

SERFF Tracking Number: CMPL-127160667 State: Arkansas
Filing Company: Health Care Service Corporation State Tracking Number: 48720
Company Tracking Number: HCSC STOP LOSS 2011 - AR - NM
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: HCSC STOP LOSS 2011 - AR - NM
Project Name/Number: HCSC STOP LOSS 2011 - AR - NM /HCSC STOP LOSS 2011 - AR - NM

Filing at a Glance

Company: Health Care Service Corporation

Product Name: HCSC STOP LOSS 2011 - AR - SERFF Tr Num: CMPL-127160667 State: Arkansas
NM

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- State Tr Num: 48720
Closed

Sub-TOI: H16G.001A Any Size Group - PPO Co Tr Num: HCSC STOP LOSS State Status: Approved-Closed
2011 - AR - NM

Filing Type: Form

Author: Nancy French

Date Submitted: 05/09/2011

Reviewer(s): Rosalind Minor

Disposition Date: 05/12/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: HCSC STOP LOSS 2011 - AR - NM

Project Number: HCSC STOP LOSS 2011 - AR - NM

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 05/12/2011

State Status Changed: 05/12/2011

Created By: Nancy French

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Arkansas Insurance Department

1200 West Third Street

Little Rock, AR 72201-1904

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Overall Rate Impact:

Deemer Date:

Submitted By: Nancy French

Re: Health Care Service Corporation, a Mutual Legal Reserve Company

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NAIC# 70670-0917 FEIN# 36-1236610

Group Major Medical Forms

Form Number(s): GB-NM-CA-2 HCSC NIL New Mexico Certificate
ETGB-AR-HCSC-2011 Arkansas Rider

Dear Commissioner:

Compliance Research Services is pleased to submit the enclosed forms on behalf of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). A letter of filing authorization is enclosed.

HCSC does business in various states as follows:

- Blue Cross and Blue Shield of Illinois in Illinois;
- Blue Cross and Blue Shield of Texas in Texas;
- Blue Cross and Blue Shield of Oklahoma in Oklahoma; and
- Blue Cross and Blue Shield of New Mexico in New Mexico.

HCSC provides group medical insurance to Illinois employers that have employees located in many states. This filing is for HCSC's New Mexico division however, we will be submitting similar filings for the other divisions of the company.

Submitted Materials. The coverage in question is true group coverage sold in Illinois by licensed Illinois agents and brokers.

The provisions of the certificate may change according to the benefits negotiated between the employer and HCSC. The enclosed certificate includes provisions for participating provider hospitals and physicians. Coverage may also be issued on a fee for service basis without the network provisions. Individuals insured under network plans have access to their local Blue Cross provider networks under the national Blue Cross association BlueCard plan. The Arkansas Rider has been drafted to bring the certificate into compliance with applicable Arkansas extraterritorial requirements. Note that a previous version of the Arkansas Rider was approved by your Department on June 3, 2008, for form ETGB-AR-HCSC-07, under SERFF Tracking Number: CMPL-125648906. This new version of the Arkansas Rider has been updated to include any new applicable Arkansas mandates passed since the prior approval.

Provisions in the certificate that may vary from employer to employer are bracketed. HCSC requests the right to change the type style and paper size or to issue the forms in electronic format.

The forms have been tested for readability. Certification of readability is enclosed.

If you have any questions or comments, please call me at 513-894-6050 or by email at dsimon@crssolutionsgroup.com.

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Thank you for your assistance in this matter.

Sincerely,

J. David Simon, CLU
President
Phone: 513.984.6050
Fax: 513.984.7212
E-Mail Address: dsimon@crssolutionsgroup.com

Company and Contact

Filing Contact Information

Nancy French, Product Manager nrfrench@crssolutionsgroup.com
10921 Reed Hartman Highway 513-984-6050 [Phone]
Suite 334 513-984-7212 [FAX]
Cincinnati, OH 45242

Filing Company Information

(This filing was made by a third party - complianceresearchservicesllc)

Health Care Service Corporation	CoCode: 70670	State of Domicile: Illinois
300 East Randolph Street	Group Code: 917	Company Type:
Chicago, IL 60601	Group Name:	State ID Number:
(513) 984-6050 ext. [Phone]	FEIN Number: 36-1236610	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$100.00
Retaliatory?	No

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Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Health Care Service Corporation	\$100.00	05/09/2011	47396613

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/12/2011	05/12/2011

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Disposition

Disposition Date: 05/12/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	if of Compliance with Rule 19	Approved-Closed	Yes
Supporting Document	Certification of compliance	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Filing Authorization	Approved-Closed	Yes
Form	New Mexico Certificate	Approved-Closed	Yes
Form	Arkansas Rider	Approved-Closed	Yes

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Form Schedule

Lead Form Number: GB-NM-CA-2 HCSC NIL

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/12/2011	GB-NM-CA-2 HCSC NIL	Certificate	New Mexico Certificate	Initial		42.000	NM Certificate.pdf
Approved-Closed 05/12/2011	ETGB-AR-HCSC-2011	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Arkansas Rider	Initial		40.000	ET_AR.pdf

Your Health Care Benefit Program



CUSTOMER ASSISTANCE

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

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

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

Street address: [4373 Alexander Blvd. NE]

Toll-free telephone number: [1-800-432-0750]

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

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

[[Admission Review and Other Preauthorizations]Preauthorizations: Medical/Surgical Services and Prescription Drugs]—For admission review and other preauthorization requests, call a Health Services representative, [Monday through Friday 8 a.m. - 5 p.m., Mountain Time]. Written requests should be sent to the address given above. **Note:** If you need preauthorization assistance between [5 p.m. and 8 a.m. or on weekends], call Customer Service. If you call after normal Customer Service hours, you will be asked to leave a message.

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

[Mental Health and Chemical Dependency]—For inquiries or preauthorizations related to mental health or chemical dependency services, call the BCBSNM behavioral health services administrator Behavioral Health Unit (BHU):

[24 hours/day, 7 days/week:] [1-800-583-6372 or 1-505-816-6790 1-888-898-0070]

Send claims* to:

[Claims, Mesa Mental Health Behavioral Health Unit
P.O. Box 92165 27630
Albuquerque, New Mexico 87199-2165 87125-7630]

All other correspondence:

[Mesa Mental Health
P.O. Box 90607
Albuquerque, New Mexico 87199-0607]

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

[www.bcbsnm.com]

***Exceptions to Claim Submission Procedures**—Claims for health care services received from providers that do not contract **directly** with BCBSNM [(or Mesa Mental Health)], should be sent to the Blue Cross and Blue Shield Plan in the state where services were received. **[Note: Do not submit drug plan claims to BCBSNM. The name and address of the pharmacy benefit manager is in a separate brochure.]** See *Section 8: Claim Payments and Appeals* for details on submitting claims.

Be sure to read this benefit booklet carefully and refer to the *Summary of Benefits*.

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

SECTION 1: HOW TO USE THIS BENEFIT BOOKLET

This section of the benefit booklet describes some important features you should know about your coverage.

DEFINITIONS

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

[SUMMARY OF BENEFITS

Throughout this benefit booklet, you are asked to refer to a separately issued *Summary of Benefits* that shows specific member cost-sharing amounts and coverage limitations of your Plan. If you do not have a *Summary of Benefits*, please contact a BCBSNM Customer Service Advocate (the phone number is at the bottom of each page of this benefit booklet). You will receive a new *Summary of Benefits* if changes are made to your Plan.]

IDENTIFICATION (ID) CARD

You will receive a BCBSNM identification (ID) card. The ID card contains your group number and your identification number (including an alpha prefix) and tells providers that you are entitled to benefits under this benefit program with BCBSNM.

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

PROVIDER NETWORK DIRECTORY

The provider network directory is available through the BCBSNM website at [www.bcbsnm.com]. It lists all providers in the BCBSNM preferred provider (PPO) network, including mental health/chemical dependency providers and participating pharmacies. It also provides links to the listings of preferred providers in other states. (If you want a paper copy of a directory, you may request one from Customer Service. It will be mailed to you free of charge.) **Note:** Although provider directories are current as of the date shown at the bottom of each page, they can change without notice. To verify a provider's status or if you have any questions about the directory, contact a Customer Service Advocate or visit the BCBSNM website.

[DRUG PLAN BENEFITS

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

BLUECARD® BROCHURE

As a member of a PPO health plan administered by BCBSNM, you take your health plan benefits with you – across the country and, for emergency services, around the world. The BlueCard Program gives you access to preferred providers almost everywhere you travel or live. Almost 90 percent of physicians in the United States contract with Blue Cross and Blue Shield (BCBS) Plans. You and your eligible family members can receive the Preferred Provider level of benefits – even when traveling or living outside New Mexico – by using health care providers that contract as preferred providers with their local BCBS Plan. You should have received a brochure describing this program in more detail. It's a valuable addition to your health care plan coverage. Instructions for locating a preferred provider outside New Mexico are in the brochure or can be found on the BCBSNM website at [www.bcbsnm.com].

[BLUEEDGE HCA BROCHURE

As a participant in the Health Care Account (HCA) program, you will receive additional materials describing how the special employer-funded "Health Care Account" (HCA) reimbursement program works with this BlueEdge Preferred Provider coverage. Your identification card will indicate the BlueEdge HCA program under which you are enrolled.]

[BLUEEDGE HSA BROCHURE

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

LIMITATIONS AND EXCLUSIONS

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

[PREFERRED PROVIDER BENEFIT ONLY

The services listed below are eligible for benefits **only** when received from preferred providers:

- [transplant and transplant-related services (Services must be received at a facility that contracts with BCBSNM, the local BCBS Plan, or the national BCBS transplant network, for the transplant being provided.)]
- [outpatient cardiac and pulmonary rehabilitation]
- [physical, occupational and speech therapy[, including physical rehabilitation admissions]]
- [spinal manipulation]
- [acupuncture]
- [skilled nursing facility services]
- [smoking/tobacco use cessation counseling]
- [adult preventive services]
- [preventive services]
- [allergy care]]
- [supplies and durable medical equipment]]
- [prosthetics and orthotics]]
- autism

ADMISSION REVIEW OR OTHER PREAUTHORIZATION REQUIRED

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

[Emergency/Maternity Admission Notification

To receive full benefits for emergency or maternity–related hospital admissions, you (or your provider) must notify BCBSNM **within 48 hours** of admission. Call BCBSNM’s Health Services department, [Monday through Friday, 8 a.m. to 5 p.m., Mountain Time]. Also, if you have a routine delivery and stay in the hospital **more than 48 hours**, or if you have a C-section delivery and stay in the hospital **more than 96 hours**, you must call BCBSNM for admission approval before you are discharged.]

Written Request Required

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

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

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

[CALL MESA MENTAL HEALTH FOR PREAUTHORIZATION

For all inpatient and outpatient mental health and chemical dependency services, you or your physician must call the BCBSNM behavioral health services administrator, Mesa Mental Health, **before** you schedule treatment. Mesa Mental Health will coordinate covered services with a preferred provider near you. If you do not call before receiving non-emergency services, benefits for covered services may be reduced or denied. Call 7 days a week, 24 hours a day. See *Section 4: Admission Review and Other Preauthorizations* for details.]

[CALL THE BEHAVIORAL HEALTH UNIT FOR PREAUTHORIZATION

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

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

BLUEEXTRASSM

Certain local and national retailers, outlets and businesses offer BCBSNM health plan members an opportunity to save money on services that are not covered under this Plan. These discount offers and other services are not part of your medical/surgical health care benefits described in this benefit booklet, and the entities making the offers and the providers of the services may not be affiliated or associated with BCBSNM or your group health care plan. However, from time to time, BCBSNM will be announcing such offers by sending manufacturer or retail discount coupons to member households, inserting information in the member newsletters, or mailing descriptions of various programs being offered to our members by businesses such as health clubs, pharmacies, vision care providers, hearing aid retailers, dentists, etc. These mailings may contain coupons or offers that enable you, at your discretion, to purchase the described product or enroll in a certain program at a discount or at no charge. The retailer, provider, or manufacturer may pay for and/or provide the content for this information. The discounts and services available to members may change at any time and BCBSNM does not guarantee that a particular discount or service will be available at any given time. For details of current discounts available, please contact a Customer Service Advocate by calling the phone number on the back of your ID card.

[OTHER MEMBER SERVICES

To help members track claim payments, make health care choices, and reduce health care costs, BCBSNM maintains a flexible array of online programs and tools for health care plan members. The online “Blue Access for Members” (BAM) tool provides convenient and secure access to claim information and account management features and to various cost comparison tools. While online, members can also access a wide range of health and wellness programs and tools, including a health risk assessment and personalized health updates, and a program in which members can earn merchandise and gift cards for making healthy lifestyle choices and for participating in various activities. To access these online programs, go to [www.bcbsnm.com], log into Blue Access for Members and create a user ID and password for instant and secure access. If you need help accessing the site, call the Blue Access Help Desk toll-free at [1-888-706-0583], [Monday through Friday 7 A.M. to 9 P.M., Mountain Time, or Saturday 6 A.M. to 2:30 P.M. Mountain Time]. **Note:** Depending on your group’s coverage, you may not have access to all online features. Check with your benefits administrator or call Customer Service at the number on the back of your ID card. BCBSNM assesses the usefulness of various programs regularly, using data about program usage and member feedback to make changes to online tools as needed. Therefore, available programs and program rules are updated, added, or terminated, and may change without notice as new programs are designed and/or as our members’ needs change. We encourage you to enroll in BAM and check the online features available to you – and check back in as frequently as you like. BCBSNM is always looking for ways to add value to your health care plan and hope you will find the website helpful.]

HEALTH CARE FRAUD INFORMATION

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

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

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

CUSTOMER ASSISTANCE

For your convenience, the toll-free customer service number for BCBSNM is printed at the bottom of every page in this booklet. Refer to *Customer Assistance* on the inside cover of this booklet for important phone numbers, website, and mailing address information. If you need help communicating with BCBSNM, we offer bilingual interpreters for members who call Customer Service. If you need language services, call the Customer Service phone number on the back of your ID card.

SECTION 2: ENROLLMENT AND TERMINATION INFORMATION

WHO IS ELIGIBLE

Unless otherwise specified in the Group Master Contract Administrative Services Agreement, all active employees who have completed the employee probationary period and are regularly working the minimum number of hours specified in the Group Master Contract Administrative Services Agreement and their eligible family members are eligible for coverage. To find out the number of hours you must work per week and to learn of any other eligibility criteria specified by your group, contact your [benefits administrator].

Employers may request coverage for regular part-time employees expected to work an average of at least 20 hours per week over a six-month period. Each employer may choose whether or not to offer health insurance to these part-time employees. Please contact your employer to find out if this optional coverage may affect you. (This optional coverage for part-time employees is not available to temporary or seasonal workers.)

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

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

ELIGIBLE FAMILY MEMBERS

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

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

- the subscriber's legal **spouse**
- the subscriber's eligible **child** through the end of the monthly billing period in which the child reaches **age 26** (Once a covered child reaches age 26, the child is automatically removed from coverage and rates are adjusted accordingly.)
- the subscriber's **unmarried** child age 26 or older who was enrolled as the subscriber's covered child in this health plan at the time of reaching the age limit, and who is medically certified as **disabled**, chiefly dependent upon the subscriber for support and maintenance, and incapable of self-sustaining employment by reason of his/her disability (Such condition must be certified by a physician and BCBSNM. Also, a child may continue to be eligible for coverage beyond age 25 only if the condition began before or during the month in which the child would lose coverage due to his/her age. BCBSNM must receive written notice of the disabling condition before the end of the month during which the child's coverage would otherwise end.)
- [the subscriber's **domestic partner** (NOTE: Not all governing bodies of the entities have approved allowing an employee's domestic partner and his/her children to be eligible for insurance coverage. Check with your [benefits administrator] for more information.)]

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

- naturally or legally adopted child of the subscriber
- child under age 18 placed in the subscriber's home for purposes of adoption (including a child for whom the subscriber is a party in a suit in which the adoption of the child by the subscriber is being sought)
- stepchild of the subscriber
- child for whom the subscriber must provide coverage because of a court order or administrative order pursuant to state law

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

- A child age **19** or older who has other group coverage available to him/her – whether through the child’s own employer or through the child’s spouse’s employer – is **not** eligible under this health plan. The child need not be enrolled in such available group coverage in order to be excluded as an eligible family member.
- Once the subscriber is no longer a legal guardian of a child or there is no longer a court order to provide coverage to a child, the child must be eligible as a natural child, legally adopted child, or stepchild of the subscriber in order to retain eligibility as a family member under this health plan.

[A **domestic partner** is a person of the same or opposite sex who meets all of the following criteria:

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

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

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

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

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

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

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

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

MEDICARE-ELIGIBLE MEMBERS

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

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

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

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

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

NOTIFICATION OF ELIGIBILITY AND ADDRESS CHANGES

The subscriber must notify BCBSNM **Group Name** **within 31 days** following any changes that may affect his/her or a family member's eligibility, including a change to a covered family member's name or address, by indicating such changes on an enrollment/change form and submitting it to BCBSNM **Group Name**. You can obtain this form at BCBSNM's Web site at [www.bcbsnm.com], from your benefits administrator, or by calling the BCBSNM Customer Service department. (Members covered under federal continuation must submit enrollment/change forms directly to the COBRA administrator.)

Employees and Their Eligible Family Members

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

COBRA Continuation Policy Members

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

APPLYING FOR COVERAGE

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

Retiree – If your plan covers retirees, an eligible retiree may apply for continued coverage, including for his/her eligible family members, by contacting your benefits administrator **60 days** prior to retirement. If you do not apply for continued coverage and arrange for payment of medical plan contributions, your coverage will end on the date specified by your group.

WHEN COVERAGE BEGINS

BCBSNM will determine your effective date of coverage according to the provisions of the Group Master Contract Administrative Services Agreement.

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

CHANGES TO COVERAGE

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

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

ADDING AN ELIGIBLE FAMILY MEMBER TO COVERAGE

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

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

[Unless listed as an exception under “Pre–Existing Conditions Limitation,” each eligible family member added to coverage is subject to the pre–existing conditions limitation.]

Adding a Spouse [or a Domestic Partner]

If a subscriber adds coverage for a spouse **within 31 days** of marriage, the effective date of the new eligible family member’s coverage will be no later than the first of the month following the date your group received the completed and signed enrollment/change application form. If the subscriber does not submit a completed and signed enrollment/change application form to his/her benefits administrator or to BCBSNM (or to the COBRA administrator), along with necessary documentation and, if required, change from [Individual to Two-Person or Family coverage] [Individual to Family coverage] **within 31 days** of marriage, the spouse may not be added to coverage except as a late applicant (or as specified under “Special Enrollment for Active Employees and Their Eligible Family Members” later in this section).

[Domestic partners and their eligible children may be added to existing coverage only during the annual open enrollment period.]

Adding an Eligible Child

If you do not submit an application for an eligible child or add additional coverage, if required, within the time frames below, the child will be considered a **late applicant**, except as specified under “Special Enrollment.”

Newborn Children

[If Family or Employee/Children] [If Family] coverage is in effect, a newborn, natural child is covered from birth. (You should, however, submit an application to add the newborn as an eligible child as soon as possible after birth.) [If Family or Employee/Children] [If Family] coverage is not in effect, you must change to [Family or Employee/Children] [Family] coverage **within 31 days** of the birth in order for newborn care to be covered beyond day 31. **Note:** A newborn who is not enrolled within 31 days of birth will be considered a late applicant unless the child was previously enrolled in a group health plan or other creditable coverage within 30 days of his/her birth and has had prior creditable coverage since that date with no significant lapse (i.e., 95 63 or more days). If the application is not received **within 31 days** and additional premium or other employee contributions for coverage, if any, are not paid, the newborn is considered a late applicant.

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

Adopted Children

A child under age 18 placed in the subscriber’s home for the purposes of adoption may be added to coverage as soon as the child is placed in the home. However, application for coverage can be made as late as **31 days** following legal adoption without being considered late. (Although a child over the age of 18 is not eligible for adoption, an adopted child is covered as any other child, subject to the same eligible child age limitations and restrictions.)

[Note: An adopted child who is not enrolled within 31 days of adoption or placement in the home will be considered a late applicant unless the child was previously enrolled in a group health plan or other creditable coverage within 30 days of his/her adoption or placement for adoption and has had prior creditable coverage since that date with no significant lapse (i.e., 95 63 or more days). The pre-existing conditions limitation will apply to a late applicant unless the child was previously enrolled in a group health care plan or other creditable coverage **within 31** days of his/her adoption, or placement for adoption, and has had prior creditable coverage since that date with no significant lapse (i.e., 95 63 or more days).]

[Note: A newborn eligible child and a newly adopted child may be added to coverage more than 31 days after birth or adoption without being subject to the pre-existing conditions limitation if the child was enrolled in a group health plan within 30 days of being born or adopted and who obtained coverage under your current BCBSNM health care plan within 95 63 days of losing the prior coverage (or if prior coverage is still in effect and there has been no significant break in the child's coverage since his/her date of birth or adoption).]

Legal Guardianship

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

Court Ordered Eligible Child Coverage

When an employee or employer is required by a court or administrative order to provide coverage for an eligible child, the eligible child may be enrolled in the subscriber's [Family or Employee/Children] [Family] coverage and will **not** be considered a late applicant. (If the subscriber has [Individual or Two-Person] [Individual] coverage, he/she may be required to pay additional premium in order for the eligible child to be added.) If not specified in the court or administrative order, the eligible child's effective date of coverage will be the date the order has been filed as public record with the State or the effective date of [Family or Employee/Children] [Family] coverage, whichever is later. BCBSNM must receive a copy of the court or administrative order.

Information for Noncustodial Parents

When a child is covered by the health care plan through the child's noncustodial parent, then BCBSNM **Group Name** will:

- Provide such information to the custodial parent as may be necessary for the child to obtain benefits through the Plan;
- Permit the custodial parent or the provider (with the custodial parent's approval) to submit claims for covered services with the approval of the noncustodial parent; and
- Make payments on claims submitted in accordance with the above provision directly to the custodial parent, the provider, or the state Medicaid agency as applicable.

LATE APPLICANT

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

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

[OPEN ENROLLMENT

Open enrollment is the 30-day period prior to the group's anniversary date (ask your employer when your group's open enrollment period is held). During the annual open enrollment period, any eligible employee and his/her eligible family members may enroll as members under this Plan. There is no penalty, benefit reduction, or pre-existing conditions waiting period for taking this action.

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

Late applicants may not enroll until the next annual open enrollment period.]

[SWITCH ENROLLMENT AND CHANGES IN PLAN

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

During an Open Enrollment Period

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

Outside the Open Enrollment Period

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

SPECIAL ENROLLMENT FOR ACTIVE EMPLOYEES AND THEIR ELIGIBLE FAMILY MEMBERS

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

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

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

Qualifying Events

The four instances of special enrollment are:

Loss of Prior Coverage

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

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

Documentation from the prior carrier – supporting the fact that the person had prior creditable coverage that was lost involuntarily – may be submitted at a later date with the employer’s approval, but the employee must submit the completed and signed enrollment/change form **within 31 days** of the loss of coverage (or denial notice).

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

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

Change in Family Status

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

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

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

[Establishing a new domestic partnership and adding a child to coverage due to a court order are **not** considered a change in family status for purposes of the "Special Enrollment" provision.]

Loss of Medicaid/SCHIP Eligibility

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

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

Medicaid/SCHIP Group Health Plan Premium Assistance Eligibility

A state may offer premium subsidies through Medicaid or a state child health plan (SCHIP) to low-income children and their families for qualified employer-sponsored coverage. This includes premium assistance for continuation coverage under federal or state law. Therefore, if an eligible employee or an eligible family member is not enrolled in the Plan and later becomes eligible for group health plan premium assistance under

Medicaid or under SCHIP, the eligible person may enroll in the Plan without being considered a late applicant. To be eligible for special enrollment, the affected person must apply for coverage through the employer no later than **60 days** after becoming eligible for premium assistance. (In order for a family member to be eligible for special enrollment, the employee must be covered under the employer's health plan. If the employee is not enrolled in the Plan when the eligible family member becomes eligible for assistance, the employee must enroll in the Plan at the same time as the eligible family member.)

Documentation from the state – supporting the fact that the person is eligible for premium assistance from Medicaid or SCHIP – may be submitted at a later date with the employer's approval, but the employee must submit the completed and signed enrollment/change form **within 60 days** of the affected person's premium assistance eligibility date. **Note:** Enrollment changes cannot be processed until **all documentation** is provided to the employer.

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

Applying for Special Enrollment

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

Waiving Coverage

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

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

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

Coverage Effective Date

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

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

[PRE-EXISTING CONDITIONS LIMITATION

Timely Applicants and Special Enrollees

No benefits are available for any pre-existing conditions for **[3-6] months** after the member's initial enrollment eligibility date.

Late Applicants

For a late applicant, no benefits are available for any pre-existing conditions for **[6-18] months** after his/her effective date of coverage.

