancy.) **Note:** Home births are not covered unless the Provider has an HMO-Participating Provider contract with his/her local BCBS Plan and is credentialed to provide the service.
- Pregnancy-Related diagnostic tests, including genetic testing or counseling if approved through **Prior Authorization** by BCBSNM (Services must be sought due to a family history of a gender-linked genetic disorder or to diagnose a possible congenital defect caused by a present, external factor that increases risk, such as advanced maternal age or Alcohol Abuse. For example, tests such as amniocentesis or ultrasound to determine the gender of an unborn child are **not** covered.)
- necessary anesthesia services by a Provider qualified to perform such services, including Acupuncture used as an anesthetic during a covered surgical procedure and administered by a Physician, a licensed Doctor of Oriental Medicine, or other Practitioner as required by law
- when necessary to protect the life of the infant or mother, coverage for transportation, including air transport, for the medically high-risk pregnant woman with an impending delivery of a potentially viable infant to the nearest available Tertiary Care Facility for newly born infants (See "Ambulance Services" for details.)
- services of a Physician who actively assists the operating surgeon in performing a covered surgical procedure when the procedure requires an assistant
- elective, spontaneous, or therapeutic termination of Pregnancy prior to full term (Copayment will be based on the place of treatment at the time of Pregnancy termination.)

This Plan does **not** cover care for normal deliveries or planned C-sections outside the BCBSNM Service Area, unless you made a reasonable effort to be in the Service Area during the six weeks preceding your anticipated delivery date or your PCP arranges out-of-area care for you by obtaining **Prior Authorization** from BCBSNM (which will direct you to a contracted provider in the area you will be visiting).

Newborn Care

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

Newborn Eligibility

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

Routine Newborn Care

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

Covered Services

Covered Services for initial Routine Newborn Care include:

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

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

Extended Stay Newborn Care

A newborn who is enrolled for coverage within the time limits specified in *Section 2: Enrollment and Termination Information* is also covered if he/she stays in the Hospital longer than the mother. The baby's services will be subject to a separate Deductible, Coinsurance and Out-of-Pocket Limit.

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

PHYSICIAN VISITS/MEDICAL CARE

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

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

Office Visits and Consultations

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

The Plan covers counseling and support services rendered by a lactation consultant such as a Certified Nurse Practitioner, Certified Nurse Midwife or midwife, not subject to Coinsurance, Deductible, Copayment, or benefit maximums when received from a Provider in the Preferred or Participating Provider network (if your plan has Out-of-Network benefits for non-Emergency services, Out-of-Network services are subject to the usual Out-of-Network Deductible, Coinsurance, and Out-of-Pocket).

Diabetes Self-Management Education

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

- Medically Necessary visits upon the diagnosis of diabetes

- visits following a Physician diagnosis that represents a significant change in your symptoms or condition that warrants changes in your self-management
- visits when re-education or refresher training is prescribed by a Health Care Provider
- medical nutrition therapy related to diabetes management

Contact CVS Caremark 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 (contact CVS Caremark), corrective lenses for conditions related to the Genetic Inborn Error of Metabolism, nutritional management and **approved** Special Medical Foods (as defined and described by CVS Caremark). 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 CVS Caremark, 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 **Prior Authorization** is received from BCBSNM. Your BCBSNM-Contracted Provider has a list of those injectable drugs that require Prior Authorization. If you need a copy of the list, call a BCBSNM Customer Service Advocate. (When you request Prior Authorization, 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 Disorder Evaluation Services

This Plan covers medication checks and intake evaluations for Mental Disorders, Alcohol, and Drug Abuse when approved through **Prior Authorization** by BCBSNM. See "Psychotherapy (Mental Disorder and Chemical Dependency)" for psychotherapy and other therapeutic service benefits.

Inpatient Medical Visits

With the exception of Dental-Related Services, this Plan covers the following services when received on a covered inpatient Hospital day:

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

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. Coverage for a recommended Preventive Service that is otherwise considered Medically Necessary for an individual will be provided regardless of an individual's sex assigned at birth, gender identity or gender that BCBSNM has recorded.

This Plan covers the following preventive services not subject to Coinsurance, Deductible, Copayment, or benefit maximums (to be implemented in the quantities and within the time period allowed under applicable law) when received from an In-Network Provider.

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.

The services listed below may include requirements pursuant to state regulatory mandates and are to be covered at no cost to the member.

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.

Drugs (including both prescription and over the counter) that fall within a category of the current "A" or "B" recommendations of the United States Preventive Services Task Force and that are listed on the ACA Preventive Services Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any Copayment Amount, Coinsurance Amount, Deductible or dollar maximum when obtained from a Participating Pharmacy. Drugs on the Preventive Services Drug List that are obtained from a non-Participating Pharmacy, may be subject to Copayment Amount, Coinsurance Amount, Deductibles, or dollar maximums, if applicable.

Covered Preventive Services **not** described in items "a" through "d" above may be subject to Copayments, and/or dollar maximums. Allergy injections are **not** considered immunizations under the "Preventive Services" benefit. If a recommendation or guideline for a particular preventive health service does not specify the frequency, method, treatment, or setting in which it must be provided, BCBSNM may use reasonable medical management techniques to apply coverage including but not limited to review by a medical director for determination of appropriate action.

The list below is subject to change. A current list is available to you and your Physician on the USPSTF website at: www.uspreventiveservicestaskforce.org/Page/Name/recommendations, or you can contact customer service at 1-800-432-0750.

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

- routine adult and pediatric immunizations, including COVID-19 vaccines
- routine digital rectal exam, routine prostate screening
- an annual routine gynecological or pelvic examination and low-dose mammogram screenings
- papilloma virus screening and cytologic screening (a Pap test or liquid-based cervical cytopathology)
- human papillomavirus vaccine (HPV) for members ages 9 - 45 years old
- access to obstetrical and gynecological care
- osteoporosis services
- well-woman visits and follow-up treatment
- alpha-fetoprotein IV screening
- 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;
- well-child care, including well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorder
- Screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum, who have not recently been screened
- vision and hearing screenings in order to detect the need for additional vision or hearing testing for Members when received as part of a routine physical examination (A screening does *not* include an eye examination, refraction or other test to determine the amount and kind of correction needed.)
- health education and counseling services if recommended by your Physician, including an annual consultation to discuss lifestyle behaviors that promote health and well-being, including smoking/tobacco use Cessation Counseling
- contraceptive drugs and devices

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
- routine eye examinations; eye refractions; or any related service or supply
- routine hearing examinations; hearing aids; or any related service or supply, unless otherwise specified in this section (See “Hearing Aids/Related Services.”)

PSYCHOTHERAPY (MENTAL DISORDER AND CHEMICAL DEPENDENCY)

Note: You do not receive a separate Mental Disorder/Chemical Dependency ID Card; use your BCBSNM ID card to receive all medical/surgical and Mental Disorder/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 Disorder 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 HMO-Participating Providers or check the BCBSNM website at www.bcbsnm.com.

Residential Treatment Centers

A facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive environment and address long term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24-hour medical availability and on-site nursing care and supervision for at least one shift a day with on call availability for other shifts for patients with Mental Illness and/or Substance Use Disorders. Blue Cross and Blue Shield of New Mexico requires that any Mental Illness and/or Substance Use Disorder Residential Treatment Center must be licensed in the state where it is located or accredited by a national organization that is recognized by Blue Cross and Blue Shield of New Mexico as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Prior Authorization Requirements

Prior Authorization for inpatient Mental Disorder and Chemical Dependency Services must be approved by the Behavioral Health Unit at the phone number listed on the back of your ID Card. Prior Authorization is also required for Outpatient Psychological Testing, Neuropsychological Testing, Intensive Outpatient Program (IOP) Treatment, Electroconvulsive Therapy (ECT), Applied Behavior Analysis (ABA) Therapies, and Repetitive Transcranial Magnetic Stimulation for treatment of Mental Illness and/or Chemical Dependency. Prior Authorization 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 Non-Emergency Services, **benefits for Covered Services may be denied** as explained in the *Prior Authorizations* section, earlier. In such cases, you may be responsible for all charges, so please ensure that you or your Provider have received Prior Authorization for any services you plan to receive. The BHU Call Center is open 24/7 to assist Members and Providers with Emergency Admission inquiries and to respond to crisis calls.

Exclusions

This Plan does **not** cover:

- psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education
- services billed by a school, halfway house or group home, or their staff Members; foster care; or behavior modification services
- maintenance therapy or care provided after you have reached your rehabilitative potential
- hypnotherapy or behavior modification services
- religious or pastoral counseling
- Custodial Care
- hospitalization or Admission to a Skilled Nursing Facility, nursing home, or other Facility for the primary purpose of providing Custodial Care Service, convalescent care, rest cures, or domiciliary care to the patient
- services or supplies received during an Inpatient stay when the stay is solely related to behavior, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental

Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and Mental Disorder conditions)

- any care that is patient-elected and is not considered Medically Necessary
- care that is mandated by court order or as a legal alternative, and lacks clinical necessity as diagnosed by a licensed Provider; services rendered as a condition of parole or probation
- special education, school testing and evaluations, counseling, therapy, or care for learning deficiencies or educational and developmental disorders; behavioral problems unless associated with manifest Mental Disorders or other disturbances
- non-national standard therapies, including those that are Experimental as determined by the Mental Disorder 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 Spinal 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 Spinal 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. Prior Authorization must be obtained from BCBSNM or benefits will be denied. See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

Chemotherapy and Radiation Therapy

This Plan covers the treatment of malignant disease by standard Chemotherapy and treatment of disease by Radiation Therapy. **High-dose chemotherapy treatments must receive Prior Authorization from BCBSNM in order to be covered.** See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

Cancer Clinical Trials

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

The Routine Patient Care Costs that are covered must be the same services or treatments that would be covered if you were receiving standard cancer treatment. Benefits also include FDA-approved Prescription Drugs that are not paid for by the manufacturer, distributor, or supplier of the drug. (Member cost-sharing provisions described by CVS Caremark will apply to these benefits.)

