BlueCross BlueShield of New Mexico

A Guide to Your Managed Health Care Program

2025 Member Handbook

bcbsnm.com/medicaid

TURQUOISECARE

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

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BlueCross BlueShield of New Mexico

Dear Member,

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

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

For more information about our company (such as its structure or operations), or to find out more about our provider network, call Member Services at **1-866-689-1523**.

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

Note: The State of New Mexico Health Care Authority may change the benefits described in this handbook. If that happens, BCBSNM will notify you within 30 calendar days. This handbook is updated yearly, and the most updated version will be mailed to you. To view this handbook electronically, you can view and download the most current version by visiting the Blue Cross and Blue Shield of New Mexico website at **bcbsnm.com/medicaid**. If you need a copy in an alternate format, call Member Services at **1-866-689-1523**.

Sincerely,

Nancy Smith-Leslie

Vice President
Blue Cross and Blue Shield of New Mexico

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Member Assistance

The New Mexico Medicaid plan is called Turquoise Care. When you have a question about Turquoise Care, call us at **1-866-689-1523**, or visit our office in Albuquerque. You do not need an appointment to visit.

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

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

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

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

24/7 Nurseline

If you can't reach your primary care provider, the 24/7 Nurseline will connect you with a nurse who can help you decide if you need to go to the emergency room or urgent care center, or if you should make an appointment with your PCP. If you think you have an urgent problem and your provider cannot see you right away, call the Nurseline for advice. Call toll-free: **1-877-213-2567**.

We also have a recorded library of more than 300 health topics available through the 24/7 Nurseline.

Non-Emergency Transportation

To request a ride to a scheduled appointment, contact ModivCare™ as follows:

- Search for and download the ModivCare app from Google Play or the Apple App Store
- Call the ModivCare™ reservation line at **1-866-913-4342** Monday through Friday from 8 a.m. to 5 p.m.

Contact ModivCare at least three working days before your visit. To return home or to arrange a ride after hours (such as for urgent care), call the Ride Assist phone line. You can call **1-866-418-9829** toll-free, 24 hours a day, seven days a week. You can read about ModivCare in **Section 4G: Transportation Benefits**.

ModivCare is an independent company that provides transportation services for Blue Cross and Blue Shield of New Mexico members.

BCBSNM Website, Unified Mobile App and Email

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

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

- Review your member handbook
- Search for health care providers that participate with BCBSNM for Turquoise Care - doctors, hospitals, others
- Submit a request to change your PCP
- Read frequently asked questions about your health plan
- Find health and wellness information
- Search for a pharmacy and for drugs that are covered by your health plan and learn about generic drugs
- Access past and current prescriptions and clinical review history
- Request a new ID card or access your digital ID card
- Download forms
- Find Internet links to other services, important phone numbers and email addresses
- Email BCBSNM a question or communicate with us via two-way, secure messaging

To check out our online features and programs, log in to BAM℠. If you have never logged in to BAM, click 'Create an Account' in the login box. Then follow the steps to register.

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

If you have questions about your Blue Cross and Blue Shield of New Mexico health plan, call Member Services at **1-866-689-1523**.

Blue for Your Health℠

The Blue Cross and Blue Shield of New Mexico newsletter, called *Blue for Your Health*, is available online through the BAM portal and on our public website. The newsletter is posted once a quarter (every three months). If you do not have access to the internet, you can request a paper copy by calling Member Services at **1-866-689-1523** (TTY: **711**).

What to do in an Emergency

If there is a need for cardiopulmonary resuscitation, or there is an immediate threat to your life or safety, call **911**. If there is no need to call **911**, go to the nearest hospital or emergency room. For members who are experiencing a mental health crisis or emergency, call **988**. Prior authorization is not needed for emergency services. You should call your PCP as soon as possible after receiving care to arrange follow-up services. Go to **Section 4A: Physical Health Benefits** for details on getting emergency care. Do not use the emergency room in a non-emergency situation. If you are a member receiving services at a Core Service Agency, you may also use your crisis plan for further instructions and contact your CSA crisis line. Before an emergency arises, contact your assigned care coordinator and ask about a personal crisis plan.

Interpreter Services

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

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

Deaf, hard-of-hearing and speech-disabled callers may use the New Mexico Relay Network. Dialing **711** connects the caller to the Health Care Authority/Medical Assistance Division transfer relay service for TTY and voice calls.

Contacting Member Services

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

Writing to Member Services

Send your question to:

Blue Cross and Blue Shield of New Mexico
Medicaid
PO Box 650712
Dallas, TX 75265-0712

How We Can Help

Whether you call, write, email or visit BCBSNM, Customer Advocates can help with:

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

After-Hours Help

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

- Leave a message for us to call you back on the next business day
- Leave a message saying you have a complaint or appeal
- Get the phone number for 24/7 Nurseline to talk to a nurse if you have a health problem

Ombudsman Specialist

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

The Ombudsman can help you:

- Address your concerns about services or benefits you feel should be covered but were denied
- Understand or clarify your rights and responsibilities and the covered services that are available to you
- Reach appropriate BCBSNM personnel
- Understand the pros and cons of your options and BCBSNM policies and procedures to help you get the most out of your health care benefits

You can reach the Ombudsman Specialist by phone or email:

Toll Free: **1-888-243-1134** TTY: **711**
Email: **ombudsman@bcbsnm.com**

Community Social Services

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

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

Health Education and Health Literacy

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

- Health education classes near you
- How to talk to your provider or nurse during your visits
- Programs to manage diabetes, asthma or tobacco cessation
- How the case management program can help when you need care

- How to set up a Virtual Visit with doctors and therapists for certain non-emergency conditions like allergies, asthma, cold/flu, ear infections, online counseling and stress management

Log in to BAM to:

- Read the health newsletter
- Find wellness guidelines and health topics
- Sign up for text messages to be sent to your cell phone and email. These messages will give you information about diabetes, asthma, heart health and fitness. You can also choose to get prescription drug reminders.

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

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

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

Member Feedback

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

Member Advisory Board

The Member Advisory Board (MAB) is a team of Blue Cross and Blue Shield of New Mexico members and staff who meet six times a year to discuss your benefits and ways to improve services. You can learn about program benefits and provide valuable feedback about your experience as a BCBSNM member..

You may receive an email or a phone call inviting you to join us for a meeting. Call or write and let us know you want to join. To learn more about MAB or to make a reservation, call **1-866-825-6034** (TTY: **711**) or email: **bcbs_ab@bcbsnm.com**. Visit our website at **bcbsnm.com/medicaid** and check under Upcoming Events.

Member Rights and Responsibilities

Member Rights

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

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

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

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

Member and Member Representative Responsibilities

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

As a member of Turquoise Care, you have the responsibility to:

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

Section 1: Enrollment

Managed Care Program Participation

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

Selecting a Managed Care Organization

You can choose an MCO when you apply for Medicaid coverage at your local ISD office or at the state's website, YESNM (**www.yes.nm.gov**).

Auto Assignment

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

Lock-In Period

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

Recertification

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

Coverage Due to Being Pregnant

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

Newborns

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

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

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

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

ID Cards

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

If you need to order a replacement Turquoise Care ID card, go to **bcbsnm.com/medicaid**, log in to BAM, and request a new member ID card. Or call Member Services at **1-866-689-1523**. Your replacement member ID card will be sent to you within 10 calendar days of ordering it. If you need services before your member ID card arrives, log in to BAM and print a temporary member ID. You can also access your digital ID card in BAM. If you have never logged in to BAM before, follow the steps to register for BAM.

Change in Eligibility and/or Address

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

When to Contact Your Local ISD Office

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

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

Section 2: Native Americans

Prior Authorizations

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

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

Care Coordinator

You can ask to be assigned to a Native American care coordinator.

Native American Advisory Board

The Native American Advisory Board (NAAB) is a team of Blue Cross and Blue Shield of New Mexico members and staff who meet four times a year to discuss your benefits and ways to improve services. You can learn about your rights and responsibilities as a member and provide feedback on member information.

You may receive an email or a phone call inviting you to join us for a meeting. Call or write and let us know you want to join. To learn more about NAAB or to make a reservation, please call **1-866-825-6034** (TTY: **711**) or email: **bcbs_ab@bcbsnm.com**. Visit our website at **bcbsnm.com/medicaid** and check under Upcoming Events.

Section 3: Providers

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

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

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

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

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

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

Provider Directory and Provider Finder®

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

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

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

Primary Care Provider

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

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

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

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

Choosing a PCP

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

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

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

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

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

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

Changing Your PCP

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

- If you call on or before the 20th of the month, the PCP change will be effective the first day of the next month.
- If you call on or after the 21st of the month, the PCP change will be effective the first day of the second following month.
- We will mail you a new ID card with the name of your new PCP. Your legal guardian or representative can request this change as well. You can begin seeing your new PCP right away. You do not have to wait for your new ID card.
- You can also go online and request to change your PCP. Just log in to BAM. Under My Health, go to the Find Care section. Follow the steps to change your PCP.

Medicare PCP Selection

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

PCP Lock-In

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

Specialists

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

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

Specialist PCP

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

Virtual Care

If it's hard to visit your doctor in person, virtual care is an option. Do you need urgent care right now? Or do you need access to a virtual PCP to help with health care? Virtual care saves time – you won't have to travel to a doctor's office. No matter where you live in New Mexico, you can get access to more doctors online.

