Your Health Care Benefits Program

Los Alamos National Security, LLC

A Guide To Your National Preferred Provider Option (PPO) Medical Program

For Medicare Retirees and Their Covered Family Members

Administered by:

N113794 01/15

CUSTOMER ASSISTANCE

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

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

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

Street address: 4373 Alexander Blvd. NE
Toll-free telephone number: 1-877-878-LANL (5265)

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

Send all **drug plan claims** to the pharmacy manager at:

Prime Therapeutics
P.O. Box 14624
Lexington, KY 40512-4624

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

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

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

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

Send claims* to:

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

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

www.bcbsnm.com

To locate **Preferred Providers** throughout the United States and the world, visit the BlueCard Doctor and Hospital Finder at www.bcbs.com; or call 1-800-810-BLUE (2583); or outside of the United States, call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or collect at 1-804-573-1177.:

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

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

A message from

LOS ALAMOS NATIONAL SECURITY, LLC

Welcome to the Medical Program for Medicare-Eligible Retirees of **Los Alamos National Security, LLC (LANS)** and their eligible family members. Blue Cross and Blue Shield of New Mexico (BCBSNM), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, and an Independent Licensee of the Blue Cross and Blue Shield Association is pleased to serve as the Claims Administrator for the **LANS** self-funded health care benefit plan. You will be accessing the Worldwide BCBS Preferred Provider network as if you were insured by BCBSNM.

This Medical Program is self-insured by LANS. This means LANS is responsible for the design of the Medical Program and the setting of contributions. LANS sets the employee contribution rates to be adequate to pay for the claims all LANS medical Program members incur. When claim costs exceed the contributions, the contribution rates have to go up. A small percentage of your contributions go towards the Medical Program administration costs (claims adjudication, customer service, provider networking, ID cards, booklet printing, etc.). The balance pays for the cost of your medical care.

In addition to this document, the LANS Health & Welfare Benefit Plan for Retirees Summary Plan Description (LANS SPD) contains information about your LANS Medical Program. If any conflict should arise between this benefit booklet and the procedures of the Claims Administrator (BCBSNM) or if any provision is not explained or only partially explained in this document, the relevant LANS SPD will govern in all cases.

Every effort has been made to make this Benefit Booklet as accurate and easy to understand as possible. It is your responsibility to read and understand the terms and conditions in this booklet. We urge you to read it carefully and use it to make well-informed benefit decisions for you and your family.

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

Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, and Independent Licensee of the Blue Cross Blue shield Association is pleased to serve as Claims Administrator for the LANS Medical Program. You will be accessing the worldwide Blue Cross Blue Shield preferred provider network as if you are insured by BCBSNM.

Note: The Medical Program's benefit administrator (BCBSNM) and **LANS** may change the benefits described in this benefit booklet. If that happens, BCBSNM or **LANS** will notify you of those mutually agreed upon changes.

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

Sincerely,

Los Alamos National Security, LLC

Note: This medical program is considered ungrandfathered, as a result members have an additional appeal level regarding disputed claims and eligibility issues. See *Section 8* for more information about appeals.

This is a Preferred Provider (PPO) Medical Program. This means that if you obtain services from an Out-of-Network (nonpreferred) provider, your share of the bill is greatly increased. It is YOUR responsibility to determine if a provider is in the national worldwide BCBS PPO network or not.

Revision History: booklet renewal ungrandfathered 1/2015

TABLE OF CONTENTS

SECTION 1: HOW TO USE THIS BENEFIT BOOKLET 3

SECTION 2: CONVERSION TO INDIVIDUAL COVERAGE 8

SECTION 3: HOW YOUR PLAN WORKS 9

SECTION 4: PREAUTHORIZATIONS 18

SECTION 5: COVERED SERVICES 25

SECTION 6: GENERAL LIMITATIONS AND EXCLUSIONS 58

SECTION 7: COORDINATION OF BENEFITS (COB) AND REIMBURSEMENT 67

SECTION 8: CLAIMS PAYMENTS AND APPEALS 69

SECTION 9: GENERAL PROVISIONS 79

SECTION 10: DEFINITIONS 81

APPENDIX: NOTICE - INQUIRIES/COMPLAINTS AND INTERNAL/EXTERNAL APPEALS FOR SELF- FUNDED PLANS 96

APPENDIX A: CONTINUATION COVERAGE RIGHTS UNDER COBRA 106

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsnm.com/coverage or by calling 1-877-878-LANL (5265).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Preferred Provider $**250**/Indiv $**750**/Family Non-Preferred Provider $**500**/Indiv $**1,500**/Family Doesn't apply to certain preventive care. Copays do not count toward the overall deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Preferred Provider **$3,000**/Indiv **$9,000**/Family Non-Preferred Provider **$6,000**/Indiv **$18,000**/Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Out-of-network inpatient facility copays, premiums, penalty amounts, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Does this plan use a network of providers?	Yes. Please call **1-877-878-LANL (5265)** or see www.bcbsnm.com	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-878-LANL (5265) or visit us at www.bcbsnm.com/coverage.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-877-878-LANL (5265) to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use preferred **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	40% coinsurance	PPO deductible waived
	Specialist visit	$20 copay/visit	40% coinsurance	PPO deductible waived
	Other practitioner office visit	$20 copay/visit	40% coinsurance	PPO deductible waived. Acupuncture max. 20 visits/year; Spinal Manipulation/Naprapathy combined max. 20 visits/year.
	Preventive care/screening/immunization	No Charge	40% coinsurance	---none---
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	Requires preauthorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsnm.com/member/rx_drugs.html.	Generic drugs	$15/Retail - $30/Mail	Not Covered	Retail prescriptions are limited up to a 30-day supply or 180 units, whichever is less. Mail-Order prescriptions are limited to a 60- or 90-day supply or 540 units, whichever is less.
	Preferred brand drugs	$30/Retail - $60/Mail	Not Covered	
	Non-preferred brand drugs	$45/Retail - $90/Mail	Not Covered	
	Specialty drugs	$45/Retail	Not Covered	Specialty Drugs are not available through mail-order.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	---none---
	Physician/surgeon fees	10% coinsurance	40% coinsurance	---none---
If you need immediate medical attention	Emergency room services	$75 copay/visit	$75 copay/visit	PPO Deductible waived for ER facility; ER physicians are subject to deductible & coinsurance.
	Emergency medical transportation	10% coinsurance	10% coinsurance	---none---
	Urgent care	$20 copay/visit	40% coinsurance	PPO deductible waived
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	$250 copay/admit and 40% coinsurance	Requires preauthorization.
	Physician/surgeon fee	10% coinsurance	40% coinsurance	Requires preauthorization.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office - $20 copay Other Outpatient Services - 10% coinsurance	40% coinsurance	PPO Deductible waived for office. Other Outpatient includes IOP and Partial Hospitalization(Requires preauthorization)
	Mental/Behavioral health inpatient services	10% coinsurance	$250 copay/admit and 40% coinsurance	Inpatient Services include Residential Treatment Center. Inpatient services require preauthorization.
	Substance use disorder outpatient services	Office - $20 copay Other Outpatient Services - 10% coinsurance	40% coinsurance	PPO Deductible waived for office. Other Outpatient includes IOP and Partial Hospitalization(Requires preauthorization)
	Substance use disorder inpatient services	10% coinsurance	$250 copay/admit and 40% coinsurance	Inpatient Services include Residential Treatment Center. Inpatient services require preauthorization.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	$20 copay/visit	40% coinsurance	PPO deductible waived. Copay charged for initial visit only.
	Delivery and all inpatient services	10% coinsurance	$250 copay/admit and 40% coinsurance	Requires preauthorization.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	Max. 100 visits/year
	Rehabilitation services	$20 copay/visit	40% coinsurance	PPO deductible waived. Includes Physical, Occupational, and Speech Therapies (office/outpatient) max. 20 visits/year per therapy.
	Habilitation services	$20 copay/visit	40% coinsurance	
	Skilled nursing care	10% coinsurance	40% coinsurance	PPO deductible waived. Includes Inpatient Physical Rehabilitation max. 100 days/year and requires preauthorization. Out-of-network max. 70 days/year.
	Durable medical equipment	10% coinsurance	40% coinsurance	---none---
	Hospice service	10% coinsurance	40% coinsurance	PPO deductible waived
If your child needs dental or eye care	Eye exam	No Charge	40% coinsurance	For Dependents age 18 or younger.
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	If dental coverage purchased, see your dental plan information.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic Surgery
- Dental Care (Routine dental for adults)
- Infertility Treatment (Unless for medical condition causing the infertility)
- Long-Term Care
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care (Unless you are diabetic)
- Weight Loss Programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture (Max. 20 visits/year)
- Bariatric Surgery (Must meet medical criteria)
- Chiropractic Care/Spinal/Naprapathy (Max. 20 visits/year)
- Hearing Aids (For members age 21 and younger; up to maximum 2 hearing aids every 3-years)
- Hearing Aids for adults (For members age 22 and older max $2,200 for any 3-year period)
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-432-0750. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U. S. Department of Health and Human Services at 1-877-267-2323 x. 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Blue Cross and Blue Shield of New Mexico (BCBSNM) Appeals Unit at 1-800-205-9926. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the New Mexico Superintendent of Insurance toll-free at 1-855-427-5674 or www.osi.state.nm.us.