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

Benefits for eligible expenses for Routine Patient Care Costs are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection,

or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

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.

Habilitative and Rehabilitative Services

Benefits will be provided for Medically Necessary Habilitative Services and Rehabilitative Services, which includes coverage for prosthetic and custom orthotic devices.

Dialysis

This Plan covers the following Services when received from a dialysis Provider, or when **Prior Authorization** is received from BCBSNM, in your home (See *Section 4: Utilization Management* for more information about Prior Authorization requirements.):

- 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)

Prior Authorization Required

To be covered, all **inpatient**, outpatient, office and home-based outpatient, Short-Term Rehabilitation treatments, including Skilled Nursing Facility and physical rehabilitation Facility Admissions, must receive **Prior Authorization** from BCBSNM. Short-Term Rehabilitation required due to reinjury or aggravation of an injury are also covered but must receive a separate **Prior Authorization** from BCBSNM, even if therapy was authorized for the original injury. Services received without Prior Authorization will be **denied**. See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

Covered Services

This Plan covers the following Short-Term Rehabilitation Services when rendered for the Medically Necessary treatment of Accidental Injury or illness:

- Occupational Therapy performed by a licensed Occupational Therapist
- Physical Therapy performed by a Physician, licensed Physical Therapist, or other Professional Provider licensed as a Physical Therapist (such as a Doctor of Oriental Medicine)
- Joint and Spinal Manipulation services when administered by a licensed Provider acting within the scope of licensure and when necessary for the treatment of Accidental Injury or medical condition
- 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 approved through **Prior Authorization** by BCBSNM

Cost Sharing

Your Copayment or Coinsurance and Deductible will be the same amount as shown on your Summary of Benefits under primary care visits for Covered Services aimed at maximizing level of function, returning to a prior level of function, or maintaining or slowing the decline of function when these services are provided by a licensed or certified Physical Therapist, Occupational Therapist or Speech Therapist. Other Covered Services are subject to usual Member cost-sharing features such as Copayment or Coinsurance or Deductible based on the type of Provider, place of treatment or type of service.

Benefit Limits

Benefits are limited, if applicable, as specified in the *Summary of Benefits.* Benefits for Autism Spectrum Disorder will not apply toward, and are not subject to, any Occupational Therapy, Physical Therapy or Speech Therapy visits. **Note:** Long-term therapy, maintenance therapy, and therapy for chronic conditions are **not** covered. This Plan covers Short-Term Rehabilitation only.

Conditions of Coverage

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

- Services must be approved through **Prior Authorization** by BCBSNM. See *Section 4: Utilization Management* for more information about Prior Authorization requirements.
- There is a documented condition or delay in recovery that can be expected to measurably improve with therapy within two months of beginning active therapy. This period may be extended upon recommendation of the referring physician, in consultation with BCBSNM.
- Improvement would not normally be expected to occur without intervention.

Exclusions

This Plan does **not** cover:

- maintenance therapy or care provided after you have reached your rehabilitative potential (Even if you have not reached your rehabilitative potential, this Plan does not cover services that exceed maximum benefit limits, if any.)
- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay, 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: Claims 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)
- private room expenses unless your medical condition requires isolation for protection from exposure to bacteria and diseases (e.g., severe burns or conditions that require isolation according to public health laws)
- Speech Therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic; other speech services that can be carried out by the patient, the family, or caregiver/teacher
- herbs, homeopathic preparations, or nutritional supplements
- drug therapy that has not received Prior Authorization

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

This plan covers the rental of hospital grade breast pumps (but not to exceed the total cost) or purchase of a manual or electric breast pump, including breast pump supplies and breast milk storage supplies with a written prescription from a health care Provider, and are not subject to coinsurance, deductible, copayment or benefit maximums when received from an in-network Provider. If your plan has out-of-network benefits for non-emergency services, out-of-network services are subject to the usual out-of-network coinsurance, deductible, and out-of-pocket expense limit. Electric breast pumps are limited to 1 per Benefit Period.

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 those with disabilities, including legally blind
- insulin pumps if **Prior Authorization** is received from BCBSNM, and insulin pump supplies
- blood glucose monitors, including for those with disabilities, including the legally blind
- Medically Necessary Podiatric Appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics that have been approved through **Prior Authorization** by BCBSNM, 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), contact CVS Caremark.

NOTE: Absent a change in diagnosis, management, or treatment of diabetes or its complications, only one prior authorization will be required for each covered diabetic supply or covered diabetic drug, per Plan Year, if prescribed as Medically Necessary by a health care Provider.

Durable Medical Equipment and Appliances

This Plan covers the following items**:**

- Orthopedic Appliances (**Prior Authorization** is required, regardless of total cost)
- replacement of items only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- oxygen and oxygen equipment, wheelchairs, hospital beds, crutches, and other Medically Necessary Durable Medical Equipment
- lens implants for aphakic patients (those with no lens in the eye) and soft lenses or sclera shells (white supporting tissue of eyeball)
- either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) when needed to replace lenses absent at birth or lost through cataract or other intraocular surgery or ocular injury, to treat conditions related to Genetic Inborn Errors of Metabolism, or prescribed by a Physician as the only treatment available for keratoconus (Duplicate glasses/lenses are not covered. Replacement is covered only if a Physician or Optometrist recommends a change in prescription due to a change in your medical condition.)
- cardiac pacemakers

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 but not limited to, penile implants required as a result of illness or Accidental Injury, if **Prior Authorization** for such items is received from BCBSNM
- externally attached prostheses to replace a limb or other body part lost after Accidental Injury or surgical removal; their fitting, adjustment, repairs and replacement
- replacement of Prosthetics only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- breast Prosthetics when required as the result of a mastectomy and mastectomy bras, which are limited to **four bras** per Calendar Year
- functional orthotics only for patients having a locomotive problem or gait difficulty resulting from mechanical problems of the foot, ankle, or leg (A functional orthotic is used to control the function of the joints and is covered only when approved through **Prior Authorization** by BCBSNM 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
- prosthetics for Medically Necessary primary gender reassignment chest and/or genital surgeries, including but not limited to breast implants, implantable erectile prosthesis, and placement of testicular prosthesis when meeting the criteria for gender dysphoria

When alternative Prosthetic Devices are available, the allowance for a prosthesis will be based upon the most Cost-Effective item. See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

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;
- repairs to items that you do not own
- comfort items such as bed boards, beds or mattresses of any kind, bathtub lifts, overbed tables, or telephone arms
- repair or rental costs that exceeds the purchase price of a new unit
- dental Appliances (See “Dental-Related Services and Oral Surgery” for exceptions.)
- accommodative orthotics (deal with structural abnormalities of the foot, accommodate such abnormalities, and provide comfort, but do not alter function)
- orthopedic shoes, unless joined to braces (Diabetic Members should refer to “Diabetic Supplies and Equipment” earlier in this section for information about covered podiatric equipment and orthopedic shoes.)
- equipment or supplies not ordered by a Health Care Provider, including items used for comfort, convenience, or personal hygiene
- duplicate items; repairs to duplicate items; or the replacement of items because of loss, theft, or destruction
- 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 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 provided by CVS Caremark)
- 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
- items not listed as covered

Medical Necessity and Nondiscrimination Standards for Coverage and Orthotics

This plan provides coverage for initial and secondary prosthetic devices and custom orthotics in a non-discriminatory manner, and without restriction based on predetermined utilization limits, at the same level and cost-sharing as the coverage provided for medical and surgical benefits. Prosthetic and custom orthotic devices are considered habilitative and rehabilitative essential health benefits and are not subject to separate financial requirements or utilization restrictions.

Coverage includes:

- Clinical care
- All supplies, materials, and devices determined by the physician to be medically necessary and most appropriate to maximize upper and lower limb function, maintain activities of daily living or essential job-related activities, and meet the medical needs for physical activities such but not limited to running, biking, swimming, strength training.
- All services, including design, fabrication, and repair
- Replacement of a device, any part of such devices, without regard to useful lifetime restrictions, if an ordering health care provider determines that a replacement device, or a replacement part is necessary because of any of the following: (2) a change in your physiological condition; an irreparable change in the condition of the device or in a part of the device; or (3) the condition of the device; or the part of the device, requires repairs and the cost of such repairs would be more than sixty percent of the cost of a replacement device or of the part being replaced.
- Access to prosthetic and custom orthotic devices from at least two distinct device providers in your network

Utilization management decisions related to coverage for prosthetic or custom orthotic devices will be applied in a non-discriminatory manner using the most recent version of evidence-based treatment and fit criteria as recognized by relevant clinical specialists or their organizations. Prosthetic and custom orthotic benefits will not be denied for an individual with limb loss or absence that would otherwise be covered for a non-disabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same daily functions and physical activity. However, coverage for prosthetic devices and custom orthotics will not be provided when required solely for comfort or convenience.

SURGERY AND RELATED SERVICES

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

Surgeon's Services

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

Cochlear Implants

This Plan covers cochlear implantation of a hearing device (such as an electromagnetic bone conductor) to facilitate communication for the profoundly hearing impaired, including training to use the device. You must submit a **written request for Prior Authorization** to BCBSNM before treatment begins. This Plan does **not** cover cochlear implant services without Prior Authorization. See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

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. that have not received Prior Authorization from BCBSNM.