There are two ways to access virtual care:

Virtual PCP by Galileo®*

Virtual PCP lets you to set up online visits for routine care or when issues come up. A PCP will focus on your health and wellness. They can coordinate care with other providers when needed. Members 18 years and older have access to:

- A U.S. board-certified PCP who will get to know you and your medical history.
- A care team to work with you on a plan to meet your personal health care needs.
- Unlimited online messaging 24/7 with your virtual care team.
- Annual wellness exams.
- Help to manage chronic health conditions.
- Requesting lab tests or medications..

Virtual Visits by MDLIVE®**

With Virtual Visits, you can speak with a board-certified doctor or therapist 24 hours a day, seven days a week for urgent care. Instead of going into a doctor's office, you can talk with a doctor or therapist while at home, work or many other places. Your live visit can happen using online video or a mobile app. A virtual visit can cost less than going to an urgent care center or emergency room. You can get help with many non-emergency conditions.

- **Urgent Care** for illness and injuries. You can talk about treatment options for:
  - Allergies
  - Cold and flu
  - Ear pain
  - Insect bites
  - Sinus problems
  - Sore throat
  - and more
- **Mental Health Care** for talk therapy from the privacy of home. Get help dealing with:
  - Addictions
  - Anxiety
  - Depression
  - Grief and loss
  - Panic disorders
  - Trauma and PTSD
  - and more

Learn more about Virtual PCP and Virtual Visits on **bcbsnm.com/medicaid**. Go to *Getting Care* and choose *Virtual Care*.

PCP Terminations

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

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

Referrals

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

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

Out-of-Network Providers

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

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

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

Filing Claims for In-Network Providers

All Turquoise Care providers file claims to BCBSNM. BCBSNM makes payments directly to your providers. Be sure these providers know you have Turquoise Care coverage. Do not file claims for in-network services yourself. Contact Member Services at **1-866-689-1523** for assistance with any billing you may have received from a provider.

Making an Appointment

Follow these steps to make an appointment:

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

If you go to a provider's office without an appointment, the provider may not be able to see you. Call your provider before you go to their office.

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

Transportation to Appointments

If you do not have a car or anyone to give you a ride, you may be eligible for transportation to your non-emergency medical, behavioral and long-term care appointments. ModivCare coordinates all non-emergency transportation for Turquoise Care members. This includes food and lodging expenses when you have to travel a long distance to get covered medical care.

Call ModivCare at least three working days before your routine appointment to schedule a ride. More information about ModivCare is provided in the section regarding non-emergency transportation services. Go to **Section 4: Covered and Non-Covered Benefits** for more information on transportation services.

Second Opinions

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

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

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

Cancelling an Appointment

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

Call your provider's office if you are going to be late. You may be asked to schedule a new time for your visit.

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

Always Talk to Your Doctor

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

Section 4: Covered and Non-Covered Benefits

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

You must use Turquoise Care network providers except in these situations:

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

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

Prior Authorization

What is a prior authorization? Not all services are automatically covered. Prior authorization means that BCBSNM can approve or deny coverage before you receive the service. If you go to a provider in the Turquoise Care network, the provider will ask BCBSNM for you. If BCBSNM does not fully approve coverage, you can file an appeal. Go to **Section 7: Grievances (Complaints)**.

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

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

*Contracted providers within 100 miles of the New Mexico border (Mexico excluded) are not considered out-of-state providers.

Times You May Have to Pay for Services

There may be times when Turquoise Care will not pay for services you received. You may have to pay for services in these situations:

- If you do not tell the provider that you are covered by Turquoise Care
- If you agree to pay for non-covered services in writing with your provider

Providers cannot bill you for charges when they don't follow Turquoise Care procedures. If you cannot pay for services that were not covered, you will not lose your Medicaid benefits.

Other Insurance

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

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

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

If this happens, Health Care Authority has the following rights:

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

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

If you have a care coordinator, they will work with your primary insurance to help set up your health care. If you do not have a care coordinator, call Member Services at **1-866-689-1523**, and they will be able to help.

If you have both Medicare and Turquoise Care, Medicare Part D will cover most of your drugs. You will still have to pay Medicare Part D copays unless you live in a nursing facility. If you have Medicare, you can use your current provider. You can get Medicare specialty services without approval from BCBSNM. We will work with your provider for the services you get. We can help you pick a provider if you do not have one. This provider can set up your Turquoise Care and Medicare services. Turquoise Care may cover some services that are not covered by Medicare.

Outside New Mexico

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

Duplicate (Double) Coverage

Turquoise Care does not cover amounts already paid when members have other sources of coverage that are legally liable. These may include private insurance, Medicare or other public programs. If you have any other health care coverage, you must let us know.

Experimental, Investigational or Unproven Services

Turquoise Care does not cover any treatment, procedure, facility, equipment, drug, device or supply not accepted as standard medical practice. Standard medical practice means the services or supplies that are in general use in the medical community in the United States, and:

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

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

With one exception, Turquoise Care also does not cover any treatment, procedure, facility, equipment, drug, device or supply not accepted as standard medical practice that is considered experimental, investigational or unproven. The one exception is for certain services in qualifying cancer trials per HCA rules. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted when services were administered, the service is experimental and will not be covered. To be considered experimental, investigational or unproven, one or more of the following conditions must be met:

- The device, drug or medicine cannot be marketed lawfully without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the device, drug or medicine is furnished.
- Reliable evidence shows that the treatment, device, drug or medicine is the subject of ongoing phase I, II, III or IV clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its capability or its capability as compared with the standard means of treatment or diagnosis.
- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity or its efficacy as compared with the standard means of treatment or diagnosis.
- The guidelines and practices of Medicare, the FDA or other government programs or agencies may be considered in a determination; however, approval by other bodies will neither constitute nor necessitate approval by BCBSNM.

- Reliable evidence means only published reports and articles in authoritative peer-reviewed medical and scientific journals; the written protocol or protocols used by the treating facility, or the protocol(s) of another facility studying mainly the same medical treatment, procedure, device or drug; or the written informed consent used by the treating facility or by another facility studying mainly the same medical treatment, procedure, device or drug.

If you disagree with BCBSNM's decision regarding any item or service, you may file an appeal. Go to **Section 7: Grievances (Complaints)**.

No Effect on Treatment Decisions

Benefit decisions by BCBSNM (like prior authorizations) are different from treatment decisions by you and your health care providers. At times, providers may use clinical practice guidelines to inform their treatment recommendations. You can request these guidelines by calling Member Services at **1-866-689-1523** (TTY: **711**). Regardless of any benefit decision, the final decision about your care and treatment is between you and your health care provider.

Utilization Management

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

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

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

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

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

Medically Unnecessary Services

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

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

BCBSNM determines whether a service or supply is medically necessary and whether it is covered. Because a provider prescribes, orders, recommends or approves a service or supply,

does not make it medically necessary or make it a covered service, even if it is not specifically listed as an exclusion.

This plan does not cover cannabis. Cannabis means all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or its resin. Cannabis with THC as an active ingredient may be called marijuana.

Cosmetic Services

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

This coverage exclusion may not apply to certain services for members who meet the eligibility requirements listed in the Gender Affirming Care section of this handbook.

Gender Affirming Care

Turquoise Care covers gender affirming care services that meet the Health Care Authority's rules for coverage.

Member Eligibility Requirements:

- Requirements and indications must be documented in the member's medical record.
- Members **must** have a diagnosis of gender dysphoria.
- Age: Members twelve years to seventeen years of age are eligible for hormone therapy only.
- Members eighteen years of age and older are eligible for hormone therapy, procedural and surgical interventions.
- Members 18 years of age or older undergoing procedural or surgical intervention should be living within their preferred gender (which includes non-binary) for at least one year.

Covered Services: Services, depending on age (see eligibility requirements above), include:

- Pubertal blockage for youth
- Masculinizing and feminizing hormone therapy
- Facial feminization/masculinization surgery
- Top surgery including chest reduction and breast augmentation
- Bottom surgery including vaginoplasty hysterectomies, metoidioplasty and orchiectomy
- Uterine ablation
- Hair removal including electrolysis and laser hair removal
- Voice and communication training

No Legal Payment Obligation

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

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

Section 4A: Physical Health Benefits

Preventive Services

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

Well Child Visits

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

Your PCP will guide you if more services are needed.

Early and Periodic Screening, Diagnostic and Treatment

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

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

Exams may include vaccinations or shots. If your child has not had a checkup this year, call the provider and schedule one.

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

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

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

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

Adults

There are recommended health screenings for both men and women. Women age 40 through 74 should have a mammogram every one to two years to screen for breast cancer. If you need help finding a screening center, talk with your health care provider or call BCBSNM Member Services at **1-866-689-1523** (TTY: **711**). Men and women ages 45 to 50 and older should be screened for colon cancer. These are just a few of the necessary screenings.