Exceptions

The following members are **not** subject to this pre-existing conditions limitation:

- a member up to age **19** (through age 18)
- newborn child (when **[Family or Employee/Children]** **[Family]** coverage is in effect on the date of birth)
- newborn child added to coverage **within 31 days** of birth (when **[Family or Employee/Children]** **[Family]** coverage is **not** in effect on the date of birth)
- adopted child under age 18 (or child under age 18 placed in the subscriber's home for the purpose of adoption) and added to coverage **prior to** or **within 31 days** of adoption
- a newborn or adopted child who was enrolled in any group health care plan or other creditable coverage **within 31 days** of birth or adoption and who has not experienced any significant lapse of coverage (i.e., 95 63 or more days) prior to enrolling in this Plan

Reduction in Waiting Period

The "Pre-existing Conditions" waiting period will be reduced for any member who had comprehensive medical/surgical coverage that was either still in effect or was terminated **within 95 63 days** of his/her initial enrollment eligibility date under this Plan. The waiting period will be reduced by at least the length of time he/she was continuously covered under the prior plan(s).

You can add up any creditable coverage you had prior to enrollment in this Plan, but if you went for 95 63 days or more without any coverage, the coverage you had before the break will not be counted. Proof of creditable coverage is required before credit will be given. (Note: Certain workers whose employment was adversely affected by international trade and who were entitled to a second COBRA election period as a result will not have the period of time between loss of coverage and COBRA election count as a break in coverage for purposes of the 95 63-day rule.)

What Is Not Considered A Break in Coverage

For purposes of determining any significant break in coverage (i.e., 95 63 or more days), lapses in coverage due to any of the following situations will not be considered as part of a break:

- a waiting period imposed by a group health care plan before it allowed you to become eligible for enrollment
- the amount of time between the date you submitted a substantially complete application for individual plan coverage, and either the date the coverage began (if you were accepted), the date on which the application was denied, or the date the offer of coverage lapsed (if you were not accepted)
- the period of time between loss of coverage and COBRA election for certain workers whose employment was adversely affected by international trade and who were entitled to a second COBRA election period as a result

For any employee who lost coverage due to military service (and his/her eligible family members), was re-employed under the provisions of the USERRA of 1994 and applied for reinstatement of coverage according to the timeliness limitations of the USERRA of 1994, the pre-existing conditions waiting period will continue to be credited during the time the employee is in military service.]

RE-ENROLLMENT

[If a previously covered employee and/or eligible family members is re-enrolled in this group Plan, he/she will usually be considered a late applicant. See “Pre-Existing Conditions Limitation,” “Leave of Absence or Military Service,” and “Special Enrollment” for exceptions and details.]

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

COVERAGE TERMINATION

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

- The employee **terminates employment** or **otherwise loses eligibility** according to the terms of the Group Master Contract t Administrative Services Agreement. If the group or subscriber fails to notify BCBSNM **within 30 days** to remove an ineligible person from coverage, BCBSNM may recover any payment made on the ineligible person’s behalf.
- When the **premium payment** or other employee contribution for coverage is not received on time. (Coverage will be suspended if premium is not paid when it is due. If premium is not received **within 30 days** after its due date, the group or affected member(s) will be terminated at the end of the last-paid billing period. Any claims received and paid for during the 30-day grace period will be billed both to the subscriber and to the group or, in the case of continuation coverage, to the subscriber.)
- When the member begins a **leave of absence** or enters the **armed forces for more than 30 days** or as provided by law. (See “Leave of Absence or Military Service.”)
- When the **member materially fails to abide by the rules**, policies, or procedures of this Plan or fraudulently provides or materially misrepresents information affecting coverage. If a member knowingly gave false material information in connection with the eligibility or enrollment of the subscriber or any of his/her eligible family members, BCBSNM **Group Name** may terminate the coverage of the subscriber and his/her eligible family members retroactively to the date of initial enrollment. The subscriber is liable for any benefit payments made as a result of such improper actions.
- When the subscriber **dies**. (Surviving eligible family members remain covered through the last-paid billing period.)
- If this Plan is primary over **Medicare** due to federal laws and regulations, when the Medicare-eligible member *chooses* Medicare as his/her primary coverage. (See “Medicare-Eligible Members” for information on coverage options for members who are entitled to Medicare.)
- At the *beginning* of the month when the member becomes **age 65** (excepting any laws to the contrary that apply to certain large group employer health plans). See “How to Continue Coverage” for more information regarding continued coverage options in these cases.
- When the member acts in a **disruptive** manner that prevents the orderly business operation of any network provider or dishonestly attempts to gain a financial or material advantage.
- When **group coverage is discontinued** for the entire group or for the employee’s enrollment classification.
- When the group **Group Name** gives BCBSNM or BCBSNM gives the group **Group Name** a minimum **30 days’ advance written notice**.

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

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

Additional Covered Family Member Termination Reasons

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

- At the end of the **last-paid billing period** for covered family member coverage.
- At the end of the [month] when a child **no longer qualifies as an eligible child** under the Plan (e.g., a child is removed from placement in the home, marries or reaches the eligible child age limit, unless the child is medically certified as handicapped).
- At the end of the [month] following the date of a final **divorce** decree or **legal separation** for a spouse.
- At the end of the [month] when the subscriber gives a minimum **30 days' advance notice** in writing to end coverage for a covered family member(s), according to the rules of your Plan as established by your [employer].
- [At the end of the [month] following the dissolution of a domestic partnership.]

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

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

Voluntary Termination of Coverage

To remove a covered family member from coverage before loss of eligibility or to voluntarily terminate his/her own coverage, the subscriber must submit a completed enrollment/change form to his/her [benefits administrator]. If voluntary termination is allowed under your Plan outside the annual [renewal period], coverage will end the first of the month following receipt of the enrollment/change form. Voluntarily terminated members may re-enroll under the Plan only as late applicants (except as provided under "Special Enrollment"). Also, these members are **not** eligible for any extension of benefits or federal [or state] continuation or conversion coverage.

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

Termination of Continuation Coverage [or Extension of Benefits]

See "How to Continue Coverage" for more information.

Leave of Absence or Military Service

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

NOTIFICATION

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

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

- changes in federal and state law; or

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

PREMIUM REFUNDS

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

- the enrollment/change form is not received **within 31 days** of the change in eligibility status; or
- any claims or capitation amounts have been paid on behalf of the terminated member during the period for which premiums have been paid.

HOW TO CONTINUE COVERAGE

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

Extension of Benefits

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

An extension of benefits is available if you:

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

If coverage is continued under this provision, benefits for the disabling condition are paid subject to all applicable limitations, exclusions, and maximums that applied at the time the group's coverage terminated. To claim an extension of benefits, you must notify BCBSNM **within 31 days** of the group's coverage termination date and provide evidence of your total disability.

Continuation Coverage

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

You are not eligible to enroll for continuation coverage if:

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

[In addition, if you elect state continuation coverage, you may not later enroll in federal continuation coverage. Contact your benefits administrator for details about enrolling in continuation coverage.]

Continuation Benefits

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

Federal Continuation (COBRA)

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

- one who **voluntarily** terminated coverage while still eligible (*Involuntary termination* includes loss of coverage under the following situations only: legal separation, divorce, loss of eligible child eligibility)

status, death of the subscriber, termination of employment, reduction in hours, or termination of employer contributions. Any other reason is considered voluntary.)

- a covered family member who was removed from coverage by the subscriber while the family member was still eligible
- any member whose BCBSNM health care coverage was terminated for good cause

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

- the first of the month when you become entitled to Medicare
- when the employer discontinues offering this Plan to employees (If this Plan is replaced by another health care plan, continuation coverage will also be replaced by the new Plan.) **Exception:** If your group declares bankruptcy and you are covered under this Plan as a retiree, you and your eligible family members may be eligible for continued coverage.
- when you become covered under another group health care plan (However, if that health plan includes a pre-existing conditions limitation, continuation coverage will not end until that limitation has been satisfied or until another event occurs which would make you ineligible for continued coverage.)
- when the continuation period expires (If this employer’s Plan is still being administered by BCBSNM, you will have the option of changing to the conversion coverage provided by BCBSNM and described under “Conversion to Individual Coverage.”)

[State Continuation Coverage

A subscriber and his/her covered family members may continue Plan coverage for six months after losing coverage for any reason other than nonpayment of premium or termination of the entire group. BCBSNM must receive the application for state continuation coverage **within 31 days** after group coverage is lost. (A health statement is not required.)

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

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

If you are entitled to both Parts A and B of Medicare, your state continuation coverage option is limited to a Medicare Supplement Plan administered by BCBSNM. Depending upon your age and the Plan you select, a health statement may be required and a pre-existing conditions limitation may apply. (The options for members under age 65 are limited.) Call a Customer Service Advocate for more information.]

USERRA Continuation Coverage

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

Direct-Pay Premium Payments

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

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

CONVERSION TO INDIVIDUAL COVERAGE

Involuntarily terminating members may change to individual (direct-pay) conversion coverage if this employer group health plan is still in effect and coverage is lost due to one of the following circumstances:

- termination of employment
- a member no longer meets the eligibility requirements of the Group Master Contract Administrative Services Agreement
- the period of continuation coverage expires
- a covered family member loses coverage for one of the following reasons:
 - divorce or legal separation from the subscriber
 - disqualification of the member under the definition of a eligible family member
 - death of the subscriber
 - an employee becomes primary under Medicare — leaving eligible family members without coverage

The subscriber and any eligible family members *who were covered* at the time that group coverage was lost are eligible to apply for conversion coverage without a health statement.

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

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

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

If you are entitled to Medicare, your conversion coverage option is limited to a Medicare Supplement Plan administered by BCBSNM. Depending upon your age and the benefit plan you select, a health statement may be required and a pre-existing conditions limitation may apply. (The options for members under age 65 are limited.) Call a Customer Service Advocate for the enrollment options available to you.

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

SECTION 3: HOW YOUR PLAN WORKS

BENEFIT CHOICES

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

[BlueNet EPO is a health care plan that provides benefits under agreement with an exclusive network of Preferred Providers. When you need nonemergency health care that is covered under the Plan, **you must choose a provider from the Blue Cross and Blue Shield "Preferred Provider Organization (PPO)" network in order to receive benefits.**

Your Choices

Preferred Provider Services	Nonpreferred Provider Services
<ul style="list-style-type: none"> •You pay an annual deductible and a percentage of covered charges (coinsurance) after the deductible is met (for exception, see last item, below). •You have an annual out-of-pocket limit (includes Preferred Provider benefit level coinsurance only). •The provider files claims for you. •The provider will not bill you for amounts above the covered charge.* •Preferred providers that contract directly with BCBSNM will obtain necessary preauthorizations and admission review for you. •Primary Preferred Provider (PPP) office visit charges are not subject to deductible. You pay only a fixed-dollar copay (see "Cost-Sharing Features" for details). Other services of a PPP and services of a non-PPP preferred provider are subject to deductible and coinsurance. 	<ul style="list-style-type: none"> •You pay a higher annual deductible and a higher coinsurance percentage. •You have a higher annual out-of-pocket limit to meet for Non-preferred Provider benefit level coinsurance. •You may need to file claims. •You may have to pay amounts above the covered charge.* •You are responsible for admission review and other preauthorizations. •Some benefits are not available unless services are received from a preferred provider. See your <i>Summary of Benefits</i> for those services not covered at the Nonpreferred Provider benefit level. •Nonpreferred provider services are not eligible for the PPP office visit copayment - even if required due to an emergency.

	Preferred Provider	Nonpreferred Provider
Cost-Sharing Differences	<p>You pay no annual deductible. For most covered services, you pay a fixed-dollar copayment only. (For some services, such as allergy care, durable medical equipment, prosthetics, orthotics, and medial supplies, you pay a percentage of the covered charge.</p> <p>You have an annual out-of-pocket limit which includes Preferred Provider benefit level copayments and coinsurance only.</p>	<p>For most covered services, you must pay an annual deductible and a percentage of covered charges. The covered charge may be less than the billed charges.</p> <p>You have a higher annual out-of-pocket limit to meet for Nonpreferred Provider benefit level coinsurance.</p>
Covered Charge vs. Billed Amount	<p>If the covered charge is less than the billed amount, the preferred provider will write off the difference. You pay only deductible, copayments, coinsurance, non-covered expenses, and penalty amounts, if any.</p>	<p>The nonpreferred provider may bill you for amounts over the covered charge. This amount is not applied to your deductible and is not applied to your out-of-pocket limit. The payment of these excess charges is solely your responsibility.</p>

Filing Claims	The preferred provider is responsible for filing claims directly to the local BCBS Plan.	You may have to pay the nonpreferred provider in full and submit your own claims; the decision is up to the provider.
Requesting Preauthorizations	Preferred providers that contract directly with BCBSNM are responsible for requesting all necessary preauthorizations on your behalf. (Providers that contract with another BCBS Plan may call for preauthorization on your behalf, but you will be responsible for making sure that preauthorization is obtained when required.)	Nonpreferred providers may call for preauthorizations on your behalf, but you are responsible for making sure that all preauthorizations are obtained when required.
Available Benefits	All services covered under this Plan are eligible for coverage at the Preferred Provider benefit level. (Specialist cost-sharing provisions apply to certain transplants.)	Some benefits are not available unless services are received from a preferred provider. See the <i>Summary of Benefits</i> for a list of services not covered at the Nonpreferred Provider benefit level.

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

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

This Plan provides benefits under agreement with an exclusive network of preferred providers. When you need non-emergency health care that is covered under this Plan, **you must choose a provider from the Blue Cross and Blue Shield “Preferred Provider Organization (PPO)” network in order to receive benefits.**

At A Glance

Preferred Provider Services
<ul style="list-style-type: none"> •You must use preferred providers except in an emergency and specified situations described under “Exceptions for Nonpreferred Providers” in this Section. •You pay an annual deductible and a percentage of covered charges (coinsurance) after the deductible is met or, in some cases a fixed-dollar amount (copayment) for a covered service. Services for which you pay only a fixed-dollar copayment are not subject to the deductible (see “Cost-Sharing Features” for details). All other services are subject to deductible and coinsurance. •You have an annual out-of-pocket limit (includes coinsurance and copayments only). •The preferred provider is responsible for filing claims for you directly to the local Blue Cross and Blue Shield Plan. •The preferred provider will not bill you for amounts above the covered charge, which may be less than the billed charge. The “covered charge” is the amount that BCBSNM determines is fair and reasonable allowance for a particular covered service. After your share of a covered charge (e.g., deductible, coinsurance, copayment, and/or penalty amount) has been calculated, BCBSNM pays the remaining amount of the covered charge, up to maximum benefit limits, if any. •Preferred providers that contract directly with BCBSNM are responsible for requesting all necessary preauthorizations and admission review for you. (Providers that contract with another BCBS Plan may call for preauthorization on your behalf, but you will be responsible for making sure that preauthorization is obtained when required. If you do not obtain preauthorization, benefits may be reduced or denied.)

PREFERRED PROVIDERS VERSUS NONPREFERRED PROVIDERS

Preferred Providers are health care professionals and facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, or another BCBS Plan as “preferred” or “PPO” providers. These providers have agreed to provide health care for PPO EPO plan members and accept the Plan’s payment for a covered service plus the mem-

ber's share of the covered charge (i.e., deductible, coinsurance, copayment and/or penalty amount, if any) as payment in full.

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

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

When you receive nonemergency medical care, covered services must be received from a provider that has contracted with BCBSNM and/or his/her local Blue Cross and Blue Shield Plan as a preferred provider.

Unless listed under "Exceptions for Nonpreferred Providers," benefits are not available for nonemergency services received from a nonpreferred provider – even if a preferred provider is not available in your area to perform the services.

SELECTING A PREFERRED PROVIDER FROM THE PROVIDER DIRECTORY AND ONLINE PROVIDER FINDER®

When you need medical care, there are a variety of ways you can choose a Primary Preferred Provider (PPP) or other preferred provider in your area. You can also access mental health providers (including those specializing in chemical dependency) and participating pharmacies. **Note:** Only those providers listed under Family Practice, General Practice, Internal Medicine, Gynecology, Obstetrics/Gynecology and Pediatrics are considered Primary Preferred Providers (PPPs). See "Cost-Sharing Features," later in this section for details.

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

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

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

Web-Based BCBSNM Provider Finder

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

www.bcbsnm.com

The website also has an Internet link to the national Blue Cross and Blue Shield Association website for services outside New Mexico. Website directories also include maps and directions to provider locations.

Paper Provider Network Directory

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

Providers Outside New Mexico

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

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

BCBSNM Website

If you have an Internet connection, you may check the BCBSNM website, click on “Provider Finder[®]” and then link to the line item entitled “Providers located outside New Mexico.” You will then be linked to the Blue Cross Blue Shield Association’s BlueCard Doctor and Hospital Finder:

www.bcbsnm.com

National Website

Visit the Blue Cross and Blue Shield Association website’s national “BlueCard Doctor and Hospital Finder” and click on “Find a Doctor or Hospital.” Then follow the instructions at:

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

National Phone Number

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

1-800-810-BLUE (2583)

International Assistance

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

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

Exceptions for Nonpreferred Providers

There are four instances in which the services of a nonpreferred provider may be eligible for coverage:

Emergency Care

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

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

Ancillary Providers

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

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

Unsolicited Providers

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

Transition of Care

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

If medically necessary covered services are not available through network professional providers, BCBSNM and the network professional will refer you to an out-of-network professional. However, the payment for the out-of-network provider will **not** exceed the payment that would have been made in the absence of any referral.

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

These are the only instances in which the services of a nonpreferred provider will be covered.

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

CALENDAR YEAR

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

[Your benefit period is a period of one year which begins on [Month Day] and ends on [Month Day]. The initial benefit period is from a member’s effective date of coverage, but ends on the date it would normally end, which may be less than 12 months.

BENEFIT LIMITATION

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

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

COST-SHARING FEATURES

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

YOUR DEDUCTIBLE

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

[Individual Deductible

[There is no deductible to meet for services of a preferred provider.

[Once a member's deductible payments for nonpreferred provider services reach the individual nonpreferred provider deductible amount indicated on the *Summary of Benefits*, this Plan will begin paying its share of that member's covered nonpreferred provider charges.

[There are **two** individual deductible amounts indicated on your *Summary of Benefits*. Once a member's deductible payments for preferred provider services reach the individual preferred provider deductible amount, this Plan will begin paying its share of that member's covered preferred provider charges. The member must meet the higher nonpreferred provider deductible before this Plan begins to pay its share of his/her covered charges from nonpreferred providers.

Covered charges for preferred provider services are **not** applied to the nonpreferred provider deductible and covered charges for nonpreferred providers are **not** applied to the preferred provider deductible.

[The individual deductible is listed on the *Summary of Benefits*. Once a member's deductible payments for covered services reach the individual deductible amount, this Plan will begin paying its share of that member's covered charges for the rest of the calendar year.

[Once a member's deductible payments reach the individual deductible amount specified in the *Summary of Benefits*, this Plan will begin paying its share of that member's covered charges.

[Family Deductible

[There is no deductible to meet for services of a preferred provider.

An entire family meets [the annual deductible for nonpreferred provider services [the applicable annual deductible [the annual deductible when the total deductible amount for all family members reaches the amount specified on your separately issued *Summary of Benefits*. [(The deductible amounts for three or more family members are combined to satisfy the family deductible.) **Note:** If a member's Individual deductible is met, no more charges incurred by that member may be used to satisfy the [applicable Family deductible.

[An entire family meets the deductible when the total deductible amount specified in the *Summary of Benefits* is reached. **Note:** If a member's individual deductible is met, no more charges incurred by that member may be used to satisfy the family deductible.

[The deductible amount you must satisfy depends on whether you have Individual or family coverage. An individual coverage member must meet the "individual coverage" deductible before this Plan begins to pay your covered

charges, including for items covered under [Prescription Drugs and Other Items] [“Prescription Drugs and Other Items”].

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

What Is Not Subject to the Deductible

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

- [charges covered under your *Drug Plan Rider*] [Prescription Drugs and Other Items] [“Prescription Drugs and Other Items”]
- [preferred provider copayments]
- [preferred provider coinsurance]
- [PPP office visit copayments]
- [fixed-dollar copayments]
- [the first \$[100–1,000] you incur in covered adult Preventive Services]
- [the following services when received from preferred providers: routine colonoscopies, the first \$500 for other routine services, diagnostic tests (excluding MRIs, PET scans, and CT scans) and services covered under the “Heart, Heart–Lung, Liver, Lung, Pancreas–Kidney” transplant provision in *Section 5: Covered Services*]
- services covered under the “Heart, Heart–Lung, Liver, Lung, Pancreas–Kidney” transplant provision in *Section 5: Covered Services*
- [Preventive Services from preferred providers for eligible children through age 17]
- [hearing aids and ear molds for members under the age of 21]
- [diagnostic lab tests and x-rays]

Admissions Spanning Two Calendar Years

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

Timely Filing Reminder

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

COPAYMENTS

[When you visit a preferred provider, the amount you pay is usually a fixed-dollar amount (copayment). There is no annual deductible or additional coinsurance to meet.

[When you visit a preferred provider in his/her office, the office visit charge is subject to the PPP office visit copayment described below. Other services received during the visit, services of other preferred providers, and the services of nonpreferred providers are subject to the deductible, coinsurance, and out-of-pocket limit provisions described below.

[Copayments are the fixed-dollar amount of a covered charge that you pay for certain services as specified on the separately issued *Summary of Benefits*.

Office Visit Copayment

[When you receive **office services** from a preferred provider, you pay only a fixed-dollar amount (or copayment), for his/her covered **office visit charge**. (You pay a lower copayment when visiting a “Primary Preferred Provider.”) The copayments for “Primary Preferred Provider” (PPP) and PPO Specialist office visits are listed on the *Summary of Benefits*. However, all other services received during the office visit (such as physical therapy or chemotherapy) will be subject to regular deductible and/or coinsurance requirements and/or to an additional copayment as listed on the *Summary of Benefits*.

Besides office visits, other services are also subject to a copayment amount. See the *Summary of Benefits*.

[**Primary Preferred Provider (PPP)** is a preferred provider in one of the following medical specialties **only**: Family Practice; General Practice; Internal Medicine; Obstetrics/Gynecology; Gynecology; or Pediatrics. PPPs do **not** include physicians specializing in any other fields such as Obstetrics only, Geriatrics, Pediatric Surgery or Pediatric Allergy.

Preferred (PPO) Specialist is a practitioner of the healing arts who is in the Preferred Provider Network – but does not belong to one of the specialties defined above as being for a “Primary Preferred Provider” (or “PPP”). A PPO Specialist does not include hospitals or other treatment facilities, urgent care facilities, pharmacies, equipment suppliers, ambulance companies, or similar ancillary health care providers.

COINSURANCE

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

For some covered services, you must pay a percentage of covered charges as “coinsurance.” After your share has been calculated, this Plan pays the rest of the covered charge, up to maximum benefit limits, if any.

[Nonpreferred providers may charge you the difference between the billed charge for a covered service and the covered charge allowed by BCBSNM – in addition to your coinsurance and deductible amount.

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

[Preferred Providers

When you receive covered services from a preferred provider you pay [no [an annual deductible[and a percentage of covered charges (coinsurance) after the deductible is met. For most covered services, you pay only a fixed-dollar copayment [(For some services, such as allergy care, durable medical equipment, prosthetics, orthotics and medical supplies, you pay a percentage of the covered charge.)

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

[Nonpreferred Providers

When you receive covered services from a nonpreferred provider, [you must pay an annual deductible and a percentage of covered charges. [you have a higher deductible amount to meet each year and you must pay a higher percentage of covered charges for nonpreferred provider services. If the covered charge is less than the billed charge, you will also be responsible for paying the difference when you receive services from a nonpreferred provider.

Drug Plan Copayment

When you purchase covered prescription drugs and other items through the separately issued *Drug Plan Rider*, your responsibility may be either a fixed-dollar amount or a percentage of the covered charge. (You may also have to pay the difference between the cost of a brand-name drug and its generic equivalent.) In either case, drug plan copayments are **not** subject to the deductible or out-of-pocket limit provisions. See your *Drug Plan Rider* for more information about the amounts you pay under the drug plan.

Drugs and other items purchased through the drug plan are subject to the annual deductible; coinsurance and/or copayment amounts you pay for covered items under the drug plan are also applied to the preferred provider out-of-pocket limit each calendar year. See *Prescription Drugs and Other Items* “Prescription Drugs and Other Items” for more information about the drug plan.

OUT-OF-POCKET LIMIT

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

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

The coinsurance amounts and copayments for preferred provider services are **not** applied to the nonpreferred provider out-of-pocket limit. In addition, the coinsurance amounts for nonpreferred provider services are not applied to the preferred provider out-of-pocket limit.

Individual Limits

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

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

Once your coinsurance and copayment amounts reach the individual amount indicated on the *Summary of Benefits*, this Plan pays 100 percent of most of your covered charges for the rest of the calendar year.

Family Limits

There is no family out-of-pocket limit; each member must meet his/her own limit in a calendar year.

An entire family meets the out-of-pocket limit during a calendar year when the total coinsurance and copayments for all family members reaches the amount specified in the *Summary of Benefits*. (When a member meets the Individual out-of-pocket limit, no more charges incurred by that member may be used to satisfy the applicable Family out-of-pocket limit.)

An entire family meets the out-of-pocket limit during a calendar year when the total coinsurance for all family members reaches the amount specified on the *Summary of Benefits*. (When a member meets the out-of-pocket limit, no more charges incurred by that member may be used to satisfy the family out-of-pocket limit.)