Obesity Surgery

This Plan covers the surgical treatment of Morbid Obesity if treatment is approved through Prior Authorization by BCBSNM before treatment begins and only when the member meets medical criteria established by BCBSNM. Medical policies are posted on BCBSNM's website (http://www.medicalpolicy.hcsc.net/medicalpolicy/index?corpEntCd=NM1) and may change without notice. Check the website for the most current medical policy or call a Customer Service Advocate for assistance. **Benefits are not available without Prior Authorization, requested in writing.** *(Morbid Obesity* means 45 kilograms or 100 percent over ideal body weight.)

Reconstructive Surgery

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

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

You or your physician must obtain **Prior Authorization**, requested in writing, from BCBSNM **before** the reconstructive service is provided. If the procedure (including any reconstructive service listed under "Dental-Related/TMJ Services and Oral Surgery") has not received Prior Authorization, **the surgery and all related charges will be denied.** Cosmetic procedures and procedures that are **not Medically Necessary**, including all services related to such procedures, will be **denied.** See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

Exclusions

This Plan does **not** cover:

- Cosmetic or plastic surgery or procedures, such as breast augmentation, rhinoplasty, and surgical alteration of the eye that does not materially improve the physiological function of an organ or body part (unless covered under "Mastectomy Services")
- procedures to correct cosmetically unsatisfactory surgical results or surgically induced scars
- refractive keratoplasty, including radial keratotomy, or any procedure to correct visual refractive defect
- unless required as part of Medically Necessary diabetic disease management, trimming of corns, calluses, toenails, or bunions (except surgical treatment such as capsular or bone surgery)

- subsequent surgical procedures needed because you did not comply with prescribed medical treatment or because of a complication from a previous non-Covered procedure (such as a non-Covered Organ Transplant or previous Cosmetic Surgery)
- any reconstructive procedure, orthognathic surgery when not related to TMJ/CMJ disorders, cochlear implant, breast reduction, or cosmetic breast surgery that has not received Prior Authorization from BCBSNM (See *Section 4: Utilization Management* for more information about Prior Authorization requirements.)
- 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

Gender Reassignment and Related Supplies and Services

This Plan covers gender reassignment Surgery, including related services and supplies, when Prior Authorization has been obtained.

Anesthesia Services

This Plan covers necessary anesthesia services, including Acupuncture used as an anesthetic, when administered during a covered surgical procedure by a physician, Certified Registered Nurse Anesthetist (CRNA), or other Practitioner licensed to provide anesthesia.

Exclusions

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

Assistant Surgeon Services

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

Exclusions

This Plan does **not** cover:

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

TRANSPLANT SERVICES

Prior Authorization, requested in writing, must be obtained from BCBSNM **before** a pretransplant evaluation is scheduled. A pretransplant evaluation is **not** covered if Prior Authorization 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 **Prior Authorization** for the actual Transplant is also received. None of the benefits described here are available unless you have this Prior Authorization. See *Section 4: Utilization Management* for more information about Prior Authorization requirements.

Facility Must Be in Transplant Network

Benefits for Covered Services will be approved only when the Transplant is performed at a Facility that contracts with BCBSNM, another Blue Cross Blue Shield (BCBS) Plan or the national BCBS Transplant network, for the Transplant being provided. Your BCBSNM case manager will assist your Provider with information on the

exclusive network of Contracted Facilities and required approvals. Call BCBSNM Health Services for information on these BCBSNM Transplant programs.

Effect of Medicare Eligibility on Coverage

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

Organ Procurement or Donor Expenses

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

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

Bone Marrow, Cornea or Kidney

This Plan covers the following Transplant procedures if **Prior Authorization** is received from BCBSNM (See *Section 4: Utilization Management* for more information about Prior Authorization requirements.):

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

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 approved through **Prior Authorization** 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: Utilization Management* for more information about Prior Authorization 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 if he recipient resides more than 50 miles from the transplant facility. 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 lifetime maximum of **$10,000** per Transplant. Travel expenses and standard per diem allowances are limited to an annual maximum of $10,000. Travel expenses and standard per diem allowances are limited to a maximum of $10,000 per transplant. Your case manager may approve travel and per diem lodging allowances based upon the total number of days of temporary relocation, up to the **$10,000** benefit maximum.

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

Transplant Exclusions

This Plan does **not** cover:

- Transplant-Related Services for a Transplant that did not receive **Prior Authorization** from BCBSNM (See *Section 4: Utilization Management* for more information about Prior Authorization requirements.)
- any Transplant or organ-combination Transplant not listed as covered
- implantation of artificial organs or devices (mechanical heart, unless covered under BCBSNM medical policy)
- nonhuman organ Transplants
- care for complications of non-Covered 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 pharmacy provider.)
- donor expenses after the donor has been discharged from the Transplant Facility
- lodging expenses in excess of the per diem allowance, if available, and food, beverage, or meal expenses
- travel or per diem expenses:
    - incurred **more than five days before** or **more than one year following** the date of transplantation
    - if the recipient's case manager indicates that travel is not Medically Necessary
    - related to a bone marrow or kidney Transplant
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; telephone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- expenses charged only because benefits are available under this provision (such as transportation received from a Member of your family, or from any other person charging for transportation that does not ordinarily do so)

SECTION 6: GENERAL LIMITATIONS AND EXCLUSIONS

These general limitations and exclusions apply to **all** services listed in this Benefit Booklet.

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

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

— 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 except when administered by a licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.) or a Board Certified Biofeedback Therapist. In order to be covered, diagnosis must be chronic pain. Prior Authorization is required or benefits will be denied.

— 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 non-Covered Service, treatment, or procedure (e.g., due to a Cosmetic surgery, Transplant, or Experimental procedure).

— Convalescent Care or Rest Cures

This Plan does not cover convalescent care or rest cures.

— Cosmetic Services

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

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

The cosmetic coverage exclusion does not apply to Medically Necessary primary gender reassignment chest and/or genital surgeries nor to pharmaceutical gender reassignment services, all of which require Prior Authorization from BCBSNM.

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

— Custodial Care

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

— Dental-Related Services and Oral Surgery

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

— Domiciliary Care

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

— Duplicate (Double) Coverage

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

— Duplicate Testing

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

— Experimental, Investigational, or Unproven Services

This Plan does not cover any treatment, procedure, Facility, equipment, drug, device, or supply not accepted as *standard medical practice* (as defined) or those considered Experimental, Investigational, or Unproven, unless for Acupuncture rendered by a licensed Doctor of Oriental Medicine or unless specifically listed as covered under "Autism Spectrum Disorders" or under "Cancer Clinical Trials" in *Section 5: Covered Services*. 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.

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— 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, or 3) covered as part of the hearing aid benefit and described under "Hearing Aids/Related Services" in *Section 5: Covered Services.* (A screening does *not* include a hearing test to determine the amount and kind of correction needed.) 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.

— Fertility Treatment

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

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

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

— Late Claim Filing

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

— Learning Deficiencies/Behavioral Problems

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

— Limited Services/Covered Charges

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

— Local Anesthesia

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

— Long-Term and Maintenance Therapy

This Plan does not cover long-term therapy whether for physical or for mental conditions, even if Medically Necessary and even if any applicable benefit maximum has not yet been reached, except that medication management for chronic conditions is covered. Therapies are considered long-term if measurable improvement is not possible **within two months** of beginning 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 covered 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).*

— Medically Unnecessary Services

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

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

— No Legal Payment Obligation

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

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

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

— 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
  - — private sanitarium
  - — dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group
  - — homeopathic or naturopathic Provider

— Nonmedical Expenses

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

- adoption or surrogate expenses
- educational programs such as behavior modification 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 Prior Authorizations; filling out of Claim forms; copies of medical records; interest expenses
- modifications to home, vehicle, or workplace to accommodate medical conditions
- 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, medical research programs, sports, or for any nonpreventive purpose
- hepatitis B immunizations when required due to possible exposure during the Member's work
- court- or police-ordered services unless the services would otherwise be covered or services rendered as a condition of parole or probation
- the cost of any damages to a treatment Facility that are caused by the Member

— Nonparticipating Provider Services

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

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

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

— 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 plan. Contact CVS Caremark for more information.

— Post-Termination Services

This Plan does not cover any service received or item or drug purchased after your coverage is terminated, even if: 1) Prior Authorization 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

Contact CVS Caremark for more information regarding pharmacy items.

— Prior Authorization Not Obtained When Required

This Plan does not cover certain services if you do not obtain Prior Authorization from BCBSNM before those services are received. See *Section 4: Utilization Management.*

— Private Duty Nursing Services

This Plan does not cover private duty nursing services.

— Psychotherapy (Mental Disorder and Chemical Dependency)

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

— Sexual Dysfunction Treatment

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

— Supplies, Equipment and Prosthetics

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

— Surgery and Related Services

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

— Therapy and Counseling Services

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

- recreational, sleep, crystal, primal scream, sex, and Z therapies
- self-help, stress management, and codependency programs
- 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 and described in *Section 5* under "Autism Spectrum Disorders"
- any therapeutic exercise equipment for home use (e.g., treadmill, weights)
- Speech Therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic, other speech services that can be carried out by the patient, the family, or caregiver/teacher

— Thermography

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

— Transplant Services

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

— Travel or Transportation

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

— Veteran's Administration Facility

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

— Vision Services

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

— War-Related Conditions

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

— Work-Related Conditions

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

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

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

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

- You fail to file a Claim within the filing period allowed by the applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations.