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

Medical/Surgical Services

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

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

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

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

The following services are covered when medically necessary:

Service	Standard Medicaid Plan Covered Service	ABP Covered Services	Prior Authorization Required
Allergy care, including tests and serum	✓	✓	Dependent on exact service
Anesthesia Services	✓	✓	No
Bariatric surgery	✓	Lifetime limit	Yes
Breast pumps and replacement supplies	✓	✓	No
Cancer clinical trials	✓	✓	Dependent on exact service
Chemotherapy and radiation therapy	✓	✓	Dependent on exact service

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

Service	Standard Medicaid Plan Covered Service	ABP Covered Services	Prior Authorization Required
Chiropractic services			
Community Interveners for Deaf and Blind	✓	✓	Yes
Covered services provided in school-based health clinics	✓	✓	No
Hemodialysis	✓	✓	Yes, if more than three times a week
DME and supplies	✓	✓ Limits apply	Call Member Services
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening	✓	✓ Age limited	No
Emergency dental care	✓	✓	No
Emergency services	✓	✓	No
EPSDT personal care services	✓	✓ Age limited	Yes - if your child is disabled, he or she may qualify for more services; call Member Services and ask to speak with a care coordinator/case manager for more information
EPSDT private duty nursing	✓	✓ Age limited	Yes - if your child is disabled, he or she may qualify for more services; call Member Services and ask to speak with a care coordinator/case manager for more information
EPSDT rehabilitation services	✓	✓ Age limited	Yes - if your child is disabled, he or she may qualify for more services; call Member Services and ask to speak with a care coordinator/case manager for more information
Family planning	✓	✓	No
Ground and air ambulance	✓	✓	Ground - No Air - No
Hearing services and devices	✓	Age limited	Yes
Home birthing	✓	✓	Dependent on exact service
Home health care and intravenous services	✓	✓ Limits apply	Yes
Hospice services	✓	✓	Yes

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

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

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

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

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

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

Non-Covered Medical Services

Turquoise Care does not cover the following medical services:

- Abdominoplasty
- Acupuncture, massage therapists, hypnotherapy, rolfing or biofeedback
- Blepharoplasty (unless necessary to restore unobstructed vision)*
- Brow lift
- Calf implants
- Cheek implants
- Chin or nose implants*
- Cosmetic services, including plastic surgery, wigs, hairpieces or medications for hair loss
- Duplicate equipment, except for backup ventilator
- External penile prosthesis (vacuum erection devices)
- Face lift (rhytidectomy)
- Facial bone reconstruction sculpturing/reduction, includes jaw shortening, forehead lift or contouring*
- Hair removal (may include donor skin sites) or hair transplantation (electrolysis or hairplasty)
- Infertility services and treatments
- Laryngoplasty
- Lip reduction or lip enhancement

- Liposuction/lipofilling or body contouring or modeling of waist, buttocks, hips and thighs reduction
- Medical services provided to a person who is an inmate of a public institution for more than 30 days
- Neck tightening
- Panniculectomy (unless necessary to restore appropriate hygiene following significant weight loss)
- Pectoral implants
- Personal care items, like toothbrushes or television sets in hospital rooms
- Private room expenses, unless your medical condition requires isolation and charges are preauthorized by BCBSNM
- Reduction thyroid chondroplasty or trachea shaving (reduction of Adam's apple)
- Redundant/excessive skin removal
- Reproductive services including but not limited to procurement cryopreservation/freezing, storage/banking and thawing of reproductive tissues, such as oocytes, ovaries, embryos, spermatozoa and testicular tissue
- Reversal of a voluntary sterilization
- Rhinoplasty (nose correction)*
- Services received outside the United States, including emergency services
- Skin resurfacing
- Some durable medical equipment and supplies (Turquoise Care suppliers of these services know what is covered by Medicaid and what needs prior authorization)
- Temporomandibular joint or craniomandibular joint treatment
- Testicular expanders*
- Voice modification surgery and/or voice (speech) therapy or voice lessons*

*Services marked with an asterisk may be eligible for coverage consistent with the Gender Affirming Care section of this handbook.

Family Planning Services

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

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

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

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

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

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

Pregnancy-Related and Maternity Services

Once you are sure you are pregnant, you may choose either your PCP or another Turquoise Care network provider to provide maternity care.

The care of a pregnant mother is important and the mother's health can affect the health of her newborn. When you call, we will:

- Help you choose a primary OB/GYN provider or certified nurse midwife for your pregnancy
- Help you enroll in a Care Coordination program
- Help you choose a PCP for your baby (if your baby is eligible for Turquoise Care coverage)

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

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

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

Prenatal Care

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

- Give you information about childbirth classes
- Tell you how often you need to visit your provider or midwife after your first visit. Usually you will visit your provider or midwife every four weeks until you are about six months pregnant. Then you will visit your provider or midwife every two weeks until your last month. You will continue visiting your provider or midwife every week during the last month
- Schedule routine lab work and other tests that will check the health of you and your baby
- Let you know about good nutrition, exercise, the dangers of smoking, alcohol/drug use and other behavior, and give you information about vitamins, breast feeding, infant safety car seats and cribs
- Ask you to return to see your provider for a postpartum visit between seven and 84 days after you have your baby
- Help you in the future with family planning (such as birth control)
- Talk to you about preventing sexually transmitted infections (STIs), flu shots during pregnancy and whether or not to get a rubella shot after delivery

Birthing Options Program

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

If you choose a midwife for at-home or birthing center delivery, it is your right and responsibility to:

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

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

Medicaid Home Visiting Program

Eligible pregnant and postpartum mothers and their infants may qualify to participate in Home Visiting. This program provides services that promote maternal, infant and early childhood health and development.

Home Visiting helps families raise happy, healthy children by providing education, support, screenings and resources. Families will learn about pregnancy, child development, parent-child bonding, support services in the community, safety, ways to promote learning through play and everyday interactions and more.

Call **1-888-421-7781** (TTY: **711**) or email **CHV@bcbsnm.com** to learn more about Home Visiting.

Living365® for Pregnancy and Postpartum

The Virtual Heath Partners (VHP) app gives you the flexibility to chat with registered dieticians 24/7 with access to meal plans during pregnancy, hospital checklists, infant safety, mental and emotional health, feeding your baby, cooking demos, fitness classes, postpartum workouts, exercising with kids, and monitoring tools. You may have access to live, one-on-one virtual appointments with a dietician based on additional risk factors.

Register by going to **https://virtualhealthpartners.com/living-365-nm-ty/** or calling Member Services at **1-866-689-1523**.

Hospital Services

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

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

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

Urgent Care Services

Urgent care is needed for sudden illnesses or injuries that are not life-threatening. If you can wait a day or more to receive care without putting your life or a body part in danger, you may not need urgent care. If you do not know if your condition is urgent, call the 24/7 Nurseline for advice.

If you think you need urgent care, choose any of the following steps:

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

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

Emergency Medical Conditions

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

Emergency Services

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

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

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

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

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

What to do in an Emergency

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

What is Not an Emergency

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

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

Emergency Room and Ambulance Services

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

Observation Stays in the Hospital

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

Follow-Up Care

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

What is Not Covered for Emergency Care

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

Section 4B: Behavioral Health Benefits

Behavioral Health Benefits

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

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

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

Learn to Live

The Learn to Live platform is a no cost, online health program. It is offered to members 13 and older and caregivers. Learn to Live gives self-paced mental health solutions plus access to 24/7 member coaches. It can help with common challenges including stress, anxiety, depression and substance abuse. To start, register at **www.learntolive.com/welcome/bcbsnmmedicaid**. (Access Code: NMMED).

Learn to Live provides educational behavioral health programs. Members considering further medical treatment should consult with a physician. Learn to Live, Inc. is an independent company that provides online behavioral health programs and tools for members with coverage through Blue Cross and Blue Shield of New Mexico. BCBSNM makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

Behavioral Health Service	Standard Medicaid Plan Covered Service	ABP Covered Services	Behavioral Health Age	Prior Authorization Required
Accredited Residential Treatment Center Services for Adults with Substance Use Disorders	✓	✓	18 years and older	Yes
Accredited Residential Treatment Center Services for Youth	✓	✓	Under age 21	Yes
Applied Behavior Analysis (ABA)	✓	✓	12 months and older	Yes*
Assertive Community Treatment	✓	✓	18 years and older	No
Behavior Management Services	✓	✓	Under age 21	No
Cognitive Enhancement Therapy	✓	✓	18 years and older	No
Comprehensive Assessments	✓	✓	All ages	No
Comprehensive Community Support Services (CCSS)	✓	✓	All ages	No
Crisis Intervention	✓	✓	All ages	No
Crisis Triage Centers	✓	✓	14 years and older	No
Day Treatment	✓	✓	Under age 21	No
Dialectical Behavior Therapy (DBT)	✓	✓	All ages	No

Note: This is not a comprehensive list of services. These services are covered when medically necessary. Other terms, conditions and/or limitations may apply. Please contact Member Services at 1-866-689-1523 for any benefit questions.