An entire family must meet the “family coverage” out-of-pocket limits indicated in the *Summary of Benefits* before this Plan begins to pay **100 percent** of preferred provider or nonpreferred provider covered charges for any covered family member. The applicable limit is met when the total deductible and coinsurance for all family members reaches the amount specified in the *Summary of Benefits*. **Note:** There are no “individual” limits to

meet for a member under “family coverage.” An entire family must first meet the out-of-pocket limit(s) and one family member may satisfy an entire preferred provider or nonpreferred provider limit for the whole family.

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

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

- [penalty amounts
- [amounts in excess of covered charges [(including amounts in excess of annual or lifetime benefit limits)
- [noncovered expenses (including services in excess of annual or lifetime day/visit limits)
- [PPP office visit copayments
- [office visit copayments, and if chemical dependency–related services are limited, they do not go to your out-of-pocket limit (See your *Summary of Benefits*.)
- [deductible amounts
- [chemical dependency related services for small employer groups
- [drug plan copayments and/or coinsurance amounts
- [*Drug Plan Rider* copayments
- [expenses covered under the “Heart, Heart-Lung, Liver, Lung, Pancreas-Kidney” transplant provision in *Section 5: Covered Services* [(There is a separate \$5000[1,000–10,000] out-of-pocket limit for certain transplant-related services. See “Transplant Services” in *Section 5: Covered Services* for details.)

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

[See the *Summary of Benefits* for coinsurance percentages and out-of-pocket limit amounts.

CHANGES TO THE COST-SHARING AMOUNTS

Coinsurance percentage amounts, [copayments, deductibles and out-of-pocket limits may change during a calendar year. If changes are made, the change applies only to services received after the change goes into effect. You will be notified if changes are made to this Plan.

If your group increases the deductible or out-of-pocket limit amounts during a calendar year, the new amounts must be met during the same calendar year. For example, if you have met your deductible and your group changes to a higher deductible, you will not receive benefit payments for services received after the change went into effect until the increased deductible is met.

If your group decreases the deductible or out-of-pocket limit amounts, you will not receive a refund for amounts applied to the higher deductible or out-of-pocket limit.

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

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

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

[BENEFIT LEVEL EXCEPTIONS

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

Emergency Care

If you visit a nonpreferred provider for emergency care services, [the preferred provider deductible and coinsurance is applied only to [you will receive benefits for the initial treatment, which includes emergency room services and, if you are hospitalized **within 48 hours** of an emergency, the related inpatient hospitalization. (Office/urgent care facility services are not considered “emergency care” for purposes of this provision.)

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

Transition of Care

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

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

[Unsolicited Providers

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

Ancillary Provider

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

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

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

IF YOU HAVE MEDICARE

Note: This section applies to you only if you are primary under Medicare and Plan benefits are going to be coordinated with Medicare as a result.

If you have Medicare as your **primary coverage**, the Plan usually pays benefits only after Medicare has paid its portion of your covered health care services. Medicare is called the “primary” coverage or carrier and pays its benefits first. The **GROUP** Medical Program is “secondary” coverage.

You may not elect to change your **GROUP** Plan to be primary coverage over Medicare and may not elect to bypass Medicare. If services are among those normally covered by Medicare, you or your doctor or hospital (your health care “provider”) must submit a claim for those services first to Medicare. Medicare will calculate its benefits and will send you an *Explanation of Medicare Benefits* (EOMB) form. This form must be attached to any claim you send to BCBSNM. **NOTE:** For services received in New Mexico, a “crossover” claim should automatically be sent by the Medicare Part B carrier or Part A intermediary to BCBSNM for secondary benefit determination. If your claims are not being sent by Medicare to BCBSNM, please call a Customer Service Advocate to verify that the correct Medicare HIC number is on file for you. For details on how to submit claims when your claim is not automatically crossed-over from Medicare, see *Section 8: Claims Payments and Appeals*.

If you plan to receive a service that is not covered by Medicare (such as while outside the United States), it is your responsibility to call Customer Service and verify that the service will be covered under this Plan.

Active Employees and Employee Eligible Family Members

If you are an active employee or the eligible family member of an active employee and are entitled to Medicare for any reason other than end-stage renal disease, this Plan pays benefits before Medicare and this section does not apply to you.

End-Stage Renal Disease

If you become eligible for Medicare *solely* due to having ESRD (i.e., you are *not* also age 65 or older and/or you are *not* also eligible for Medicare due to a non-ESRD disability), this Plan pays benefits **before** Medicare **only** during the “ESRD coordination time period.” The length of this time period may change if changes are made in Medicare Secondary Payer laws. You will be advised of the length of the ESRD coordination time period once you begin dialysis. This section does not apply to you if you are still within the initial ESRD coordination time period during which this Plan pays primary benefits.

If you complete the ESRD coordination time period or reach age 65 while eligible for Medicare as an ESRD patient, Medicare determines its benefits **before** this Plan pays its portion of covered charges. **This section of the booklet applies to such members who are primary under Medicare; your Plan benefits will be coordinated with Medicare.** See the **GROUP** for enrollment rules.

Medicare-Eligible Retirees and Retiree Eligible Family Members

If you are a Medicare-eligible retiree or the Medicare-eligible family member of a retiree receiving primary coverage from Medicare, Medicare determines its benefits before this Plan pays its portion of covered charges. **This section of the booklet applies to such members who are primary under Medicare; your Plan benefits will be coordinated with Medicare.** **NOTE:** If you are a retiree and eligible for Medicare, see the **GROUP** for enrollment rules.

How Benefits are Paid

All expenses are subject to the same annual Plan deductible, copayment, coinsurance, and out-of-pocket limits. This Plan’s benefits are determined and the balance due after Medicare or the usual Plan benefit will be paid, whichever is less. **Note:** You must be enrolled in both Parts A and B of Medicare in order to retain coverage under this **GROUP** Plan. If you privately contract with a provider, BCBSNM will calculate amounts that would have been paid by Medicare and deduct those amounts from the billed charge for a covered service in order to arrive at a benefit payment, subject to Plan deductible and coinsurance or Plan copayments.

Services that are not covered by Medicare may also be eligible for benefits under this Plan. See *Section 5: Covered Services* for a list of services that are covered by the Plan (services must be medically necessary and not listed as an exclusion in *Section 6: General Limitations and Exclusions*).

The following services are not subject to this Medicare coordination provision:

- non-Medicare-covered services that are not covered by the Plan and received at a Veteran's Administration, Department of Defense, or other government facility for a nonservice-connected condition (For outpatient service, benefits are calculated using a maximum of 20 percent of the billed charge as the covered charge, which is then subject to regular Plan deductible, coinsurance, and/or copayments. For inpatient services, the covered charge is equal to the Part A hospital deductible, subject to regular Plan deductible, coinsurance, and/or copayments.

SECTION 4: ADMISSION REVIEW AND OTHER PREAUTHORIZATIONS

You or your provider must obtain authorization from BCBSNM *before* you are admitted as an inpatient (admission review approval) or receive certain types of services (other preauthorizations).

In order to receive benefits:

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

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

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

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

Most preauthorization requests will be evaluated and you and/or the provider notified of BCBSNM's decision **within 15 days** of receiving the request (**within 72 hours** for urgent care requests). If requested services are not approved, the notice will include: 1) the reasons for denial; 2) a reference to the health care plan provisions on which the denial is based; and 3) an explanation of how you may appeal the decision if you do not agree with the denial (see [*Section 8: Claims Payments and Appeals*]) and "If Your Preauthorization Request is Denied" later in this section).

Retroactive approvals will not be given and you may be responsible for the charges if preauthorization is not obtained **before** the service is received.

BCBSNM PREFERRED PROVIDERS

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

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

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

NONPREFERRED PROVIDERS OR PROVIDERS OUTSIDE NEW MEXICO

If any provider outside New Mexico (except for those contracting as preferred providers directly with BCBSNM) or any nonpreferred provider recommends an admission or a service that requires preauthorization, the provider is **not** obligated to obtain the preauthorization for you. In such cases, it is **your** responsibility to ensure that approval is obtained. [**Remember:** Nonpreferred providers are covered only for emergency care and in those specific circumstances described in *Section 3: How Your Plan Works.*]

If approval is not obtained **before** services are received, **you will incur a penalty for a covered admission or, for some services, be entirely responsible for the charges.** The provider may call on your behalf, but it is **your responsibility** to ensure that BCBSNM (or the BHU, when applicable) [(or Mesa Mental Health, when applicable)] is called.

ADMISSION REVIEW APPROVAL

Preauthorization is required for most admissions **before** you are admitted to the:

- [hospital]
- [skilled nursing facility]
- [physical rehabilitation facility]
- [other treatment facility]

If you do not obtain preauthorization within the time limits indicated in the table below, benefits for covered facility services will be **reduced or denied** as explained under “Penalty for Not Obtaining Preauthorization.”

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

How the Preauthorization Procedure Works

When you or your provider call, BCBSNM's Health Services representative will ask for information about your medical condition, the proposed treatment plan, and the estimated length of stay. The Health Services representative will evaluate the information and notify the attending physician and the facility (usually at the time of the call) if benefits for the proposed hospitalization are preauthorized. If the admission is not preauthorized, you may appeal the decision as explained in [Section 8: Claims Payments and Appeals] and in “If Your Preauthorization Request is Denied” later in this section).

Penalty for Not Obtaining Preauthorization

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

If, based on a review of the claim:	Then:
The admission was not for a covered service .	Benefits for the facility and all related services will be denied .*
The admission was for an item listed under “ Other Preauthorizations ,” (e.g., high-dose chemotherapy).	Benefits for the facility and all related services will be denied .*
The admission was for any other covered service but hospitalization was not medically necessary .	Benefits will be denied for room, board, and other charges that are not medically necessary.*
The admission was for a medically necessary covered service .	Benefits for the facility's covered services will be reduced by \$300 400 .*

*The admission review penalty of \$300 400 and charges for noncovered and denied services are **not applied** to any deductible or out-of-pocket limit. You are responsible for paying this amount.

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

Preauthorization of Mental Health/Chemical Dependency Services

All inpatient and outpatient mental health and chemical dependency services must be preauthorized by the Behavioral Health Unit (BHU) at the phone number listed on the back of your ID card. You or your health care provider should call the BHU **before** you schedule treatment. **NOTE:** Your provider may be asked to submit clinical information in order to obtain preauthorization for the services you are planning to receive. Services may be authorized or may be denied based on the clinical information received. (*Clinical information* is information based on actual observation and treatment of a particular patient.)

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

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

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

Summary of Contact Information for Preauthorization, Customer Service, Claim Submission, and Appeal (or Reconsideration) Processes for Medical/Surgical and Behavioral Health Services:		
Process:	Type of Service:	Send to:
Request preauthorization	Medical/surgical	BCBSNM
	Mental health/chemical dependency	Behavioral Health Unit
Customer Service Inquiry	Medical/surgical	BCBSNM
	Mental health/chemical dependency	Behavioral Health Unit
Submit claim (post-service)	Medical/surgical	BCBSNM or local BCBS Plan
	Mental health/chemical dependency	BCBSNM or local BCBS Plan
Request appeal or reconsideration of claim or preauthorization decision	Medical/surgical	BCBSNM Appeals Unit
	Mental health/chemical dependency	BCBSNM Appeals Unit

[OTHER PREAUTHORIZATIONS

In addition to admission review for all inpatient services, preauthorization is required for certain other services. Most preauthorizations may be requested over the telephone. If a *written* request is needed and you call, a Health Services representative will give you instructions for filing a written request for preauthorization.

If preauthorization is not obtained, **benefits will be denied** for the following services and all related services:

- [air ambulance services (unless during a medical emergency)]
- [alcohol or drug abuse services][(Preauthorization is obtained from the BHU.) (Preauthorization is obtained from Mesa Mental Health.)]
- [autism spectrum disorders for children]
- [cardiac or pulmonary rehabilitation]
- [chemotherapy (high-dose)]
- [dental-related services in a hospital or other facility (the procedure may not be covered even if benefits for the hospitalization are approved as medically necessary; see *Section 5: Covered Services*); [oral/maxillofacial surgery procedures;]treatment of **accidental injuries to teeth** (except initial treatment); **orthognathic surgery**; and treatment of **orthognathism**]

- **[diabetic supplies; insulin pumps; and diabetic equipment costing \$500 (or more)]**
- **diagnostics** including **PET scans; cardiac CT scans; sleep studies; genetic testing and/or counseling; infertility testing**
- **dialysis** (home)
- **[durable medical equipment, medical supplies and prosthetic devices costing \$ 500 (or more) or requiring long-term rental; orthopedic appliances, orthotics; and surgically implanted prosthetics, regardless of total cost]**
- **[enteral nutritional products, special medical foods, and certain drugs covered under [the Drug Plan Rider;]]**["Prescription Drugs and Other Items"] prescription **refills** before the supply should have been exhausted]
- **[home health care]**
- **home infusion therapy (HIT)**
- **[hospice care]**
- **[infertility-related services (Only limited services are covered.)]**
- **injections** for growth hormone, Avonex, Copaxone
- **inpatient hospital/treatment facility admissions** including hospital care, rehabilitation facilities, inpatient hospice, and skilled nursing facilities (SNFs)
- **[private room charges]**
- **[psychiatric intake evaluations and medication checks; electroshock therapy; psychological testing; psychotherapy]**
- **[rehabilitative services (outpatient/office physical, occupational, and speech therapy)]**
- **[smoking/tobacco use cessation drug therapy]** [(See your *Drug Plan Rider.*)]
- **surgery** including, but not limited to, **cochlear implants, reconstructive surgery, and mastectomy services**
- **[transplant procedures** for heart, lung, heart/lung, liver, pancreas–kidney, including pretransplant evaluations

The services listed above may not be approved for payment (for example, due to being experimental, investigational, unproven, or not medically necessary). It is strongly recommended that you request preauthorization for high-cost services in order to reduce the likelihood of benefits being denied *after* charges are incurred. The complete list of services requiring preauthorization is subject to review and change by BCBSNM. BCBSNM-contracted providers have a list of all procedures and services, including individual surgical procedures and injectable drugs, that require preauthorization. If you need a copy of this list, call a Customer Service Advocate.]

IF YOUR PREAUTHORIZATION REQUEST IS DENIED

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

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

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

Appeal Procedure for Pre-Service Denial

If your request for preauthorization has been denied in whole or in part, you may appeal the decision and have your request for service reviewed. Within **180 days** after you receive notice of the decision, call or write to BCBSNM Customer Service and explain your reasons for disagreeing with the adverse determination. You may also ask to see relevant documents and may submit written issues, comments, and additional medical information. Requests for review received more than 180 days following notification will not be considered unless you can satisfy BCBSNM that matters beyond your control prevented an earlier request for review.

For urgent care, BCBSNM follows the “Expedited Review” process. For all other services, BCBSNM follows the “Standard Review” process.

- **Standard Review:** After reviewing your initial preauthorization request and any additional information you provide in your appeal, BCBSNM will notify you of the decision within 30 days after receiving your appeal request.
- **Expedited Review:** For urgently needed services, you may request an “expedited review” of your appeal request either orally or in writing. After reviewing your initial preauthorization request and any additional information you provide in your appeal, BCBSNM will notify you of the decision within 72 hours after receiving your appeal request.

If You Are Not Satisfied

If you are not satisfied with the results of the decision made by BCBSNM, see *Section 8: Claim Payment and Appeals.*]

ADVANCE BENEFIT INFORMATION

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

UTILIZATION REVIEW/QUALITY MANAGEMENT

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

SECTION 5: COVERED SERVICES

This section describes the services and supplies covered by this Plan, subject to the limitations and exclusions in *Section 3: How Your Plan Works* and *Section 6: General Limitations and Exclusions*. All payments are based on covered charges as determined by BCBSNM.

Reminder: It is to your financial advantage to receive care from Primary Preferred Providers (PPPs) and other preferred providers.

MEDICALLY NECESSARY SERVICES

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

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

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

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

If Medicare is Primary

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

AMBULANCE SERVICES

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

Air Ambulance

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

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

Exclusions

This Plan does **not** cover:

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

AUTISM SPECTRUM DISORDERS

For a member **19 years old or younger** (or, if enrolled in high school, 22 years old or younger), this Plan covers the habilitative and rehabilitative treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy, and applied behavioral analysis (ABA) when provided by an in-network provider. Providers must be credentialed to provide such therapy. **Note:** ABA services are not indicated for children over the age of seven.

Treatment must be prescribed by the member's treating physician in accordance with a treatment plan. The treatment plan must be **preauthorized** by BCBSNM; if services are received but were not approved as part of the treatment plan, benefits for covered services will be denied. Once maximum functionality has been reached and no additional improvement is expected, no therapies are covered unless required to maintain that member's current functionality (that is, in the absence of additional treatment, the patient would suffer a setback). **No benefits are available for any treatments not shown to be habilitative or rehabilitative.**

Benefits for all Applied Behavioral Analysis (ABA) services for the treatment of autism spectrum disorder are limited for each eligible BCBSNM-insured person to **\$36,000** per calendar year and to **\$200,000** in total lifetime benefits. Once the annual maximum for ABA is reached, no more benefits for ABA autism therapy are provided until the next year. Once a lifetime maximum is reached, no more benefits for autism therapy are provided for that BCBSNM member.

Changing from one plan to another under the same group, reinstating prior BCBSNM coverage, changing employers, changing policyholder or subscriber, or moving from individual coverage to group coverage or vice versa does **not** reinstate autism benefits once an annual or lifetime maximum is reached for a particular insured member. All amounts payable under this provision are tracked at the member level regardless of the policy number under which charges accrued. For example, if a member is covered under two BCBSNM policies, the maximum annual benefit and the maximum lifetime benefit is not doubled for that member. Regardless of the number of policies under which the member is covered, benefits will not exceed the *per member* annual and lifetime maximum benefits mandated by law.

Services are subject to usual member cost-sharing features such as deductible, coinsurance, copayments, and out-of-pocket limits – based on place of treatment and type of service. All services are subject to the *General Limitations and Exclusions* of the member's plan except where explicitly mentioned as being an exception. For example, certain autism spectrum disorder services mandated by law are not excepted from exclusions such as the "Nonpreferred Provider Services" or "Pre-Existing Conditions" exclusions.

Regardless of the type of therapy received, claims for services related to autism spectrum disorder should be mailed to BCBSNM – **not** to the behavioral health services administrator.

Exclusions

This Plan does **not** cover:

- any experimental, long-term, or maintenance treatments not required under state law
- any treatment or therapy from an out-of-network provider
- medically unnecessary or nonhabilitative services under any circumstance
- applied behavioral analysis (ABA) for children over the age of seven
- any services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children 3 to 22 years old who have autism spectrum disorder
- services that have not been preauthorized by BCBSNM or are provided by an out-of-network provider
- respite services or care

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

DENTAL-RELATED/TMJ SERVICES AND ORAL SURGERY

The following services are the only dental-related services and oral surgery procedures covered under this Plan. When alternative procedures or devices are available, benefits are based upon the least costly, medically appropriate procedure or device available.

Dental and Facial Accidents

Benefits for covered services for the treatment of accidental injuries to the jaw, mouth, face or sound natural teeth are generally subject to the same limitations, exclusions and member cost-sharing provisions that would apply to similar services when not dental-related (e.g., x-rays, medical supplies, surgical services).

To be covered, *initial* treatment for the accidental injury must be sought **within 72 hours** of the accident. Any services required after the initial treatment must receive **preauthorization**, requested **in writing**, from BCBSNM and be received **within 12 months** of the date of accident in order to be covered. (For treatment of TMJ or CMJ injuries, see “TMJ/CMJ Services.”)

Facility Charges and General Anesthesia for Dental-Related Services

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

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

All hospital covered services for dental procedures must be **preauthorized** by BCBSNM. **Note:** Unless listed as a covered service in this section, the dentist’s services for the procedure will not be covered. **Reminder: If hospital covered services are recommended by an out-of-network provider, you are responsible for obtaining admission review approval for the admission or preauthorization for outpatient covered services to receive maximum benefits.** (See *Section 4: Admission Review and Other Preauthorizations.*)

Oral Surgery

This Plan covers the following oral surgical procedures only:

- medically necessary orthognathic surgery if **preauthorization** is received from BCBSNM
- external or intraoral cutting and draining of cellulitis (not including treatment of dental-related abscesses)
- incision of accessory sinuses, salivary glands or ducts

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

TMJ/CMJ Services

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

Exclusions

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

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

DIABETIC SERVICES

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

For insulin and over-the-counter diabetic supplies, see your separately issued Drug Plan Rider "Prescription Drugs and Other Items" Prescription Drugs and Other Items.

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

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

EMERGENCY CARE AND URGENT CARE

Emergency Care

This Plan covers medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to his/her health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part, or

disfigurement. (In addition, services must be received in an emergency room, trauma center, or ambulance to qualify as an emergency.) Examples of emergency conditions include, but are not limited to: heart attack or suspected heart attack, coma, loss of respiration, stroke, acute appendicitis, severe allergic reaction, or poisoning.

For accidental injury to the mouth, jaw, teeth, or TMJ, see “Dental-Related/TMJ Services and Oral Surgery.”

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

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

If you visit a nonpreferred provider for emergency care, the preferred provider benefit is applied only to the initial treatment, which includes emergency room services and, if you are hospitalized **within 48 hours** of an emergency, the related inpatient hospitalization. Once you are discharged, covered follow-up care from a non-preferred provider is **not covered** paid at the nonpreferred provider benefit level (Services received in an office or urgent care facility are not considered emergency care for purposes of this provision.)

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

Emergency Admission Notification

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

Member Copayments

If you are directly admitted as an inpatient, the copayment for emergency room services is waived. The inpatient hospital benefit will apply in such cases.

Urgent Care

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

Care received in an urgent care facility is covered as any other type of service, subject to the copayment listed on your *Summary of Benefits*. If services are received in an emergency room or other trauma center, the condition must meet the definition of an “emergency” in order to be covered.

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

HEARING AIDS/RELATED SERVICES FOR CHILDREN UNDER AGE 21

This Plan covers the cost of hearing aids, the fitting and dispensing fees for hearing aids and ear molds, up to a combined maximum amount of **\$2,200 per hearing impaired ear every 36 months** for members under 21 years old. This 36-month benefit period begins on the date the first covered hearing aid-related service is received and payable under this provision and ends 36 months later. The next benefit period for the impaired ear begins 36 months after the first hearing aid-related service (e.g., fitting cost, ear mold, etc.) OR on the date the next hearing aid-related service for that ear, whichever length of time is greater.

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

for hearing aids.) **Routine hearing examinations and related services are not covered for members age 21 and older.**

HOME HEALTH CARE/HOME I.V. SERVICES

For oxygen, ostomy supplies and medical equipment, see “Supplies, Equipment and Prosthetics.”

Conditions and Limitations of Coverage

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

Preauthorization Required

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

Covered Services

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

- skilled nursing care provided on an intermittent basis by a registered nurse or licensed practical nurse
- physical, occupational, or respiratory therapy provided by licensed or certified physical, occupational, or respiratory therapists
- speech therapy provided by a speech pathologist or an American Speech and Hearing Association certified therapist
- intravenous medications and other prescription drugs ordinarily not available through a retail pharmacy if **preauthorization** is received from BCBSNM (If drugs are not provided by the home health care agency, see your separately issued *Drug Plan Rider. Prescription Drugs and Other Items.*)“Prescription Drugs and Other Items”.)
- laboratory services that would have been covered during an inpatient admission
- parenteral and enteral nutritional products that can only be legally dispensed by the written prescription of a physician and are labeled as such on the packages (If *not* provided by the home health care agency or if products do not require a prescription, see your separately issued *Drug Plan Rider. Prescription Drugs and Other Items.*“Prescription Drugs and Other Items”.)
- medical supplies
- skilled services by a qualified aide to do such things as change dressings and check blood pressure, pulse, and temperature

Exclusions

This Plan does **not** cover:

- care provided primarily for your or your family’s convenience
- homemaking services or care that consists mostly of bathing, feeding, exercising, preparing meals for, moving, giving medications to, or acting as a sitter for the patient (See the “Custodial Care” exclusion in *Section 6: General Limitations and Exclusions.*)
- services provided by a nurse who ordinarily resides in your home or is a member of your immediate family
- nonprescription enteral nutritional products (See your separately issued *Drug Plan Rider* for details about possible benefits for these products.)(See *Prescription Drugs and Other Items.*)(See “Prescription Drugs and Other Items”.)

HOSPICE CARE SERVICES

Conditions and Limitations

This Plan covers inpatient and home hospice services for a terminally ill member received during a hospice benefit period when provided by a hospice program approved by BCBSNM. Hospice care benefits are limited as specified in the *Summary of Benefits*.

If you need an extension of the hospice benefit period, the hospice agency must provide a new treatment plan and the attending physician must recertify your condition to BCBSNM.