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

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

SECTION 7: COORDINATION OF BENEFITS (COB) AND REIMBURSEMENT

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 Prior Authorization) must be followed or benefits may be denied.

The following rules determine which coverage pays first:

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

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

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

Subscriber/Family Member — If the Member who received care is covered as an employee, 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:

- **State of New Mexico** 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 and your legal representative as a result of that sickness or injury, in the amount of the total Covered Charges for Covered Services for which **State of New Mexico has provided benefits to you or your covered family m**embers.
- State of New Mexico is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits **State of New Mexico provided for that sickness or injury.**

State of New Mexico 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 **State of New Mexico** has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that BCBSNM and/or **State of New Mexico** 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

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 Prior Authorization requirements or benefits may be denied as explained in *Section 4: Utilization Management.* 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.)

HMO-PARTICIPATING PROVIDERS

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

NONPARTICIPATING PROVIDERS

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

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

Please contact the Nonparticipating Provider for any balance billing issues. If you need additional assistance you may also contact the Managed Health Care Bureau (MHCB) at OSI.

Office of Superintendent of Insurance – MHCB

P.O. Box 1689

1120 Paseo de Peralta

Santa Fe, NM 87504-1689

1-(505) 827-4601 or toll free at 1-(855) 407-5674

Fax: (505) 827-6341, Attn: MHCB

Email: mhcb.grievance@state.nm.us

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 Disorder/Chemical Dependency Claims

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

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

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

Non-Emergency care received outside the United States is not covered. For covered Emergency 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. **Note:** Services received outside the United States (including Puerto Rico, Jamaica, and the U.S. Virgin Islands) and Canada **will be covered only if they are for Emergency treatment.**

You will need to pay up front for care received from a D**octor,** a P**articipating Outpatient Hospital,** and/or a N**onparticipating Hospital.** Then, complete an *International Claim Form* and send it with the bill(s) to the service center (the address is on the form). The *International Claim Form* is available from BCBSNM, the service center, or on-line at:

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

The Blue Cross Blue Shield Global Core *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 Blue Cross Blue Shield Global Core at the address below. Blue Cross Blue Shield Global Core 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:

Service Center
P.O. Box 2048
Southeastern, PA 19399

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 Prior Authorization 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. **You also have 180 days in which to appeal a decision.**

Covered Charge

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

HMO-Participating Providers

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

Nonparticipating Providers

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

Accident-Related Hospital Services

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

Assignment of Benefits

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

Medicaid

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

Medicare

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

Overpayments

If your Group's benefit plan or the Claim Administrator pays benefits for Covered Charges incurred by you or your Eligible Family Members and it is found that the payment was more than it should have been, or it was made in error ("Overpayment"), your Group's benefit plan or the Claim Administrator has the right to obtain a refund of the Overpayment amount from: (i) the person to, or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to Participating Providers or Nonparticipating Providers.

If no refund is received, your Group's benefit plan and/or Blue Cross and Blue Shield of New Mexico (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

a. Any future benefit payment made to any person or entity under this Benefit Booklet, whether for the same or a different Member; or

b. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield administered ASO benefit program and/or Blue Cross and Blue Shield administered insured benefit program or policy, if the future benefit payment owed is to a Contracted Provider; or

c. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured Group benefit plan or individual policy, if the future benefit payment owed is to a Contracted Provider; or

d. Any future benefit payment, or other payment, made to any person or entity; or

e. Any future payment owed to one or more Contracted Providers.

Further, the Claim Administrator has the right to reduce your benefit plan's payment to a Contracted Provider by the amount necessary to recover another Blue Cross and Blue Shield's plan or policy Overpayment to the same Contracted Provider and to remit the recovered amount to the other Blue Cross and Blue Shield plan or policy.

BLUECARD℠ PROGRAM

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 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 Physician (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.

When services are received by you outside 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.

Services Received from Contracted Providers Outside New Mexico

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.

For inpatient facility services received in a Hospital, the Host Blue's Participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the Participating Provider will be sanctioned based on the Host Blue's contractual agreement with the Provider, and the Member will be held harmless for the Provider sanction.

Whenever you access out-of-area covered services outside of the BCBSNM 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; or
- 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 Health Care Provider. Sometimes, it is an estimated price that takes into account special arrangements with your Health Care 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 Health Care 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.

In some cases, BCBSNM may, but is not required to, in its sole discretion, negotiate a payment with a Non-Contracting Health Care Provider on an exception basis.

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, BCBSNM would then calculate your liability for any covered services according to applicable law.

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 laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations, 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, to determine the amount BCBSNM will pay for services rendered by Non-Contracted Healthcare Providers, such as (i) billed charges for Covered Services, (ii) the payment we would make if the Health Care Services had been obtained within our Service Area, (iii) a special negotiated payment, as permitted under the Inter-Plan Arrangements (iv) for Professional Providers, make a payment based on publicly available data and historic reimbursement to Providers for the same or similar professional services, adjusted for geographical differences where applicable; or (v) for

Hospital or Facility Providers, make a payment based on publicly available data reflecting the costs that Hospitals or Facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or Facility. In these situations, the Member may be responsible for the difference between the amount that the Non-Contracted Provider bills and the payment BCBSNM will make for the Covered Services as set forth in this paragraph.

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.

INTER-PLAN ARRANGEMENTS: FEDERAL/STATE TAXES/SURCHARGES/FEES

Federal or state laws or regulations may impose a surcharge, tax, or other fee. If applicable, BCBSNM will include any such surcharge, tax or other fee as part of the Claim charge passed on to you.

SPECIAL CASES: VALUE-BASED PROGRAMS

If you received Covered Services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the Provider incentives, risk-sharing, and/or care coordinator feed that are a part of such an arrangement, except when a Host Blue passes these fees to BCBNSM through average pricing or fee schedule adjustments. Additional information available upon request.

BLUE CROSS BLUE SHIELD GLOBAL CORE

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard Service Area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard Service Area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient, and Professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard Service Area, you will typically have to pay the Providers and submit the Claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a Doctor or Hospital) outside the BlueCard Service Area, you should call the Blue Cross Blue Shield Global Core service center at 1-800-810-BLUE (2583), or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

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.

Emergency Care Services

This Plan covers only limited Health Care Services received outside of the United States. As used in this section, "Out-of-Area Covered Services" include Emergency services and Urgent Care obtained outside of the United States. Follow-up care following an Emergency is also available provided the services are approved through Prior Authorization by BCBSNM. Any other services will not be eligible for Benefits unless approved through Prior Authorization by BCBSNM.

- **Inpatient Services**

  In most cases, if you contact the Blue Cross Blue Shield Global Core service center for assistance, Hospitals will not require you to pay for covered Inpatient Services, except for your cost-share amounts (Deductibles, Coinsurance, etc.). In such cases, the hospital will submit our Claims to the Blue Cross Blue Shield Global Core service center to begin Claims processing. However, if you paid in full at the time of service, you must submit a Claim to receive reimbursement for Covered Services. You must contact BCBSNM to obtain Prior Authorization for non-Emergency Inpatient Services.

- **Outpatient Services**

  Outpatient Services are available for Emergency Care treatment. Physicians, Urgent Care centers and other

outpatient Providers located outside the BlueCard Service Area will typically require you to pay in full at the time of service. You must submit a Claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

  When you pay for Covered Services outside the BlueCard Service Area, you must submit a Claim to obtain reimbursement. For institutional and professional Claims, you should complete a Blue Cross Blue Shield Global Core International Claim form and send the Claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core service center (the address is on the form) to initiate Claim processing. Following the instructions on the Claim form will help ensure timely processing of your Claim. The Claim form is available from BCBSNM, the Blue Cross Blue Shield Global Core service center, or online at www.bcbsglobalcore.com. If you need assistance with your Claim submission, you should call the Blue Cross Blue Shield Global Core service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, 7 days a week.

MEMBER DATA SHARE

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 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 ways, 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.

COMPLAINTS AND APPEALS: SUMMARY OF PROCEDURES

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

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

Many complaints or problems can be handled informally by calling, writing, or e-mailing BCBSNM Customer Service. If you are not satisfied with the initial response, you can request internal review as described in the detailed *Appendix: Notice - Claims Determinations - Timeframes* notice applicable to your health plan you should have received in your enrollment packet (or included in the back of your booklet).

BCBSNM Contacts for Appeals

An appeal is an oral or written request for review of an "adverse benefit determination" or an adverse action by

BCBSNM, its employees, or a Participating Provider. To file an appeal or for more information about appeals, contact:

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

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

External Actions

If you are still not satisfied after having completed the BCBSNM complaint, appeal, grievance, or reconsideration procedure, you may have the option of taking other steps, as outlined in the *Appendix: Notice - Claims Determinations - Timeframes* notice applicable to your health plan. No legal action may be taken or arbitration demand made earlier than **60 days** after BCBSNM has received the claim for benefits or Prior Authorization request, or later than **three years** after the date that the Claim for benefits should have been filed with BCBSNM.

SECTION 9: GENERAL PROVISIONS

AVAILABILITY OF PROVIDER SERVICES

BCBSNM does not guarantee that a certain type of room or service will be available at any Hospital or other Facility within the BCBSNM network, nor that the services of a particular Hospital, Physician, or Other Provider will be available.

CATASTROPHIC EVENTS

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

CHANGES TO THE BENEFIT BOOKLET

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

DISCLAIMER OF LIABILITY

BCBSNM has no control over any diagnosis, treatment, care, or other service provided to you by any Facility or Professional Provider, whether Preferred or not. BCBSNM is not liable for any loss or injury caused by any Health Care Provider by reason of negligence or otherwise.