*For Adaptive Behavior Treatment by Protocol (97153) and Adaptive Behavior Treatment with Protocol Modification (0373T)

†Per the Behavioral Health Level of Care Guidelines, ECT services for members under age 13 require a court order

Behavioral Health Service	Standard Medicaid Plan Covered Service	ABP Covered Services	Behavioral Health Age	Prior Authorization Required
Electroconvulsive Therapy		✓	14 years and older†	No
Emergency Services	✓	✓	All ages	No
Eye Movement Desensitization and Reprocessing (EMDR)	✓	✓	All ages	No
Family Peer Support Services	✓	✓	All ages	No
Family Support (Behavioral Health)	✓	✓	All ages	No
Functional Family Therapy (FFT)	✓		11–18 years old	No
Group Home	✓	✓	Under age 21	Yes
High Fidelity Wraparound (HFW)	✓		Children and Youth	No
Inpatient Psychiatric Service	✓	✓	All ages	Yes
Inpatient Substance Abuse Services	✓	✓	All ages	Yes
Integrated Care and Interdisciplinary Teaming	✓	✓	All ages	No
Intensive Outpatient Programs for Mental Health and Substance Use Disorders	✓	✓	11 years and older	No

Note: This is not a comprehensive list of services. These services are covered when medically necessary. Other terms, conditions and/or limitations may apply. Please contact Member Services at 1-866-689-1523 for any benefit questions.

*For Adaptive Behavior Treatment by Protocol (97153) and Adaptive Behavior Treatment with Protocol Modification (0373T)

†Per the Behavioral Health Level of Care Guidelines, ECT services for members under age 13 require a court order

Behavioral Health Service	Standard Medicaid Plan Covered Service	ABP Covered Services	Behavioral Health Age	Prior Authorization Required
Medication Assisted Treatment: Buprenorphine for Opioid Use Disorder	✓	✓	All ages	No
Multi-Systemic Therapy	✓	✓	Ages 10 to 18	No
Non-Accredited Residential Treatment Center Services for Youth	✓	✓	Under age 21	Yes
Opioid Treatment Program	✓	✓	All ages	No
Outpatient Crisis Stabilization Center	✓	✓	14 years and older	No
Outpatient Professional Services	✓	✓	All ages	No
Partial Hospitalization	✓	✓	5 years and older	Yes, requires prior authorization beyond 45 days
Peer Support Services	✓	✓	All ages	No
Psychological/Neuropsychological Testing	✓	✓	All ages	No
Psychosocial Rehabilitation (PSR) Program	✓	✓	18 years and older	No
Recovery Services	✓	✓	All ages	No

Note: This is not a comprehensive list of services. These services are covered when medically necessary. Other terms, conditions and/or limitations may apply. Please contact Member Services at 1-866-689-1523 for any benefit questions.

*For Adaptive Behavior Treatment by Protocol (97153) and Adaptive Behavior Treatment with Protocol Modification (0373T)

†Per the Behavioral Health Level of Care Guidelines, ECT services for members under age 13 require a court order

Behavioral Health Service	Standard Medicaid Plan Covered Service	ABP Covered Services	Behavioral Health Age	Prior Authorization Required
Respite Care	✓	✓	Under age 21	Yes, for services beyond 30 days or 720 hours in a calendar year
Screening, Brief Intervention, Referral to Treatment (SBIRT) Services	✓	✓	Age 11 and older	No
Smoking Cessation	✓	✓	All ages	No
Standard Office Visits to Mental Health Specialists (which could include counselors, social workers, psychiatrists or psychologists)	✓	✓	All ages	No
Subacute Residential Treatment Center for Youth	✓	✓	Under age 21	Yes
Supportive Housing	✓	✓	All ages	No
Telemedicine Services	✓	✓	All ages	No
Trauma-Focused Cognitive Behavior Therapy (TF-CBT)	✓		Under age 18	No
Treat First	✓	✓	All ages	No
Treatment Foster Care	✓	✓	Under age 21	Yes

Note: This is not a comprehensive list of services. These services are covered when medically necessary. Other terms, conditions and/or limitations may apply. Please contact Member Services at 1-866-689-1523 for any benefit questions.

*For Adaptive Behavior Treatment by Protocol (97153) and Adaptive Behavior Treatment with Protocol Modification (0373T)

†Per the Behavioral Health Level of Care Guidelines, ECT services for members under age 13 require a court order

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

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

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

What is Not Covered for Behavioral Health Benefits

Non-covered services are the services not paid for by Turquoise Care. These services are paid for by you. Call Member Services at **1-866-689-1523** to learn if a service is covered or not covered.

Turquoise Care does not cover the following behavioral health services:

- Activity therapy, group activities and other services that are primarily recreational in nature
- Biofeedback
- Conditions that do not meet the standard of medical necessity as defined in Turquoise Care rules
- Educational or vocational services related to traditional academic subjects or vocational training
- Experimental or investigational procedures, technologies or non-drug therapies and related services
- Hypnotherapy
- Services for which prior authorization is required but was not obtained
- Services provided by a behavioral health practitioner who is not in compliance with Turquoise Care rules or renders services outside their scope of practice
- Services not considered medically necessary for the condition of the eligible recipient
- Treatment greater than 15 days a month in Institutions for Mental Disease (IMD) for members between the ages of 22 and 64
- Treatment of intellectual disabilities alone

Certified Peer Support Workers

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

Call Care Coordination at **1-877-232-5518** and select option 3 for information on how to contact a behavioral health CPSW or wellness center.

Section 4C: Long-Term Care and Community Benefits

Long-Term Care and Community Benefits

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

If your care requires it, coverage is available for nursing facilities and swing bed hospital services. Prior authorization is required. If you live in a nursing home and want to move out, we want to help you find a place that is right for you.

Call your care coordinator to learn more about the Community Benefit. This benefit offers the same needed care services at home for members who are eligible for nursing facility services.

You may be eligible for the Community Benefit based on Medicaid eligibility requirements or your medical needs and program availability as determined by HCA/MAD.

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

If you are eligible for the Community Benefit, you will participate in the Agency-Based Community Benefit (ABCB) and after a minimum of 120 days have the option to switch to the Self-Directed Community Benefit.

Choosing the Right Nursing Home

Finding the best nursing home for you is important. Consider different things to get the best care.

Start by looking at places near you. Check their ratings online using the links below. Find nursing homes that have a good standing for:

- giving safe care
- keeping clean spaces
- hiring kind and experienced staff

Visit in person to see what they are like. Be sure to ask questions about their services and workers. They can also share information with you about activities offered at their nursing home.

To help find a good nursing home, you can visit:

1. New Mexico Department of Health- Nursing Home Search: **https://www.nmhealth.org/about/dhi/hflc/prop/srep/**
2. CMS's Nursing Home Comparison website: **https://www.medicare.gov/care-compare/?redirect=true&providerType=NursingHome**

Community Benefit Services

A list of services available for the Community Benefit is included in the table below. Please remember that some of these services are only covered for agency-based community benefits and some for self-directed community benefits. The "✓" in the column will tell you if the service(s) are covered for ABCB, SDCB or both. To learn more about prior authorizations, go to **page 22** of this handbook. For a description of services, go to page 46.

Service	ABCB	SDCB	Prior Authorization Required	Details
Adult Day Health	✓		Yes	
Assisted Living	✓		Yes	These services will not be covered for individuals in Assisted Living Facilities: Personal Care, Respite Environmental Modifications, Emergency Response or Adult Day Health. The Assisted Living Program is responsible for all of these services at the Assisted Living Facility.
Behavioral Support Consultation	✓	✓	Yes	
Community Transition (community reintegration members only)	✓		Yes	Limit: Coverage for these services is limited to $4,000 per person every five years. Deposits for Assisted Living Facilities are limited to a maximum of $500. To be eligible for this service, the person must have a nursing facility stay at least 90 days prior to transition into the community.
Customized Community Supports		✓	Yes	
Emergency Response	✓	✓	Yes	
Employment Supports	✓	✓	Yes	
Environmental Modification	✓	✓	Yes	Limit: Coverage for these services is limited to $6,000 every five years.
Home Health Aide	✓	✓	Yes	
Nutritional Counseling	✓	✓	Yes	
Personal Care Services (consumer-directed and consumer-delegated)	✓		Yes	
Private Duty Nursing Services for Adults (RN or LPN)	✓	✓	Yes	

NOTE: There is an annual cost limit for Community Benefits. It is set by HCA. Your Comprehensive Needs Assessment will decide your cost of care for Community Benefits. If the cost from your Comprehensive Needs Assessment is greater than the annual cost limit from HCA, BCBSNM is not required to pay more than the limit from HCA.

Service	ABCB	SDCB	Prior Authorization Required	Details
Related Goods (phone, internet, printer, etc.)		✓	Yes	Limit: Coverage is limited to $2,000 every year (this is separate from the one-time funding for start-up goods). Experimental or prohibited treatments and goods are not covered.
Respite (short-term or temporary care)	✓	✓	Yes	Limit: Coverage is limited annually to 300 maximum hours per care plan year.
Respite RN	✓	✓	Yes	Limit: Coverage is limited annually to 300 maximum hours per care plan year. Additional hours may be requested if an eligible member's health and safety needs exceed the specified amount. Nursing respite services must not be provided by a member of the member's household or by any relative approved as the employed caregiver.
Self-Directed Personal Care (Homemaker)		✓	Yes	
Skilled Maintenance Therapy Services (occupational, physical and speech therapy)	✓	✓	Yes	A signed therapy referral for treatment notice must be provided from the member's Primary Care Provider.
Specialized Therapies (acupuncture, biofeedback, chiropractic, cognitive rehabilitation therapy, hippotherapy, massage therapy, naprapathy, Native American healers)		✓	Yes	Limit: Coverage is limited to $2,000 every year for all combined therapy services (Value-Added Services have separate limits).
Start-up Goods		✓	Yes	Limit: One-time coverage up to $2,000
Transportation - Non-Medical		✓	Yes	Limit: Only vehicle mileage and bus/taxi passes are covered. Coverage is limited to a total of $1,000 every year for vehicle mileage and bus/taxi passes. Not a covered service for minors. Limited to a 75-mile radius of the member's home.