Questions: Call **1-877-878-LANL (5265)** or visit us at **www.bcbsnm.com/coverage**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf** or call **1-877-878-LANL (5265)** to request a copy.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-432-0750.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-432-0750.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-432-0750.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-432-0750.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,630
- **Patient pays** $910

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$250
Copays	$20
Coinsurance	$490
Limits or exclusions	$150
Total	**$910**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,150
- **Patient pays** $1,250

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$250
Copays	$800
Coinsurance	$120
Limits or exclusions	$80
Total	**$1,250**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

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

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

SECTION 1: HOW TO USE THIS BENEFIT BOOKLET

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

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

DEFINITIONS

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

SUMMARY OF BENEFITS AND COVERAGE (SBC)

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

IDENTIFICATION (ID) CARD

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

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

PROVIDER NETWORK DIRECTORY

Because this is a Preferred Provider (PPO) Medical Program, it is to your financial advantage to receive covered services from providers that are within the worldwide BCBS Preferred Provider network. Since it is your responsibility to determine if a provider is in the BCBS Preferred Provider network or not, BCBSNM has made every effort to assist you with finding a Preferred Provider - even while you are traveling. The provider network directory is available through the BCBSNM website at www.bcbsnm.com. It lists all providers in the BCBSNM preferred provider (PPO) network and participating pharmacies. It also provides links to the listings of preferred providers in other states. (If you want a paper copy of a directory, you may request one from Customer Service. It will be mailed to you free of charge.) **Note:** Although provider directories are current as of the date shown at the bottom of each page, they can change without notice. To verify a provider's status or if you have any questions about the directory, contact a Customer Service Advocate or visit the BCBSNM website at www.bcbsnm.com/lanl.

DRUG PLAN BENEFITS

BCBSNM has contracted with a separate pharmacy benefit manager to administer your outpatient drug plan benefits. For information specific to your drug plan coverage, see "Prescription Drugs and Other Items" in *Section 5: Covered Services*.

BLUECARD® BROCHURE

As a member of a PPO health plan administered by BCBSNM, you take your health plan benefits with you – across the country and around the world. The BlueCard Program gives you access to preferred providers almost everywhere you travel or live. Almost 90 percent of physicians in the United States contract with Blue Cross and Blue Shield (BCBS) Plans. You and your eligible family members can receive the Preferred Provider level of benefits – even when traveling or living outside New Mexico – by using health care providers that contract as preferred providers with their local BCBS Plan. For more information please contact Customer Service and request a brochure. 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.

OTHER BENEFIT RELATED MATERIALS

In addition to this Medical Program booklet you should have received (or have access to) a Summary Plan Description (SPD). You have on-line access to the SPD through Empyean Customer Care Center, Your Benefit Resources web site. The LANS SPD provides a summary of the principal features of the entire LANS Health & Welfare Benefit Plan for Retirees, ERISA Plan 502 (each called a Plan). The LANS SPD provides summaries of all retiree benefits such as, but not limited to, life insurance, short-term disability, survivor benefits, etc. This benefit booklet is only one component of the LANS SPD and is referenced in Appendix C of the LANS SPD as Benefits Program Material of the medical/surgical health plan. This document provides a summary only for Medical Program benefits and exclusions, basic eligibility and enrollment requirement, cost-sharing features (such as deductible and applicable copayments), and administrative provision of the Claims Administrator (such as preauthorization requirements, coordination of benefits rules, appeal procedures, etc). The LANS SPD for your Benefit Program is available by contacting Empyrean Customer Care for LANL at (844) 805-0002.

LIMITATIONS AND EXCLUSIONS

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

PREAUTHORIZATION REQUIRED

To receive full benefits for some nonemergency admissions and certain medical/surgical services, you or your provider must call the BCBSNM Health Services department at (800) 325-8334 **before** you receive treatment. Call Monday through Friday, 8 A.M. to 5 P.M., Mountain Standard Time. See *Section 4: Preauthorizations* for details. **Note:** Call Customer Service if you need preauthorization assistance after 5 P.M.

Emergency/Maternity Admission Notification

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

Written Request Required

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

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

Written requests may also be submitted over the BCBSNM web site at www.bcbsnm.com. Please ask your health care provider to submit your request early enough to ensure that there is time to process the request before the date you are planning to receive services.

PREAUTHORIZATION OF BEHAVIORAL HEALTH CARE

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

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

PREAUTHORIZATION AND COMPLAINT/APPEAL PROCEDURES

In addition to the summary of complaint and appeal procedures presented in this booklet, you can access a special notice that provides all of the details of the BCBSNM complaint and appeals procedures, including independent external review and other actions that may be available under your health plan by calling customer service.

CUSTOMER SERVICE

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

Customer Service representatives can help with the following:

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

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

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

Website: www.bcbsnm.com

Behavioral Health Customer Service

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

Toll-free: 1-888-898-0070

Deaf and Speech Disabled Assistance

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

Translation Assistance

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

After Hours Help

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

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

24/7 Nurseline

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

Toll-free: 1-800-973-6329

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

Special Beginnings®

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

Toll-free: 1-888-421-7781

BLUE ACCESS FOR MEMBERS SM

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

If you need help accessing the BAM site, call:

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

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

OTHER LANS PROGRAM ASSISTANCE

For questions about eligibility, enrollment, termination, and continuation of Medical Program coverage, for information about switching Medical Programs or adding or cancelling a family member's coverage, contact:

	For Retirees:
Customer Service	Empyrean Customer Care Center PO Box 3128 Ballaire, TX 77402
Phone Number	(844) 805- 0002 Fax Number (866) 754- 1396
Web Site	https://ess5.empyreanbenefitssolutions.com/lanl

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.