Nothing in this Benefit Booklet is intended to limit, restrict, or waive any Member rights under the law and all such rights are reserved to the individual.

DISCLOSURE AND RELEASE OF INFORMATION

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

EXECUTION OF PAPERS

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

INDEPENDENT CONTRACTORS

The relationship between BCBSNM and its Participating 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 Participating 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 Participating 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 receive information about BCBSNM, our services, Practitioners and Providers and Member rights and responsibility.
- The right to participate with Practitioners in making decisions about your health care.
- The right to make recommendations regarding BCBSNM's Member rights and responsibility policy.
- The right to be treated with courtesy and consideration, and with respect for your dignity and your need for privacy.
- The right to have their privacy respected, including the privacy of medical and financial records maintained by BCBSNM and its Health Care Providers as required by law.
- The right to be provided with information concerning BCBSNM's policies and procedures regarding products, services, Providers, and appeals procedures and other information about the company and the benefits provided.
- The right to choose a PCP within the limits of the covered benefits and plan network, including the right to refuse care of specific Practitioners.
- The right to 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 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 Prior Authorization and utilization review.
- The right to make recommendations regarding BCBSNM's Member rights and responsibilities policies.
- The right to a complete explanation of why care is denied, an opportunity to appeal the decision to BCBSNM's internal review and the right to a secondary appeal.

MEMBER RESPONSIBILITIES

As a Member enrolled in a Managed Health Care Plan administered by BCBSNM, you have these responsibilities:

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

MEMBERSHIP RECORDS

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

RESEARCH FEES

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

SENDING NOTICES

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

TRANSFER OF BENEFITS

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

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.

Administrative Services Agreement — A contract for Health Care Services which by its terms limits eligibility to Members of a specified Group. The Administrative Services Agreement includes the Benefit Program Application and may include coverage for family members.

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

Adverse Determination — A decision made either pre-service or post-service by BCBSNM that a Health Care Service requested by a Provider or Member has been reviewed and based upon the information available does not meet the requirements for coverage or Medical Necessity and the requested health care service is either denied 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 (ASD) — A condition that meets the diagnostic criteria for Autism Spectrum Disorder published in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American psychiatric association; or a condition diagnosed as autistic disorder, Asperger's disorder, pervasive development disorder not otherwise specified, Rett's disorder or childhood disintegrative disorder pursuant to diagnostic criteria published in a previous edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American psychiatric association.

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

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

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

BlueCard — BlueCard is a national program that enables Members of one Blue company to obtain Health Care Services while traveling or living in another Blue company's Service Area. The program links participating Health Care 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 www.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.*

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

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

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

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

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

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

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

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

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

Covered Charge — The amount that BCBSNM determines is a fair and reasonable allowance for a particular Covered Service.

Covered Services — Those services and other items for which benefits are available under the terms of the benefit plan of an Eligible Plan Member.

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

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

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

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

Dentist, Oral Surgeon — A Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.) who is licensed to practice prevention, diagnosis, and treatment of diseases, Accidental Injuries and malformation of the teeth, jaws, and mouth.

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

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

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

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

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

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

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

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

Drug Abuse Treatment Facility— An appropriately licensed provider primarily engaged in detoxification and rehabilitation treatment for Chemical Dependency.

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 Mental Disorder or Chemical Dependency 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 — Any treatment, procedure, Facility, equipment, drug, device, or supply that is not accepted as standard medical practice in the state where services are provided. In addition, if a federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is Experimental. To be considered standard medical practice and not Experimental or Investigational, treatment must meet all five of the following criteria:

- a technology must have final approval from the appropriate regulatory government bodies; however, approval by a governmental or regulatory agency will be taken into consideration by BCBSNM in assessing Experimental/Investigational status of a drug, device, biological product, supply and equipment for medical treatment or procedure but will not be determinative;
- the scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes;
- the technology must improve the net health outcome;
- the technology must be as beneficial as any established alternatives; and
- the improvement must be attainable outside the Investigational settings.

Facility — A Hospital (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.

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).

Habilitative Services — Occupational Therapy, Physical Therapy, Speech Therapy and other Health Care Services that help you keep, learn, or improve skills and functioning for daily living, as prescribed by your Physician pursuant to a treatment plan. Examples include therapy for a child who isn't walking or talking at the expected age and includes therapy to enhance the ability of a child to function with a Congenital, Genetic or Early Acquired Disorder. These pathology and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings, with coverage as described in this Benefit Booklet.

Health Care Facility — An institution providing Health Care Services, including a Hospital or other licensed inpatient center, an ambulatory surgical or treatment center, a Skilled Nursing Facility, a Residential Treatment Center, a Home Health Care Agency, a diagnostic laboratory or imaging center, and a rehabilitation or other therapeutic health setting.

HMO-Participating Provider — Either a Facility (i.e., a Hospital) or a Professional Provider (i.e., a Physician) that, for the service being provided, contracts with BCBSNM as an HMO-Participating Provider, either directly or indirectly, or with the National BCBS Transplant Network to Provide Health Care Services to Members with an expectation of receiving payment (other than Copayments, Coinsurance, or Deductibles) directly or indirectly from BCBSNM. An HMO-Participating Provider also agrees to bill BCBSNM and to accept this Plan's payment (provided in accordance with the provisions of the contract) plus the member's Copayment as payment in full for Covered Services. BCBSNM, as Claims Administrator, will pay the HMO-Participating Provider directly.

The contracts between BCBSNM and its Providers include a "hold harmless" clause so that an HMO Member cannot be liable to the provider for moneys owed by BCBSNM for services covered under this Plan.

BCBSNM may add, change, or terminate specific Participating Providers at its discretion or recommend a specific Provider for specialized care as Medical Necessity warrants. Participating Providers are not required by BCBSNM to comply with any specified numbers, targeted averages, or maximum durations of patient visits.

HMO-Participating Specialist — A health care practitioner who has an HMO-Participating Provider contract with BCBSNM, but is **not** specially contracted as a "PCP." A specialist does not include Hospitals or other treatment facilities, Urgent Care Facilities, pharmacies, equipment suppliers, Ambulance companies, or similar ancillary health care Providers.

Home Health Care Agency — An appropriately licensed Provider that both:

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

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

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

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

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

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

- diagnosis and treatment of illness, injury, deformity, abnormality or Pregnancy
- clinical laboratory, diagnostic x-ray, and definitive medical treatment provided by an organized medical staff within the institution
- treatment facilities for Emergency Care and Surgical Services either within the institution or through a contractual arrangement with another licensed Hospital (These Contracted services must be documented by a well-defined plan and related to community needs.)

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 Disorder or Chemical Dependency care during any 24-hour period in a treatment Facility).

Intensive Outpatient Program (IOP) — Distinct levels or phases of treatment that are provided by a certified/licensed Chemical Dependency or Mental Disorder 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. 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 receive no benefits for non-Emergency services received outside the 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. See "Maternity/Reproductive Services and Newborn Care" in *Section 5: Covered Services* for more information.

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

Medical Detoxification — Treatment in an acute care Facility for withdrawal from the physiological effects of Alcohol or Drug Abuse. (Detoxification usually takes about three days in an acute care Facility.)

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

Medical Supplies — Expendable items (except Prescription Drugs) ordered by a Physician or other Professional Provider, that are required for the treatment of an illness or Accidental Injury.

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

Medicare — The program of health care for the aged, End-Stage Renal Disease (ESRD) patients and disabled persons established by Title XVIII of the Social Security Act of 1965, as amended.

Member — An enrollee (the Subscriber or any Eligible Family Member) who is enrolled for coverage and entitled to receive benefits under this Plan in accordance with the terms of the Administrative Service Agreement. Throughout this Benefit Booklet, the terms "you" and "your" refer to each Member.

Mental Disorder — A clinically significant behavioral or psychological syndrome or condition that causes distress and disability and for which improvement can be expected with relatively short-term treatment. Mental Disorder does not include developmental disabilities, Autism or Autism Spectrum Disorders, drug or Alcohol Abuse, or learning disabilities.

Morbid Obesity — A serious health condition that can interfere with a person's basic physical functions such as breathing or walking and that meets the following criteria with respect to such person's weight and/or health:

- a body mass index (BMI) equal to or greater than 40 kg/meters^2;
- a BMI equal to or greater than 35kg/meters^2 with at least one (1) of the following clinically significant -related diseases or complications that are not controlled by best practice medical management: hypertension, dyslipidemia, diabetes mellitus, coronary heart disease, sleep apnea, or osteoarthritis.

Network Service Area —The geographic area designated by BCBSNM, within which the benefits of this Plan are available to Members. This Plan accepts Members if they reside, live or work in the geographic Network Service Area. A Member may call the Customer Service Department at the number shown on the back of the Identification Card (ID) or visit the website at www.bcbsnm.com to determine if he/she is in the Network Service Area.-

Nonparticipating Provider — An appropriately licensed health care Provider that has **not** contracted directly with a BCBS Plan to be a part of the BCBS HMO-Participating Provider Network.

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 semi-rigid support that eliminates, restricts, or supports motion of a weak, injured, deformed, or diseased body part; for example, functional hand or leg brace, Milwaukee brace, or fracture brace.

OSI — The Office of Superintendent of Insurance.

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

Other Providers — Clinical Psychologists and the following masters-degreed psychotherapists (an independently licensed Professional Provider with either an M.A. or M.S. degree in psychology or counseling): Licensed Independent Social Workers (L.I.S.W.); Licensed Professional Clinical Mental Disorder Counselors (L.P.C.C.); masters-level Registered Nurse Certified in Psychiatric Counseling (R.N.C.S.); Licensed Marriage and Family Therapist (L.M.F.T.). For Chemical Dependency services, a Provider also includes a Licensed Alcohol and Drug Abuse Counselor (L.A.D.A.C.).