NOTE: There is an annual cost limit for Community Benefits. It is set by HCA. Your Comprehensive Needs Assessment will decide your cost of care for Community Benefits. If the cost from your Comprehensive Needs Assessment is greater than the annual cost limit from HCA, BCBSNM is not required to pay more than the limit from HCA.

Community Benefit Services Descriptions

Adult Day Health: Day programs in the community where members can enjoy activities such as making art, exercising or visiting others.

Behavioral Support Consultation: Training and supports for individuals who are caring for members with special needs.

Customized Community Support: Day programs in the community where members can enjoy activities such as making art, exercising or visiting with others.

Emergency Response: An electronic device that will help members get help in an emergency.

Employment Support: Helps members with job training or finding a job.

Home Health Aide: A trained provider helps members with activities of daily living, including bathing, dressing and eating.

Nutritional Counseling: Eating plans and support for health conditions such as diabetes, under-nutrition, cardiovascular health, etc.

Personal Care Services (consumer-directed and consumer-delegated): Helps members with activities of daily living, including bathing, dressing, cooking and shopping. Members may choose the consumer delegated or consumer directed model. A family member may be able to provide this service.

- **Private Duty Nursing Services for Adults (RN or LPN):** Health-related services provided by an RN or LPN.
- **Self-Directed Personal Care (Homemaker):** Helps members with activities of daily living, including bathing, dressing, cooking and shopping. A family member may be able to provide this service.
- **Start-Up Goods:** Start-up goods are available to members transitioning from the ABCB to the SDCB for the first time. Start-up goods help members in self-directing their services. Examples of start-up goods include, but are not limited to, a computer, fax machine and printer.

Agency-Based Community Benefit

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

What is Not Covered for Agency-Based Community Benefit Services

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

Self-Directed Community Benefit

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

Your Participation

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

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

Support Broker

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

A support broker will be available to help make sure you meet all of the requirements. If you are interested in SDCB service, call Member Services at **1-877-232-5518** to speak with a care coordinator.

Recruiting, Hiring, Supervising and Firing Providers

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

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

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

The EOR cannot be paid for doing the EOR tasks.

What is Not Covered for Self-Directed Community Benefit Services

Turquoise Care does not cover the following SDCB services:

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

Section 4D: Prescription Drug Benefits

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

Drug List

The Drug List is a list of covered drugs. HCA approves the Drug List for all Medicaid managed care plans, and it is updated quarterly. BCBSNM will send a copy of the Drug List if you request one. You can access the Drug List on our website at **bcbsnm.com/medicaid**.

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

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

Exceptions

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

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

In an emergency, BCBSNM will respond to your provider's request within 24 hours. You may use the appeals process. Go to **Section 7: Grievances (Complaints)** if your request is denied.

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

Pain Medication Requirement

BCBSNM recommends that a doctor provide a diagnosis code for your medication. This allows the pharmacy to pay for your medication. This also helps BCBSNM to understand the reason why your doctor has written the pain medication prescription for you. Additional requirements for pain medications may apply.

Covered Medications and Other Items

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

- Prescription drugs and medicines on the Drug List, unless listed as an exclusion
- Certain vaccines that can be given at a pharmacy (such as flu shots)
- Specialty pharmacy drugs such as self-administered injectable drugs. Most injectable and high-cost drugs require prior authorization from BCBSNM. Some self-administered drugs, whether injectable or not, are specialty pharmacy drugs, and you must order them through an in-network specialty pharmacy provider to be covered
- Insulin, insulin needles, syringes and other diabetic supplies (e.g., glucagon emergency kits, autolet, injection aids, lancets, blood glucose and visual reading urine and ketone test strips)
- Non-prescription medications and birth control items on the Drug List and prescribed by your provider. These will not be covered if a prescription is filled anywhere other than at an in-network pharmacy. Non-prescription medications are subject to quantity limits (usually one package size per 30 days). Some over-the-counter products will not be covered for members under the age of four or over the age of 18
- Prescription or over-the counter drugs to help you quit tobacco or smoking. You may also seek support/assistance from a Tobacco Cessation Nurse by calling Member Services at **877-232-5518**. Select option 3, then option 2 (TTY: **711**).

Retail Pharmacy Program

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

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

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

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

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

Drug Plan Supply Limits

For most medications, you can get up to a 31-day supply of a single covered prescription drug. For commercially packaged items (such as an inhaler, a tube of ointment or a blister pack of tablets or capsules), you will receive one package as a 30-day supply. Covered birth control products are exempt from this limit.

93-Day Supply

You can fill a 93-day supply of medications used to treat chronic conditions through our mail-order program. Narcotic pain medications (opioids) are not allowed for mail-order.

Mail-Order Program

You can use the mail-order program to order a 93-day supply of a medication that you use regularly for a long-term or chronic condition. To use the mail-order program, call Member Services. We will help you fill out a mail-order form so you will get your medication in the mail.

What is Not Covered for Prescription Drugs and Other Items

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

- Prescription, non-prescription and over-the-counter drugs that are not listed as covered on the Drug List, including herbal or homeopathic preparations
- Drugs or other items purchased from an out-of-network pharmacy or any other provider that does not contract with BCBSNM, unless in an emergency
- Refills needed earlier than expected if you took the number of pills each day the provider indicated. Call Member Services for instructions on obtaining a greater supply if you are leaving home for more than 30 days
- Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced
- Infertility medications
- Drugs or other items for treatment of any sexual dysfunction
- Medications or preparations for cosmetic purposes, such as for hair growth or medicated cosmetics, including tretinoin (sold under such brand names as Retin-A) for cosmetic purposes
- Non-prescription enteral nutritional products taken by mouth or delivered by a temporary naso-enteric tube (e.g., nasogastric, nasoduodenal or nasojejunal tube), unless you have a genetic inborn error of metabolism and the product is preauthorized by BCBSNM
- Shipping, handling or delivery charges, unless preauthorized by BCBSNM
- Drugs required for international travel or work

- Food, diet supplements, special medical foods, nor commercially available food alternatives, such as low- or sodium-free foods, low- or fat-free foods, low- or cholesterol-free foods, low- or sugar-free foods, low- or high-calorie foods for weight loss or weight gain or alternative foods due to food allergies or intolerance
- Drugs, medicines, drug combinations, or devices not approved by the FDA and any experimental, investigational or unproven products
- Methadone used in drug treatment programs
- Personal care items, such as non-prescription shampoo or soap
- Probiotics
- Weight loss or weight control drugs
- Cough and cold products for members under the age of four
- Drug Efficacy Study Implementation (DESI) drugs, compounded drugs that use a product that has not been approved by the FDA for the intended use, compound drugs that do not have a national drug code and have not been approved by the FDA for use in humans or repackaged drug products
- The following over-the-counter products for members over the age of 21:
  - Pain relievers/fever reducers
  - Ear, nose and throat products (except sodium chloride inhalation solution)
  - Stomach products (to treat heartburn, constipation, diarrhea)
  - Eye products (except eye lubricants)
  - Cough/cold products
  - Benzoyl peroxide
  - Antibiotics for use on the skin
  - Supplements (except oral electrolyte replacement and prenatal vitamins)
  - MCT Oil
  - Neutra-Phos, Neutro-Phos K

Brand-Name Exclusion

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

Pharmacy Lock-In

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

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

Section 4E: Vision Benefits

Vision Coverage

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

The following routine services are covered under your Turquoise Care plan:*

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

***Note:** Alternative Benefit Plan (ABP) members have coverage for one routine eye exam as listed above but are not covered for refraction or eye glasses (other than for Aphakia following removal of lens).

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

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

What is Not Covered for Vision Care

Turquoise Care does not cover the following vision care services:

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

ABP Members

ABP members have routine vision benefits.

One eye exam will be covered every 36 months for an ABP eligible member 21 years or older. An ABP eligible member under age 21 has coverage for one eye exam every 12 months. Refractions or eyeglasses are not covered under the ABP plan, except for aphakia following the removal of the lens.

Section 4F: Dental Benefits

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

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

Covered Dental Services

The services listed in the chart on **page 59** are covered under your Turquoise Care plan.

What is Not Covered for Dental Services

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

- Permanent fixed bridges
- Cosmetic services
- Desensitization, re-mineralization or tooth bleaching
- TMJ disorders, bite openers and orthotic appliances
- Implants and implant-related services
- Removable unilateral cast metal partial dentures

Finding a Dentist

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

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

Urgent Dental Care

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

Non-Urgent Dental Care

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

Routine Dental Checkup

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

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

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

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

Section 4G: Transportation Benefits

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

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

The services in the table below are covered under your Turquoise Care plan. To learn more about prior authorizations, go to **page 22** of this handbook.