ELIGIBILITY

Please refer to the applicable LANS Welfare Benefit Plan Summary Plan Description for enrollment, eligibility, termination, and Plan Administration information including details about continuation of group coverage under COBRA and USERRA.

SECTION 2: CONVERSION TO INDIVIDUAL COVERAGE

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

- termination of employment
- a member no longer meets the eligibility requirements of the 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

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

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

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

SECTION 3: HOW YOUR PLAN WORKS

BENEFIT CHOICES

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

Your Choices

	Preferred Provider	Nonpreferred Provider
Cost-Sharing Differences	You pay either a fixed-dollar copayment amount (which is usually not subject to the annual deductible) or you pay a deductible and a percentage of covered charges after the deductible is met.	You must meet a higher deducible amount, pay a higher percentage of covered charges, and meet a higher out-of-pocket limit. Note: Transplants are not covered if received from a noncontracted provider or facility.
Covered Charge vs. Billed Amount	If the covered charge is less than the billed amount, the preferred provider will write off the difference. You pay only applicable copayments, coinsurance, non-covered expenses, and penalty amounts, if any.	The nonpreferred provider may bill you for amounts over the covered charge. BCBSNM also will not pay the nonpreferred provider directly, so you will be responsible for arranging to pay the entire billed amount to the provider.
Filing Claims	The preferred provider is responsible for filing claims directly to the local BCBS Plan. The provider will ask for your ID card, for your signature, for information about other coverage, etc. so that the provider may file a claim for you. The provider will be paid directly by BCBSNM.	You may have to pay the nonpreferred provider in full and submit your own claims; the decision is up to the provider. If you file the claim, you must send the itemized bill for covered services to BCBSNM, attached to a member claim form, within 12 months of receiving the service. If you do not meet the time limit for filing claims, the claim will be denied.
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 (i.e., BCBS of Texas) 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. If preauthorization is not obtained, you may have to pay an additional penalty, or the services may be denied completely.
Available Benefits	All services covered under this Medical Program 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 *Summary of Benefits* for a list of services not covered at the Nonpreferred Provider benefit level, if applicable.

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 (commonly known as an "In-Network Provider").

PREFERRED PROVIDERS VERSUS NONPREFERRED PROVIDERS

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

Nonpreferred Providers (Out-of-Network) 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 (In-Network). A "participating" provider is a provider that falls under out-of-network benefit, however this provider agrees to a covered charge and will not balance bill the member for amounts above the covered charge. See "Filing Claims" in *Section 8: Claim Payments and Appeals* for more information.)

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

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

PROVIDER DIRECTORY AND ONLINE PROVIDER FINDER®

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

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

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

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

Web-Based BCBSNM Provider Finder

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

www.bcbsnm.com

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

Paper Provider Network Directory

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

Finding a Pharmacy

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

www.MyPrime.com

Click on *Find a Pharmacy.* You will then be asked to select from a list of BCBS Plans. **You must select "Blue Cross and Blue Shield of New Mexico"** and then select **"Other BCBSNM Plans"** in order to get the correct list of participating pharmacies for this health plan. After you have selected "Blue Cross and Blue Shield of New Mexico" as your health plan administrator, you will be able to locate participating pharmacies throughout the United States based on zip code or state name. You may also request a paper copy of the list of participating pharmacies by calling a Customer Service Advocate at BCBSNM.

Providers Outside New Mexico

Out-of-state providers that contract with their local Blue Cross and/or Blue Shield Plan and international providers that contract with the Blue Cross and Blue Shield Association as **Preferred Providers** are also eligible for the "Preferred Provider" level of benefits for covered services listed on the *Summary of Benefits.* **Note:** Providers who have a "participating-only" contract are **not** preferred providers and benefits will be paid according to the out-of-network schedule of benefits. You will not be balance billed by a "participating" provider for amounts above the covered charge. You must use **preferred providers** in order to obtain the higher benefit (unless listed under **"Benefit Level Exceptions,"** later in this section).

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

BCBSNM Website

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

BCBSNM website: www.bcbsnm.com

National Website

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

Blue Cross and Blue Shield Association website:

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

National Phone Number

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

1-800-810-BLUE (2583)

International Assistance

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

preauthorization is different from the following phone numbers, which are strictly for locating a Preferred Provider while outside the United States:

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

COORDINATION WITH MEDICARE

Medicare-Covered Services

Medicare-Participating Provider - Facilities that have contracted with Medicare to provide services to Medicare beneficiaries (e.g., hospitals, skilled nursing facilities, home health care agencies, hospice programs, rural health clinics, comprehensive outpatient rehabilitation facilities, community mental health centers, and end-stage renal disease dialysis centers). Participating professional providers (nonfacility providers such as physician, podiatrists, and other professional providers) are those that have signed agreements with Medicare to accept Medicare assignment (accepting Medicare assignment means the provider agrees to accept the Medicare-approved amount as payment in full).

Nonparticipating Provider - Those health care providers that have Medicare provider identification numbers but who have not signed agreements with Medicare to accept the Medicare-approved amount as payment in full. However, on a claim-by-claim basis, nonparticipating providers can agree to accept the Medicare-approved amount. If the provider does not accept assignment, Medicare will usually impose a "limiting charge" beyond which physician cannot bill you.

When Medicare covers a service for an eligible retiree or retiree's eligible family members, that service will be considered covered under this LANS Medical Program. The Medical Program will pay the lesser of the usual benefit under the Medical Program or the balance due, whichever is less. If, by paying the claim, the amount would exceed any Medical Program benefit limitations (such as annual or lifetime limits on certain services), no benefit payment will be made by the Medical Program. If Medicare does not cover a service, see "Services Not Covered by Medicare" below.

Assigned vs. Nonassigned Medicare Services - For Medicare-covered services, you can choose at the time that care is needed whether to see a provider who accepts Medicare assignment or a provider who does not accept assignment. (All Medicare-participating providers accept Medicare assignment. Nonparticipating physician and other professional providers may accept a one-time Medicare assignment on a claim-by-claim basis.) For Medicare-covered services, your choice of a Medicare-participating or nonparticipating provider can make a difference in the amount you pay.

- If you visit a provider that is Medicare-participating or a nonparticipating provider that accepts Medicare assignment, you will not have to pay the difference between the Medicare allowable and the provider's billed charge.
- If you visit a nonparticipating provider that does not accept Medicare assignment, a provider that is not Medicare-eligible, or if you privately contract with a provider, you will be responsible for paying amounts over the Medicare allowable, up to the Medicare limiting charge, if any which is not applied to the out out-of-pocket limit.

Services Not Covered By Medicare

This Medical Program may cover some services that are not covered by Medicare. Regular benefits, as described on the *Summary of Benefits*, apply to those services. In addition, please be aware of the following special cases:

Nonparticipating Facilities - Except for limited emergency services, there are no Medicare benefits for services provided by facilities that do not participate with Medicare (nonparticipating facilities). If you received services from a nonparticipating facility without preauthorization from BCBSNM, benefits may be denied (except for limited emergency services at a hospital).

Member Privately Contracting With a Physician or Other Provider - When Medicare is your primary coverage (e.g., you are a retiree or a covered family member of a retiree or have completed the end-stage renal disease coordination period) or you have privately contracted with a provider as set forth in section 4507 of the Balanced Budget Act of 1997, BCBSNM will make the determination whether or not a service is covered by the medical Program. If you privately contract with a provider, BCBSNM will estimate the amount that would have been paid by Medicare had you been able to submit a claim to Medicare for primary payment.