Out-of-Area Services — Covered Services that are provided to you when outside the BCBSNM HMO Service Area.

Out-of-Pocket Limit — The maximum total Copayments that any one *Member* will pay for basic health care services (as defined in federal and state regulations) in any Calendar Year will not exceed twice the annual premium.

Outpatient Services — Medical/Surgical Services received in the outpatient department of a Hospital, observation room, Emergency room, Ambulatory Surgical Facility, freestanding Dialysis Facility, or other covered outpatient treatment Facility.

Outpatient Surgery — Any Surgical Services that is performed in an Ambulatory Surgical Facility or the outpatient department of a Hospital, but **not** including a procedure performed in an office or clinic. Outpatient Surgery includes any procedure that requires the use of an Ambulatory Surgical Facility or an outpatient Hospital operating or recovery room.

Participating Provider — See definition of "HMO-Participating Provider," earlier in this section.

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

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

Physician — 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.

Post Service Medical Necessity Review — A review, sometimes referred to as a retrospective review or Post-Service claims request, is the process of determining coverage after treatment has already occurred and is based on Medical Necessity guidelines.

Pregnancy-Related Services — See definition of "Maternity," earlier in the section.

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

Primary Care Provider (PCP) — HMO-Participating Providers who have signed special "Primary Care Provider" agreements with BCBSNM and are listed as "PCPs" in the provider directory or online provider finder. They include family and general practice, internal medicine, obstetrics/gynecology, and pediatric health care Providers conveniently located throughout New Mexico and along the New Mexico border of neighboring states. See the definition of "Provider" for more information. Other Health Care Professionals may also provide primary care.

Prior Authorization — An advance confirmation to determine Medical Necessity, as may be required where permitted by law, for certain services to be eligible for benefits.

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

Professional Provider (Health Care Professional) — A Physician or Health Care Practitioner, including a pharmacist, who is licensed, certified, or otherwise authorized by the state to provide Health Care Services consistent with state law.

Prosthetics 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.

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.

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

Recommended Clinical Review — An optional voluntary review of a Provider's recommended medical procedure, treatment or test, that does not require Prior Authorization, to make sure it meets approved Blue Cross and Blue Shield medical policy guidelines and Medical Necessity requirements.

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

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

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

Rehabilitation Hospital — An appropriately licensed Facility that provides rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of a multidisciplinary team of Physical, Occupational, Speech, and Respiratory Therapists, medical social workers, and rehabilitation nurses to enable patients disabled by illness or Accidental Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

Rehabilitative Service — Including, but not limited to Speech Therapy, Physical Therapy and Occupational Therapy. Treatment, as determined by your Physician that must be limited to therapy which is expected to result in significant improvement in the conditions for which it is rendered, "Rehabilitative Services" must be expected to help a person regain, maintain or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, inquiry or disabling condition.

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

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

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

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

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

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

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

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

https://www.bcbsnm.com/provider/clinical/clinical-resources/preventive-care-guidelines

Service Area — BCBSNM's Service Area is the geographic area where BCBSNM is licensed to conduct business (all counties in New Mexico).

Short-Term Rehabilitation — Inpatient, outpatient, office- and home-based occupational, physical, and Speech Therapy techniques that are Medically Necessary to restore and improve lost bodily functions following illness or Accidental Injury. (This does not include services provided as part of an approved home health or Hospice Admission, which are subject to separate benefit limitations and exclusions, and does not include Alcohol or Drug Abuse rehabilitation.)

Skilled Nursing Care — Care that can be provided only by someone with at least the qualifications of a Licensed Practical Nurse (L.P.N.) or Registered Nurse (R.N.).

Skilled Nursing Facility — A Facility or part of a Facility that:

- is licensed in accordance with state or local law; *and*
- is a Medicare-Participating Facility; *and*

- is primarily engaged in providing Skilled Nursing Care to inpatients under the supervision of a duly licensed Physician; *and*
- provides continuous 24-hour nursing service by or under the supervision of a Registered Nurse; *and*
- does **not** include any Facility that is primarily a rest home, a Facility for the care of the aged, or for treatment of tuberculosis, or for intermediate, Custodial care or Educational Care.

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

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

Special Enrollment — When an otherwise Eligible Employee or Eligible Family Member did not enroll in the Plan when initially eligible, there are certain instances (or "qualifying events") during which the employee and his/her Eligible Family Members, if any, may enroll in the Plan at a later date - or more than 31 days after becoming eligible - and not considered Late Applicants. The "Special Enrollment" period is the period of time during which an otherwise Late Applicant may apply for coverage outside the annual open enrollment period.

Special Medical Foods — Nutritional substances in any form that are consumed or administered internally under the supervision of a Physician, specifically processed or formulated to be distinct in one or more nutrients present in natural food; intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs, or certain nutrients contained in ordinary foodstuffs, or who have other specific nutrient requirements as established by medical evaluation; and essential to optimize growth, health, and metabolic homeostasis. Special Medical Foods are covered only when prescribed by a Physician for treatment of genetic orders of metabolism, and the Member is under the Physician's ongoing care. Special Medical Foods are not for use by the general public and may not be available in stores or supermarkets. Special Medical Foods are not those foods included in a healthy diet intended to decrease the risk of disease, such as reduced-fat foods, low sodium foods, or weight loss products.

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 Administrative Services Agreement (e.g., COBRA members).

Summary of Benefits and Coverage (SBC) — 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.

Telemedicine — The use by a licensed health care professional, acting within the scope of their license, of interactive, simultaneous audio and video or store-and-forward technology using information and telecommunications technologies to deliver health care services at a site other than the site where the patient is

located, including the use of electronic media for consultation relating to the diagnosis or treatment of the patient in real time or through the use of store-and-forward technology.

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 — With respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a similarly situated person who is in good health.

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

Transplant-Related Services — Any hospitalizations and medical or Surgical Services related to a covered Transplant or 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.

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).

Well-Child Care — Periodic health and development assessments and screenings, immunizations, and physical exams provided to children who have no symptoms of current illness as recommended by the American Academy of Pediatrics and the U.S, Preventive Services Task Force (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.

Summary of Health Insurance Grievance Procedures

This is a summary of the process you must follow when you request a review of a decision by BCBSNM. You will be provided with detailed information and complaint forms by BCBSNM at each step. In addition, you can review the complete New Mexico regulations that control the process under the **Managed Health Care Bureau** page found under the **Departments** tab on the Office of Superintendent of Insurance (OSI) website, located at www.osi.state.nm.us. You may also request a copy from BCBSNM at:

State of New Mexico DSU, Grievance Coordinator
Mailing Address: P.O. Box 27630
Albuquerque, New Mexico 87125-7630
Telephone (toll-free): (877) 994-2583
Email: sonmcorr@bcbsnm.com
Fax: (505) 889-2601

or from OSI by calling 1-505 827-4601 or toll free at 1-855-427-5674.

What types of decisions can be reviewed?

You may request a review of two different types of decisions:

Adverse determination: You may request a review if BCBSNM has denied pre-authorization (certification) for a proposed procedure, has denied full or partial payment for a procedure you have already received, or is denying or reducing further payment for an ongoing procedure that you are already receiving and that has been previously covered. (BCBSNM must notify you *before* terminating or reducing coverage for an ongoing course of treatment, and must continue to cover the treatment during the appeal process.) This type of denial may also include a refusal to cover a service for which benefits might otherwise be provided because the service is determined to be experimental, investigational, or not medically necessary or appropriate. It may also include a denial by BCBSNM of a participant's or beneficiary's eligibility to participate in a plan. These types of denials are collectively called **"adverse determinations."**

Administrative decision: You may also request a review if you object to how BCBSNM handles other matters, such as its administrative practices that affect the availability, delivery, or quality of health care services; claims payment, handling or reimbursement for health care services; or if your coverage has been terminated.

Review of an Adverse Determination

How does pre-authorization for a health care service work?

When BCBSNM receives a request to pre-authorize (certify) payment for a healthcare service (service) or a request to reimburse your healthcare provider (provider) for a service that you have already had, it follows a two-step process.

Coverage: First, BCBSNM determines whether the requested service is covered under the terms of your health benefits plan (policy). For example, if your policy excludes payment for adult hearing aids, then BCBSNM will not agree to pay for you to have them even if you have a clear need for them.

Medical necessity: Next, if BCBSNM finds that the requested service is covered by the policy, BCBSNM determines, in consultation with a physician, whether a requested service is medically necessary. The consulting physician determines medical necessity either after consultation with specialists who are experts in the area or after application of uniform standards used by BCBSNM. For example, if you have a crippling hand injury that could be corrected by plastic surgery and you are also requesting that BCBSNM pay for cosmetic plastic surgery to give you a more attractive nose, BCBSNM might certify the first request to repair your hand and deny the second, because it is not medically necessary.

Depending on terms of your policy, BCBSNM might also deny certification if the service you are requesting is outside the scope of your policy. For example, if your policy does not pay for experimental procedures, and the service you are requesting is classified as experimental, BCBSNM may deny certification. BCBSNM might also deny certification if a procedure that your provider has requested is not recognized as a standard treatment for the condition being treated.

IMPORTANT: If BCBSNM determines that it will not certify your request for services, you may still go forward with the treatment or procedure. **However,** you will be responsible for paying the provider yourself for the services.

How long does initial certification take?

Standard decision: BCBSNM must make an initial decision within 5 working days. However, BCBSNM may extend the review period for a maximum of 10 calendar 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 your provider within the original 5 working day review period.