Preauthorization Required

Before you receive hospice care, you, your attending physician, or the hospice agency must request **preauthorization** from BCBSNM. **Hospice care services are not covered without preauthorization.**

Covered Services

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

- visits from hospice physicians
- skilled nursing care by a registered nurse or licensed practical nurse
- physical and occupational therapy by licensed or certified physical or occupational therapists
- speech therapy provided by an American Speech and Hearing Association certified therapist
- medical supplies (If supplies are *not* provided by the hospice agency, see “Supplies, Equipment and Prosthetics.”)
- drugs and medications for the terminally ill patient (If drugs are *not* provided by the hospice agency, see your separately issued *Drug Plan Rider Prescription Drugs and Other Items* “Prescription Drugs and Other Items”).
- medical social services provided by a qualified individual with a degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training and experience (Such services must be recommended by a physician to help the member or his/her family deal with a specified medical condition.)
- services of a home health aide under the supervision of a registered nurse and in conjunction with skilled nursing care
- nutritional guidance and support, such as intravenous feeding and hyperalimentation
- respite care for a period **not to exceed five continuous days for every 60 days** of hospice care and **no more than two respite care periods** during each hospice benefit period (*Respite care* provides a brief break from total care-giving by the family.)

Exclusions

This Plan does **not** cover:

- food, housing, or delivered meals
- medical transportation
- homemaker and housekeeping services
- comfort items
- private duty nursing
- pastoral, spiritual, or bereavement counseling
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this Plan

- care or services received after the member's coverage terminates

The following services are **not** hospice care benefits but may be covered elsewhere under this Plan: acute inpatient hospital care for curative services, durable medical equipment, physician visits unrelated to hospice care, and ambulance services.

HOSPITAL/OTHER FACILITY SERVICES

Blood Services

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

Inpatient Services

Admission Review Required

If hospitalization is recommended by a nonpreferred provider in an emergency or you are outside New Mexico, **you are responsible** for obtaining admission approval. If you do not follow the admission review procedures, benefits for covered facility services will be **reduced** or **denied** as explained in *Section 4: Admission Review and Other Preauthorizations*.

Covered Services

For acute inpatient medical or surgical care received during a covered hospital admission, this Plan covers semi-private room or special care unit (e.g., ICU, CCU) expenses and other medically necessary services provided by the facility. (If you have a private room for any reason other than isolation, covered room expenses are limited to the average semiprivate room rate, whether or not a semiprivate room is available. BCBSNM must give **preauthorization** for medically necessary private room charges to be covered.)

Medical Detoxification

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

Exclusions

This Plan does **not** cover:

- private room expenses, unless your medical condition requires isolation for protection from exposure to bacteria or diseases (e.g., severe burns or conditions that require isolation according to public health laws)
- admissions related to noncovered services or procedures (See "Dental-Related/TMJ Services and Oral surgery" for an exception.)
- extended care facility admissions or admissions to similar institutions
- admissions for rehabilitative treatment, such as oxygen therapy (For physical rehabilitation benefits, see "Rehabilitation and Other Therapy.")

Outpatient or Observation Services

Coverage for outpatient or observation services and related physician or other professional provider services for the treatment of illness or accidental injury depends on the type of service received (for example, see "Lab, X-Ray, Other Diagnostic Services" or "Emergency and Urgent Care").

LAB, X-RAY, OTHER DIAGNOSTIC SERVICES

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

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

- psychological testing with **preauthorization** from Mesa Mental Health from the BHU
- x-ray and radiology services, ultrasound, and imaging studies
- laboratory and pathology tests
- EKG, EEG, and other electronic diagnostic medical procedures
- genetic testing, with **preauthorization** from BCBSNM (Tests such as amniocentesis or ultrasound to determine the gender of an unborn child are not covered; see “Maternity/Reproductive Services and Newborn Care.”)
- infertility-related testing, with **preauthorization** from BCBSNM (See “Maternity/Reproductive Services and Newborn Care.”)
- PET (Positron Emission Tomography) scans and cardiac CT scans with **preauthorization** from BCBSNM
- sleep disorder studies with **preauthorization** from BCBSNM (If services must be performed on an inpatient basis, admission approval is required.)
- audiometric (hearing) and vision tests for the diagnosis and/or treatment of an accidental injury or an illness

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

MATERNITY/REPRODUCTIVE SERVICES AND NEWBORN CARE

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

Family Planning and Infertility-Related Services

For oral contraceptive coverage and contraceptive devices purchased from a pharmacy, see your Drug Plan Rider-Prescription Drugs and Other Items“Prescription Drugs and Other Items”.

Family Planning

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

- injection of Depo-Provera for birth control purposes
- diaphragm, including fitting
- IUDs or cervical caps, including fitting, insertion, and removal
- surgical sterilization procedures such as vasectomies and tubal ligations

Infertility-Related Services

This Plan covers the following infertility-related treatments when **preauthorization** is received from BCBSNM (**Note:** the following procedures only *secondarily* treat infertility):

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

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

Infertility *testing*, when **preauthorization** is received from BCBSNM, is covered only to diagnose the cause of infertility. Once the cause has been established and the treatment determined to be noncovered, no further testing

is covered. For example, this Plan will cover lab tests to monitor hormone levels following the hormone replacement treatment listed as covered above. However, daily ultrasounds to monitor ova maturation are **not** covered since the testing is being used to monitor a noncovered infertility treatment.

Exclusions

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

- contraceptive devices that do not require a prescription, including over-the-counter contraceptive products such as condoms and spermicide
- sterilization reversal for males or females
- infertility treatments and related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization
- Gamete Intrafallopian Transfer (GIFT)
- Zygote Intrafallopian Transfer (ZIFT)
- cost of donor sperm
- artificial conception or insemination; fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such as in-vivo or in-vitro (test tube) fertilization, and embryo transfer; drugs for induced ovulation; or other artificial methods of conception

Pregnancy-Related/Maternity Services

If you are pregnant, you should call BCBSNM before your maternity due date, soon after your pregnancy is confirmed. You are responsible for making sure that BCBSNM is notified **within 48 hours** of admission for a routine delivery or **within 96 hours** for a C-section delivery (or as soon as possible). If not notified within this time period, benefits for covered facility services will be reduced by **\$300400**. See *Section 4: Admission Review and Other Preauthorizations*.

A covered eligible daughter also has coverage for maternity services. However, if the parent of the newborn is an eligible child of the subscriber (i.e., the newborn is the subscriber's grandchild), benefits are **not** available for the newborn.

Covered Services

Covered maternity services include:

- hospital or other facility charges for semiprivate room and ancillary services, including the use of labor, delivery, and recovery rooms (This Plan covers all medically necessary hospitalization, including at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a C-section delivery.)
- routine or complicated delivery, including prenatal and postnatal medical care of an obstetrician, certified nurse-midwife or licensed midwife (Expenses for prenatal and postnatal care are included in the total covered charge for the actual delivery or completion of pregnancy. **Note:** Home births are not covered at the Preferred Provider level unless the provider has a preferred provider contract with his/her local BCBS Plan and is credentialed to provide the service.). The office visit during which a pregnancy is confirmed is subject to the member cost-sharing provisions that apply to any other office visit.)
- pregnancy-related diagnostic tests, including genetic testing or counseling if **preauthorized** by BCBSNM (Services must be sought due to a family history of a gender-linked genetic disorder or to diagnose a possible congenital defect caused by a present, external factor that increases risk, such as advanced maternal age or alcohol abuse. For example, tests such as amniocentesis or ultrasound to determine the gender of an unborn child are **not** covered.)
- necessary anesthesia services by a provider qualified to perform such services, including acupuncture used as an anesthetic during a covered surgical procedure and administered by a physician, a licensed doctor of oriental medicine, or other practitioner as required by law

- when necessary to protect the life of the infant or mother, coverage for transportation, including air transport, for the medically high-risk pregnant woman with an impending delivery of a potentially viable infant to the nearest available tertiary care facility for newly born infants (See “Ambulance Services” for details.)
- services of a physician who actively assists the operating surgeon in performing a covered surgical procedure when the procedure requires an assistant
- elective, spontaneous, or therapeutic termination of pregnancy prior to full term

Newborn Care

Covered services for initial routine newborn care include:

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

For children who are covered from their date of birth, benefits include coverage of injury or sickness, including covered services related to the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities as required by New Mexico state law. **Note:** If the parent of the newborn is an eligible child of the subscriber (i.e., the newborn is the subscriber’s grandchild), services for the newborn are **not** covered.

If both the mother’s charges and the baby’s charges are eligible for coverage under this Plan, no additional deductible or hospital copayment for the newborn is required for the facility’s initial routine nursery care if the covered newborn is discharged on the same day as the mother.

Extended Stay Newborn Care

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

If you are in a nonpreferred facility, you must ensure that BCBSNM is called **before** the mother is discharged from the hospital. If you do not, benefits for the newborn’s covered facility services will be reduced by \$300 400. The baby’s services will be subject to a separate deductible, coinsurance, hospital copayment and out-of-pocket limit.

PHYSICIAN VISITS/MEDICAL CARE

Benefits for services received in a physician’s office are based on the type of service received while in the office. This section describes benefits for therapeutic injections, allergy care and testing, and other nonsurgical, nonroutine medical visits to a health care provider for evaluating your condition and planning a course of treatment. See specific topics referenced in this section for more information regarding a particular type of service (e.g., “Preventive Services,” “Transplant Services,” etc.).

This Plan covers medically necessary care provided by a physician or other professional provider for an illness or accidental injury. **Your choice of provider can make a difference in the amount you pay.** (See *Section 3: How Your Plan Works.*)

Office Visits and Consultations

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

Allergy Care

This Plan covers direct skin (percutaneous and intradermal) and patch allergy tests, radioallergosorbent testing (RAST), allergy serum, and appropriate FDA-approved allergy injections administered in a provider’s office or in a facility. Services must be received from a preferred provider in order to be covered.

Diabetes Self-Management Education

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

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

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

Genetic Inborn Errors of Metabolism

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

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

Injections and Injectable Drugs

This Plan covers most FDA-approved therapeutic injections administered in a provider’s office. However, this Plan covers some injectable drugs only when **preauthorization** is received from BCBSNM. Your BCBSNM-contracted provider has a list of those injectable drugs that require preauthorization. If you need a copy of the list, contact a BCBSNM Health Services representative. (When you request preauthorization, you may be directed to purchase the self-injectable medication through your Drug Plan.)

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

Mental Health Evaluation Services

This Plan covers medication checks and intake evaluations for mental disorders, alcohol, and drug abuse when **preauthorized** by Mesa Mental Health the BHU. See “Psychotherapy (Mental Health and Chemical Dependency)” for psychotherapy and other therapeutic service benefits.

Inpatient Medical Visits

With the exception of dental-related services (see “Dental-Related/TMJ Services and Oral Surgery”), this Plan covers the following services when received on a covered inpatient hospital day:

- visits for a condition requiring **only** medical care, unless related to hospice care (See “Hospice Care Services.”)

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

PRESCRIPTION DRUGS AND OTHER ITEMS

Covered Medications and Other Items

This Plan covers the following drugs, supplies and other products through this drug plan provision **only when dispensed by a participating pharmacy** under the Retail Pharmacy Program or Specialty Pharmacy Drug Program (unless required as the result of an emergency) **or ordered through the Mail Order Service Program**:

- prescription drugs and medicines (including compounded medications of which at least one ingredient is a prescription drug, prescriptive oral agents for controlling blood sugar levels and prescription contraceptive medications), insulin, glucagon, and prescription contraceptive devices purchased from a participating pharmacy, unless listed as an exclusion (**Note:** Prescription contraceptive devices fitted or inserted by, and purchased directly from a physician are payable under the “Family Planning” benefit, if any, of your medical/surgical Plan)
- specialty pharmacy drugs such as, but not limited to, self-administered injectable drugs such as growth hormone, Copaxone, Avonex. (Most injectable drugs require **preauthorization** from BCBSNM. Some self-administered drugs, whether injectable or not, are identified as specialty pharmacy drugs and must be acquired through a participating specialty pharmacy provider in order to be covered.)
- insulin needles, syringes and diabetic supplies (e.g., glucagon emergency kits, autolets, lancets, lancet devices, blood glucose and visual reading urine and ketone test strips). (A separate copayment amount applies for each item purchased.) These items are **not** covered as a medical supply or medical equipment expense under any medical or surgical provisions of this benefit booklet.
- nonprescription enteral nutritional products and special medical foods only when **preauthorized** and either: 1) delivered through a medically necessary enteral access tube that has been surgically placed (e.g., gastrostomy, jejunostomy) or 2) meeting the definition of special medical foods used to treat and to compensate for the metabolic abnormality of members with genetic inborn errors of metabolism in order to maintain their adequate nutritional status.
- **two, 90-day courses of preauthorized** treatment with FDA-approved prescription drugs to assist you with quitting tobacco use or smoking. (Starting any course of prescription drug therapy counts as one entire course of drug therapy – even if you discontinue or fail to complete the course. Therefore, if you purchase a one-month supply of a prescription drug for smoking cessation and do not continue the drug beyond the one month, you have used up one entire 90-day course of treatment with the 30-day supply.)

Other Preauthorizations

Certain prescription drugs, injectable medications and specialty pharmacy drugs may require **preauthorization** from BCBSNM. A list of drugs requiring preauthorization is available on the BCBSNM website at www.bcbsnm.com. Your physician can request the necessary preauthorization.

Member Copayments

For covered prescription drugs (including specialty pharmacy drugs), insulin, diabetic supplies, and nutritional products, you pay a copayment, not to exceed the actual retail price, for each prescription filled or item purchased (not to exceed supply limitations described in this section). Copayments are **not** included in the out-of-pocket limit, and are not eligible for reimbursement once the out-of-pocket limit is reached. You may also have to pay the

difference in cost between the brand-name drug and its generic equivalent (see below). The copayments are listed on the *Summary of Benefits*.

Brand-Name vs. Generic Drug Costs

If you or the provider requests the brand-name drug when there is an FDA-approved generic equivalent available, **you must pay the difference in cost between the brand-name and its generic equivalent**, plus the generic drug copayment.

Retail Pharmacy and Specialty Pharmacy Drug Program

All items covered under this provision must be purchased from a participating retail pharmacy. **Some drugs may have to be purchased from a participating specialty pharmacy provider in order to be covered.** (See your Provider Directory, call a Customer Service Advocate or visit the BCBSNM website at www.bcbsnm.com for a list of participating pharmacies and specialty pharmacy providers.)

You must present your BCBSNM identification (ID) card to the pharmacist at the time of purchase to receive your drug benefits. (You do not receive a separate prescription ID card; use your BCBSNM ID card to receive all your medical/surgical and prescription drug services covered under this Plan.)

You can use your ID card to purchase covered items only for yourself and covered family members. When coverage for you or a family member ends under this Plan, the ID card may not be used to purchase drugs or other items for the terminated family member(s).

If you do not have your ID card with you or if you purchase your prescription or other item from a nonparticipating pharmacy provider in an **emergency**, you must pay for the purchase in full and then submit a claim directly to the BCBSNM pharmacy benefit manager. (You should have received the address of the pharmacy benefit manager in the materials you received upon enrollment. If you did not, call Customer Service for the address and a claim form or visit the BCBSNM website at www.bcbsnm.com.)

If you are leaving the country or need an extended supply of medication, call Customer Service **at least two weeks** before you intend to leave. (Extended supplies or vacation overrides are not available through the Mail Order Service Program (see below) but may be approved only through the Retail Pharmacy Program. In some cases, you may be asked to provide proof of continued enrollment eligibility under the Retail Pharmacy Program.)

Mail Order Service

The Mail Order Service Program offers you the convenience of home delivery at a lower cost per 30-day supply than what you would pay through the Retail Pharmacy Program.

Except for supply limitations and nutritional products, all items that are covered under the Mail Order Service are the same items that are covered under the Retail Pharmacy Program and are subject to the same limitations and exclusions. **Items covered through a specialty pharmacy provider may not be covered through the Mail Order Service.** To use the Mail Order Service, follow the instructions outlined in the materials provided to you in your enrollment packet. (If you do not have this information, call a Customer Service Advocate.) **Note:** Prescription drugs and other items may **not** be mailed outside the United States. Extended supplies or vacation overrides required when you are outside the country may be approved only through the Retail Pharmacy Program.

Cost-Sharing Features

For covered prescription drugs (including specialty pharmacy drugs), insulin, diabetic supplies, enteral nutritional products and special medical foods, you pay a percentage amount (not to exceed supply limitations described below). The coinsurance you pay has a minimum amount you may be charged, but you will never pay more than the actual retail price. Coinsurance amounts are subject to the overall Plan deductible and the out-of-pocket limit provisions (see *Summary of Benefits*). Once your coinsurance amounts reach the out-of-pocket limit, items covered under this Plan will be payable at **100 percent** for the rest of the benefit period.

When the coinsurance for an item purchased under the drug plan is greater than the covered charge for the supply being purchased from a participating pharmacy, you pay the **lesser of:** 1) your minimum coinsurance amount or 2) the pharmacy's or vendor's retail price. For claims submitted to the pharmacy benefit manager for reimbursement,

you are paid the **lesser of**: 1) the sum of the drug ingredient cost, the dispensing fee that would be payable to a participating pharmacy and any sales tax minus the applicable coinsurance amount or 2) the pharmacy's retail price minus the applicable coinsurance amount.

Retail Pharmacy and Specialty Pharmacy Drug Program Supply Limitations

For each copayment listed on the *Summary of Benefits*, you can obtain the following supply of a single covered prescription drug or other item:

Program Type	Supply Maximum	Copay Requirement* (see note)
Covered Nutritional Products	30-day supply during any 30-day period	50 percent of covered charges
Retail Pharmacy and Specialty Pharmacy	During each one-month period, a 30-day supply or 120 units (e.g., pills) whichever is less	One copayment as listed on the Summary of Benefits. If more than 120 units are needed to reach a 30-day supply, another copayment will apply to each additional 120 units (or portion thereof) purchased. For oral contraceptives, the supply is limited to one menstrual cycle (normally 28 days).
Mail-Order	During each three-month period, a 90-day supply or 360 units (e.g., pills) whichever is less	Two 1/2 copayments as listed on the Summary of Benefits. If less than a 90-day supply is ordered, one copayment will apply. If more than 360 units are needed to reach a 90-day supply, 2 1/2 more copayments will apply to each additional 360 units (or portion thereof) purchased.

NOTE: For commercially packaged items (such as an inhaler, a tube of ointment or a blister pack of tablets or capsules), you will pay the applicable copayment for each package, **regardless of the number of days supply the package represents**. For example, if two inhalers are purchased under the Retail Pharmacy Program, 2 1/2 copayments will apply. Under Mail-Order, you can receive up to three times the number of packages obtainable from a retail pharmacy for the same copayment amount payable under the Retail Pharmacy Program.

Minimums and Maximums

For each prescription, you are required to pay a specific percentage amount up to, but not to exceed, a maximum payment amount (see *Summary of Benefits*). You will pay less than the minimum amount listed **only** if the full retail cost is less than the minimum amount due from you under this Plan. The following is an example of how the minimum and maximum percentage amounts work when you purchase a generic drug through the Retail Pharmacy Program:

- **Medication A** costs less than \$20. You pay the actual retail cost of the prescription.
- **Medication B** costs \$40. Since 25% is less than \$20, you pay the minimum amount of \$20.
- **Medication C** costs \$120. Since 25% is greater than \$20 and less than \$75, you pay 25% (or \$30).
- **Medication D** costs \$700. Since 25% is greater than \$75, you pay the maximum amount of \$75.

Exclusions

This Plan does **not** cover:

- nonprescription and over-the-counter drugs unless specifically listed as covered, including herbal or homeopathic preparations and nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum, or prescription drugs that have over-the-counter equivalents This exclusion includes nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum.
- non-commercially available compounded medications, regardless of whether or not one or more ingredients in the compound requires a prescription (Non-commercially available compounds are those made by mixing or

reconstituting ingredients in a manner or ratio that is inconsistent with United States Food and Drug Administration–approved indications provided by the ingredients’ manufacturers.)

- prescriptions or other covered items purchased from a nonparticipating pharmacy, nonparticipating specialty pharmacy provider or other provider unless eligible for benefits in an emergency situation
- refills before the normal period of use has expired, in excess of the number specified by the physician or requested **more than one year** following the physician’s original order date (Prescriptions cannot be refilled until **at least 75 percent** of the previously dispensed supply will have been exhausted according to the physician’s instructions. Call Customer Service for instructions on obtaining a greater supply if you are leaving home for more than a 30-day period of time.)
- replacement of drugs or other items that have been lost, stolen, destroyed or misplaced
- infertility medications
- drugs or other items for the treatment of sexual or erectile dysfunction
- therapeutic devices or appliances, including support garments and other nonmedicinal substances
- medications or preparations used for cosmetic purposes (such as preparations to promote hair growth or medicated cosmetics), including tretinoin (sold under such brand names as Retin-A) for cosmetic purposes
- nonprescription enteral nutritional products that are taken by mouth or delivered through a temporary naso-entertic tube (e.g., nasogastric, nasoduodenal, or nasojejunal tube), unless the patient meets criteria for genetic inborn errors of metabolism and the product is prior-approved by BCBSNM); or nonprescription nutritional products that have not been prior-approved by BCBSNM
- shipping, handling or delivery charges
- prescription drugs required for international travel or work
- appetite suppressant or diet aids; weight reduction drugs food or diet supplements and medication prescribed for body building or similar purposes

PREVENTIVE SERVICES

This Plan covers the following preventive services, not subject to coinsurance, deductible, copayment, or benefit maximums when received from an in–network provider (out–of–network services are subject to the usual out–of–network deductible, coinsurance, and out–of–pocket limit):

- a. evidence–based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);
- b. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- c. evidence–informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents;
- d. additional preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.

Covered preventive services not included in the above list will be subject to regular plan benefits (e.g., benefits for diagnostic testing, office visits, etc.).

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009). Examples of covered services include, but are not limited to:

This Plan covers the following routine physical examinations and associated testing in accordance with national medical standards, the state of New Mexico, the American Academy of Pediatrics and the U.S. Preventive Services Task Force:

- routine physical, breast, and pelvic examinations
- routine adult and pediatric immunizations

- routine screening colonoscopies and mammograms at 100 percent of covered charges when received from an in-network provider, not subject to any annual maximum for preventive care. Deductible, copayment, and coinsurance provisions do not apply at the in-network level. Out-of-network benefits for these services are covered (or not covered) as described on your *Summary of Benefits* under “Routine Screening” (or similar) line item.
- an annual routine gynecological or pelvic examination and low-dose mammogram screenings
- papilloma virus screening and cytologic screening (a Pap test or liquid-based cervical cytopathology)
- human papillomavirus vaccine (HPV) for members ages 9 – 26 years old
- periodic blood hemoglobin, blood pressure and blood glucose level tests
- periodic colorectal screening tests
- periodic blood cholesterol or periodic fractionated cholesterol level including a low-density lipoprotein (LDL) and a high-density lipoprotein (HDL) level; periodic stool examination for the presence of blood
- periodic left-sided colon examination of 35 to 60 centimeters or colonoscopy
- well-child care, including well-baby and well-child screening for diagnosing the presence of autism spectrum disorder (not limited by the \$36,000 annual or \$200,000 lifetime maximum benefit for autism spectrum disorders ABA services; see “Autism Spectrum Disorders” for additional covered services.)
- periodic glaucoma eye tests
- vision and hearing screenings in order to detect the need for additional vision or hearing testing for members through age 17 when received as part of a routine physical examination (A screening does *not* include an eye examination, refraction or other test to determine the amount and kind of correction needed.)
- health education and counseling services if recommended by your physician, including an annual consultation to discuss lifestyle behaviors that promote health and well-being, including smoking/tobacco use cessation counseling

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

Your preventive services benefit pays covered preventive services at 100 percent of the covered charge, no deductible, for preferred provider services – up to a maximum annual payment of \$500. After you have reached the \$500 limit, benefits for covered preventive services are subject to the deductible and coinsurance provisions. However, there is no maximum annual overall benefit for preventive services. (Note: Routine colonoscopies from preferred providers are not subject to the \$500 limit for services that are eligible for 100 percent benefit payment.) Routine/preventive services from a nonpreferred provider are subject to the nonpreferred provider deductible and coinsurance provisions.

Children Services (Through Age 17)

Your child preventive services benefit (for members **through age 17**) pays covered preventive services for children at **100 percent** of the covered charge, no deductible for preferred provider services. There is no maximum annual benefit for preferred provider services. Nonpreferred provider preventive services are subject to the nonpreferred provider deductible and coinsurance provisions and are limited to an annual maximum benefit payment of \$ per member.

Adult Services (Age 18 and Older)

Your adult preventive services benefit pays covered preventive services for adults at 100 percent of the covered charges, no deductible for preferred provider services, up to a maximum amount of \$ per calendar year. After you have reached the \$ limit, benefits for covered preventive services are subject to the deductible and coinsurance provisions.

Adult preventive services received from nonpreferred providers are not covered.

Exclusions

This Plan does **not** cover:

- employment physicals, insurance examinations, or examinations at the request of a third party (the requesting party may be responsible for payment); premarital examinations; sports or camp physicals; any other nonpreventive physical examination
- immunizations or medications required for international travel
- hepatitis B immunizations when required due to possible exposure during the member's work
- routine eye examinations; eye refractions; visual screening for members over age 17 ; or any related service or supply
- routine hearing examinations; hearing aids; hearing screening for members over age 17 ; or any related service or supply, unless otherwise specified in this section (See "Hearing Aids/Related Services for Children Under Age 21.")