Providers Not Recognized by Medicare - You do not need to file your claim first with Medicare if services are received from a provider type not recognized by Medicare, such as a licensed professional clinical mental health counselor (L.P.C.C.) and licensed marriage and family therapist (L.M.F.T.). However, you will need preauthorization from BCBSNM in order to receive benefits for covered mental health/chemical dependency services received from L.P.C.C. and L.M.F.T. providers.

For Medicare-Covered services, if Medicare pays the provider, the Medical Program will generally pay the provider; if Medicare does not pay the provider, BCBSNM will generally pay the subscriber. For Medicare-covered services, the covered charge is Medicare's approved amount for assigned claims, or Medicare's limiting charge (or 115 percent of the Medicare-approved amount) for non-assigned claims.

CALENDAR YEAR

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

BENEFIT LIMITS

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

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

COST-SHARING FEATURES

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

YOUR DEDUCTIBLE

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

Individual Deductible

Once a member's deductible payments for preferred provider services reach the individual preferred provider deductible amount indicated on the *Summary of Benefits*, this Medical Program will begin paying its share of that member's covered preferred provider charges (In-Network Provider).

Family Deductible

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

What Is Not Subject to the Deductible

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

- charges covered under "Prescription Drugs and Other Items"
- preventive services
- fixed dollar copayments
- Out-of-Network preventive services for children under age 2

Admissions Spanning Two Calendar Years

If the 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 preferred provider that are received during the new calendar year are subject to the deductible for the new calendar year.

Timely Filing Reminder

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

COPAYMENTS

The fixed-dollar amount of a covered charge that you pay for some covered services such as, but not necessarily limited to: office, emergency room, and urgent care facility visits from Preferred Providers and for residential treatment center care. (Other services received during the visit may be subject to to deductible and/or coinsurance; see the *Summary of Benefits*.)

Drug Plan Copayment

When you purchase covered prescription drugs and other items through the drug plan, 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. See "Prescription Drugs and Other Items" for more information about the drug plan.

COINSURANCE

For some covered 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 Medical Program 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.

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.

OUT-OF-POCKET LIMIT

The out-of-pocket limit is the maximum amount of deductible, coinsurance, copayments and drug plan charges 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 Medical Program 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 amounts for preferred provider services are **not** applied to the Nonpreferred Provider out-of-pocket limit. In addition, the out-of-pocket amounts for nonpreferred provider services are not applied to the Preferred Provider out-of-pocket limit.

Individual Limits

Once your coinsurance, deductible, and copayment amounts for preferred provider (In-Network provider) services in a calendar year reaches the individual preferred provider amount indicated on the *Summary of Benefits,* this Medical Program pays 100 percent of most of your covered preferred provider charges (excludes inpatient hospital copayment, services in excess of annual or lifetime limits and residential treatment center copayment) for the rest of the calendar year.

Once your coinsurance amounts for nonpreferred provider services (Out-of-Network) in a calendar year reaches the higher individual nonpreferred provider amount indicated on the *Summary of Benefits*, this Medical Program pays 100 percent of most of your covered nonpreferred provider charges (excludes inpatient hospital copayment, services in excess of annual or lifetime limits and residential treatment center copayment) for the rest of the calendar year.

Family Limits

An entire family meets the out-of-pocket limit when the total coinsurance, deductible and specified copayment amounts for all family members reach the Family amount indicated on the *Summary of Benefits*. (When a member meets an out-of-pocket limit, no more charges incurred by that member may be used to satisfy an applicable family out-of-pocket limit.)

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

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

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

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

CHANGES TO THE COST-SHARING AMOUNTS

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

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.

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 (Out-of-Network) for emergency care services, the Preferred Provider (In-Network) deductible and coinsurance 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. (Office/urgent care facility services are not considered "emergency care" for purposes of this provision.)

Except in emergencies, BCBSNM will generally NOT authorize services of a non-preferred provider if the services could be obtained from a preferred provider. Authorizations for such services are given only under very special circumstances related to medically necessity and lack of provider availability in the preferred provider network. BCBSNM will NOT authorize any such request based on non-medical issues such as whether or not you or your doctor prefer the nonpreferred (Out-of-Network) provider or find the provider more convenient. If a preferred (in-network) provider is available in another city, you may have to travel to that city to receive benefits for nonemergency care.

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

For follow-up care (which is no longer considered emergency care) and for all other nonemergency care, you will receive the Nonpreferred Provider (Out-of-Network) benefit for the services of a nonpreferred provider, even if a preferred provider (In-Network) 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. Note: Christian Science Practitioners and Sanatoriums are not considered unsolicited under this provision and you will receive benefits based solely on whether or not the provider in question has a Preferred Provider contract with the local BCBS Plan.

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** (Out-of-Network) surgeon provides your care or you are admitted to a nonpreferred (Out-of-Network) hospital or other treatment facility, you **will** be responsible for amounts over the covered charge for any services received from nonpreferred (Out-of-Network) 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.

COORDINATION WITH MEDICARE

Since Medicare is your primary coverage, the Medical Program 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 LANS Medical program is "secondary" coverage.

You may not elect to change your LANS Medical Program 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. If an Explanation of Medicare Benefits (EOMB) form is not received with your claim, BCBSNM will estimate your benefits as if you had Medicare Part B and will pay as secondary to Medicare. 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*.

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

How Benefits are Paid - All covered expenses are subject to the same annual Medical Program deductible, copayment, coinsurance, and out-of-pocket limits. This Medical Program's benefits are determined and the balance due after Medicare or the usual Medical Program Benefit will be paid, whichever is less. Note: you must be enrolled in both Parts A and B or Medicare in order to retain coverage under this LANS Medical Program. 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 Medical Program deductible and coinsurance or Medical Program copayments.

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

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

- non-Medicare-covered services that are covered by the Medical Program and received at a Veteran's Administration, Department of Defense, or other government facility for a non-service-connected condition (For outpatient services, benefits are calculated using a maximum of 20 percent of the billed charge as the covered charge, which is then subject ot regular Medical Program deductible, coinsurance and/or copayments. For inpatient services, the coverage charge is equal to the Medical Part A hospital deductible, subject ot regular Medical Program deductible, coinsurance, and/or copayments.)

SECTION 4: PREAUTHORIZATIONS

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

In order to receive benefits:

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

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

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

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

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

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

How the Preauthorization Procedure Works

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

BCBSNM PREFERRED PROVIDERS

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

- when recommending any nonemergency admission, readmission, or transfer
- when a covered newborn stays in the hospital longer than the mother
- before providing or recommending a service listed under "Other Preauthorizations," later in this section
- before recommending that you go to a provider for whose services you expect to receive benefits (such requests may be denied.)

Note: Providers that contract with other Blue Cross and Blue Shield Plans may not be familiar with the preauthorization requirements of BCBSNM. Unless a provider contracts directly with BCBSNM as a preferred provider (In-Network), the provider is not responsible for being aware of this Medical Program's preauthorization requirements.

NONPREFERRED PROVIDERS OR PROVIDERS OUTSIDE NEW MEXICO

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

Except in emergencies, BCBSNM must preauthorize a visit to a nonparticipating provider. If preauthorization is not obtained before a visit to a nonparticipating provider, benefits will not be available for the service.