What if I need services in a hurry?

Urgent care situation: An **urgent care situation** is a situation in which a decision from BCBSNM is needed quickly because: **(1)** delay would jeopardize your life or health; **(2)** delay would jeopardize your ability to regain maximum function; **(3)** the physician with knowledge of your medical condition reasonably requests an expedited decision; **(4)** the physician with knowledge of your medical condition, believes that delay would subject you to severe pain that cannot be adequately managed without the requested care or treatment; or **(5)** the medical demands of your case require an expedited decision.

If you are facing an urgent care situation **or** BCBSNM has notified you that payment for an ongoing course of treatment that you are already receiving is being reduced or discontinued, you or your provider may request an expedited review and BCBSNM must either certify or deny the initial request quickly. BCBSNM must make its initial decision in accordance with the medical demands of the case, but within 24 hours after receiving the request for an **expedited** decision.

If you are dissatisfied with BCBSNM's initial expedited decision in an urgent care situation, you may then request an **expedited review** of the decision by both BCBSNM and an external reviewer called an Independent Review Organization (IRO). When an **expedited** review is requested, BCBSNM must review its prior decision and respond to your request within 72 hours. If you request that an IRO perform an expedited review simultaneously with BCBSNM's review and your request is eligible for an IRO review, the IRO must also provide its expedited decision within 72 hours after receiving the necessary release of information and related records. If you are still dissatisfied after the IRO completes its review, you may request that the Superintendent review your request. This review will be completed within 72 hours after your request is complete.

The internal review, the IRO review, and the review by the Superintendent are described in greater detail in the following sections.

IMPORTANT: If you are facing an emergency, you should seek medical care immediately and then notify BCBSNM as soon as possible. BCBSNM will guide you through the claims process once the emergency has passed.

When will I be notified that my initial request has been either certified or denied?

If the initial request is approved, BCBSNM must notify you and your provider within 1 working day after the decision, unless an urgent matter requires a quicker notice. If BCBSNM denies certification, BCBSNM must notify you and the provider within 24 hours after the decision.

If my initial request is denied, how can I appeal this decision?

If your initial request for services is denied or you are dissatisfied with the way BCBSNM handles an administrative matter, you will receive a detailed written description of the grievance procedures from BCBSNM as well as forms and detailed instructions for requesting a review. You may submit the request for review either orally or in writing depending on the terms of your policy. BCBSNM provides representatives who have been trained to assist you with the process of requesting a review. This person can help you to complete the necessary forms and with gathering information that you need to submit your request. For assistance, contact BCBSNM's as follows:

BCBSNM, State of New Mexico DSU, Appeals
P.O. Box 27630 Albuquerque, NM 87125-9815
Telephone (toll-free): (800) 205-9926
E-mail: see website at www.bcbsnm.com
Fax: (505) 816-3837

You may also contact the Managed Health Care Bureau (MHCB) at OSI for assistance with preparing a request for a review at:

Telephone: 1-(505) 827-4601 or toll free at 1-(855) 427-5674
Address: Office of Superintendent of Insurance - MHCB
P.O. Box 1689, 1120 Paseo de Peralta
Santa Fe, NM 87504-1689
FAX #: (505) 827-6341, Attn: MHCB
E-mail: mhcb.grievance@state.nm.us

Who can request a review?

A review may be requested by you as the patient, your provider, or someone that you select to act on your behalf. The patient may be the actual subscriber or a dependent who receives coverage through the subscriber. The person requesting the review is called the **"grievant."**

Appealing an adverse determination – first level review

If you are dissatisfied with the initial decision by BCBSNM, you have the right to request that the decision be reviewed by its medical director. The medical director may make a decision based on the terms of your policy, may choose to contact a specialist or the provider who has requested the service on your behalf, or may rely on BCBSNM's standards or generally recognized standards.

How much time do I have to decide whether to request a review?

You must notify BCBSNM that you wish to request an internal review within **180 days** after the date you are notified that the initial request has been denied.

What do I need to provide? What else can I provide?

If you request that BCBSNM review its decision, BCBSNM will provide you with a list of the documents you need to provide and will provide to you all of your records and other information the medical director will consider when reviewing your case. You may also provide additional information that you would like to have the medical director consider, such as a statement or recommendation from your Doctor, a written statement from you, or published clinical studies that support your request.

How long does a first level internal review take?

Expedited review. If a review request involves an urgent care situation, BCBSNM must complete an expedited internal review as required by the medical demands of the case, but in no case later than 72 hours from the time the internal review request was received.

Standard review. BCBSNM must complete both the medical director's review and (if you then request it) BCBSNM's internal panel review within 30 days after receipt of your pre-service request for review or within 60 days if you have already received the service. The medical director's review generally takes only a few days.

The medical director denied my request - now what?

If you remain dissatisfied after the medical director's review, you may either request a review by a panel that is selected by BCBSNM or you may skip this step and ask that your request be reviewed by an IRO that is appointed by the Superintendent.

- If you ask to have your request reviewed by BCBSNM's panel, then you have the right to appear before the panel in person or by telephone or have someone, (including your attorney), appear with you or on your behalf. You may submit information that you want the panel to consider, and ask questions of the panel Members. Your health provider may also address the panel or send a written statement.
- If you decide to skip the panel review, you will have the opportunity to submit your information for review by the IRO, but you will not be able to appear in person or by telephone. OSI can assist you in getting your information to the IRO.

IMPORTANT: If you are covered under the NM State Healthcare Purchasing Act, you may NOT request an IRO review if you skip the panel review.

How long do I have to make my decision?

If you wish to have your request reviewed by BCBSNM's panel, you must inform BCBSNM within **5 days** after you receive the medical director's decision. If you wish to skip panel review and have your matter go directly to the IRO, you must inform OSI of your decision within **4 months** after you receive the medical director's decision.

What happens during a panel review?

If you request that BCBSNM provide a panel to review its decision, BCBSNM will schedule a hearing with a group of medical and other professionals to review the request. If your request was denied because BCBSNM felt the requested services were not medically necessary, were experimental or were investigational, then the panel will include at least one specialist with specific training or experience with the requested services.

BCBSNM will contact you with information about the panel's hearing date so that you may arrange to attend in person or by telephone, or arrange to have someone attend with you or on your behalf. You may review all of the information that BCBSNM will provide to the panel and submit additional information that you want the panel to consider. If you attend the hearing in person or by telephone, you may ask questions of the panel Members. Your medical provider may also attend in person or by telephone, may address the panel, or send a written statement.

BCBSNM's internal panel must complete its review within 30 days following your original request for an internal review of a request for pre-certification or within 60 days following your original request if you have already received the services. You will be notified within 1 day after the panel decision. If you fail to provide records or other information that BCBSNM needs to complete the review, you will be given an opportunity to provide the missing items, *but the review process may take much longer and you will be forced to wait for a decision.*

Hint: If you need extra time to prepare for the panel's review, then you may request that the panel be delayed for a maximum of 30 days.

State of New Mexico Grievance Review Procedures

If you are not satisfied with BCBSNM's internal review decision, you may file a complaint with **STATE OF NEW MEXICO** within 30 days after BCBSNM's internal review decision. (Note: You may contact **STATE OF NEW MEXICO** at any time during the internal review process.) Upon receipt of your complaint, the **STATE OF NEW MEXICO** will review the case and respond to the parties involved within 30 days. If your situation requires expedited review, a response will be provided within 48 hours of receipt by **STATE OF NEW MEXICO** of the complaint. Your complaint should be submitted to:

General Services Department, Risk Management Division, Employee Benefits Bureau
1100 S. St. Francis Dr., Room 2073
P.O. Box 6850
Santa Fe, New Mexico 87502

Phone number: (505) 827-2036
Fax: (505) 827-2843

If I choose to have my request reviewed by the BCBSNM's panel, can I still request the IRO review?

Yes. If your request has been reviewed by the BCBSNM's panel and you are still dissatisfied with the decision, you will have **4 months** to request a review by an IRO.

What's an IRO and what does it do?

An IRO is a certified organization appointed by OSI to review requests that have been denied by an insurer. The IRO employs various medical and other professionals from around the country to perform reviews. Once OSI selects and appoints an IRO, the IRO will assign one or more professionals who have specific credentials that qualify them to understand and evaluate the issues that are particular to a request. Depending on the type of issue, the IRO may assign a single reviewer to consider your request, or it may assign a panel of reviewers. The IRO must assign reviewers who have no prior knowledge of the case and who have no close association with BCBSNM or with you. The reviewer will consider all of the information that is provided by BCBSNM and by you. (OSI can assist you in getting your information to the IRO.) In making a decision, the reviewer may also rely on other published materials, such as clinical studies.

The IRO will report the final decision to you, your provider, BCBSNM, and to OSI. BCBSNM must comply with the decision of the IRO. If the IRO finds that the requested services should be provided, then BCBSNM must provide them.

The IRO's fees are billed directly to BCBSNM – there is no charge to you for this service.

How long does an IRO review take?

The IRO must complete the review and report back within 20 days after it receives the information necessary for the review. (However, if the IRO has been asked to provide an expedited review regarding an urgent care matter, the IRO must report back within 72 hours after receiving all of the information it needs to review the matter.)

Review by the Superintendent of Insurance

If you remain dissatisfied after the IRO's review, you may still be able to have the matter reviewed by the Superintendent. You may submit your request directly to OSI, and if your case meets certain requirements, a hearing will be scheduled. You will then have the right to submit additional information to support your request and you may choose to attend the hearing and speak. You may also ask other persons to testify at the hearing. The Superintendent may appoint independent co-hearing officers to hear the matter and to provide a recommendation.