PSYCHOTHERAPY (MENTAL HEALTH AND CHEMICAL DEPENDENCY)

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

Medical Necessity

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

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

Covered Services/Providers

Covered services include solution-focused evaluative and therapeutic mental health services (including individual and group psychotherapy) received in a psychiatric hospital, an IOP (intensive outpatient program), or an alcoholism treatment program that complies with applicable state laws and regulations, and services rendered by psychiatrists, licensed psychologists, and other providers as defined in *Section 10: Definitions*. See your BCBSNM *Provider Directory* for a list of contracting providers or check the BCBSNM website at www.bcbsnm.com or the Mesa Mental Health website at www.mesamentalhealth.com.

Services for the treatment of mental disorders and chemical dependency are not covered when received from nonpreferred providers.

Preauthorization Required

All inpatient and outpatient mental health and chemical dependency services must be preauthorized by the Behavioral Health Unit at the phone number listed on the back of your ID card. You or your physician should call the Behavioral Health Unit **before** you schedule treatment. If you do not call before receiving nonemergency services, whether inpatient or outpatient, **benefits for covered services may be reduced or denied** as explained in the *Admission Review* section, earlier. In such cases, you may be responsible for all charges, so please ensure that you or your provider have received preauthorization for any services you plan to receive.

This Plan also covers electroshock therapy when **preauthorization** is received from Mesa Mental Health.the BHU.

Benefit Limits

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

Chemical Dependency Benefit Period Limitation

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

Minimum Coverage for Alcohol Abuse Rehabilitation

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

Exclusions

This Plan does **not** cover:

- care received from a nonpreferred provider
- care that has not been **preauthorized** by BCBSNM
- psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education
- services billed by a school, halfway house or group home, or their staff members; foster care, day treatment, residential treatment centers, or behavior modification services
- long-term therapy or therapy for the treatment of chronic mental disorders or incurable conditions for which treatment produces minimal or temporary change of relief – except that medication management for chronic conditions is covered (Chronic conditions are conditions such as, but not limited to, autism, Down’s Syndrome and developmental delays.) See “Early Developmental Delay and Disability” in *Section 8: Claims Payments and Appeals* for reimbursement of certain services provided to eligible children by the Department of Health.
- maintenance therapy or care provided after you have reached your rehabilitative potential (See the “Long-Term or Maintenance Therapy” exclusion in the *General Limitations and Exclusions* section.)
- biofeedback, hypnotherapy, or behavior modification services
- religious or marital counseling
- custodial care (See the “Custodial Care” exclusion in *Section 6: General Limitations and Exclusions*.)
- any care that is patient-elected and is not considered medically necessary
- care that is mandated by court order or as a legal alternative, and lacks clinical necessity as diagnosed by a licensed provider; services rendered as a condition of parole or probation
- special education, school testing and evaluations, counseling, therapy, or care for learning deficiencies or educational and developmental disorders; behavioral problems unless associated with manifest mental disorders or other disturbances (See “Early Developmental Delay and Disability” in *Section 8: Claim Payments and Appeals* for reimbursement of certain services provided to eligible children by the Department of Health.)

- non-national standard therapies, including those that are experimental as determined by the mental health professional practice
- the cost of any damages to a treatment facility
- care in excess of the annual or lifetime maximum benefits specified in the *Summary of Benefits*, if any

REHABILITATION AND OTHER THERAPY

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

Acupuncture and Spinal Manipulation

This Plan covers acupuncture and spinal manipulation services when administered by a licensed provider acting within the scope of licensure and when necessary for the treatment of an illness or accidental injury. Benefits for acupuncture and spinal manipulation are limited as specified in the *Summary of Benefits*. **Services must be received from a preferred provider in order to be covered.**

This Plan does **not** cover these services when received from nonpreferred providers.

Acupuncture/Chiropractic Services

This Plan covers acupuncture when administered by a licensed provider acting within the scope of licensure and chiropractic services administered by a chiropractor acting within the scope of his/her licensure and according to the standards of chiropractic medicine in New Mexico (or the state in which the services were rendered). Services must be necessary for the treatment of an illness or injury. Benefits for acupuncture (which includes acupuncture used as an anesthetic) and for chiropractic services (which includes physical therapy, spinal manipulation, x-rays, office visits, and other covered services performed by the chiropractor), are limited as specified on your *Summary of Benefits*.

This Plan does **not** cover:

- herbs or homeopathic preparations
- services of a massage therapist or rolfing
- any therapeutic exercise equipment prescribed for home use
- maintenance therapy or care or long-term therapy

Cardiac and Pulmonary Rehabilitation

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

This Plan does **not** cover these services when received from nonpreferred providers.

Chemotherapy and Radiation Therapy

This Plan covers the treatment of malignant disease by standard chemotherapy and treatment of disease by radiation therapy. **High-dose chemotherapy treatments must receive preauthorization from BCBSNM in order to be covered.**

Cancer Clinical Trials

If you are a participant in an approved cancer clinical trial that is being conducted in New Mexico, you may receive coverage for certain routine patient care costs incurred in the trial. Trials designed to test toxicity or disease pathophysiology are not included. Trials must have a therapeutic intent and be provided as part of a study being conducted in a cancer clinical trial in New Mexico. The persons conducting the trial must provide BCBSNM with notice of when the member enters and leaves a qualified cancer clinical trial and must accept BCBSNM’s covered charges as payment in full.

The routine patient care costs that are covered must be the same services or treatments that would be covered if you were receiving standard cancer treatment. Benefits also include FDA-approved prescription drugs that are not paid for by the manufacturer, distributor, or supplier of the drug. (Member cost-sharing provisions described under your separately issued *Drug Plan Rider Prescription Drugs and Other Items* “Prescription Drugs and Other Items” will apply to these benefits.)

If benefits for services provided in the trial are denied, you may contact the Superintendent of Insurance for an expedited appeal.

Blue Distinction Centers for Specialty Care

While you are not required to use a Blue Distinction Center for treatment of cancer, if you choose a Blue Distinction Center and services are **preauthorized** by your BCBSNM case manager, you may be eligible for travel and lodging benefits described under “Travel, Food, and Lodging,” later in this *Section 5*, which applies to this cancer treatment coverage for up to five days before a covered treatment and for one year following the date of the initial cancer treatment. Facilities selected as Blue Distinction Centers feature:

- multi-disciplinary team input, including sub-specialty trained teams for complex and rare cancers and demonstrated depth of expertise across cancer disciplines in medicine, surgery, radiation oncology, pathology, and radiology
- ongoing quality management and improvement programs for cancer care
- ongoing commitment to using clinical data registries and providing access to appropriate clinical research for complex and rare cancers
- sufficient volume of experience in treating rare and complex cancers such as:
 - acute leukemia (inpatient/nonsurgical)
 - bladder cancer
 - bone cancer
 - brain cancer – primary
 - esophageal, gastric, liver, pancreatic, and rectal cancers
 - head and neck cancers
 - ocular melanoma
 - soft tissue sarcomas
 - thyroid cancer – medullary or anaplastic

Note: Although facilities in the Blue Distinction network may be designated by their subspecialties for rare and complex cancers, each facility provides comprehensive cancer care services. Because there are so many types of cancer, they cannot all be listed on the Blue Distinction website. Therefore, consult with your physician and/or with a BCBSNM Cancer Care Coordinator to determine which facility is best for you. You may view the entire list of Blue Distinction Centers and review the criteria used in selecting facilities for the designation at the Blue Cross and Blue Shield Association website:

www.bcbs.com/innovations/bluedistinction

You may be referred by your physician to this specialty cancer care, or you may self-refer by contacting the BCBSNM Health Services department toll-free at 1-800-325-8334. When prompted, select the “Cancer Care Coordinator” option. The Cancer Care Coordinator will help you find a cancer treatment resource using the Blue Distinction Centers, facilitate an introduction to the case manager at the facility, and continue to follow your progress and care throughout the course of treatment.

Dialysis

This Plan covers the following services when received from a dialysis provider, or when **preauthorization** is received from BCBSNM, in your home:

- renal dialysis (hemodialysis)
- continual ambulatory peritoneal dialysis (CAPD)

- apheresis and plasmapheresis
- the cost of equipment rentals and supplies for home dialysis

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

Preauthorization Required

To be covered, all inpatient, outpatient, office and home-based short-term rehabilitation treatments, including skilled nursing facility and physical rehabilitation facility admissions, must receive **preauthorization** from BCBSNM and be received from a **preferred provider**. Short-term rehabilitation required due to reinjury or aggravation of an injury is also covered but must receive a separate **preauthorization** from BCBSNM, even if therapy was authorized for the original injury.

Covered Services

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

- occupational therapy performed by a licensed occupational therapist
- physical therapy performed by a physician, licensed physical therapist, or other professional provider licensed as a physical therapist (such as a doctor of oriental medicine)
- joint and spinal manipulation services when administered by a licensed provider acting within the scope of licensure and when necessary for the treatment of accidental injury or medical condition
- speech therapy, including audio diagnostic testing, performed by a properly accredited speech therapist for the treatment of communication impairment or swallowing disorders caused by disease, trauma, congenital anomaly, or a previous treatment or therapy
- inpatient physical rehabilitation and skilled nursing facility services

Benefit Limits

Benefits for all inpatient, outpatient, office, and home-based services combined are limited as specified in the *Summary of Benefits*. **Note:** Long-term therapy, maintenance therapy, and therapy for chronic conditions are **not** covered. This Plan covers short-term rehabilitation only.

Conditions of Coverage

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

- Services must be received from **preferred providers** and **preauthorized** by BCBSNM.
- There is a documented condition or delay in recovery that can be expected to measurably improve with therapy within two months of beginning active therapy. This period may be extended upon recommendation of the referring preferred physician, in consultation with BCBSNM.
- Improvement would not normally be expected to occur without intervention.

Exclusions

This Plan does **not** cover:

- maintenance therapy or care provided after you have reached your rehabilitative potential except as required under New Mexico State law (Even if you have not reached your rehabilitative potential, this Plan does not cover services that exceed maximum benefit limits, if any. See “Autism Spectrum Disorders” in this *Covered Services* section and the “Long-Term and Maintenance Therapy” exclusion in *Section 6: General Limitations and Exclusions*.)
- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay, except as required by law and described in this *Covered Services* section under “Autism Spectrum Disorders” (See “Early Developmental Delay and Disability” in *Section 8: Claim Payments and Appeals* for reimbursement of certain services provided to eligible children by the Department of Health.)

- diagnostic, therapeutic, rehabilitative, or health maintenance services provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered provider
- therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights)
- private room expenses
- speech therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic; other speech services that can be carried out by the patient, the family or caregiver/teacher
- long-term therapies even if you have not yet used or exhausted maximum benefits, if any (See the “Long-Term and Maintenance Therapy” exclusion in *Section 6: General Limitations and Exclusions*.)
- herbs, homeopathic preparations, or nutritional supplements
- services of a massage therapist, or rolfing
- any therapeutic exercise equipment prescribed for home use

SMOKING/TOBACCO USE CESSATION

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

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

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

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

Exclusions

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

- cessation counseling or treatment received from nonpreferred providers or drug therapy that has not received preauthorization
- drug therapy that has not received preauthorization
- acupuncture, biofeedback, or hypnotherapy for smoking/tobacco use cessation
- over-the-counter tobacco cessation products, including but not limited to items such as nicotine patches or nicotine gum (See your separately issued *Drug Plan Rider Prescription Drugs and Other Items* “Prescription Drugs and Other Items” for copayments and other limitations that apply to prescription drugs.)

SUPPLIES, EQUIPMENT AND PROSTHETICS

For contraceptive devices, see “Maternity/Reproductive Services and Newborn Care: Family Planning.”

For diabetic supplies such as needles, syringes, and test strips, see your separately issued Drug Plan Rider. “Prescription Drugs and Other Items.”

For supplies or equipment used during an inpatient or outpatient stay, see “Hospital/Other Facility Services.” (Supplies or equipment that are dispensed by a facility for use outside of the facility are subject to the provisions of this “Supplies, Equipment and Prosthetics” section.)

If you have a question about durable medical equipment, medical supplies, prosthetics or appliances not listed, please call the BCBSNM Health Services Department. All services must be received from a preferred provider to be covered.

Preauthorization from BCBSNM is required for:

- **specific items** listed in this section
- **long-term rental** of an item
- when total charges for an item equal **\$500[100–5,000]** or more (*Total charges* means either the total purchase price of the item or total rental charges for the estimated period of use.)

Diabetic Supplies and Equipment

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

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

Reminder: Preauthorization is required for items costing **over \$500[100–5,000]** or requiring long-term rental. For additional diabetic supply coverage, (e.g., insulin needle and syringes, autolet, test strips for glucose monitors, glucagon emergency kits) see your *Drug Plan Rider. Prescription Drugs and Other Items.* “Prescription Drugs and Other Items.”

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

Durable Medical Equipment and Appliances

This Plan covers the following items (**preauthorization is required for items costing over \$500[100–5,000] or requiring long-term rental**):

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

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

Note: Benefits for durable medical equipment received from a **nonpreferred provider** are limited each benefit period to the amount indicated in the *Summary of Benefits*. (The limitation does not apply to diabetic equipment, oxygen or oxygen equipment.) Benefits for durable medical equipment received from a preferred provider are not limited. **This Plan does not cover durable medical equipment received from a nonpreferred provider.**

Medical Supplies

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

- colostomy bags, catheters
- gastrostomy tubes
- hollister supplies
- tracheostomy kits, masks
- lamb's wool or sheepskin pads
- ace bandages, elastic supports when billed by a physician or other provider during a covered office visit
- slings
- support hose prescribed by a physician for treatment of varicose veins (2-12 pair per calendar year)

Note: Benefits for medical supplies received from a **nonpreferred** provider are limited each benefit period to the amount indicated in the *Summary of Benefits*. (The limitation does not apply to diabetic equipment, oxygen, or oxygen equipment.) Benefits for medical supplies received from a preferred provider are not limited. **This Plan does not cover medical supplies received from a nonpreferred provider.**

Orthotics and Prosthetic Devices

When medically necessary and ordered by a provider, this Plan covers the following items:

- surgically implanted prosthetics or devices, including penile implants required as a result of illness or accidental injury, if **preauthorization** for such items is received from BCBSNM
- externally attached prostheses to replace a limb or other body part lost after accidental injury or surgical removal; their fitting, adjustment, repairs and replacement
- replacement of items only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- breast prosthetics when required as the result of a mastectomy and mastectomy bras, which are limited to **2-12 bras** per calendar year)
- functional orthotics only for patients having a locomotive problem or gait difficulty resulting from mechanical problems of the foot, ankle, or leg (A functional orthotic is used to control the function of the joints and is covered only when **preauthorized by BCBSNM** and prescribed by a physician or podiatrist.)

When alternative prosthetic devices are available, the allowance for a prosthesis will be based upon the least costly item.

Note: Benefits for orthotics and prosthetics received from a **nonpreferred** provider are limited each benefit period to the amount indicated in the *Summary of Benefits*. (The limitation does not apply to breast prosthetics or mastectomy bras.) Benefits for prosthetics and orthotics received from a preferred provider are not limited. **This Plan does not cover orthotics and prosthetics received from a nonpreferred provider.**

Exclusions

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

- air conditioners, biofeedback equipment, humidifiers, purifiers, self-help devices, or whirlpools
- items that are primarily nonmedical in nature such as Jacuzzi units, hot tubs, exercise equipment, heating pads, hot water bottles, or diapers
- nonstandard or deluxe equipment, such as motor-driven wheelchairs, chairlifts or beds; external prosthetics that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing
- repairs to items that you do not own
- comfort items such as bedboards, beds or mattresses of any kind, bathtub lifts, overbed tables, or telephone arms
- repair costs that exceed the rental price of another unit for the estimated period of need, or repair or rental costs that exceed the purchase price of a new unit
- dental appliances (See “Dental-Related/TMJ Services and Oral Surgery” for exceptions.)
- accommodative orthotics (deal with structural abnormalities of the foot, accommodate such abnormalities, and provide comfort, but do not alter function)
- orthopedic shoes, unless joined to braces (Diabetic members may be eligible to receive benefits for these items. Call BCBSNM Health Services for details.)
- equipment or supplies not ordered by a health care provider, including items used for comfort, convenience, or personal hygiene
- duplicate items; repairs to duplicate items; or the replacement of items because of loss, theft, or destruction
- stethoscopes or blood pressure monitors
- voice synthesizers or other communication devices
- eyeglasses or contact lenses or the costs related to prescribing or fitting of glasses or contact lenses, unless listed as covered; sunglasses, special tints, or other extra features for eyeglasses or contact lenses
- hearing aids or ear molds, fitting of hearing aids or ear molds, or related services or supplies, unless otherwise specified in *Section 5: Covered Services* (For surgically implanted devices for the profoundly hearing impaired, see “Surgery and Related Services.”)
- syringes or needles for self-administering drugs (Coverage for insulin needles and syringes and other diabetic supplies not listed as covered in this section is described under your separately issued *Drug Plan Rider Prescription Drugs and Other Items* “Prescription Drugs and Other Items”).
- items that can be purchased over-the-counter, including but not limited to dressings for bed sores and burns, gauze, and bandages
- contraceptive devices that do not require a prescription, including over-the-counter contraceptive products such as condoms and spermicide (See “Maternity/Reproductive Services and Newborn Care: Family Planning” for devices requiring a prescription.)
- items not listed as covered
- costs for items received from a nonpreferred provider that exceed the maximum benefit listed in the *Summary of Benefits*, if any
- costs for items received from a nonpreferred provider

SURGERY AND RELATED SERVICES

For accidental injuries to the jaws, mouth, or teeth, oral surgery, or treatment of TMJ disorders or injuries, see “Dental-Related/TMJ Services and Oral Surgery.”

See “Maternity/Reproductive Services and Newborn Care” for deliveries, C-sections, surgical sterilizations and limited infertility-related treatments or “Transplant Services,” if applicable.

You are responsible for obtaining admission review and/or other preauthorization when necessary (see Section 4: Admission Review and Other Preauthorizations).

Surgeon's Services

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

Cochlear Implants

This Plan covers cochlear implantation of a hearing device (such as an electromagnetic bone conductor) to facilitate communication for the profoundly hearing impaired, including training to use the device. You must submit a **written request for preauthorization** to BCBSNM before treatment begins. This Plan does **not** cover cochlear implant services without preauthorization.

Mastectomy Services

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

This Plan also covers cosmetic breast surgery, when **preauthorized** by BCBSNM and received **within 12 months** of a mastectomy for breast cancer (unless a later surgical procedure is approved as medically appropriate by BCBSNM). Coverage is limited to:

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

This Plan does **not** cover subsequent procedures to correct unsatisfactory cosmetic results attained during the initial breast/nipple surgery or tattooing or breast surgery that has not received preauthorization from BCBSNM.

Reconstructive Surgery

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

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

You or your physician must obtain **preauthorization, requested in writing**, from BCBSNM **before** the reconstructive service is provided. If the procedure (including any reconstructive service listed under "Dental-Related/TMJ Services and Oral Surgery") has not received preauthorization, **the surgery and all related charges will be denied**. Cosmetic procedures and procedures that are not medically necessary, including all services related to such procedures, will also be **denied**.

Exclusions

This Plan does **not** cover:

- cosmetic or plastic surgery or procedures, such as breast augmentation, rhinoplasty, and surgical alteration of the eye that does not materially improve the physiological function of an organ or body part (unless covered under "Mastectomy Services")
- procedures to correct cosmetically unsatisfactory surgical results or surgically induced scars
- refractive keratoplasty, including radial keratotomy, or any procedure to correct visual refractive defect

- unless required as part of medically necessary diabetic disease management, trimming of corns, calluses, toenails, or bunions (except surgical treatment such as capsular or bone surgery)
- sex change operations or complications arising from transsexual surgery
- subsequent surgical procedures needed because you did not comply with prescribed medical treatment or because of a complication from a previous noncovered procedure (such as a noncovered organ transplant, sex change operation or previous cosmetic surgery)
- obesity treatment, including the surgical treatment of morbid obesity
- any reconstructive procedure, orthognathic surgery, cochlear implant, breast reduction, orthotripsy, or cosmetic breast surgery that has not received preauthorization from BCBSNM
- the insertion of artificial organs, or services related to transplants not specifically listed as covered under “Transplant Services”
- standby services unless the procedure is identified by BCBSNM as requiring the services of an assistant surgeon and the standby physician actually assists

Anesthesia Services

This Plan covers necessary anesthesia services, including acupuncture used as an anesthetic, when administered during a covered surgical procedure by a physician, certified registered nurse anesthetist (CRNA), a licensed doctor of oriental medicine (for acupuncture) or other practitioner as required by law. (See “Rehabilitation and Other Therapy” for information about acupuncture benefits.)

Exclusions

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

Assistant Surgeon Services

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

Exclusions

This Plan does **not** cover:

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

TRANSPLANT SERVICES

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

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

Facility Must Be in Transplant Network

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

Blue Distinction Centers for Transplants

While you can select any in-network facility for your transplant, the Blue Distinction Centers for Transplants® program can help you find the transplant program that meets your needs. Blue Distinction Centers for Transplants have demonstrated their commitment to quality care, resulting in better overall outcomes for transplant patients. Each facility meets stringent clinical criteria, established in collaboration with expert physician and medical organization recommendations, including the Center for International Blood and Marrow Transplant Research (CIBMTR), the Scientific Registry of Transplant Recipients (SRTR) and the Foundation for the Accreditation of Cellular Therapy (FACT), and is subject to periodic reevaluation as criteria continue to evolve.

Blue Distinction Centers for Transplants provide a range of services for transplants, including:

- heart or heart–lung
- lung (deceased and living donor)
- liver (deceased and living donor), liver/small bowel, small bowel
- kidney or simultaneous pancreas–kidney (SPK)
- pancreas (PAK/PTA)
- bone marrow/peripheral stem cell (autologous and allogeneic, meaning either from yourself or from a compatible donor), with or without high–dose chemotherapy (Not all bone marrow transplants are covered. If a separate charge is made for bone marrow/stem cell search, a maximum benefit of **\$25,000** is payable for all charges made in connection with the search.)

Organ or tissue transplants or multiple organ transplants other than those listed above are **not** covered.

You may view the entire list of Blue Distinction Centers and review the criteria used in selecting facilities for the designation at the Blue Cross and Blue Shield Association website:

www.bcbs.com/innovations/bluedistinction

You may be referred by your physician to a Blue Distinction transplant facility, or you may self–refer by contacting the BCBSNM Health Services department toll–free at 1–800–325–8334. When prompted, select the “Transplant Care Coordinator” option from the menu. The Transplant Care Coordinator will help you find a transplant resource using the Blue Distinction Centers, facilitate an introduction to the case manager at the facility, and continue to follow your progress and care throughout the course of treatment.

Effect of Medicare Eligibility on Coverage

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

Organ Procurement or Donor Expenses

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

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

Bone Marrow, Cornea or Kidney

This Plan covers the following transplant procedures if **preauthorization** is received from BCBSNM:

- bone marrow transplant for a member with aplastic anemia, leukemia, severe combined immunodeficiency disease (SCID), or Wiskott-Aldrich syndrome, and other conditions determined by BCBSNM to be medically necessary and not experimental, investigational, or unproven
- cornea transplant

- kidney transplant

Cost-Sharing Provisions

Covered services related to the above transplants are subject to the usual cost-sharing features and benefit limits of this Plan (e.g., deductible, coinsurance, copayments and out-of-pocket limits; and annual home health care maximums).

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

This Plan also covers transplant-related services for a **heart, heart-lung, liver, lung or pancreas-kidney** transplant. Services must be **preauthorized** in order to be covered. Also, all other limitations, requirements, and exclusions of this “Transplant Services” provision apply to these transplant-related services. In addition, the following provisions apply to the above-listed transplants for **one year** following the date of the actual transplant or retransplant. After one year, usual benefits apply and the services must be covered under other provisions of the Plan in order to be considered for benefit payment.

Facility Must Be in Transplant Network

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

Recipient Travel and Per Diem Expenses

If BCBSNM requires you (i.e., the transplant recipient) to temporarily relocate outside of your city of residence to receive a covered transplant, travel to the city where the transplant will be performed is covered. A standard per diem benefit (**\$125**) will be allocated for food and lodging expenses for the recipient and one additional adult traveling with the transplant recipient. If the transplant recipient is an eligible child under the age of 18, benefits for travel and per diem expenses for **two adults** to accompany the child are available.

If BCBSNM requires you (i.e., the transplant recipient) to temporarily relocate outside of your city of residence to receive a covered transplant, travel to the city where the transplant will be performed is covered. A standard per diem benefit (**\$50**) will be allocated for lodging expenses, for the recipient and one additional adult traveling with the transplant recipient. If the transplant recipient is an eligible child under the age of 19, benefits for travel and per diem expenses for **two adults** to accompany the child are available.

Travel expenses and standard per diem allowances are limited to a total combined lifetime maximum benefit of **\$10,000– \$20,000** per transplant for all transplants combined. Your case manager may approve travel and per diem food and lodging allowances based upon the total number of days of temporary relocation, up to the **\$10,000 – \$20,000** benefit maximum.