NONPARTICIPATING PROVIDERS OR PROVIDERS OUTSIDE NEW MEXICO

Care received from a nonparticipating provider without a BCBSNM preauthorization is covered only if a delay in reaching a participating provider would result in death or disfigurement, jeopardize your health, or seriously impair the function of any bodily organ or part.

BCBSNM may deny a request to preauthorize a visit to a nonparticipating provider. Any nonemergency services received from a nonparticipating provider must be unavailable from a participating provider. If services are available within the BCBSNM participating network, BCBSNM will not preauthorize a visit to a nonparticipating provider. If a participating provider is available in another city, you may have to travel to that city to receive benefits for nonemergency care. Also, this Medical Program does not cover services received outside the United States, unless there is an emergency.

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

If a nonparticipating provider or provider outside New Mexico recommends service under very special medical circumstances, BCBSNM may preauthorize a visit to a nonparticipating provider. If that provider recommends an admission or a service that requires preauthorization for you. In such cases, it is your responsibility to ensure that preauthorization is obtained. If preauthorization is not obtained before services are received, you will be entirely responsible for the charges.

INPATIENT PREAUTHORIZATION

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

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

Penalty for Not Obtaining Inpatient Preauthorization

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

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

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

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

OTHER PREAUTHORIZATIONS

In addition to preauthorization review for all nonemergency inpatient services, preauthorization is required for the services listed below. Most preauthorizations may be requested over the telephone. If a *written* request is needed, have your provider call a Health Services representative for instructions for filing a written request for preauthorization. An out-of-network provider, or an out-of-state network provider may call on your behalf, but it is **your responsibility** to ensure that BCBSNM is called. Preferred providers that contract **directly** with BCBSNM are responsible for requesting all necessary preauthorizations for you. (See "Inpatient Preauthorization" for further information regarding inpatient preauthorization requirements.)

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

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

- **air ambulance** services (unless during a medical emergency)
- **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**
- **MRIs**
- **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** purchased through the drug plan; prescription refills before the supply should have been exhausted
- **fetal echocariograms and other in-utro services for a fetus**
- **home health care and home I.V. services**
- **hospice care**
- **infertility-related services** (Only limited services are covered.)
- certain **injections,** including but not limited to **intravenous immunoglobulin** (**IVIG**)
- nonemergency or **elective hospital** or other facility admissions
- **genetic testing or counseling; infertility testing**
- **private room charges**
- **psychological testing; neuropsychological testing; electroconvulsive therapy (ECT); repetitive transcranial magnetic stimulation** and **intensive outpatient program (IOP)** treatment
- **rehabilitative services** (outpatient/office physical, occupational, and speech therapy)
- **speech therapy for children under age three**
- **surgery** procedures, whether inpatient or outpatient, including, but not limited to, **bariatric (obesity) surgery, breast reduction, breast surgery following a mastectomy (only cosmetic procedure covered under this Medical Program), cochlear implants, reconstructive surgery,** and **transplants, including transplant evaluations**
- **transition of care** for nonpreferred providers
- **travel and lodging** when available through the Cancer Treatment, Congenital Heart Disease, or Transplant Services case management and care coordination programs
- **weight management** programs for obesity such as dietary control, advice or exercise

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

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

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

Preauthorization of Mental Health/Chemical Dependency Services

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

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

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

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

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

Summary of Contact Information for Preauthorization, Customer Service, Claim Submission, and Appeal (or Reconsideration) Processes for Medical/Surgical and Behavioral Health Services:			
Process:	**Type of Service:**	**Phone:**	**Send to:**
Request preauthorization	Medical/surgical	1-800-325-8334	Send to P.O. number listed on inside cover.
	Mental health/chemical dependency	1-888-898-0070	BH Unit P.O. Box 27630 Albuquerque, NM 87125-7630
Customer Service Inquiry	Medical/surgical	1-877-878-LANL (5265)	Send to P.O. number listed on inside cover.
	Mental health/chemical dependency	1-888-898-0070	BH Unit P.O. Box 27630 Albuquerque, NM 87125-7630
Submit claim (post-service)	Medical/surgical		Send claim to P.O. number listed on inside cover.
	Mental health/chemical dependency		Send claim to BH Unit P.O. Box 27630 Albuquerque, NM 87125-7630
Request **appeal** or reconsideration of **claim** or **preauthorization** decision	Medical/surgical	1-800-205-9926	BCBSNM Appeals Unit P.O. Box 27630 Albuquerque, NM 87125-9815
	Mental health/chemical dependency	1-888-898-0070	BCBSNM Appeals Unit P.O. Box 27630 Albuquerque, NM 87125-9815

DISEASE MANAGEMENT

If you are living with a long term health condition, you may have a hard time managing your health on a day-to-day basis. Help is available with disease management programs offered by BCBSNM. These programs, which you do not

have to participate in if you don't want to, are for members with diabetes, heart conditions, asthma, low back pain, migraine headaches, and lung disease. BCBSNM will try to identify members who could use these programs, but you can also enroll yourself. If you are enrolled, you will be called by a Blue Care Advisor, a nurse that will identify your needs and work with you and your doctors.

CASE MANAGEMENT

When BCBSNM helps you, your doctor, and other providers plan for major services, it is called case management. When you have a need for many long term services or services for more than on condition, BCBSNM has a Care Coordination program that is part of case management. Case Management for medical health care uses a team of medical social workers and nurses (case managers), who help you make sure you are getting the help you need. They are there to help if you:

- have special health care needs
- need help with a lot of different appointments or getting community services not covered by the Medical Program
- are going to have a transplant or other serious operation
- have a high-risk pregnancy or have problems with your pregnancy

Case managers work closely with your doctor to develop a care plan, which will help meet your personal medical needs. Please call Customer Service if you have any questions. (If you need case management for behavior health needs, call the BCBSNM Behavior Health Unit.) BCBSNM will work together with you and your doctor to make sure you get the care you need.

Care Coordination and Special Health Care Needs - Some members need extra help with health care, may have long-term health problems and need more health care services than most members, and/or may have physical or mental health problems that limit their ability to function. BCBSNM has programs to help members with special health care needs, whether at home or in the hospital. For example, you have special health care needs, the authorization you receive for equipment and medical supplies may be valid for longer than usual so that your doctor does not have to order them so often for you.

If you believe your covered dependents have special health care needs, please call one of BCBSNM's care coordinators at the phone number below. The coordinator can provide you a list of resources to help you with special needs. BCBSNM also provides education for members with special health care needs and their care givers. Programs include dealing with stress and information to help you and your family cope with a chronic illness.

If you have special needs, care coordination helps you by:

- assigning a person at BCBSNM who is responsible for coordinating your health care services
- making sure you have access to providers who are experts for members with special needs
- helping you schedule services for complex care, finding community resources such as the local food bank, housing, etc. and helping you get prepared in case of an emergency
- helping with coordinating health services between doctors in the Preferred Provider network as well as facilities in the Blue Distinction program for cancer treatment and transplants
- making sure case management is provided when needed

You can call BCBSNM care coordinator at: **1-800-325-8344** (select the LANS option)

ADVANCE BENEFIT INFORMATION/PREDETERMINATION

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

UTILIZATION REVIEW/QUALITY MANAGEMENT

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

SECTION 5: COVERED SERVICES

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

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

MEDICALLY NECESSARY SERVICES

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

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

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

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

If Medicare is Primary - When Medicare is primary (for example, you are a retiree and eligible for Medicare due to age, you are under age 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 Medical Program 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 Medical Program.