Covered Service	Prior Authorization Required	Prior Notice to ModivCare
Ride to routine appointment	No	Three working days up to two weeks
Ride to behavioral health appointment	No	Three working days up to two weeks
Mass transit	No	Four working days
Mileage reimbursement	Yes	Call at least 14 calendar days prior, up to the day of the appointment
Meals	Yes	Three working days
Lodging	Yes	Three working days
For Justice-Involved Members with a valid, current and unfilled prescription, one trip within seven days of release from jail or prison to pharmacy and then home within the same city limits as pick up.	No	Within seven days after release

What is Not Covered for Transportation Services

Turquoise Care does not cover the following transportation services:

- Transportation to a pharmacy to get prescriptions or to a medical supply store to get medical supplies or durable medical equipment
- Transportation for non-medical needs
- Transportation to a provider who is 120 miles or farther away from where you live, needs special authorization from the referring or servicing doctor
  - The doctor will need to state care is not available in your home community.
  - If continued out-of-community care is authorized and non-emergency transportation is received, the information will need to be submitted every 12 months.
- Transportation to an out-of-network provider without special authorization from ModivCare.

Scheduling Transportation for Routine Care

There are two ways to schedule transportation:

1. Use the ModivCare App. Search ModivCare on either Google Play® or the Apple App Store® to download. Use your email address to create the account. Then requesting a ride is only a few clicks away. By downloading the ModivCare App, you have access to: booking, changing, or cancelling rides; live ride tracking, driver's real-time location and estimated time of arrival; text or calling the driver to ensure trips are not missed; and contacting support within the app to talk to a live agent. For technical issues related to the ModivCare App, call the Member Services Technical Support number at **1-800-597-2049**. Select option 5 (Technical Support).
2. Call the Reservation Line phone number to schedule a ride to your appointment from 8 a.m. to 5 p.m., Monday through Friday at **1-866-913-4342**. When you call ModivCare's Reservation Line, tell them you are a Turquoise Care member and give them your ID number. Give the date, time and location of the appointment. Contact ModivCare at least three working days before your routine appointment to schedule a ride. Saturdays, Sundays and holidays are not working days. If you do not call at least three working days before your appointment, your request may be denied. This does not apply to urgent care. When you call for a ride on the same day as your appointment, ModivCare must call your provider to verify you have an appointment, and your ride may take up to four hours to arrive. To see a provider on a regular basis, you may schedule your ride two weeks (10 working days) ahead of time.

Call the Ride Assist phone line at **1-866-418-9829** to be picked up after seeing your provider, after being discharged from a hospital or if your ride is late.

Drivers are required to wait only five minutes, so be ready to leave when the driver arrives. If you are not ready within five minutes, the driver will not wait longer because he or she has other people to transport.

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

If your medical appointment is canceled, call at least two hours before you were supposed to be picked up to cancel your ride.

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

Transportation Services Needing Prior Authorization for Long Distance Travel

Sometimes you must travel a long distance for medical or behavioral health care. If you must travel more than 120 miles (one way) from your home, you must get a written note of approval from the referring provider or the service provider. You must also get a written note from the service provider you traveled to see. This note should explain that medical or behavioral health care you need is not available in your home community.

Sometimes you must travel outside New Mexico to receive health care. This is called out-of-state transportation. Out-of-state transportation and related expenses require prior authorization.

Sometimes you must travel to another city or state for an approved appointment. You need to plan your transportation for these trips. You should make your plans at least two weeks

(10 working days) ahead of time. If that is not possible, make your plans no later than three working days before the appointment.

Meals and Lodging

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

When a trip takes more than four hours one way and an overnight stay is medically necessary for covered services, call ModivCare to arrange for lodging. All lodging expenses must be coordinated by ModivCare. Do not arrange your own lodging for any expenses not authorized in advance by ModivCare.

If you need to get paid for lodging and/or meals authorized by ModivCare, you are required to fill out a Transportation Meals and Lodging Expense Report available on the BCBSNM website at **bcbsnm.com/medicaid** (under 'Member Resources/Forms') or call Member Services.

When you call ModivCare for approval, you will be given an authorization/job number if the travel is approved. You must include original receipts for each meal and lodging expenses (not photocopies) and write your authorization/job number on the ModivCare Expense Report you send in to ModivCare. You will not be paid for meals or lodging if the form and receipts are received more than 60 days after you travel. Mail the form to the address shown on the form.

Payment for Mileage

You might be able to be repaid for mileage if you have to drive your own vehicle to a covered appointment. This must be preauthorized by ModivCare. Do not expect to be paid for mileage if you do not call the ModivCare Reservation Line first at **1-866-913-4342** or contact ModivCare through the app. ModivCare will verify you have an appointment and will tell you the number of miles covered. You must contact ModivCare at least 14 calendar days prior, up to the day of the appointment. If ModivCare authorizes your trip, you will be given a trip/job number. You must have this number to be paid for your mileage. If you cannot drive yourself, a friend or family member may drive you. He or she can get mileage reimbursement as well. The same procedures and authorization requirements apply.

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

Send the completed, signed form through the mobile app or to the address on the form within 60 days of the appointment.

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

Address for Expense Reports

ModivCare - Travel Department
798 Park Avenue NW, 4th Floor
Norton, VA 24273

Address for Mileage Reimbursement

ModivCare Solutions Mileage Reimbursement
798 Park Avenue NW, 4th Floor
Norton, VA 24273

Transportation Services for Rides to PCP Offices Requiring Authorization

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

Rides to Out-of-Network Providers

Call BCBSNM Care Coordination first when you need a ride to any out-of-network provider (even for family planning and even if you already have prior authorization for the visit). Approval for a ride to an out-of-network provider is different from prior authorization received for the provider visit itself.

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

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

Accompanying Persons or Family Members

Turquoise Care covers one other person to ride with you to your appointments plus the other person's meals and lodging in the following situations:

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

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

Picking Up Medical Supplies and Prescriptions

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

Section 4H: Value-Added Services

In addition to covering the services required by state law, your Turquoise Care health plan offers extra services to help keep you and your family healthy. These are called Value-Added Services.

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

Value-Added Service	Applies To	Members on Standard Medicaid Plan	Members on Alternative Benefit Plan (ABP)	Members on ABP-Exempt Plan	Prior Authorization Required for Value-Added Service
Physical Health Services					
Home Meal Delivery	Members transitioning from an inpatient facility into the community, who are receiving community benefits and unable to prepare their meals or purchase their groceries, and pregnant women with gestational diabetes	✓	✓	✓	Yes
Native American Traditional Healing and Wellness (grant for traditional healing practices used to treat medical conditions)	Native American members	✓	✓	✓	No
Remote Monitoring Program	Members with chronic conditions like diabetes or high blood pressure	✓	✓	✓	Member must participate in the Paramedicine Program; requires an assessment
Respite Bed (temporary bed based on medical necessity and availability)	Certain members discharging from an emergency room or hospital	✓	✓	✓	Yes

*Must participate in BCBSNM's Care Coordination program to redeem
Please note funding is limited.

Value-Added Service	Applies To	Members on Standard Medicaid Plan	Members on Alternative Benefit Plan (ABP)	Members on ABP-Exempt Plan	Prior Authorization Required for Value-Added Service
Physical Health Services *(continued)*					
Assistance with Social Determinants of Health* (payments for tangible goods such as interview clothing, bus passes for work and more)	Medicaid and Medicaid Expansion Population members	✓	✓	✓	Yes
Health Housing Program*	Bernalillo County homeless members with behavioral health and substance abuse disorders	✓	✓	✓	Yes
Shower Chairs	Elderly or members with disabilities who need a convenience shower chair	✓	✓	✓	No
After School or Youth Activities	Members under 18 years old	✓			Yes
Friends and Family Circle	Parents/caregivers who are caring for family members with complex needs	✓	✓	✓	Yes
Virtual Lifestyle Modification Support for Fitness and Nutrition	Members with specific diagnoses such as prediabetes, diabetes, hypertension, obesity and/or kidney disease	✓	✓	✓	Yes

*Must participate in BCBSNM's Care Coordination program to redeem
Please note funding is limited.

Value-Added Service	Applies To	Members on Standard Medicaid Plan	Members on Alternative Benefit Plan (ABP)	Members on ABP-Exempt Plan	Prior Authorization Required for Value-Added Service
Maternity Services					
Infant Car Seat*	Pregnant members	✓	✓	✓	Yes
Portable Infant Crib*	Pregnant members	✓	✓	✓	Yes
Diapers	Pregnant members and new mothers	✓	✓	✓	Yes
Behavioral Health Services					
Resource tool kit (Justice/Homeless)	Justice involved members and members experiencing homelessness	✓	✓	✓	No
Electroconvulsive Therapy (ECT) treatment for psychiatric conditions	Members who meet standard ECT medical necessity criteria	✓	Not a Value-Added Service; standard ABP benefits apply	Not a Value-Added Service; standard benefits apply	No
Transitional Living for Chemically Dependent/Psychiatrically Impaired Adults 18 years or older	Members enrolled in outpatient substance abuse center or in active treatment for psychiatric issues	✓	✓	✓	Yes

*Must participate in BCBSNM's Care Coordination program to redeem
Please note funding is limited.