The co-hearing officers will provide a recommendation to the Superintendent within 30 days after the hearing is complete. The Superintendent will then issue a final order.

There is no charge to you for a review by the Superintendent of Insurance and any fees for the hearing officers are billed directly to BCBSNM. However, if you arrange to be represented by an attorney or your witnesses require a fee, you will need to pay those fees.

Review of an Administrative Decision

How long do I have to decide if I want to appeal and how do I start the process?

If you are dissatisfied with an initial administrative decision made by BCBSNM, you have a right to request an internal review within **180 days** after the date you are notified of the decision. BCBSNM will notify you within 3 days after receiving your request for a review and will review the matter promptly. You may submit relevant information to be considered by the reviewer.

How long does an internal review of an Administrative Decision take?

BCBSNM will mail a decision to you within 30 days after receiving your request for a review of an administrative decision.

Can I appeal the decision from the internal reviewer?

Yes. You have **20 days** to request that BCBSNM form a committee to reconsider its administrative decision.

What does the reconsideration committee do? How long does it take?

When BCBSNM receives your request, it will appoint two or more Members to form a committee to review the administrative decision. The committee Members must be representatives of the company who were not involved in either the initial decision or the internal review. The committee will meet to review the decision within 15 days after BCBSNM receives your request. You will be notified at least 5 days prior to the committee meeting so that you may provide information, and/or attend the hearing in person or by telephone.

If you are unable to prepare for the committee hearing within the time set by BCBSNM, you may request that the committee hearing be postponed for up to 30 days.

The reconsideration committee will mail its decision to you within 7 days after the hearing.

State of New Mexico Grievance Review Procedures

If you are not satisfied with BCBSNM's internal review decision, you may file a complaint with **STATE OF NEW MEXICO** within 30 days after BCBSNM's internal review decision. (Note: You may contact **STATE OF NEW MEXICO** at any time during the internal review process.) Upon receipt of your complaint, the **STATE OF NEW MEXICO** will review the case and respond to the parties involved within 30 days. If your situation requires expedited review, a response will be provided within 48 hours of receipt by **STATE OF NEW MEXICO** of the complaint. Your complaint should be submitted to:

General Services Department, Risk Management Division, Employee Benefits Bureau
1100 S. St. Francis Dr., Room 2073
P.O. Box 6850
Santa Fe, New Mexico 87502
Phone number: (505) 827-2036
Fax: (505) 827-2843

How can I request an external review?

If you are dissatisfied with the reconsideration committee's decision, you may ask the Superintendent to review the matter within **20 days** after you receive the written decision from BCBSNM or the Executive Director. You may submit the request to OSI using forms that are provided by BCBSNM. Forms are also available on the OSI website located at www.osi.state.nm.us. You may also call OSI to request the forms at (505) 827-4601 or toll free at 1-(855)-427-5674.

How does the external review work?

Upon receipt of your request, the Superintendent will request that both you and BCBSNM submit information for consideration. BCBSNM has 5 days to provide its information to the Superintendent, with a copy to you. You may also submit additional information including documents and reports for review by the Superintendent. The Superintendent will review all of the information received from both you and BCBSNM and issue a final decision within 45 days. If you need extra time to gather information, you may request an extension of up to 90 days. Any extension will cause the review process and decision to take more time.

General Information

Confidentiality

Any person who comes into contact with your personal health care records during the grievance process must protect your records in compliance with state and federal patient confidentiality laws and regulations. In fact, the provider and insurer cannot release your records, even to OSI, until you have signed a release.

Special needs and cultural and linguistic diversity

Information about the grievance procedures will be provided in accessible means or in a different language upon request in accordance with applicable state and federal laws and regulations.

Reporting requirements

Insurers are required to provide an annual report to the Superintendent with details about the number of grievances it received, how many were resolved and at what stage in the process they were resolved. You may review the results of the annual reports on the OSI website.

GENERAL INQUIRIES AND COMPLAINTS

Inquiry - A general request for information regarding claims, benefits, or membership.

Complaint - An expression of dissatisfaction by you, either orally or in writing. Issues may include, but are not limited to, claims payments or denials, quality of care, and locating a network provider.

If you have an inquiry or a concern about any Preauthorization request, claims payment, claims that have been denied or only partially paid, the quality of care you receive, the cancellation of your coverage, or any other review decisions made by BCBSNM, call the BCBSNM **STATE OF NEW MEXICO** Designated Service Unit toll free at (877) 994-2583. Many complaints or problems can be handled informally by calling, writing, or e-mailing the BCBSNM **STATE OF NEW MEXICO** Designated Service Unit. If you are not satisfied with the initial response, you can request internal review as described below.

RETALIATORY ACTION

No retaliatory action will be taken against you for making a complaint or for requesting internal or external review under this health benefits plan.

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.

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 **State of New Mexico** and Blue Cross and Blue Shield of New Mexico (BCBSNM) includes the following documents:

- this Benefit Booklet and any amendments, riders, or endorsements;
- the enrollment/change form(s) for the Subscriber and his/her dependents;
- the Members' Identification Cards; and
- the *Summary of Benefits*

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

- the Benefit Program Application from the employer; and
- the Administrative Services Agreement between BCBSNM and **State of New Mexico**.

The above documents constitute the entire legal agreement between BCBSNM and **State of New Mexico**. 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.

State of New Mexico reserves the right to amend, modify, or discontinue coverage provided for employees and their dependents. This Benefit Booklet is not an implied contract and does not guarantee benefits or employment.

BCBSNM provides administrative Claims payment services only and does not assume any financial risk or obligation with respect to Claims, except as may be specified in the Professional Services Agreement.

AMENDMENTS

BENEFIT BOOKLET
NO SURPRISES ACT AMENDMENT

Amendment Effective Date: This Amendment is effective on the Employer's Contract Anniversary Date or for the Plan Year of your Employer's Group Health Plan occurring on or after January 1, 2022.

The terms of this Amendment supersede the terms of the Benefit Booklet to which this Amendment is attached and becomes a part of the Benefit Booklet. Unless otherwise required by Federal or New Mexico law, in the event of a conflict between the terms on this Amendment and the terms of the Benefit Booklet, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to You and Your mean any Member, including Subscriber and Dependents.

The Benefit Booklet is hereby amended as indicated below:

I. PCP Selection

The Plan requires the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in our network and who is available to accept You or Your family Members.

Until you make this designation, Blue Cross and Blue Shield of New Mexico designates one for You. For information on how to select a PCP and for a list of the participating PCPs, contact BCBSNM at www.bcbsnm.com or customer service at the toll-free number on the back of Your identification card.

For Dependent children, You may designate any Participating Provider who specializes in pediatric care as their Primary Care Physician (PCP).

II. OB/GYN Care

You are not required to obtain a referral or authorization from Your Primary Care Physician (PCP) or Women's Principal Health Care Provider (WPHCP) before obtaining Covered Services from any Participating Provider specializing in obstetrics or gynecology. However, before obtaining Covered obstetrical or gynecological care, the Provider must comply with certain policies and procedures required by Your Plan, including Prior Authorization and referral policies. For a list of Participating Providers who specialize in obstetrics or gynecology, visit www.bcbsnm.com or contact customer service at the toll-free number on the back of Your identification card.

III. Continuity of Care

If You are under the care of a Participating Provider as defined in the Benefit Booklet who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), You may be able to continue coverage for that Provider's Covered Services at the Participating Provider Benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,

3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for Your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if You are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date The Plan notifies You of the Provider's termination, or any longer period provided by state law. If You are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the Benefit Booklet.

IV. Federal No Surprises Act

1. Definitions

The definitions below apply only to this No Surprises Act Amendment. To the extent the same terms are defined in both the Benefit Booklet and this Amendment, those terms will apply only to their use in the Benefit Booklet or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this Amendment only,

- a medical screening examination performed in the emergency department of a hospital or a Freestanding Emergency Department;
- further medical examination or treatment You receive at a Hospital, regardless of the department of the Hospital, or a Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until Your condition is stabilized; and

- Covered Services You receive from a Non-Participating Provider during the same visit after Your Emergency Medical Condition has stabilized unless:
    1. Your Non-Participating Provider determines You can travel by non-medical or non-emergency transport;
    2. Your Non-Participating Provider has provided You with a notice to consent form for balance billing of services; and
    3. You have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with BCBSNM for furnishing such item or service under the Plan to which this Amendment is attached.

"Non-Participating Emergency Facility" means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSNM for furnishing such item or service under the Plan to which this Amendment is attached.

"Participating Provider" means, for purposes of this Amendment only, with respect to a Covered Service, a physician or other health care provider who has a contractual relationship with BCBSNM setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Participating Facility" means, for purposes of this Amendment only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSNM setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached. Whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Qualifying Payment Amount" means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

2. <u>Federal No Surprises Act Surprise Billing Protections</u>

a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.

- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless You give written consent and give up balance billing protections).
- Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

b. Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

c. Cost-Sharing

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward Your Participating Provider Deductible and/or Out-of-Pocket Limit, if any.

3. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If You receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill You is Your in-network cost-share. You cannot be balance billed for these Emergency Services unless You give written consent and give up Your protections not to be balanced billed for services You receive after You are in a stable condition.

When You receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill You is Your Plan's in-network cost-share requirements. When You receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill You and may not ask You to give up Your protections not to be balance billed. If You get other services at Participating Facilities, Non-Participating Providers can't balance bill You unless You give written consent and give up Your protections.

If Your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill You is Your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

NOTE: The revisions to Your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal

regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.

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