AMBULANCE SERVICES

This Medical Program 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 Medical Program also covers medically necessary ambulance transportation to a hospital with appropriate facilities, or from one hospital to another.

Outside the Service Area

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

Air Ambulance

Ground ambulance is usually the approved method of transportation. This Medical Program 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.

Nonemergency air transport is covered only if transfer to another facility is medically necessary to protect the life of the patient. It is recommended that you request preauthorization before securing the services of any air transportation provider in order to verify that the service is medically necessary and will be covered.

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 Medical Program 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

DENTAL-RELATED SERVICES AND ORAL SURGERY

The following services are the only dental-related services and oral surgery procedures covered under this Medical Program. When alternative procedures or devices are available, benefits are based upon the most cost-effective, medically appropriate procedure or device available.

Dental and Facial Accidents

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

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

Facility Charges

This Medical Program covers inpatient, outpatient hospital and general anesthesia expenses for dental-related services **only** if the patient is under age six or has a nondental, hazardous physical condition (e.g., heart disease or hemophilia) that makes hospitalization medically necessary. All hospital services for dental-related and oral surgery services must be **preauthorized** by BCBSNM. **Note:** The dentist's services for the procedure will not be covered unless listed as eligible for coverage in this section.

Reminder: If hospital covered services are recommended by a nonpreferred (out-of-network) provider, you are responsible for assuring that your provider obtains preauthorization for outpatient covered services or benefits may be reduced or denied. (See *Section 4: Preauthorizations*.)

Oral Surgery

This Medical Program covers the following oral surgical procedures only:

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

TMJ/CMJ Services

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

Exclusions

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

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

DIABETIC SERVICES

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

For insulin and over-the-counter diabetic supplies, including glucose meters, see "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

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

This Medical Program 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 or in the case of a pregnant woman the health of the unborn child. (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 Services and Oral Surgery."

Emergency Room Services

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.

To decide if you have an emergency, you should ask yourself:

- Are you using reasonably good judgment?
- Do you have severe medical or behavioral condition (including severe pain)?
- Do you believe your health could be seriously harmed if you do not get health care right away?
- Do you believe a bodily function, body part, or organ can be damaged if you do not get health care right away?

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

- bad chest pain or other pain
- hard time breathing
- bleeding you cannot stop
- loss of consciousness (passing out) or a new or bad seizure
- poisoning or drug overdose
- severe burns
- serious injury from an accident or fall such as a broken bone
- gunshot or stab wound
- injured eye
- feeling of wanting to hurt yourself or others

What is NOT an emergency? Do not go to an emergency room if you are not having a true emergency. The emergency room should never be used because it seems easier for you or your family. You may have to wait to be seen for a very long time and the charges for emergency room services are very expensive - even if you have only a small problem. **Members who use an emergency room when it is not necessary will be responsible for paying emergency room charges.**

You should NOT go to an emergency room for conditions such as, but not limited to:

- sore throat
- earache
- runny nose or cold
- rash
- stomach ache

This is NOT a complete list of nonemergency conditions. If you have one of the above illnesses or problems or any other condition that is not an emergency, call your doctor first. If you can not reach your doctor, call BCBSNM's free 24/7 Nurseline. A nurse will help you decide what to do to get better on your own or where you should go to get the kind of care that you need. The nurse may tell you to go to your doctor or an urgent care center. If your doctor's office is closed, BCBSNM nurses can also help you decide what you should do.

If you call your doctor and his/her office staff instruct you to go to an emergency room and you believe that your condition is not a true emergency, you may wish to consult the BSBSNM free 24/7 Nurseline for confirmation. Do NOT go to an emergency room if you do not believe you have an emergency. Nonemergency services, or ambulance services, will not be covered - even if your doctor's office staff instructed you to go to an emergency room.

You do not need BCBSNM authorization before seeking **emergency room or emergency ambulance** services from either participating or a nonparticipating provider. **Nonparticipating provider care received without a preauthorization in any other setting (e.g., physician's office or urgent care center) will not be covered.** (See *Section 4: Preauthorizations* for more information about preauthorization requirements.) Emergency room and ambulance services for a condition that meets the definition of "emergency care" will be covered within the limits of the health care plan. Services for conditions that do *not* meet the definition of "emergency care" and have not been **preauthorized** will **not** be covered.

Emergency Admission Notification

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

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.

You do not need BCBSNM authorization before seeking **emergency room** services or being hospitalized as an inpatient from the emergency room for emergency care. However, you should call BCBSNM for preauthorization of nonparticipating facility services or in order to notify BCBSNM of any emergency inpatient admission as soon as reasonably possible. Such services, when received without preauthorization, may be reviewed for medical necessity/appropriateness and you may be responsible for all charges.

Follow-Up Care

After a visit to the emergency room, you may need follow-up care. The health care you receive will either keep your health stable or improve or resolve your health problem, called post-stabilization care. This Medical Program covers post-stabilization care in a hospital or other facility. For all follow-up care (which is no longer considered emergency care) and for all other nonemergency care, you will receive the nonpreferred provider benefit for the covered services of a nonpreferred provider, even if a preferred provider is **not** available to perform the service.

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

Filing Claims for Services of a Nonparticipating Provider

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

Urgent Care

This Medical Program 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).

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

- Call your doctor's office and tell them you need to see a doctor as soon as possible, but that there is no emergency. If your doctor tells you to go to the emergency room because he or she cannot see you right away and you do not believe you have an emergency, please call the free BCBSNM 24/7 Nurseline for advice.

- Ask your doctor to recommend another provider if he/she is unable to see you within 24 hours.
- Visit the nearest urgent care center in the preferred provider network.
- If there is not a preferred provider center nearby, go to the closest urgent care center (services will be covered only at the nonpreferred provider level of benefits).
- If you are outside New Mexico and need urgent care, call a Customer Service Advocate to help or go to a local urgent care center.

Care received in an urgent care facility is subject to the amount 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.

The urgent care amount will apply to care received in an urgent care facility (including hospital- based urgent care centers). Covered services received in an emergency room or other trauma center are subject to the emergency room amount and your condition must meet the definition of "emergency " in order to be covered.

HEARING AIDS/RELATED SERVICES FOR CHILDREN UNDER AGE 21

This Medical Program covers the cost of hearing aids, the fitting and dispensing fees for hearing aids and ear molds, up to a combined maximum of one hearing aid per ear every three years. 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.

HEARING AIDS/RELATED SERVICES FOR MEMBERS AGE 21 AND OVER

This Medical Program 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** every 36 months. This 36-month benefit period begins on the date the first covered hearing aid-related service is received and payable under this provision and ends 36 months later. The next benefit period 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.

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 Medical Program covers home health care services and home I.V. services provided under the direction of a physician. Nursing management must be through a home health care agency approved by BCBSNM. A *visit* is one period of home health service of up to four hours.

Preauthorization Required

Before you receive home health care services or home I.V. therapy, you, your physician or home health care agency must obtain **preauthorization** from BCBSNM. **This Medical Program does not cover home health care services or home I.V. services without preauthorization.** See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Covered Services

This Medical Program 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 "Prescription Drugs and Other Items.") See *Section 4: Preauthorizations* for more information about preauthorization requirements.
- drugs, medicines, or laboratory services that would have been covered during an inpatient admission
- enteral nutritional supplies (e.g., bags, tubing) (For enteral nutritional formulas, see "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 Medical Program does **not** cover:

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

HOSPICE CARE SERVICES

Conditions and Limitations

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

Preauthorization Required

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

Covered Services

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

- visits from hospice physicians
- skilled nursing care by a registered nurse or licensed practical nurse
- physical and occupational therapy by licensed or certified physical or occupational therapists
- speech therapy provided by an American Speech and Hearing Association certified therapist
- medical supplies (If supplies are *not* provided by the hospice agency, see "Supplies, Equipment and Prosthetics.")