Value-Added Service	Applies To	Members on Standard Medicaid Plan	Members on Alternative Benefit Plan (ABP)	Members on ABP-Exempt Plan	Prior Authorization Required for Value-Added Service
Behavioral Health Services *(continued)*					
Wellness/Drop-in Centers and Family Support Centers	Medicaid members	✓	✓	✓	No
Assistance with Social Determinants of Health* (payments for tangible goods such as interview clothing, bus passes for work and more)	Medicaid and Medicaid Expansion population members	✓	✓	✓	Yes
Health Housing Program*	Bernalillo County homeless members with behavioral health and substance abuse disorders	✓	✓	✓	Yes
Learn to Live	Medicaid and Medicaid Expansion members 13 years or older	✓	✓	✓	No
Friends and Family Circle	Parents/caregivers who are caring for family members with complex needs	✓	✓	✓	Yes

*Must participate in BCBSNM's Care Coordination program to redeem
Please note funding is limited.

Section 4I: Member Rewards

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

To use your credits, you must enroll at **turquoiserewards.com** or call Turquoise Rewards at **1-877-806-8964**. Credits can be used by making choices from a catalog. You can order catalog items through the Turquoise Rewards website or by calling Turquoise Rewards at **1-877-806-8964**.

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

Healthy Actions and the Reward Benefits are called 'credits.' The full list of Healthy Actions and the current Reward Benefits are available on the **turquoiserewards.com** website.

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

*Credits are for qualifying catalog use only. Credits have no cash or monetary value and can never be exchanged or redeemed for cash. They are not transferable to other persons. They may not be combined with other member's credits or with other rewards or incentive programs offered by Turquoise Care. Turquoise Rewards are subject to change without notice.

Section 5: Alternative Benefit Plan

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

There are two kinds of ABP benefit packages.

ABP Benefit Package

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

ABP Exempt Benefit Package

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

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

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

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

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

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

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

ABP Exempt Covered and Non-Covered Services

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

Value-Added Services

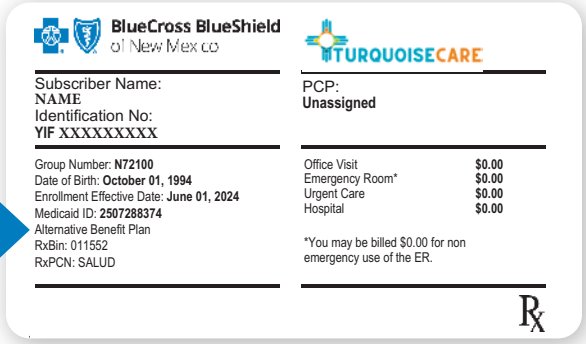
ABP VAS

Go to the table in **Section 4H: Value-Added Services** for a list of ABP VAS.

ID Cards

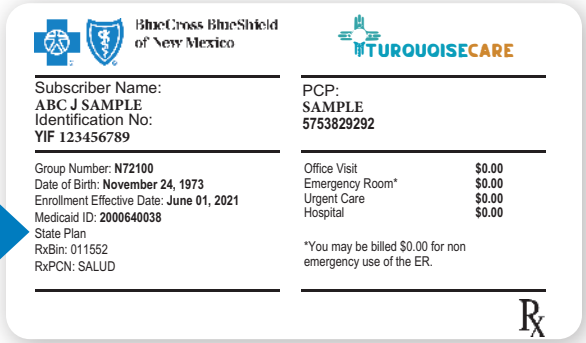
ABP ID Cards

When you apply for Medicaid coverage, you will know that you are eligible for the ABP.
Another way to know is by looking at the front of your Turquoise Care ID card. Check the example below:



ABP Exempt ID Cards

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



Provider Network

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

Section 6: Care Coordination

Considering Your Needs

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

BCBSNM will look at your completed Health Risk Assessment to identify your medical, long-term care and behavioral health needs and will determine if you require a second Comprehensive Needs Assessment (CNA).

Care Coordination Levels

Level 1: A care coordinator will work directly with you. Your care coordinator will conduct a CNA. We use this assessment to connect you with providers who can help with your identified needs. It will happen in person in your home. Your care coordinator will contact you often to monitor your care plan and provide education on concerns you may be dealing with.

Level 2: A care coordinator who knows a lot about special health needs works directly with you. Your care coordinator will conduct a CNA in person with you in your home. This assessment helps us make sure you are getting all the care you need from the right providers. Your care coordinator will contact you often to monitor your care plan. You can talk to your care coordinator about any education needed to help you with your illness.

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

Care Coordination

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

Care Coordination also includes complex case management and disease management. You may have a chronic condition, such as childhood asthma or adult diabetes, a complex condition or several health conditions, which might include mental health or substance use. BCBSNM's care coordinators can work with you and your provider. At a time that can be very stressful, our care coordinators can help you understand your medical condition/diagnosis and treatment plans, communicate with your providers to coordinate your care, get the health benefits you are entitled to and find health care services based on your condition(s). Your caregiver or your provider can refer you to the program or you can self-refer. You can end the program at any time.

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

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

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

The State of New Mexico Health Care Authority (HCA) has recommended that Managed Care Organizations (MCOs) partner with community Providers to deliver care coordination. Providers are designated as Delegation of Care Coordination Entities (DCCE). If you are pregnant, care coordination will be offered by a maternity provider.

The care coordinator provides information to the member and/or their representative to ensure appropriate health care is received. This service may improve the quality of care, enhance patient satisfaction and promote self-care. It is especially helpful for members with multiple chronic conditions, such as diabetes, asthma, heart disease and cancer because they can be at a higher risk for poor health outcomes.

Benefits to patients who are offered care coordination include:

- Help with finding providers and community resources as needed
- Helping patients understand their condition
- Setting up care with providers and, if appropriate, attending provider visits with patient
- Assisting with coordination of transportation
- Confirming delivery of necessary care, such as Durable Medical Equipment (DM) or therapies at home
- Encouraging positive health outcomes through multiple interventions, ongoing support and wellness education.
- Identifying and addressing service gaps

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

Getting Help with Special Health Care Needs

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

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

Community Social Services

The Community Social Service program connects you to local resources that meet social needs, and improve your overall health and wellness. This program can help with non-emergency transportation issues, hunger, place of residence and understanding your health.

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

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

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

Call Community Social Services at **1-877-232-5518**.

Supportive Housing

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

Our goal is to first determine housing needs then find the right community resources to help.

Some of these services include:

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

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

Tobacco Cessation

Turquoise Care has partnered with the New Mexico Department of Health to enhance its Tobacco Cessation Program. This program can help you or your family members quit smoking, vaping or using other tobacco products.
The program offers:

- Free phone-and-web-based services and support
- A personalized Quit Plan including unlimited sessions with a trained coach
- Free nicotine patches, gums, and lozenges
- Text messaging support with motivational and educational reminders
- Specialized help for teens and their families

Enrollment

You can enroll via phone or web:

- Call **1-800-QUIT-NOW** (**1-800-784-8669**)
- Visit **quitnow.net/newmexico**
- QR Code.

Additional Assistance

To speak to a Care Coordinator, or for assistance finding a primary care provider who can help you reach your quitting goals, call **1-877-232-5518**. Select option 3, then option 2 (TTY: **711**).

Section 7: Grievances (Complaints)

There is a difference between a grievance and appeals.

Grievance (Complaint)

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

Filing a Grievance

If you have a grievance about BCBSNM or a provider, call our Member Services line at **1-866-689-1523** or call **711** for TTY service for help. Member Services can help you file a grievance and will get it to a Turquoise Care Appeals/Grievance Coordinator.

Grievance Address and Phone Number

To file a grievance, contact Turquoise Care Grievances by writing a letter to the address below. You can also call member services, write to us, email or fax to the number below.

Turquoise Care Grievances
PO Box 660717
Dallas, TX 75266

Telephone (toll-free): **1-866-689-1523**

Fax: **1-888-240-3004**

Email: **GPDAG@bcbsnm.com**

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

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

Time Limits for Filing a Grievance

You may file a grievance verbally or in writing at any time from the date the dissatisfaction occurred. We will send you a letter within five business days of receiving your grievance to let you know we received it and are working to resolve it within 30 calendar days. If you have information that supports your grievance, send that as well. We will add it to your file for consideration. Send this information to the address, fax or email address listed under the Grievance Address and Phone Number section.

Time Frame for an Answer to a Grievance

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

People Who Can File a Grievance

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

Section 8: Appeals

A Grievance is Not an Appeal

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

Appeal

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

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

Appeals and HCA Fair Hearings are not available if BCBSNM limits, reduces, denies or stops any VAS.

Time Limits for Filing an Appeal

You have to appeal within 60 calendar days from the date of the Adverse Benefit Determination. You can file an appeal verbally or in writing. Call Member Services to get help with submitting your appeal request. BCBSNM then has 30 calendar days from the day of your initial request to resolve the appeal. If you do not file an appeal within 60 calendar days from the date of the Adverse Benefit Determination, you may lose your right to appeal.

Filing an Appeal

You can file an appeal by:

- Calling Member Services
- Mailing, emailing or faxing a written appeal to the address, email address or fax number on **page 79**.