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

Cost-Sharing Features

Covered services under this “Heart, Heart-Lung, Liver, Lung, Pancreas-Kidney” provision are subject to **20 percent** coinsurance and to a separate **\$5,000 per transplant** out-of-pocket limit. (After the copayments and coinsurance for services related to a single transplant reaches the separate transplant out-of-pocket limit, all further services related to the transplant and received **within one year** of the transplant will be paid at **100 percent** of covered charges, up to maximum benefit amounts, if any.) There is also no deductible to meet. If you need a retransplant, these cost-sharing provisions renew starting from the date of the retransplant procedure.

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

Transplant Exclusions

This Plan does **not** cover:

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

SECTION 6: GENERAL LIMITATIONS AND EXCLUSIONS

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

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

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

Before Effective Date of Coverage

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

Biofeedback

This Plan does not cover services related to biofeedback.

Blood Services

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

Complications of Noncovered Services

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

Convalescent Care or Rest Cures

This Plan does not cover convalescent care or rest cures.

Cosmetic Services

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

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

Exception: Cosmetic breast/nipple surgery required due to a mastectomy that occurred less than **12 months** before the planned cosmetic procedure may be covered. However, **preauthorization, requested in writing**, must be obtained from BCBSNM for such services. Also, prior-approved reconstructive surgery, which may have a coincidental cosmetic effect, may be covered when required as the result of accidental injury, illness, or congenital defect. See "Surgery and Related Services" in *Section 5: Covered Services* for details.

Custodial Care

This Plan does not cover custodial care or care in a place that is primarily your residence when you do not require skilled nursing care. **This Plan does not cover** services to assist in activities of daily living (such as sitter's or homemaker's services), or services not requiring the continuous attention of skilled medical or paramedical personnel, regardless of where they are furnished or by whom they were recommended.

Dental-Related/TMJ Services and Oral Surgery

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

Reminder: The Preferred Provider benefit level is not available for nonemergency services received from a non-preferred provider – even if a preferred provider is not available in your area to perform the services.

Domiciliary Care

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

Duplicate (Double) Coverage

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

Duplicate Testing

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

Experimental, Investigational, or Unproven Services

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

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

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

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

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

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

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

Food or Lodging Expenses

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

Genetic Testing or Counseling

This Plan does not cover genetic counseling or testing, unless the testing has received **preauthorization** from BCBSNM. See “Maternity/Reproductive Services and Newborn Care” in *Section 5: Covered Services* for details. **This Plan does not cover** tests such as amniocentesis or ultrasound to determine the gender of an unborn child.

Hair Loss Treatments

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

[Hearing Examinations, Procedures and Aids

This Plan does not cover audiometric (hearing) tests **unless** 1) required for the diagnosis and/or treatment of an accidental injury or an illness, or 2) covered as a preventive *screening* service for children through age 17, or 3) covered as part of the hearing aid benefit for members under age 21 and described under “Hearing Aids/Related Services for Children Under Age 21” in *Section 5: Covered Services*. (A screening does *not* include a hearing test to determine the amount and kind of correction needed.) **This Plan does not cover** hearing aids or ear molds, fitting of hearing aids or ear molds, or any related service or supply for **members age 21 and older**. For **members under age 21**, see “Hearing Aids/Related Services for Children Under Age 21” in *Section 5*. (For surgically implanted devices, see “Surgery and Related Services” in *Section 5: Covered Services*.)]

Home Health, Home I.V. and Hospice Services

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

Hypnotherapy

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

[Infertility Services/Artificial Conception

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

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

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

Late Claim Filing

This Plan does not cover services of a nonparticipating provider if the claim for such services is received by BCBSNM **more than 12 months** after the date of service. (Preferred providers contracting directly with BCBSNM and providers that have a “participating” provider agreement with BCBSNM will file claims for you and must submit them within a specified period of time, usually 180 days.) If a claim is returned for further information, resubmit it **within 45 days**. **Note:** If there is a change in the Claims Administrator, the length of the timely filing period may also change. See “Filing Claims” in *Section 8: Claim Payments and Appeals* for details.

Learning Deficiencies/Behavioral Problems

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

Limited Services/Covered Charges

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

Local Anesthesia

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

Long-Term and Maintenance Therapy

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

This Plan does not cover maintenance therapy or care or any treatment that does not significantly improve your function or productivity, or care provided after you have reached your rehabilitative potential (unless therapy is covered during an approved hospice benefit period). In a dispute about whether your rehabilitative potential has been reached, you are responsible for furnishing documentation from your physician supporting his/her opinion. **Note:** Even if your rehabilitative potential has not yet been reached, **this Plan does not cover** services that exceed maximum benefit limits.

Medical Policy Determinations

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

Medically Unnecessary Services

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

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. (BCBSNM determines medical necessity based on the criteria given in *Section 5: Covered Services*.)

No Legal Payment Obligation

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

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

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

Noncovered Providers of Service

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

- member of your immediate family or a person normally residing in your home
- physician, other person, supplier, or facility (including staff members) that are not specifically listed as covered in this benefit booklet, such as a:
 - health spa or health fitness center (whether or not services are provided by a licensed or registered provider)
 - school infirmary
 - halfway house
 - massage therapist
 - private sanitarium
 - extended care facility or similar institution[
 - residential treatment center (A residential treatment center is a facility where the primary services are the provision of room and board and constant supervision or a structured daily routine for a person who is impaired but whose condition does not require acute care hospitalization.)]
 - dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group

Nonemergency Services

This Plan does not cover nonemergency services outside the United States.

Nonmedical Expenses

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

- adoption or surrogate expenses
- educational programs such as behavior modification and arthritis classes (Some diabetic services and other educational programs may be covered; see “Physician Visits/Medical Care” and “Preventive Services” in *Section 5: Covered Services* for details.)
- vocational or training services and supplies
- mailing and/or shipping and handling
- missed appointments; “get-acquainted” visits without physical assessment or medical care; telephone consultations; provision of medical information to perform admission review or other preauthorizations; filling out of claim forms; copies of medical records; interest expenses
- modifications to home, vehicle, or workplace to accommodate medical conditions; voice synthesizers; other communication devices
- membership at spas, health clubs, or other such facilities
- personal convenience items such as air conditioners, humidifiers, exercise equipment, or personal services such as haircuts, shampoos, guest meals, and television rentals
- personal comfort services, including homemaker and housekeeping services, except in association with respite care covered during a hospice admission
- immunizations or medications required for international travel
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; phone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- physicals or screening examinations and immunizations given primarily for insurance, licensing, employment, camp, weight reduction programs, medical research programs, sports, or for any nonpreventive purpose
- hepatitis B immunizations when required due to possible exposure during the member’s work
- court- or police-ordered services unless the services would otherwise be covered or services rendered as a condition of parole or probation
- the cost of any damages to a treatment facility that are caused by the member
- psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education

[Nonpreferred Provider Services

This Plan does not cover the following services when received from a nonpreferred provider: acupuncture, spinal manipulation, outpatient cardiac and pulmonary rehabilitation, inpatient or outpatient physical therapy, speech therapy, occupational therapy, [adult preventive services,] [smoking/tobacco use cessation counseling,] skilled nursing facility services, inpatient or outpatient psychotherapy and transplants.]

This Plan does not cover smoking/tobacco use cessation counseling or transplants when received from a nonpreferred provider.

This Plan does not cover nonemergency services provided by a nonpreferred provider unless **preauthorization** for such services is received from BCBSNM. You will be financially responsible for the services of a nonpreferred provider if you did not receive, in advance, a valid approval from BCBSNM. **Note:** When preauthorization is requested, BCBSNM may require that you travel to another city to receive services from a preferred provider.

Except in emergencies, BCBSNM will generally NOT authorize services of a nonpreferred provider if the services could be obtained from a preferred provider. Authorizations (preauthorizations) for such services are given only under very special circumstances related to **medical necessity** and **lack of provider availability in the BCBSNM preferred provider network**. BCBSNM will NOT approve an authorization request based on non-medical issues such as whether or not you or your doctor prefer the out-of-network provider or find the provider more convenient. Regardless of medical necessity or non-medical issues, nonpreferred providers’ services are NOT covered under this Plan, except during an emergency, if you do not first obtain preauthorization.

Nonprescription Drugs

This Plan does not cover nonprescription or over-the-counter drugs, medications, ointments, or creams, including herbal or homeopathic preparations, or prescription drugs that have over-the-counter equivalents, except for those products specifically listed as covered [in your separately issued *Drug Plan Rider*][under [Prescription Drugs and Other Items]]["Prescription Drugs and Other Items"]. This exclusion includes nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum.

Nutritional Supplements

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

[Obesity Treatment

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

Post-Termination Services

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

[Pre-Existing Conditions

For members who are subject to this provision, **this Plan does not cover** [any pre-existing conditions for up to [3-6] months following the member's initial enrollment eligibility date.][A late applicant accepted for coverage is not covered for pre-existing conditions for up to [6-18] months following his/her effective date of coverage.] (See "Pre-Existing Conditions Limitation" in *Section 2: Enrollment and Termination Information*.)]

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

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see ["Prescription Drugs and Other Items"]for additional exclusions.]

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see *Section 5: Covered Services*, ["Prescription Drugs and Other Items"]for additional exclusions.]

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

Preauthorization Not Obtained When Required

This Plan does not cover certain services if you do not obtain preauthorization from BCBSNM before those services are received. See *Section 4: Admission Review and Other Preauthorizations*.

[Private Duty Nursing Services

This Plan does not cover private duty nursing services.]

Private Room Expenses

This Plan does not cover private room expenses, unless your medical condition requires isolation for protection from exposure to bacteria or diseases (e.g., severe burns and conditions that require isolation according to public health laws). Private room charges must be **preauthorized** by BCBSNM to be covered.

Sex-Change Operations and Services

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

Sexual Dysfunction Treatment

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

Supplies, Equipment and Prosthetics

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

Surgery and Related Services

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

Therapy and Counseling Services

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

- recreational, sleep, crystal, primal scream, sex, and Z therapies
- self-help, stress management[, weight-loss,] and codependency programs
- [smoking/tobacco use cessation counseling programs of preferred providers that do not meet the standards set by the NM Public Regulation Commission [or that are received from nonpreferred providers]
- [smoking/tobacco use cessation counseling programs that do not meet the standards set by the NM Public Regulation Commission
- services of a massage therapist, or rolfing
- transactional analysis, encounter groups, and transcendental meditation (TM); moxibustion; sensitivity or assertiveness training
- vision therapy; orthoptics
- pastoral, spiritual, religious, marital, or bereavement counseling
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this Plan
- therapy for chronic conditions such as, but not limited to, cerebral palsy or developmental delay, except as required by law and described in *Section 5* under “Autism Spectrum Disorders” (See “Early Developmental Delay and Disability” in *Section 8: Claim Payments and Appeals* for coverage of certain services provided to eligible children by the Department of Health.)
- any therapeutic exercise equipment for home use (e.g., treadmill, weights)

Thermography

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

TMJ/CMJ Services

This Plan does not cover nonstandard diagnostic, therapeutic, or surgical TMJ/CMJ treatments. **This Plan does not cover** orthodontic appliances and treatment, crowns, bridges, or dentures for TMJ/CMJ treatments unless required as the result of an accidental injury to the TMJ/CMJ.

Transplant Services

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

Travel or Transportation

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

Veteran’s Administration Facility

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

Vision Services

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

War-Related Conditions

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

[Weight Management

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

Work-Related Conditions

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

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

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

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

- You fail to file a claim within the filing period allowed by the applicable law.

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

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

SECTION 7: COORDINATION OF BENEFITS (COB) AND REIMBURSEMENT

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

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

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

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

The following rules determine which coverage pays first:

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

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

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

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

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

Eligible Child — For an eligible child whose parents are not separated or divorced, the coverage of the parent whose birthday falls earlier in the calendar year pays first. If the other valid coverage does not follow this rule, the father’s coverage pays first.

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

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

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

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

Responsibility For Timely Notice

BCBSNM is not responsible for coordination of benefits if timely information is not provided.

Facility of Payment

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

Overpayments – Right of Recovery

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

REIMBURSEMENT

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

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

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

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

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

SECTION 8: CLAIMS PAYMENTS AND APPEALS

FILING CLAIMS

You must submit claims **within 12 months** after the date services or supplies were received. **A claim submitted more than 12 months after the service was received will not be accepted under any circumstance.** If a claim is returned for further information, resubmit it **within 45 days**. **Note:** If there is a change in the Claims Administrator, the length of the timely filing period may also change.

IMPORTANT NOTE ABOUT FILING CLAIMS

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

IF YOU HAVE OTHER VALID COVERAGE

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

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

PARTICIPATING AND PREFERRED PROVIDERS

Your “preferred” provider may have two agreements with the local BCBS Plan — a preferred provider contract and another participating provider contract. Some providers have **only** the participating provider contract and are **not** considered preferred providers [and their services are **not** covered except during an emergency or unless listed as an “exception” in *Section 3: How Your Plan Works*]. However, all participating and preferred providers file claims with their local BCBS Plan and payment is made directly to them. Be sure that these providers know you have health care coverage administered by BCBSNM. Do **not** file claims for these services yourself.

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

PROVIDERS NETWORK

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

NONPARTICIPATING PROVIDERS

A nonparticipating provider is one that has neither a preferred or a participating provider agreement. If your nonparticipating provider does not file a claim for you [for emergency care], submit a separate claim form for each family member as the services are received. Attach itemized bills and, if applicable, your other valid coverage's payment explanation, to a *Member Claim Form*. (Forms can be printed from the BCBSNM Web site at [www.bcbsnm.com] or requested from a Customer Service Advocate.) Complete the claim form using the instructions on the form. (See special claim filing instructions for out-of-country claims under “Where to Send Claim Forms” later in this section.)

ITEMIZED BILLS

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

- member's identification number
- member's and subscriber's name and address
- member's date of birth and relationship to the subscriber
- name, address, National Provider Identification number (NPI), and tax ID or social security number of the provider
- date of service or purchase, diagnosis, type of service or treatment, procedure, and amount charged for each service (each service must be listed separately)
- accident or surgery date (when applicable)

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

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

WHERE TO SEND CLAIM FORMS

If your nonparticipating provider does not file a claim for you, you (not the provider) are responsible for filing the claim. **Remember:** Participating and preferred providers will file claims for you; these procedures are used only when you must file your own claim.

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

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

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

[Mental Health[/Chemical Dependency] Claims

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

**[Mesa Mental Health
P.O. Box 92165
Albuquerque, New Mexico 87199-2165]**

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

[Drug Plan Claims

If you purchase a prescription drug or other item covered under the drug plan from a nonparticipating pharmacy or other provider in an emergency, or if you do not have your ID card with you when purchasing a prescription or other covered item, you must pay for the prescription in full and then submit a claim to BCBSNM's pharmacy benefit manager. **Do not send these claims to BCBSNM.** The bills or receipts must be issued by the pharmacy and must

include the pharmacy name and address, drug name, prescription number, and amount charged. If not included in your enrollment materials, you can obtain the name and address of the pharmacy benefit manager and the necessary claim forms from a Customer Service Advocate or on the BCBSNM Web site at [\[www.bcbsnm.com\]](http://www.bcbsnm.com).]

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

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

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

www.bcbs.com/coverage/bluecard/bluecard-worldwide.html

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

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

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

IF YOU HAVE MEDICARE

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

Filing Claims if Medicare is Primary

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

If you must file a claim for services that were covered by Medicare (for example, because services were received outside New Mexico and the claim does not automatically "cross-over" once Medicare has paid its portion), you will have to file a copy of the EOMB that you receive from Medicare and all other required claim information with the local BCBS Plan. ON the EOMB you receive from Medicare, **print your Plan ID number (found on your**

Plan ID card issued by BCBSNM) – including the three alphabetic characters that precede the nine–digit number – and your correct mailing address and zip code. Make a copy of the EOMB for your records.

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

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

Medicare–Covered Facility Services

All Medicare–participating providers of Part A services, including skilled nursing facilities and hospice agencies, will submit claims directly to Medicare. To file claims, the facility must have the information from the identification cards issued to you by **both** Medicare and BCBSNM.

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

Medicare–Covered Non–Facility Services

A claim for physician and other professional provider services must be filed **first** with Medicare Part B Medical Insurance. (All Medicare providers must file claims for you to Medicare.)

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

Services Not Covered by Medicare

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

When an EOMB is Not Required

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

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

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

Services Outside Medicare Territorial Limits

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

If you receive covered services while outside the United States, call the BlueCard Worldwide Service Center, collect, at 804-673-1177 for assistance with claims filing. Or visit the Blue Cross and Blue Shield Association website to locate nearby participating physicians and hospitals.

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

CLAIMS PAYMENT PROVISIONS

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

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

If A Claim Is Denied

If benefits are denied or only partially paid, BCBSNM will notify you of the determination. The notice to you will include: 1) the reasons for denial; 2) a reference to the health care plan provisions on which the denial is based; and 3) an explanation of how you may appeal the decision if you do not agree with the denial.]

Covered Charge

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

Participating and Preferred Providers

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

Nonparticipating Providers

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

Accident-Related Hospital Services

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

Assignment of Benefits

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

Early Development Delay and Disability

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

Medicaid

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

Overpayments

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

Pricing of Noncontracted Provider Claims

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

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

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

- services for which a Medicare Allowable cannot be determined based on the information submitted on the claim (in such cases, the covered charge is 50 percent of the billed charge)
- home health claims (the covered charge is 50 percent of the billed charge)
- services administered and priced by any subcontractor of BCBSNM or by the Blue Cross and Blue Shield Association

- claims paid by Medicare as primary coverage and submitted to your health plan for secondary payment
- New Mexico ground ambulance claims (for which the state’s Public Regulatory Commission sets fares)

NOTE: Nonemergency services are generally **not covered** under EPO plans when received out-of-network from noncontracted providers. The pricing methods above apply **only** when the claim for out-of-network services has been authorized for payment and does not satisfy any of the conditions below:

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

- covered services required during an emergency and received in a hospital, trauma center, or ambulance
- covered claims priced by another BCBS Plan through BlueCard using local pricing methods
- for PPO health plans, services from noncontracted providers that satisfy at least one of the three conditions below and, as a result, are eligible for the Preferred Provider benefit level of coverage
- for EPO health plans, services from noncontracted providers that satisfy at least one of the three conditions below and, as a result, are eligible for coverage under EPO health plans
 - covered services from noncontracted providers within the United States that are classified as “unsolicited” as explained earlier in *Section 3: How Your Plan Works* and as determined by the member’s Host Plan while outside the service area of BCBSNM , but excluding services of a noncontracted rolfer
 - preauthorized transition of care services received from noncontracted providers
 - covered services received from a noncontracted anesthesiologist, pathologist, or radiologist while you are a patient at a **contracted** facility receiving covered services or procedures that have been preauthorized, if needed
- claims for acupuncture received outside New Mexico **ARA**
- preauthorized services from noncontracted providers when eligible for benefits due to network availability issues as explained in *Section 3: How Your Plan Works* **LANS/EPO only**

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

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

Provider Payment Example

The two examples on the following page demonstrate the difference between your liability for services from an in-network provider versus an out-of-network provider. Both examples are for a plan that pays 80 percent of covered charges with the remaining 20 percent of covered charges paid by the member.

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

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

Example 2. Out– of–Network Provider Claim Payment (Plan pays 80 percent; deductible is met):

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

BLUECARD PROGRAM

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

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

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

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

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

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

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

RECONSIDERATION OF A CLAIM

BCBSNM has established written procedures for reviewing and resolving your concerns. There are two different procedures depending on the type of issue involved. This is a summary of the procedures that apply to claims for services that you have already received (“post–service claims”) and other non–utilization management issues. (“Non–utilization management” involves subjects that are not related to the denial of a preauthorization request, such as inquiries or concerns about any BCBSNM claims payment, claims that have been denied or only partially paid, the quality of care you receive, and the cancellation of your coverage. If a preauthorization request is denied, terminated, or reduced, please refer to “If Your Preauthorization Request is Denied,” in *Section 4: Admission Review and Other Preauthorization.*) You may request a detailed written explanation of the complaint reconsideration, and appeal procedures by calling BCBSNM Customer Service.

You may designate a representative to act for you in the review and reconsideration procedures. Your designation of a representative must be in writing in order to protect against disclosure of information about you except to your authorized representative.

If you make an inquiry or request a reconsideration under the following procedures, you will not be subject to retaliatory action by BCBSNM.

Initial Informal Review of Claim Decision/Complaint

If you have an inquiry or a concern about any non–utilization management review decisions, call your Customer Service Advocate for assistance. Many complaints or problems can be handled informally by calling or writing BCBSNM Customer Service. If you make an oral complaint, a BCBSNM Customer Service Advocate will assist you.

If your request for claim payment has been denied in whole or in part, you may ask BCBSNM to review its benefit determination. Within **180 days** after you receive notice of an adverse determination (denial or partial denial) on a claim, call or write to BCBSNM Customer Service and explain your reasons for disagreeing with the determination. You may also ask to see relevant documents and may submit written issues, comments, and additional medical information. Requests for review received more than 180 days following notification will not be considered unless you can satisfy BCBSNM that matters beyond your control prevented an earlier request for review.

Reconsideration of Claim Decision/Complaint

If you are dissatisfied with the results of the informal review, you may file a request for reconsideration. Call a BCBSNM Customer Service Advocate for assistance. Send your request to a BCBSNM Customer Service Advocate and, if possible, include:

- a copy of the *Explanation of Benefits* (EOB) and/or denial letter; *and*
- copies of related medical records from your provider; *and*
- any additional information from your provider in support of your request.

The formal reconsideration request must be filed to BCBSNM within **180 days** of the date of the first denial or payment notice is mailed. If you do not file the reconsideration request within the 180–day period, you waive your right to request a reconsideration or to appeal.

BCBSNM will acknowledge receipt of the request for reconsideration. BCBSNM will review your request and give you a decision within 60 calendar days, unless you are asked for more information. If there is no change in the original decision, you are provided reasons in writing.

APPEALS PROCESS

Grievances (Complaints)

If you have an inquiry or a concern about any prior authorization request, claims payment, claims that have been denied or only partially paid, the quality of care you receive, the cancellation of your coverage, or any other review decisions made by BCBSNM, call a BCBSNM Customer Service Advocate for assistance. Many complaints or problems can be handled informally by calling, writing, or e-mailing BCBSNM Customer Service. If you are not satisfied with the initial response, you can request internal review as described below.

If you make an oral grievance, a BCBSNM Customer Service Advocate will assist you. The Managed Health Care Bureau of the New Mexico Insurance Division is also available to assist you with the grievances, questions, or complaints. Call

1-888-427-5772 or (505) 827-3928

You may designate a representative to act for you in the internal review. Your designation of a representative must be in writing in order to protect against disclosure of information about you except to your authorized representative. You, your guardian or representative, or a provider acting on your behalf can contact a BCBSNM Customer Service Advocate in person, by letter, by e-mail, or by telephone if you have an inquiry or complaint about a prior authorization request, a claim payment or denial, or any other issue. If you make an inquiry or complaint or file a grievance under the following procedures, you will not be subject to retaliatory action by BCBSNM. **Note:** This is a summary of procedures. You may request a more detailed written explanation of these procedures by calling BCBSNM Customer Service.

Grievance Procedures

If you are not satisfied with the initial decision made by BCBSNM, you can request internal review. Within **180 days** after you receive notice of a BCBSNM decision (payment, denial, or partial denial) on a claim or a prior authorization request, call or write BCBSNM Customer Service and explain your reasons for disagreeing with the decision. If you do not submit the request for internal review within the 180-day period, you waive your right to internal review, unless you can satisfy BCBSNM that matters beyond your control prevented you from timely filing the request. You may also ask to see relevant documents and you may submit written issues, comments and additional medical information as part of the internal review.

Adverse Determination Grievance

This is a summary of the grievance procedure that applies to “adverse determinations” made by BCBSNM regarding a request for a health care service. An “adverse determination” means a decision made either pre-service or post-service by BCBSNM that a health care service requested by a provider or member has been reviewed and, based upon the information available, does not meet the requirements for coverage or medical necessity and the requested health care service is either denied, reduced, or terminated.

If your request for health care service has been denied in whole or in part, you may request internal review of the adverse determination. The internal review will be either “expedited” or “standard.”

Expedited Review

If required by the medical exigencies of the request, BCBSNM will conduct an “Expedited Review” and will render a decision as soon as practicable, but not later than **72 hours** from receipt of the request.

Standard Review

If not medically exigent, BCBSNM will conduct a “Standard Review.” If the request for internal review is made **before** you receive the health care service (“pre-service request for review”), the **entire** internal review process shall be completed within **20 working days** of receipt of the request for internal review. If the request for internal review is made **after** you receive the health care service (“post-service request for review”), the **entire** internal review shall be completed within **40 working days** of the request for internal review. BCBSNM may extend the review period **10 working days** in pre-service cases and **20 working days** in post-service cases.

If BCBSNM upholds the adverse determination, BCBSNM will notify you of that decision by telephone (if available) and by mail. You will be informed of the next internal level of appeal at that time and will be asked whether you want to pursue an “internal panel review” (second level of appeal) of the initial decision. If you elect to pursue the internal panel review, BCBSNM will notify you of the date, time, and location that the panel will convene and will make arrangements for you to participate by phone or in person, if necessary. BCBSNM will not unreasonably deny your request for a postponement. The internal panel decision will be provided to you by telephone, if available, and in writing within the time frames set forth by the applicable regulations, subject to any extensions or postponements.