Appeals forms are available at **bcbsnm.com/medicaid** under Member Resources on the Forms page.

Types of Appeal Helpers

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

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

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

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

An Authorized Representative for a Medicaid appeal is not the same as an agent who you make your power of attorney for health care. A power of attorney for health care lets you name another person as agent to make health care decisions for you in a clinical setting (e.g., at a hospital) if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. If you want to make someone your power of attorney for health care, please use the health care power of attorney form available at **bcbsnm.com/medicaid under Member Resources on the Forms page.

After your appeal is filed, you can give more information to BCBSNM before your appeal is decided. The information can be written comments, documents or verbal testimony. The information can also be written or verbal arguments of law or facts. You or your Authorized Provider, Authorized Representative or Spokesperson can give this information to us. To give us more information before your appeal is decided, you must ask us right away because BCBSNM has limited time to finish your appeal. It is important to submit this additional information quickly. We have 30 calendar days from the date of your appeal to complete our review. Call Member Services at **1-866-689-1523** with this information. You may also write or fax us at the address or fax number provided. If you need more time to gather your information, you can request an extension of the appeal up to 14 more calendar days. When you ask for an extension, please tell us why.

Appeals Address and Phone Number

Turquoise Care Appeals
PO Box 660717
Dallas, TX 75266

Telephone (toll-free): **1-866-689-1523**
Fax: **1-888-240-3004**
Email: **GPDAG@bcbsnm.com**

Include your ID number and all information related to your appeal including provider name, date of service and your reason for filing the appeal.

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

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

How Your Appeal is Handled

Within five business days of receiving your appeal request, BCBSNM will send you a notice confirming we have received it. The notice will also tell you when BCBSNM expects to have an answer for you. If you or your provider believes the normal 30-calendar-day appeal time will put your health at risk, you can ask us to expedite your appeal.

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

Keeping Your Services During an Appeal and HCA Fair Hearing

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

Appeals Address and Phone Number:
Turquoise Care Appeals
PO Box 660717
Dallas, TX 75266

Telephone (toll-free): **1-866-689-1523**
Fax: **1-888-240-3004**
Email: **GPDAG@bcbsnm.com**

To request a pharmacy appeal you can:
Call the BCBSNM Customer Advocate Department toll-free at **1-866-689-1523** (TTY: **711**), Monday through Friday, 8 a.m. to 5 p.m., Central Time.

Mail a written appeal to:
Turquoise Care
Attn: Prime Therapeutics Appeals Department
2900 Ames Crossing Road
Eagan, MN 55121

Fax a written appeal to 855-212-8110.

Have your doctor submit online at:
MyPrime.com or **CoverMyMeds.com**

Remember to include your ID number and all information related to your appeal including provider name, date of service and your reason for filing the appeal. Telephone hours are Monday through Friday, 8 a.m. to 5 p.m. Closed Saturdays and Sundays. If you want to leave us a message about your appeal after normal business hours, call **1-877-232-5520** (TTY: **711**). We will return your message by 5 p.m. the next business day.

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

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

Expedited Appeal

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

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

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

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

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

Expedited Appeal Request Denials

If an expedited appeal request is denied, it goes through the normal appeal process. It will be resolved within 30 calendar days. BCBSNM will call you within one working day to tell you the appeal is not going to be expedited. We will also follow up in writing within two calendar days. If we deny your expedited request, you can request an HCA Fair Hearing.

HCA Fair Hearing

You have the right to ask for a hearing with the HCA Fair Hearings Bureau if after exhausting BCBSNM's internal appeal process, you do not agree with the final decision. You also have the right to ask for an HCA Fair Hearing if we denied your request for an expedited appeal. You or your representative must ask for an HCA Fair Hearing from the HCA Fair Hearings Bureau within no less than 90 calendar days of BCBSNM's final appeal decision. You have the right to have someone represent you at the hearing. The parties who may attend the HCA Fair Hearing include representatives from BCBSNM, as well as you and/or your representative, or attorney or the representative of a deceased member's estate. You will receive a summary of evidence (SOE) packet for the HCA Fair Hearing. The SOE provides information regarding your appeal. Your case may be dismissed if you do not go to your scheduled hearing without a good reason. If you requested continuation of benefits, and the result of the HCA Fair Hearing is not in your favor, you will have to pay for the services received.

You can ask for an HCA Fair Hearing by calling or writing:

New Mexico Health Care Authority
HCA Fair Hearings Bureau
PO Box 2348
Santa Fe, NM 87504-2348

Telephone: **1-800-432-6217**, then press 6;
or **(505) 476-6213** TTY: **711**
Fax: **(505) 476-6215**
Email: **HCA-FairHearings@state.nm.us**

Section 9: Disenrollment

Annual Choice Period

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

Moving Out of State

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

Member Disenrollment Requests

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

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

HCA Reasons for Disenrolling Members

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

- Loss of Medicaid eligibility
- At any time during the HCA Fair Hearing process, HCA finds it would be best for the member or HCA for the member to disenroll

BCBSNM Reasons for Disenrolling Members

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

Long-Term Care Residential or Employment Support Provider Leaving Network

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

Disenrolling During a Hospital Stay or While in a Nursing Facility

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

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

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

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

How to Disenroll

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

You need to contact ISD if you:

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

Section 10: General Information

Changes to Handbook or Benefits

HCA/MAD reserves the right to add or delete benefits to the Turquoise Care program.

Disclosure and Release of Information

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

Accessing your Medical Records

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

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

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

Advance Directives

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

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

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

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

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

Mental Health Advance Directives

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

Major Disasters

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

Women's Health and Cancer Rights Act of 1998

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

Health Care Fraud and Abuse

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

Definitions:

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

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

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

How You Can Help

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

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

Reporting Fraud and Abuse

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

You can report fraud and abuse by doing the following:

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

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

Medical Policy

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

- Cosmetic
- Under investigation or experimental
- Medically necessary

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

Privacy of Your Information

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

BCBSNM manages a contract with HCA to provide its health plan to Turquoise Care members. So that you may use the benefits of this plan, BCBSNM has access to your PHI in all its forms. Due to this fact, we want you to know how BCBSNM protects and secures your PHI.

How We Use or Share Your PHI

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

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

BCBSNM only shares your PHI when allowed by law.

Your Rights:

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

How We Protect Your PHI

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

Information

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

Independent Companies

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

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at **1-866-689-1523**.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator	Phone:	**1-855-664-7270** (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	**1-855-661-6965**
300 E. Randolph St., 35th Floor	Fax:	**1-855-661-6960**
Chicago, IL 60601	Email:	civilrightscoordinator@bcbsil.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

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

US Dept of Health & Human Services	Phone: **1-800-368-1019**
200 Independence Avenue SW	TTY/TDD: **1-800-537-7697**
Room 509F, HHH Building	Complaint Portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Washington, DC 20201	Complaint Forms: https://www.hhs.gov/civil-rights/filing-a-complaint/index.html

If you are a Blue Cross and Blue Shield of New Mexico member, this notice is available on our website at https://www.bcbsnm.com/turquoise-care/legal-and-privacy/non-discrimination-notice.

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **1-866-689-1523** (TTY: **711**) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al **1-866-689-1523** (TTY: **711**) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم **1-866-689-1523** (TTY: **711**) أو تحدث إلى مقدم الخدمة الخاص بك.

中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 **1-866-689-1523** (TTY: **711**) 或咨询您的服务提供商。
Français French	ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le **1-866-689-1523** (TTY: **711**) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie **1-866-689-1523** (TTY: **711**) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે બીજી ભાષા બોલો છો, તો તમારા માટે મફત ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટે યોગ્ય સહાયક મદદ અને સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. **1-866-689-1523** (TTY: **711**) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। **1-866-689-1523** (TTY: **711**) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: Se parli italiano, puoi usufruire gratuitamente di servizi di assistenza linguistica. Sono inoltre disponibili, senza costi, strumenti e servizi ausiliari per ricevere informazioni in formati accessibili. Chiama il numero **1-866-689-1523** (TTY: **711**) o rivolgiti a un assistente.
한국어 Korean	주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. **1-866-689-1523** (TTY: **711**)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHÓÓ: Diné Bizaad k'ehjí éí dinits'á'go, t'áá nizaad k'ehjí níká a'doo wołgo bohónéedzą. Łahgo bee ata' hodoonigo áádóó éí doodago ałtaa át'éego níka a'doowołgo t'áá jiik'e nábee ahoot'i'. **1-866-689-1523** (TTY: **711**) jį' hodíílni éí doodago nits'íís náyaa áhályánii bich'į' hadíídzi.
فارسي Farsi	توجه: اگر فارسی صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و تماس خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با **1-866-689-1523** (TTY: **711**) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer **1-866-689-1523** (TTY: **711**) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону **1-866-689-1523** (TTY: **711**) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa **1-866-689-1523** (TTY: **711**) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے مفت زبان کی مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاونامداد اور خدمات بھی مفت دستیاب ہیں۔ **1-866-689-1523** (TTY: **711**) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں.
Tiếng Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ và dịch vụ phụ trợ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số **1-866-689-1523** (TTY: **711**) hoặc trao đổi với người cung cấp dịch vụ của bạn.

BlueCross BlueShield of New Mexico