Administrative Grievance

This is a summary of the grievance procedure followed by BCBSNM for any oral or written complaint about any aspect of the Plan other than a request for health care service including, without limitation:

- administrative practices of BCBSNM that affect the availability, delivery, or quality of health care services;
- claims payment, handling, or reimbursement for health care services, and
- termination of coverage.

If you are dissatisfied with a decision, action, or inaction of BCBSNM, you have the right to request an initial internal review of the administrative grievance orally or in writing. A BCBSNM representative will complete the internal review and mail a written decision to you within **15 working days** of receipt of the administrative grievance. The decision will be binding unless you request reconsideration of the internal review within **20 working days** of your receipt of the initial decision.

Upon receipt of your request for reconsideration of the internal review, BCBSNM will appoint a reconsideration committee to schedule and hold a hearing. Arrangements will be made for you to participate in the hearing in person or by telephone. The hearing shall be held within **15 working days** after the receipt of your request for reconsideration and the decision of committee will be provided to you in writing within **7 working days** after the hearing. BCBSNM will not unreasonably deny your request for a postponement.

BCBSNM Contacts

For more information, contact:

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

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

EXTERNAL APPEALS

If you are still not satisfied after having completed the BCBSNM inquiry, appeals, and grievance procedures, you have the option of taking one or more of the following steps. (You may not take legal action to recover benefits under this Plan until 60 days after BCBSNM has received the claim or prior authorization request in question. Also, you may not take any legal action after three years from the date that the claim in question must be filed with BCBSNM.)

If you are still not satisfied after having completed the BCBSNM reconsideration procedure (for claims for services already received and described earlier in this section) or the appeal procedure (for preauthorization requests and described in *Section 4: Admission Review and Other Approvals*), you may have a right to bring a civil action under ERISA section 502(a). No legal action may be taken earlier than 60 days after BCBSNM has received the claim for benefits or preauthorization request, or later than three years after the date that the claim for benefits should have been filed with BCBSNM.

[Review by the NM Superintendent of Insurance

If you are dissatisfied with the BCBSNM internal review of your grievance or appeal decision, you have the right to request an external review by the New Mexico Superintendent of Insurance by filing a written request **within 20 working days** of receipt of the written decision from BCBSNM. You may file your request by:

- Mail to the Superintendent of Insurance, Attention: Managed Health Care Bureau –External Review Request, New Mexico Public Regulation Commission, P.O. Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico, 87504–1269;
- Fax to Managed Health Care Bureau–External Review Request at (505) 827–4734;
- E–mail to mhcb.grievance@state.nm.us (subject: “External Review Request”);
- Online by using a Division of Insurance Complaint Form at <http://www.nmprc.state.nm.us>; or
- If required by medical exigencies of the case, by telephone at 1–888–427–5772 or (505) 827–3928.

You will need to provide a copy of the BCBSNM decision; a fully executed release form authorizing the Superintendent to obtain any necessary medical records from BCBSNM or other health care provider; and any other supporting documentation. You may contact the Managed Health Care Bureau to assist you in this process by calling toll–free at 1–888–427–5772.

[ERISA Appeals Procedures

For plans subject to the Employee Retirement Income Security Act of 1974 (ERISA), BCBSNM’s time frames for responding to your request for review may be different than those described on the previous page. As stated on the previous page, you have **180 days** from receiving a notice of adverse benefit determination to submit an appeal. Under the “Expedited Review” process for pre–service urgent care claims, BCBSNM will respond as soon as possible, but also no later than 72 hours after receiving your initial inquiry. However, under the “Standard Review” process, BCBSNM will make a decision on your appeal (administrative or clinical) and advise you of the decision within the following time frames (unless a delay is needed):

- **30 calendar days** after receiving your initial request for internal review of a **pre–service** claim; and
- **60 calendar days** after receiving your initial request for internal review of a **post–service** claim.

These time frames may be extended in accordance with ERISA. If you are not satisfied after completing the ERISA Appeal Procedure, you may have the right to bring a civil action under ERISA section 502(a). See below as to right to file a legal action if you are in an ERISA plan, and right to demand arbitration if you are in a non–ERISA plan.

[External Appeal for ERISA Plans

This Plan provided by your group may be part of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). The “External Appeal for ERISA Plans” right is applicable to all group plans except governmental plans, church plans, and plans maintained outside the United States primarily for the benefit of persons substantially all of whom are nonresident aliens. Therefore, if this Plan is governed by ERISA and you are still not satisfied after having completed the reconsideration or appeal process administered by BCBSNM, you may have a right to bring a civil action under ERISA section 502(a).]

[Arbitration for Non-ERISA Plans

The “Arbitration for Non-ERISA Plans” provision applies to all governmental plans, church plans, and plans maintained outside the United States primarily for the benefit of persons substantially all of whom are nonresident aliens. If a dispute about coverage, benefits or handling of claims, or preauthorization requests continues after the member has followed and exhausted the reconsideration or appeal process administered by BCBSNM, the issue or claim shall be submitted to arbitration upon agreement by the member. The rules for arbitration shall be the “Commercial Arbitration Rules” developed by the American Arbitration Association. You may obtain a copy of these rules from a Customer Service Advocate. The rules are also available from the American Arbitration Association’s Web site (www.adr.org). The use of arbitration does not limit your ability to seek other means by which to resolve disputes, but is an avenue available to you.]

CATASTROPHIC EVENTS

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

SECTION 9: GENERAL PROVISIONS

APPLICATION STATEMENT

No statement (except a fraudulent statement) you make in any application for coverage that is **more than two years old** can void this coverage or be used against you in any legal action or proceeding relating to this coverage unless the application or a true copy of it is incorporated in or attached to the contract.

AVAILABILITY OF PROVIDER SERVICES

BCBSNM does not guarantee that a certain type of room or service will be available at any hospital or other facility within the BCBSNM network, nor that the services of a particular hospital, physician, or other provider will be available.

CHANGES TO THE BENEFIT BOOKLET

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

CONSUMER ADVISORY BOARD

BCBSNM has established a Consumer Advisory Board to provide input from the member's point-of-view about BCBSNM's general operations and internal policies and to identify areas that need improvement.

DISCLAIMER OF LIABILITY

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

DISCLOSURE AND RELEASE OF INFORMATION

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

ENTIRE CONTRACT

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

EXECUTION OF PAPERS

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

HOLD-HARMLESS

The contracts between BCBSNM and its preferred providers include a "hold harmless" clause which provides that a PPO plan member (or other EPO plan member) cannot be liable to the provider for monies owed by BCBSNM for health care plan services covered under the EPO health plan.

INDEPENDENT CONTRACTORS

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

MEMBER RIGHTS

All members have these rights:

- The right to available and accessible services, when medically necessary, as determined by your primary care or treating physician in consultation with BCBSNM, 24 hours per day, 7 days a week, or urgent or emergency care services, and for other health services as defined by your benefit booklet.
- The right to be treated with courtesy and consideration, and with respect for your dignity and your need for privacy.
- The right to have their privacy respected, including the privacy of medical and financial records maintained by BCBSNM and its health care providers as required by law.
- The right to be provided with information concerning BCBSNM's policies and procedures regarding products, services, providers, and appeals procedures and other information about the company and the benefits provided.
- The right to choose a PPP within the limits of the covered benefits and plan network, including the right to refuse care of specific practitioners.
- The right to all the rights afforded by law, rule, or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language you understand.
- The right to receive from your physician(s) or provider, in terms that you understand, an explanation of your complete medical condition, recommended treatment, risk(s) of treatment, expected results and reasonable medical alternatives, irrespective of BCBSNM's position on treatment options. If you are not capable of understanding the information, the explanation shall be provided to your next of kin, guardian, agent or surrogate, if able, and documented in your medical record.
- The right to prompt notification of termination or changes in benefits, services or provider network.
- The right to file a complaint or appeal with BCBSNM or with the New Mexico Superintendent of Insurance and to receive an answer to those complaints within a reasonable time.
- The right to request information about any financial arrangements or provisions between BCBSNM and its preferred providers that may restrict referral or treatment options or limit the services offered to members.
- The right to adequate access to qualified health professionals near your work or home within the BCBSNM service area (the state of New Mexico).
- The right to affordable health care, with limits on out-of-pocket expenses, including the right to seek care from a nonpreferred provider, and an explanation of your financial responsibility when services are provided by a nonpreferred provider, or provided without required preauthorization.
- The right to detailed information about coverage, maximum benefits, and exclusions of specific conditions, ailments or disorders, including restricted prescription benefits, and all requirements that you must follow for preauthorization and utilization review.
- The right to make recommendations regarding BCBSNM's member rights and responsibilities policies.
- The right to a complete explanation of why care is denied, an opportunity to appeal the decision to BCBSNM's internal review and the right to a secondary appeal, and the right to request the assistance of the Superintendent of Insurance.

MEMBER RESPONSIBILITIES

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

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

MEMBERSHIP RECORDS

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

RESEARCH FEES

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

SENDING NOTICES

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

TRANSFER OF BENEFITS

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

SECTION 10: DEFINITIONS

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

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

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

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

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

Adverse determination — A decision made either pre-service or post-service by BCBSNM that a health care service requested by a provider or member has been reviewed and based upon the information available does not meet the requirements for coverage or medical necessity and the requested health care service is either denied, reduced, or terminated.

Alcohol abuse — Conditions defined by patterns of usage that continue despite occupational, social, marital, or physical problems related to compulsive use of alcohol. Alcohol abuse may also be defined by significant risk of severe withdrawal symptoms if the use of alcohol is discontinued.

Alcohol abuse treatment facility, alcohol abuse treatment program — An appropriately licensed provider of medical detoxification and rehabilitation treatment for alcohol abuse.

Ambulance — A specially designed and equipped vehicle used **only** for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an ambulance.

Ambulatory surgical facility — An appropriately licensed provider, with an organized staff of physicians, that meets all of the following criteria:

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis; *and*
- provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility; *and*
- does not provide inpatient accommodations; *and*
- is not a facility used primarily as an office or clinic for the private practice of a physician or other provider.

Appliance — A device used to provide a functional or therapeutic effect.

Applied behavioral analysis (ABA) — Services that include behavior modification training programs that are based on the theory that behavior is learned through interaction between an individual and the environment. The goal of behavior management is to reinforce and increase desirable, functional behaviors while reducing undesirable, “maladaptive” behaviors. Services would not apply to children over the age of seven.

Autism spectrum disorder — A condition that meets the diagnostic criteria for the pervasive developmental disorders published in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision, also known

as *DSM-IV-TR*, published by the American Psychiatric Association, including autistic disorder; Asperger's disorder; pervasive development disorder not otherwise specified; Rhett's disorder; and childhood integrative disorder.

Benefit booklet — This document or evidence of coverage, which explains the benefits, limitations, exclusions, terms, and conditions of your health coverage.

Benefit period — A period of one year that begins on [Month Day] and ends on [Month Day] of the following year. The initial benefit period is from a member's effective date of coverage but ends on the date it would normally end, which may be less than 12 months.

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

Brand-name drug — A drug that is available from only one source or when available from multiple sources is protected with a patent.

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

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

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

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

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

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

- is designed to build positive behavior change practices and provides counseling at a minimum on: establishment of reasons for quitting, understanding nicotine addiction, techniques for quitting, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse prevention information, and follow-up;
- operates under a written program outline that meets minimum requirements established by the NM Public Regulation Commission;
- employs counselors who have formal training and experience in tobacco cessation programming and are active in relevant continuing education activities; and
- uses a formal evaluation process, including mechanisms for data collection and measuring participant rate and impact of the program.

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

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

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

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

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

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

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

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

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

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

Copayment — A fixed-dollar amount that you are required to pay towards some covered services.

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

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

Covered charge — The amount BCBSNM is a fair and reasonable allowance for a particular covered service. After your share of a covered charge (e.g., deductible, copayment, coinsurance, and/or penalty amount) has been calculated, BCBSNM pays the remaining amount of the covered charge, up to maximum benefit limits, if any. **The covered charge may be less than the billed charge.** Your choice of provider will determine if you will also have to pay the difference between the covered charge and the billed charge. Also see “Claims Payment Provision” in *Section 8: Claim Payments and Appeals*.

Covered charge — The amount that BCBSNM allows for covered services using a variety of pricing methods and based on generally accepted claim coding rules. The covered charge for services from “contracted providers” is the amount the provider, by contract with BCBSNM (or another entity, such as another BCBS Plan), will accept as payment in full under this health plan. For information about pricing of noncontracted provider claims, see “Pricing of Noncontracted Provider Claims” in *Section 8: Claim Payments and Appeals*.

Noncontracting allowable amount — The maximum amount, not to exceed billed charges, that will be allowed for a covered service received from a noncontracted provider in most cases. The BCBSNM

noncontracting allowable amount is based on the **Medicare Allowable** amount for a particular service, which is determined by the Centers for Medicaid and Medicare Services (CMS).

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

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

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

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

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

Deductible — The amount of covered charges that you must pay in a benefit period before this Plan begins to pay its share of nonpreferred provider covered charges you incur during the same benefit period. If the deductible amount remains the same during the benefit period, you pay it only once each benefit period and it applies to all nonpreferred provider covered services you receive during that benefit period. (There is no annual deductible to meet for services of a preferred provider.)

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

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

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

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

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

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

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

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

Drug List — A list of prescription drugs that are preferred for use by BCBSNM for retail and mail-order pharmacy benefits. You pay the lower “Tier-One” and “Tier-Two” copayments for drugs listed in the BCBSNM Drug List. You pay the higher “Tier-Three” copayment for drugs not listed. The list is subject to periodic review and change by BCBSNM. BCBSNM-contracted providers should have received a copy of the list. If you need a list of commonly prescribed drugs on the BCBSNM Drug List, request it from a Customer Service Advocate or visit the BCBSNM Web site. Your drug plan may or may not use a Drug List. See your separately issued *Drug Plan Rider* for details. See “Prescription Drugs and Other Items” for details..

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

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

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

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

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

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

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

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

Generic drug — The chemical equivalent of a brand-name drug. According to the U.S. Food and Drug Administration (FDA) regulations, brand-name drugs and generic drugs must meet the same standards for safety, purity, strength, and quality. A generic drug is usually available from multiple sources and is not protected by a patent.

Genetic inborn error of metabolism — A rare, inherited disorder that is present at birth; if untreated, results in mental retardation or death, and requires that the affected person consume special medical foods.

Good cause — Failure of the subscriber to pay the premiums or other applicable charges for coverage; a material failure to abide by the rules, policies, or procedures of this Plan; or fraud or material misrepresentation affecting coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

- diagnosis and treatment of illness, injury, deformity, abnormality or pregnancy
- clinical laboratory, diagnostic x-ray, and definitive medical treatment provided by an organized medical staff within the institution

- treatment facilities for emergency care and surgical services either within the institution or through a contractual arrangement with another licensed hospital (These contracted services must be documented by a well-defined plan and related to community needs.)

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

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

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

Inpatient services — Care provided while you are confined as an inpatient in a hospital or treatment center for at least 24 hours. inpatient care includes partial hospitalization (a nonresidential program that includes from 3-12 hours of continuous psychiatric care in a treatment facility). Inpatient hospital services include, but are not limited to, semi-private room accommodations, general nursing care, meals, and special diets or parenteral nutrition when medically necessary, physician and surgeon services, use of all hospital facilities when use of such facilities is determined to be medically necessary by your treating physician, pharmaceuticals and other medications, anesthesia and oxygen services, special duty nursing when medically necessary, radiation therapy, inhalation therapy, and administration of whole blood and blood components when medically necessary.

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

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

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

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

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

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

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

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

Maternity — Any condition that is related to pregnancy. Maternity care includes prenatal and postnatal care and care for the complications of pregnancy, such as ectopic pregnancy, spontaneous abortion (miscarriage), elective abortion or C-section. See “Maternity/Reproductive Services and Newborn Care” in *Section 5: Covered Services* for more information.

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

Medical detoxification — Treatment in an acute care facility for withdrawal from the physiological effects of alcohol or drug abuse. (Detoxification usually takes about three days in an acute care facility.)

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

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

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

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

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

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

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

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

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

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

Nonpreferred provider — Providers that have not contracted with BCBSNM, either directly or indirectly (for example, through another BCBS Plan). These providers may have “participating-only” or “HMO” provider agreements, but are **not** considered “preferred” providers and are **not** eligible for Preferred Provider coverage under your health

plan –unless listed as an exception under “Benefit Exceptions for Nonpreferred Providers” “Exceptions for Nonpreferred Providers” earlier in the booklet. See the definition of “Participating provider” for more information.) **Note: See the *Summary of Benefits* for those services that are not covered if received from a nonpreferred provider.**

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

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

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

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

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

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

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

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

Participating pharmacy — See definition of “Provider,” on the next page.

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

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

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

Physician — See definition of “Provider,” below.

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

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

Preauthorization — A requirement that you or your provider must obtain authorization from BCBSNM *before* you are admitted as an inpatient (admission review approval) and before you receive certain types of services (other preauthorizations).

Pre-existing conditions — A physical or mental condition for which medical advice, medication, diagnosis, care or treatment was recommended for or received by an applicant **within a [3–6]-month period** before his/her initial enrollment eligibility date. Pregnancy and pregnancy-related diagnoses are **not** considered pre-existing conditions.

Preferred provider or preferred specialist — See definition of “Provider,” below.

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

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

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

Primary Preferred Provider (PPP) — See definition of “Provider.”

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

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

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

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

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

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

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

PPP (Primary Preferred Provider): A preferred provider in one of the following medical specialties **only:** Family Practice; General Practice; Internal Medicine; Obstetrics/Gynecology; Gynecology; or Pediatrics. PPPs do **not**

include Physicians specializing in any other fields such as Obstetrics only, Geriatrics, Pediatric Surgery or Pediatric Allergy.

PPO Specialist: A practitioner of the healing arts who is in the Preferred Provider Network – but does not belong to one of the specialties defined above as being for a “Primary Preferred Provider” (or “PPP”). A specialist does not include hospitals or other treatment facilities, urgent care facilities, pharmacies, equipment suppliers, ambulance companies, or similar ancillary health care providers.

Preferred (PPO) Provider: Practitioners of the healing arts and facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, or another BCBS Plan, as “preferred” or “PPO” providers. These providers belong to the Preferred Provider Network.

Transplant provider: These providers have contracted with BCBSNM through the Blue Cross and Blue Shield Association to provide transplant services covered under this health plan. They belong to the “National BCBS Transplant Network”.

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

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

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

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

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

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

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

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

Residential treatment center — See the “Noncovered Providers of Service” exclusion in *Section 6: General Limitations and Exclusions*.

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

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

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

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

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

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

Note: BCBSNM Preventive Care Guidelines may be found at our Web site:

[www.bcbsnm.com/Members/Health and Wellness](http://www.bcbsnm.com/Members/Health_and_Wellness)

Short-term rehabilitation — Inpatient, outpatient, office- and home-based occupational, physical, and speech therapy techniques that are medically necessary to restore and improve lost bodily functions following illness or accidental injury. (This does not include services provided as part of an approved home health or hospice admission, which are subject to separate benefit limitations and exclusions, and does not include alcohol or drug abuse rehabilitation, which are also subject to separate limitations and exclusions.)

Skilled nursing care — Care that can be provided only by someone with at least the qualifications of a licensed practical nurse (L.P.N.) or registered nurse (R.N.).

Skilled nursing facility — A facility or part of a facility that:

- is licensed in accordance with state or local law; *and*
- is a Medicare-participating facility; *and*
- is primarily engaged in providing skilled nursing care to inpatients under the supervision of a duly licensed physician; *and*
- provides continuous 24-hour nursing service by or under the supervision of a registered nurse; *and*

- does **not** include any facility that is primarily a rest home, a facility for the care of the aged, or for treatment of drug abuse, mental disorder, tuberculosis, or for intermediate, custodial or educational care.

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

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

Special enrollment — When an otherwise eligible employee or eligible family member did not enroll in the Plan when initially eligible, there are certain instances (or “qualifying events”) during which the employee and his/her eligible family members, if any, may enroll in the Plan at a later date – or more than 31 days after becoming eligible – and not considered late applicants. The “special enrollment” period is the period of time during which an otherwise late applicant may apply for coverage outside the annual open enrollment period and/or without increasing the pre-existing conditions waiting period, if any, under your Plan.

Special medical foods — Nutritional substances in any form that are consumed or administered internally under the supervision of a physician, specifically processed or formulated to be distinct in one or more nutrients present in natural food; intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs, or certain nutrients contained in ordinary foodstuffs, or who have other specific nutrient requirements as established by medical evaluation; and essential to optimize growth, health, and metabolic homeostasis.

Specialty pharmacy drugs — Specialty pharmacy drugs: a) are high cost, b) used in limited patient populations or indications, c) are typically self-injected, d) have limited availability, require special dispensing or delivery, and/or patient support is required and, therefore, are difficult to obtain via traditional pharmacy channels, and/or e) require complex reimbursement procedures. Also, a considerable portion of the use and costs are frequently generated through office-based medical claims.

Specialty pharmacy provider — See definition of “Participating Pharmacy.”

Speech therapist — A speech pathologist certified by the American Speech and Hearing Association. A speech therapist assists patients in overcoming speech disorders.

Speech therapy — Services used for the diagnosis and treatment of speech and language disorders.

Subscriber — The individual whose employment or other status, except for family dependency, is the basis for enrollment eligibility, or in the case of a direct-pay contract, the person in whose name the contract is issued. The term “subscriber” may also encompass other persons in a nonemployee relationship with the employer, group, or business if specified in the Group Master Contract (e.g., COBRA members).

Summary of Benefits — The separately issued schedule that defines your coinsurance requirements, deductible, out-of-pocket limit, and annual or lifetime benefits, and provides an overview of covered services.

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

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

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

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

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

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

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

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

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

Waiting period — The length of time during which benefits will not be available for pre-existing conditions.

APPENDIX A: CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

This notice generally explains:

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

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

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

COBRA CONTINUATION COVERAGE

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

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

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

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

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

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

- the parent-employee dies;
- the parent-employee’s hours of employment are reduced;
- the parent-employee’s employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes enrolled in Medicare (Part A, Part B or both);
- the parents become divorced or legally separated; or
- the child stops being eligible for coverage under the Plan as an “eligible child”.

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage of any retiree covered under the Plan, the retiree is a qualified beneficiary with respect to the bankruptcy. The retiree's spouse, surviving spouse and eligible children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan administrator has been notified that a qualifying event has occurred.

The employer must notify the Plan administrator **within 30 days** when the qualifying event is:

- the end of employment;
- the reduction of hours of employment;
- the death of the employee;
- with respect to a retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
- the enrollment of the employee in Medicare (Part A, Part B or both).

For the other qualifying events (divorce or legal separation of the employee and spouse or an eligible child losing eligibility for coverage as an eligible child), you must notify the Plan administrator. The Plan requires you to notify the Plan administrator **within 60 days** after the qualifying event occurs. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

Once the Plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage may last for up to 36 months when the qualifying event is:

- the death of the employee;
- the enrollment of the employee in Medicare (Part A, Part B or both);
- your divorce or legal separation; or
- an eligible child losing eligibility as an eligible child.

When the qualifying event is the end of employment or reduction in hours of employment, COBRA continuation coverage lasts for **up to 18 months**. There are two ways in which this 18-month period of COBRA continuation can be extended:

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during **the first 60 days** of COBRA continuation coverage and you notify the Plan administrator in a timely fashion, you and your entire family can receive **up to an additional 11 months** of COBRA continuation coverage, **for a total maximum of 29 months**. You must make sure that your Plan administrator is notified of the Social Security Administration's determination **within 60 days** of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and eligible children in your family can get additional months of COBRA continuation coverage, **up to a maximum of 36 months**. This extension is available to the spouse and eligible children if the former employee dies, enrolls in Medicare (Part A, Part B or both), or gets divorced or legally separated. The extension is also available to an eligible child when that child stops being eligible under the Plan as an eligible child.

In all of these cases, you must make sure that the Plan administrator is notified of the second qualifying event **within 60 days** of the second qualifying event. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

IF YOU HAVE QUESTIONS

If you have questions about COBRA continuation coverage, contact the Plan administrator or the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at [www.dol.gov/ebsa].

In order to protect your family's rights, you should keep the Plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Plan administrator.

PLAN CONTACT INFORMATION

[Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.]

[Information about the Plan and COBRA continuation coverage can be obtained on request by contacting:

[])



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RIDER FOR RESIDENTS OF THE STATE OF ARKANSAS

If you reside permanently in the state of Arkansas, the [Certificate][Benefit Booklet] to which this [rider][Rider] is attached and becomes a part is amended as stated below to conform to the requirements of the state of Arkansas. In the event of a conflict between the [Certificate][Benefit Booklet] and this [rider][Rider], the provisions resulting in greater [benefits][Benefits] will be in effect.

1. Individual and Family Eligibility

The eligibility provision outlining a change in coverage from [individual coverage][Individual Coverage] to [family coverage][Family Coverage] is changed as follows:

If you apply for a change from [individual coverage][Individual Coverage] to [family coverage][Family Coverage] within 90 days of the birth or within 60 days of the adoption or [placement for adoption][Placement for Adoption] of a [child][Child], your [family coverage][Family Coverage] will be effective from the date of the birth, adoption or [placement for adoption][Placement for Adoption].

If you do not apply for [family coverage][Family Coverage] within 90 days of the birth or within 60 days of the adoption or [placement for adoption][Placement for Adoption] of a [child][Child], you can make application at any time. The change will be effective on a date that has been mutually agreed to by your [Employer][Group] and [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma].

2. Family Coverage

The eligibility provision concerning adding [dependents][Dependents] to [family coverage][Family Coverage] is changed as follows:

If you apply to add your newborn [child][Child] to your [family coverage][Family Coverage] within 90 days of the [child's][Child's] birth or to add your adopted [child][Child] or [child][Child] placed for adoption to your [family coverage][Family Coverage] within 60 days of the adoption or [placement for adoption][Placement for Adoption], coverage for your [dependent][Dependent] will be effective from the date of the birth, adoption or [placement for adoption][Placement for Adoption].

If you do not apply to add your newborn within 90 days of the birth, or your adopted [child][Child] within 60 days of the adoption or [placement for adoption][Placement for Adoption], you can make application at any time. The change will be effective on a date that has been mutually agreed to by your [Employer][Group] and [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma].

3. Mentally and Physically Handicapped Children

Benefits are provided for your [dependent][Dependent] [child][Child] after they reach the limiting age if the [dependent][Dependent] [child][Child] is incapable of self-sustaining employment by reason of mental or physical handicap; became incapacitated prior to the attainment of age 19; and is chiefly dependent on you for support and maintenance. Proof of the incapacity and dependency must be furnished to [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma].

4. Providers

Benefits for the following [providers][Providers] will be paid at the same level as other [providers][Providers].

- [Advanced practice nurses][Advanced Practice Nurses].
- Athletic trainers.
- [Audiologists][Licensed Audiologists].
- Certified orthotists.
- [Chiropractors][Doctors of Chiropractic].
- Community mental health centers or clinics.
- [Dentists][Doctors of Dentistry]
- [Home health care][Home Health Care][Coordinated Home Care].
- Hospice care.
- Hospital-based service.
- Hospitals.
- Licensed ambulatory surgery centers.
- Licensed [social workers][Clinical Social Workers].
- Licensed [dieticians][Dieticians].
- Licensed [professional counselors][Professional Counselors].
- Licensed psychological examiners.
- Long-term care facilities
- Nurse Anesthetists
- [Occupational therapists][Licensed Occupational Therapists][Occupational Therapists].
- Optometrists.

- Pharmacists.
- [Physical therapists][Licensed Physical Therapists][Physical Therapists].
- Physicians and surgeons (M.D. and D.O.).
- [Podiatrists][Doctors of Podiatry].
- Prostheticists.
- [Psychologists][Doctors of Psychology].
- Respiratory therapists.
- Rural health clinics; and
- [Speech pathologists][Licensed Speech–Language Pathologists].

In addition, benefits will be provided for non–[hospital][Hospital] based medical facilities providing clinical diagnostic services for sleep disorder, and non–[hospital][Hospital] based medical [facilities][facilities] providing magnetic resonance imaging, computed axial tomography, or other imaging diagnostic testing.

5. Well Child Care

Benefits will be provided for [covered charges][Allowable Charges][Allowable Amounts][Eligible Charges] rendered by a [physician][Physician] to [children][Children] under age 19, even though they are not ill. Benefits will be limited to the following services:

- Immunizations;
- Routine diagnostic tests;
- 20 physical examinations at approximately the following age intervals:
 - Birth,
 - Two weeks,
 - Two months,
 - Four months,
 - Six months,
 - Nine months,
 - 12 months,
 - 15 months,
 - 18 months,
 - Two years,

- Three years,
- Four years,
- Five years,
- Six years,
- Eight years,
- 10 years,
- 12 years,
- 14 years,
- 16 years, and
- 18 years.

Benefits will not be subject to any [copayment][Copayment][Copayment Amount], [deductible][Deductible], [coinsurance][Coinsurance][Coinsurance Amount] or [benefit period][Benefit Period] dollar maximum.

6. Mammograms

If your [employer][Employer] elects to cover mammograms, benefits will be provided as follows:

- A base line mammogram for a female who is at least 35 years of age but less than 40 years of age;
- One mammogram every one to two years for a female who is from 40 to 49 years of age; and
- One mammogram a year for a female who is at least 50 years of age; or
- A mammogram upon recommendation of a woman's [physician][Physician], without regard to age, when the woman has had a prior history of breast cancer or when the woman's mother or sister has had a history of breast cancer.

Benefits are not subject to a [deductible][Deductible],[copayment][Copayment][Copayment Amount] or the [coinsurance][Coinsurance][Coinsurance Amount].

7. Colorectal Cancer

Benefits will be provided for colorectal cancer examinations as follows:

- If you are more than 50 years of age;
- If you are age 50 and under and are at high risk for colorectal cancer according to the American Cancer Society colorectal cancer screening guidelines; or

- If you are experiencing bleeding from the rectum or blood in the stool, or if you have a change in bowel habits such as diarrhea, constipation or narrowing of the stool that lasts for more than five days.

Colorectal screening shall involve an examination of the entire colon including the following:

- An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five years;
- A double-contrast barium enema every five years; or
- A colonoscopy every ten years; and
- Any additional medically recognized screening tests for colorectal cancer required the Director of the Department of Health.

Benefits are not subject to a [deductible][Deductible],[copayment][Copayment][Copayment Amount] or the [coinsurance][Coinsurance][Coinsurance Amount].

8. Prostate Cancer

Benefits will be provided for at least one screening per year for any man 40 years of age or older according to the National Comprehensive Cancer Network guidelines. Benefits are not subject to a [deductible][Deductible],[copayment][Copayment][Copayment Amount] or the [coinsurance][Coinsurance][Coinsurance Amount].

9. Phenylketonuria Treatment

Benefits will be provided for amino acid modified preparations, low protein modified food products and any other special dietary products and formulas prescribed by a [physician][Physician] for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism.

10. Musculoskeletal Disorders

Benefits will be provided for the surgical and non-surgical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head including [temporomandibular joint syndrome][temporomandibular joint dysfunction][Temporomandibular Joint Dysfunction] and craniomandibular disorder. Your [benefits][Benefits] for musculoskeletal disorders are the same as your [benefits][Benefits] for any other condition.

11. In Vitro Fertilization

Benefits will be provided for in vitro fertilization procedures for you or your [dependent][Dependent] spouse when:

- Your or your spouse's oocytes are fertilized with the sperm of you or your spouse, and

- You or your spouse have a history of unexplained infertility of at least two years duration; or
- The infertility is associated with one or more of the following medical conditions:
 - Endometriosis;
 - Exposure in utero to diethylstilbestrol, commonly known as DES;
 - Blockage of or removal of one or both fallopian tubes that is not a result of voluntary sterilization; or
 - Abnormal male factors contributing to the infertility.
- The in vitro fertilization procedures are performed at a [facility][Facility] licensed or certified by the Arkansas Department of Health which conforms to the standards of the American College of Obstetricians and Gynecologists', or are performed at a [facility][Facility] certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization.
- You or your spouse has been unable to obtain successful pregnancy through any less costly infertility treatment for which coverage is available under the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan].

The [benefits][Benefits] for in vitro fertilization are the same as the [benefits][Benefits] provided under [maternity][Maternity] [benefit][Benefit] provisions. Cryopreservation, the procedure whereby embryos are frozen for late implantation, is included as an in vitro fertilization procedure.

12. Diabetes Supplies and Training

The provision related to the treatment of diabetes is revised to provide [benefits][Benefits] for blood glucose monitors, blood glucose monitors for the legally blind, test strips (for monitors, glucose control solutions, lancet devices and lancets), visual reading and urine testing strips, insulin, injection aids, syringes, insulin pumps and supplies (such as skin preparations, adhesive supplies, infusion sets, cartridge and batteries) oral agents for controlling blood sugar, podiatric appliances for prevention of complications associated with diabetes (including therapeutic molded or depth-inlay shoes, replacement inserts, preventive devices and shoe modifications for prevention and treatment) and glucagon emergency kits. In addition, [benefits][Benefits] will be provided for [inpatient][Inpatient] and [outpatient][Outpatient] self-management training and education, including medical nutrition therapy, relating to diet, caloric intake and diabetes management but excluding programs the primary purposes of which are weight reduction.

13. Maternity Care

The coverage for [Maternity Services][Maternity Care][maternity care] is changed to allow [routine nursery care][Routine Nursery Care] and pediatric charges for a well newborn [child][Child] for up to five full days in a [hospital][Hospital] nursery or until the mother is discharged from the [hospital][Hospital] following the birth.

14. Cancer Treatment

Benefits will be provided for drugs used for the treatment of cancer if:

- The drug has been approved by the federal Food and Drug Administration for the treatment of the specific type of cancer for which it has been prescribed; and
- The drug is recognized for treatment of that specific type of cancer in one of the standard reference compendia or in the medical literature.

15. Hearing Aids

Benefits will be provided for a hearing aid or hearing instrument sold by a licensed professional. The coverage for hearing aids shall be for not less than \$1,400 per ear, and is not subject to [deductibles][Deductibles] or [copayments][Copayments][Copayment Amounts].

16. Anesthesia and Dental Procedures

Benefits will be provided for anesthesia, [hospital][Hospital] or [ambulatory surgical facility][Ambulatory Surgical Facility] charges for dental procedures if it is certified that general anesthesia is required to safely perform the procedures and the patient is:

- A [child][Child] under seven years of age who is determined by two licensed [dentists][Dentists] to require without delay necessary dental treatment in a [hospital][Hospital] or [ambulatory surgical facility][Ambulatory Surgical Facility] for a significantly complex dental condition;
- A person with a diagnosed serious physical condition or [mental illness][Mental Illness][Mental Health Care disorder]; or
- A person with a significant behavioral problem as determined by your [physician][Physician].

17. Contraceptive Drugs and Devices

If your coverage provides benefits for prescription drugs on [outpatient][Outpatient] basis, then [benefits][Benefits] will be provided for [prescription drugs][Prescription Drugs] or devices approved by the United States Food and Drug Administration for use as a contraceptive. A religious organization is not required to provide this [benefit][Benefit]. A “religious employer” means an entity that: (1) is organized and

operated for religious purposes and has received a section 501(c)(3) designation from the Internal Revenue Service; (2) has as one of its primary purposes the inculcation of religious values; and (3) employs primarily persons who share its religious tenets.

18. Late Claim Payments

The interest rate for a [claim][Claim] not paid on time by the claim administrator is 12%.

19. Continuation of Coverage

If you have been insured continuously under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] for at least three months and your coverage has been terminated for any reason other than nonpayment of the required contribution, you may continue coverage under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] for an additional three months. You must request continuation in writing no later than 10 days after the termination of employment or membership or a change in marital status. You must pay the entire premium including any portion paid by your former [employer][Employer]. Continuation of coverage is subject to the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] or a successor [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] remaining in force.

Continuation of coverage shall end at the earliest of the following dates:

- 120 days after continuation of coverage begins;
- The end of the period for which the individual made a timely contribution;
- The contribution due date following the date the individual becomes eligible for Medicare; or
- The date on which the [policy][contract] is terminated or the [group][Group] withdraws from the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan].

20. Conversion Privilege

If your coverage under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] should terminate for any reason, including the discontinuance of the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] in its entirety, and you want to continue [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] coverage with no interruption, you may do so if your [Employer][Group] has not cancelled this coverage and replaced it with other coverage. Here is what to do:

1. Tell [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico]

co][Blue Cross and Blue Shield of Oklahoma] or your [group][Group] administrator that you wish to continue your coverage and you will be provided with the necessary application.

2. Send the application and first premium to [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] within 31 days of the date you leave your [employer][Employer][group][Group] or within 15 days after you have been given written notice of the conversion privilege, but in no event later than 60 days after you leave your [employer][Employer][group][Group].

Having done so, you will then be covered by [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] on an individual “direct pay” basis. This coverage will be effective from the date your coverage under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] terminates so long as the premiums charged for the direct pay coverage are paid when due.

These direct pay [benefits][Benefits] (and the premium charged for them) may not be exactly the same as the [benefits][Benefits] under the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. However, by converting your coverage, your [benefits][Benefits] under the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] are not interrupted and you will not have to repeat [waiting periods][Waiting Periods] (if any).

[Should any or all of your [dependents][Dependents] become ineligible for coverage under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan], they may convert to direct pay coverage by following the instructions stated above.]

3. Coordination of Benefits

DEFINITIONS

- A. A [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] is any of the following that provides [benefits][Benefits] or services for medical or dental care or treatment. If separate [contracts][Contracts] are used to provide coordinated coverage for [members][Members] of a [group][Group], the separate [contracts][Contracts] are considered parts of the same [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] and there is no coordination of benefits (COB) among those separate [contracts][Contracts].

(1) A [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] includes: [group][Group] and nongroup [contracts][Contracts], [health maintenance organization][Health Maintenance Organization]

nance Organization] (HMO) [contracts][Contracts], closed panel plans or other forms of [group][Group] coverage (whether insured or uninsured); [medical care][Medical Care] components of [long term care][Long Term Care] [contracts][Contracts], such as [skilled nursing care][Skilled Nursing Care]; medical benefits under [group][Group] or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) A [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] does not include: [hospital][Hospital] indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of [long term care][Long Term Care] policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law. Each [contract][Contract] for coverage under (1) or (2) is a separate [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. If a [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate [group health plan][Group Health Plan][Group Policy][Health Benefit Plan].

- B. This [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] means, in a COB provision, the part of the [contract][Contract] providing the health care benefits to which the COB provision applies and which may be reduced because of the [benefits][Benefits] of other [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. Any other part of the [contract][Contract] providing health care benefits is separate from this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. A [contract][Contract] may apply one COB provision to certain [benefits][Benefits], such as dental [benefits][Benefits], coordinating only with similar [benefits][Benefits], and may apply another COB provision to coordinate other [benefits][Benefits].
- C. The order of [benefit][Benefit] determination rules determine whether this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] is a primary plan or secondary plan when the person has health care coverage under more than one [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. When this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] is primary, it determines payment for its [benefits][Benefits] first before those of any other [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] without considering any other [group health plan's][Group Health Plan's][Group Policy's][Health Benefit Plan's] [benefits][Benefits]. When this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] is secondary, it determines payment for its [benefits][Benefits] only after payment for the [benefits][Benefits] of the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] it is secondary to.

fit Plan] is secondary, it determines its [benefits][Benefits] after those of another [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] and may reduce the [benefits][Benefits] it pays so that all [benefits][Benefits] do not exceed 100% of the total allowable expense.

D. Allowable expense is a health care expense, including [deductibles][Deductibles], [coinsurance][Coinsurance][Coinsurance Amounts] and [copayments][Copayments][Copayment Amounts], that is covered at least in part by any [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] covering the person. When a [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] provides [benefits][Benefits] in the form of services, the reasonable cash value of each service will be considered an allowable expense and a [benefit][Benefit] paid. An expense that is not covered by any [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] covering the person is not an allowable expense. In addition, any expense that a [provider][Provider] by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses that are not allowable expenses:

(1) The difference between the cost of a semi-private [hospital][Hospital] room and a private [hospital][Hospital] room is not an allowable expense, unless one of the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] provides coverage for private [hospital][Hospital] room expenses.

(2) If a person is covered by two or more [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] that compute their [benefit][Benefit] payments on the basis of [usual and customary][Usual and Customary] fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific [benefit][Benefit] is not an allowable expense.

(3) If a person is covered by two or more [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] that provide [benefits][Benefits] or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] that calculates its [benefits][Benefits] or services on the basis of [usual and customary][Usual and Customary] fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] that provides its [benefits][Benefits] or

services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all [group health plans][Group Health Plans][Group Policies][Health Benefit Plans]. However, if the [provider][Provider] has contracted with the secondary plan to provide the [benefit][Benefit] or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the [provider's][Provider's] [contract][Contract] permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its [benefits][Benefits].

(5) The amount of any [benefit][Benefit] reduction by the primary plan because a covered person has failed to comply with the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, [precertification][Precertification] of [admissions][Admissions], and [preferred provider][Preferred Provider] arrangements.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more [group health plans][Group Health Plans][Group Policies][Health Benefit Plans], the rules for determining the order of [benefit][Benefit] payments are as follows:

- A. The primary plan pays or provides its [benefits][Benefits] according to its terms of coverage and without regard to the [benefits][Benefits] under any other [group health plan][Group Health Plan][Group Policy][Health Benefit Plan].
- B. (1) Except as provided in Paragraph (2), a [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] state that the complying [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] is primary.

(2) Coverage that is obtained by virtue of membership in a [group][Group] that is designed to supplement a part of a basic package of [benefits][Benefits] and provides that this supplementary coverage shall be excess to any other parts of the [group health plans][Group Health Plans][Group Policies][Health Benefit Plans] provided by the [contract][Contract] holder. Examples of these types of situations are major medical coverages that are superimposed over base plan [hospital][Hospital] and surgical [benefits][Benefits], and insurance type coverages that are written in connection with a closed panel plan to provide [out-of-network][Out-of-Network] [benefits][Benefits].

EFFECT ON THE BENEFITS OF THIS PLAN

- A. When this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] is secondary, it may reduce its [benefits][Benefits] so that the total [benefits][Benefits] paid or provided by all [group health plans][Group Health Plans][Group Policies][Health Benefit Plans] during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any [claim][Claim], the secondary plan will calculate the [benefits][Benefits] it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total [benefits][Benefits] paid or provided by all [benefits][Benefits] for the [claim][Claim] do not exceed the total allowable expense for that [claim][Claim]. In addition, the secondary plan shall credit to its plan [deductible][Deductible] any amounts it would have credited to its [deductible][Deductible] in the absence of other health care coverage.
- B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, [benefits][Benefits] are not payable by one closed panel plan, COB shall not apply between that [group health plan][Group Health Plan][Health Benefit Plan] and other closed panel plans.

FACILITY OF PAYMENT

A payment made under another [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] may include an amount that should have been paid under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. If it does, [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a [benefit][Benefit] paid under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] will not have to pay that amount again. The term “payment made” includes providing [benefits][Benefits] in the form of services, in which case “payment made” means the reasonable cash value of the [benefits][Benefits] provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] is

more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the [benefits][Benefits] or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any [benefits][Benefits] provided in the form of services.

Except as amended by this [rider][Rider], all terms, conditions, limitations and exclusions of the [Certificate][Benefit Booklet] to which this [rider][Rider] is attached will remain in full force and effect.

[Attest: Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)
(Blue Cross and Blue Shield of Texas)
(Blue Cross and Blue Shield of New Mexico)
(Blue Cross and Blue Shield of Oklahoma)



Thomas C. Lubben
Secretary



Patricia A. Hemingway Hall
President]

SERFF Tracking Number: CMPL-127160667 State: Arkansas
 Filing Company: Health Care Service Corporation State Tracking Number: 48720
 Company Tracking Number: HCSC STOP LOSS 2011 - AR - NM
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: HCSC STOP LOSS 2011 - AR - NM
 Project Name/Number: HCSC STOP LOSS 2011 - AR - NM /HCSC STOP LOSS 2011 - AR - NM

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	05/12/2011
Comments:		
Attachment: Readability BCBSNM and AR ET.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	05/12/2011
Bypass Reason: While we acknowledge this requirement, there is no policy or application with this submission.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: PPACA Uniform Compliance Summary	Approved-Closed	05/12/2011
Bypass Reason: This is not a PPACA Filing		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: if of Compliance with Rule 19	Approved-Closed	05/12/2011
Comments:		
Attachment: AR_AR Certif of Compliance with Rule 19.pdf		

	Item Status:	Status Date:
Satisfied - Item: Certification of compliance	Approved-Closed	05/12/2011
Comments:		
Attachment:		

SERFF Tracking Number: CMPL-127160667 State: Arkansas
 Filing Company: Health Care Service Corporation State Tracking Number: 48720
 Company Tracking Number: HCSC STOP LOSS 2011 - AR - NM
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: HCSC STOP LOSS 2011 - AR - NM
 Project Name/Number: HCSC STOP LOSS 2011 - AR - NM /HCSC STOP LOSS 2011 - AR - NM
 AR BCBSNM Certification of Benefit Differential.pdf

		Item Status:	Status
			Date:
Satisfied - Item:	Cover Letter	Approved-Closed	05/12/2011
Comments:			
Attachment:			
	AR BCBSNM ET Filing Letter 2011.pdf		

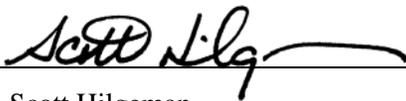
		Item Status:	Status
			Date:
Satisfied - Item:	Filing Authorization	Approved-Closed	05/12/2011
Comments:			
Attachment:			
	2011 Authorization.pdf		

**Health Care Service Corporation
300 E. Randolph Street
Chicago, IL 60601**

READABILITY CERTIFICATION

To the best of our knowledge and ability we have determined the Flesch scale analysis readability test scores to be as shown:

Form Number	Flesch Score
GB-NM-CA-2 HCSC NIL	42.0
ETGB-AR-HCSC – 2011	40.0

By: 
Scott Hilgeman

Title: Vice President and Chief Underwriter

Insurer: Health Care Service Corporation, a Mutual Legal Reserve Company

Form Number(s): GB-NM-CA-2 HCSC NIL
ETGB-AR-HCSC-2011

A handwritten signature in black ink, appearing to read "Scott Hilgeman", with a long horizontal flourish extending to the right.

Signature of Company Officer

Scott Hilgeman

Name

Vice President and Chief Underwriter

Title

February 3, 2011

Date

STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE

Company Name: Health Care Service Corporation

Form Numbers: GB-NM-CA-2 HCSC NIL and ETGB-AR-HCSC-2011

I hereby certify that to the best of my knowledge and belief, the above forms and submission comply with Arkansas Insurance Bulletin 9-85, in that the differential of benefits between PPO and non-PPO providers does not exceed 25%.



Scott Hilgeman
Vice President and Chief Underwriter

February 3, 2011
Date



10921 Reed-Hartman Highway, Suite 334
Cincinnati, Ohio 45242
(Tel) 513.984.6050
(Fax) 513.984.7212
(E-mail) dsimon@crssolutionsgroup.com

February 3, 2011

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Re: Health Care Service Corporation, a Mutual Legal Reserve Company
NAIC# 70670-0917 FEIN# 36-1236610

Group Major Medical Forms
Form Number(s): GB-NM-CA-2 HCSC NIL New Mexico Certificate
ETGB-AR-HCSC-2011 Arkansas Rider

Dear Commissioner:

Compliance Research Services is pleased to submit the enclosed forms on behalf of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). A letter of filing authorization is enclosed.

HCSC does business in various states as follows:

- Blue Cross and Blue Shield of Illinois in Illinois;
- Blue Cross and Blue Shield of Texas in Texas;
- Blue Cross and Blue Shield of Oklahoma in Oklahoma; and
- Blue Cross and Blue Shield of New Mexico in New Mexico.

HCSC provides group medical insurance to Illinois employers that have employees located in many states. This filing is for HCSC's New Mexico division however, we will be submitting similar filings for the other divisions of the company.

Submitted Materials. The coverage in question is true group coverage sold in Illinois by licensed Illinois agents and brokers.

The provisions of the certificate may change according to the benefits negotiated between the employer and HCSC. The enclosed certificate includes provisions for participating provider hospitals and physicians. Coverage may also be issued on a fee for service basis without the network provisions. Individuals insured under network plans have access to their local Blue Cross provider networks under the national Blue Cross association BlueCard plan. The Arkansas Rider has been drafted to bring the certificate into compliance with applicable Arkansas extraterritorial requirements. Note that a previous version of the Arkansas Rider was approved by your Department on June 3, 2008, for form ETGB-AR-HCSC-07, under SERFF Tracking Number: CMPL-125648906. This new version of the Arkansas Rider has been updated to include any new applicable Arkansas mandates passed since the prior approval.

Provisions in the certificate that may vary from employer to employer are bracketed. HCSC requests the right to change the type style and paper size or to issue the forms in electronic format.

The forms have been tested for readability. Certification of readability is enclosed.

If you have any questions or comments, please call me at 513-894-6050 or by email at dsimon@crssolutionsgroup.com.

Thank you for your assistance in this matter.

Sincerely,

A handwritten signature in black ink that reads "J. David Simon". The signature is written in a cursive style with a large, prominent initial "J".

J. David Simon, CLU
President
Phone: 513.984.6050
Fax: 513.984.7212
E-Mail Address: dsimon@crssolutionsgroup.com



**BlueCross BlueShield
of Illinois**

January 3, 2011

NAIC Company Code: 70670

Re: Group Medical Forms
TOI H16G.002A

To: All State Insurance Departments

Health Care Service Corporation, a Mutual Legal Reserve Company which also does business as Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of Texas, Blue Cross and Blue Shield of Oklahoma, Blue Cross and Blue Shield of New Mexico, hereby authorizes Compliance Research Services, LLC to represent us in the submission of the above-referenced forms and to negotiate with insurance department for their approval.

Sincerely,

Health Care Service Corporation,
A Mutual Legal Reserve Company

A handwritten signature in cursive script that reads "Karen Atwood".

Karen Atwood
President Illinois Division