- drugs and medications for the terminally ill patient (If drugs are *not* provided by the hospice agency, see "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 period for up to a maximum of ten days each during the six-month hospice benefit period (*Respite care* provides a brief break from total care-giving by the family.)
- bereavement counseling provided by an M.S.W. or M.A. for immediate family members if ordered and received under the hospice program during a hospice benefit period or within three months of the death of the member covered under this Medical Program (a maximum of three counseling sessions will be covered.)

Exclusions

This Medical Program does **not** cover:

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

HOSPITAL/OTHER FACILITY SERVICES

If applicable, see:
"Dental-Related Services and Oral Surgery"
"Emergency and Urgent Care"
"Hospice Care"
"Maternity/Reproductive Services and Newborn Care"
"Psychotherapy (Mental and Chemical Dependency)

For inpatient physician medical visits, see "Physician Visits/Medical Care."

For physical rehabilitation and skilled nursing facility services, see "Short-Term Rehabilitation: Occupational, Physical, Speech Therapy (Inpatient and Outpatient, Including Skilled Nursing Facility."

See other subheadings in this section that apply to the type of service required during an admission, such as, "Surgery and Related Services" or "Transplant Services."

Blood Services

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

Inpatient Services

Preauthorization Required

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

Covered Services

For acute inpatient medical or surgical care received during a covered hospital admission, this Medical Program covers semiprivate room and board or special care unit (e.g., ICU, CCU) expenses and other medically necessary services provided by the facility. If you have a private room for any reason other than isolation, covered room expenses are limited to the average semiprivate room rate, whether or not a semiprivate room is available. BCBSNM must give **preauthorization** for medically necessary private room charges to be covered. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Acute Medical/Surgical Services

For acute inpatient medical or surgical care received during a covered hospital admission, this Medical Program 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 semi-private room rate, whether or not a semi-private room is available. BCBSNM must give preauthorization for medically necessary private room charges to be covered.)

Medical Detoxification

This Medical Program also covers medically necessary services related to medical detoxification from the effects of alcohol or drug abuse. Detoxification is the treatment in an acute care facility for withdrawal from the physiological effects of alcohol or drug abuse, which usually takes about three days in an acute care facility. Benefits for detoxification services are the same as for any other acute medical/surgical condition. Preauthorization is required for all inpatient hospitalizations. See "Psychotherapy (Mental Health and Chemical Dependency)" for information about benefits for chemical dependency rehabilitation. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Christian Science Sanatorium

A Christian Science Sanatorium will be considered a hospital if it is accredited by the Commission of Accreditation of Christian Science Nursing Organization/Facilities, Inc. and the member is admitted for the active care of an illness or injury. This Medical Program does not cover spiritual refreshment and all other exclusions and provisions of this benefit booklet that apply to medical care apply equally to Christian Science services. Note: Christian Science practitioners and sanatoriums are not considered unsolicited and you will receive benefits based soley on whether or not the provider in question has a preferred provider contract with the local BCBS plan.

Blue Distinction Centers for Specialty Care

Blue Distinction is a designation awarded by Blue Cross Blue Shield companies to medical facilities that have demonstrated expertise in delivering quality health care. Among other diseases, hundreds of Blue distinction Centers are available to members nationwide for the treatment of the following conditions:

- congenital heart disease (see Cardiac Care and Pulmonary Rehabilitation)
- cancer (see Cancer Treatment, Chemotherapy, and Radiation Therapy)
- transplants (see Transplants)

While you are not required to see Blue Distinction Centers when you need care for one of the conditions listed above, if you choose a Blue Distinction Center for cancer treatment or cardiac care for a congenital heart defect or if you choose any in-network facility for a transplant (and services are **preauthorized** by your BCBSNM case manager), you may be eligible for covered travel and lodging benefits through the Medical Program (for a full description of this additional coverage, see Travel and Lodging later in this section).

Exclusions

This Medical Program does **not** cover:

- transplants or related services when transplant received at a facility that does not contract directly with a BCBSNM participating provider or through a BCBS transplant network. (See "Transplant Services" for more information.)
- admissions related to noncovered services or procedures (See "Dental-Related Services and Oral surgery" for an exception.)
- custodial care facility admissions

Outpatient or Observation Services

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

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

- x-ray and radiology services, ultrasound, and imaging studies
- laboratory and pathology tests
- EKG, EEG, and other electronic diagnostic medical procedures
- genetic testing 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, cardiac CT scans with **preauthorization** from BCBSNM
- MRIs
- psychological or neuropsychological testing with **preauthorization** from BCBSNM
- audiometric (hearing) and vision tests for the diagnosis and/or treatment of an accidental injury or an illness

Note: All services, including those for which preauthorization is required, must meet the standards of medical necessity criteria established by BCBSNM and will not be covered if excluded for any reason under this Medical Program. **Some services requiring preauthorization will not be approved for payment.** See *Section 4: Preauthorizations* for more information about preauthorization requirements.

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 "Prescription Drugs and Other Items."

Family Planning

Covered family planning services include:

- health education

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

For these following covered family planning services, no coinsurance, deductible, copayment, or benefit maximums will apply when received from a provider in the preferred (In-Network) or participating provider network. When these services are received from an out-of-network provider the usual out-of-network deductible, coinsurance, and out-of-pocket will apply.

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

Infertility-Related Services

This Medical Program 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 deferens when the obstruction is **not** the result of a surgical sterilization
- replacement of deficient, naturally occurring hormones **if** there is documented evidence of a deficiency of the hormone being replaced

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

Diagnostic *testing*, when **preauthorization** is received from BCBSNM, is covered only to diagnose the cause of infertility. See *Section 4: Preauthorizations* for more information about preauthorization requirements.) Once the cause has been established and the treatment determined to be noncovered, no further testing is covered. For example, this Medical Program 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 Medical Program does **not** cover:

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

Pregnancy-Related/Maternity Services

If you are pregnant, you should call BCBSNM before your maternity due date, soon after your pregnancy is confirmed. BCBSNM must be notified as soon as possible if the mother's stay is greater than **48 hours** for a routine delivery or greater than **96 hours** for a C-section delivery. If not notified, benefits for covered facility services may be reduced by **$300**. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Covered Services

Covered pregnancy-related services include:

- hospital or other facility charges for semiprivate room and board and ancillary services, including the use of labor, delivery, and recovery rooms (This Medical Program covers all medically necessary hospitalization, including at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a C-section delivery. **Note:** Newborns who are not eligible for coverage under this Medical Program will not be not be covered beyond the 48 or 96 hours required under federal law.)
- routine or complicated delivery, including prenatal and postnatal medical care of an obstetrician, certified nurse-midwife or licensed midwife (Expenses for prenatal and postnatal care are included in the total covered charge for the actual delivery or completion of pregnancy. The office visit during which a pregnancy is confirmed is subject to the member cost-sharing provisions that apply to any other office visit.) **Note:** Home births are not covered at the preferred provider benefit level unless the provider has a preferred provider contract with his/her local BCBS Medical Program and is credentialed to provide the service.
- pregnancy-related diagnostic tests, including genetic testing or counseling if **preauthorized** by BCBSNM (Services must be sought due to a family history of a gender-linked genetic disorder or to diagnose a possible congenital defect caused by a present, external factor that increases risk, such as advanced maternal age or alcohol abuse. For example, tests such as amniocentesis or ultrasound to determine the gender of an unborn child are **not** covered.) See *Section 4: Preauthorizations* for more information about preauthorization requirements.
- necessary anesthesia services by a provider qualified to perform such services, including acupuncture used as an anesthetic during a covered surgical procedure and administered by a physician, a licensed doctor of oriental medicine, or other practitioner as required by law
- when necessary to protect the life of the infant or mother, coverage for transportation, including air transport, for the medically high-risk pregnant woman with an impending delivery of a potentially viable infant to the nearest available tertiary care facility for newly born infants (See "Ambulance Services" for details.)
- services of a physician who actively assists the operating surgeon in performing a covered surgical procedure when the procedure requires an assistant
- elective, spontaneous, or therapeutic termination of pregnancy prior to full term

Special Beginnings

This is a maternity program for BCBSNM members that is available whenever you need it. It can help you better understand and manage your pregnancy. To take full advantage of the program, you should enroll within three months of becoming pregnant. When you enroll, you will receive a questionnaire to find out if there may be any problems with your pregnancy to watch out for, information on nutrition, newborn care, and other topics helpful to new parents. You will also receive personal and private phone calls from an experienced nurse - all the way from pregnancy to six weeks after your child is born. To learn more, or to enroll, call toll-free at:

1-888-421-7781

Newborn Care

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

Newborn Eligibility

If you do not elect to add coverage for your newborn within 31 days, and wish to add the child to coverage later, the child is considered a late applicant unless eligible for a special enrollment. **Note:** If the parent of the newborn is a covered child of the subscriber (i.e., the newborn is the subscriber's grandchild), services for the newborn are **not** covered except for the first 48 hours of routine newborn care (or 96 hours in the case of a C-section).

Routine Newborn Care

If both the mother's charges and the baby's charges are eligible for coverage under this Medical Program, 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.

Covered Services

Covered services for initial routine newborn care include:

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

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

Extended Stay Newborn Care

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

If the pediatrician is a nonparticipating provider or you are in a nonparticipating hospital and services are eligible for coverage, you must ensure that BCBSNM is called **before** the mother is discharged from the hospital. If you do not, benefits for the newborn's covered facility services may be reduced or denied. The baby's services will be subject to a separate copayment and out-of-pocket limit.

PHYSICIAN VISITS/MEDICAL CARE

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

This Medical Program covers medically necessary care provided by a physician or other professional provider for an illness or accidental injury.

Office Visits and Consultations

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

Allergy Care

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

Breastfeeding Support and Services

This Medical Program covers counseling and support services rendered by a lactation consultant such as a certified nurse practitioner, certified nurse midwife or midwife, not subject to coinsurance, deductible, or benefit maximums when received from a provider in the preferred or participating provider network (if your plan has out-of-network benefits for nonemergency services, out-of-network services are subject to the usual out-of-network deductible, coinsurance, and out-of-pocket).

Christian Science Practitioners

A Christian Science practitioner will be considered a physician under this Medical Program if such practitioner is approved and listed in the current issue of The Christian Science Journal, the official organ of the First Church of Christ, Scientist; and is providing active treatment for a diagnosed illness or injury according to the healing practices of Christian Science. This Medical Program does not cover spiritual refreshment and all other exclusions and provisions of this benefit booklet that apply to medical care apply equally to Christian Science services. Note: Christian Science practitioners and sanatoriums are not considered unsolicited and you will receive benefits based solely on whether or not the provider in question has a preferred provider contract with the local BCBS plan.

Diabetes Self-Management Education

This Medical Program 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 "Prescription Drugs and Other Items" for benefits for insulin and oral agents to control blood glucose levels, glucose meters, needles, syringes, and test strips; see "Supplies, Equipment and Prosthetics" for other covered supplies and equipment required due to diabetes.

Genetic Inborn Errors of Metabolism

This Medical Program 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 "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 "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 Medical Program that apply to that particular type of service (e.g., special medical foods are covered under "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, dieticians and nutritionists, who have specific training in managing patients diagnosed with genetic inborn errors of metabolism.

Injections and Injectable Drugs

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

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

Mental Health Evaluation Services

This Medical Program covers medication checks and intake evaluations for mental disorders, alcohol, and drug abuse when **preauthorized** by BCBSNM. See "Psychotherapy (Mental Health and Chemical Dependency)" for psychotherapy and other therapeutic service benefits.

Inpatient Medical Visits

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

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

Nutritional Counseling

This Medical Program covers services provided by a registered dietician in an individual session for members with medical conditions that require a special diet. Such medical conditions include: diabetes mellitus, coronary artery disease, congestive heart failure, sever obstructive airway disease, gout, renal failure, phenylketoriua, or hyperlipidemias. Benefits for nutritional counseling are limited to three individual sessions during a member's lifetime for each covered medical condition.

Weight Management Programs

This Medical Program covers weight loss or other weight management programs, dietary control or medical obesity treatment if dietary advice and exercise are provided by a physician, nutritionist or dietician licensed by the appropriate agency and the service is **preauthorized** by BCBSNM. The member must have a body mass index of 40 or more (BMI is calculated as the patient's weight in kilograms divided by the patient's height in meters quartered). See Surgery and Related Services for information about surgery for weight loss purposes. This Medical Program does not cover nonmedical services such as Weight Watchers, Jenny Craig Personal Weight Management, gym, fitness club or spa programs.

PRESCRIPTION DRUGS AND OTHER ITEMS

Covered Medications and Other Items

This Medical Program 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** vendor:

- prescription drugs, prenatal vitamins, and medicines, unless listed as an exclusion (covered drugs/items include insulin, glucagon, prescriptive oral agents for controlling blood sugar levels and prescription contraceptive devices and medications purchased from a participating pharmacy, including compounded medications of which at least one ingredient is a prescription drug) **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 Medical Program.
- specialty 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 drugs and must be acquired through a participating specialty pharmacy provider in order to be covered.)

- vaccinations for flu or pneumonia, or Zostavax® vaccinations when received from certain participating pharmacies (For a list of pharmacies that are contracted with BCBSNM to provide this service, go to the BCBSNM website at www.bcbsnm.com.)
- insulin needles, syringes, glucose meters, and other 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. See "Supplies, Equipment, and Prosthetics" later in this section for a list of diabetic equipment that *is* covered under the medical/surgical portion of your health plan.
- 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 (These products must be ordered by a physician and **preauthorization** received from BCBSNM in order to be covered.) See *Section 4: Preauthorizations* for more information about preauthorization requirements.

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. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Member Copayment

For covered prescription drugs (including specialty 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). You may also have to pay the difference in cost between the brand-name drug and its generic equivalent (see below). The difference in cost between the brand-name and its generic equivalent does not count toward the out-of-pocket limit.The copayments are listed on the *Summary of Benefits.*

Brand-Name vs. Generic Drug Costs

If you request 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 Program

All items covered under this provision must be purchased from a participating retail pharmacy unless there is an emergency. **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.)

For a list of participating pharmacies, call Customer Service at the phone number on the back of your ID card and request a provider directory - or visit the BCBSNM website at www.bcbsnm.com. The pharmacies that are participating in the BCBSNM Retail Pharmacy Program may change from time to time. You should check with your pharmacy before obtaining drugs or supplies to make certain of its participating status.

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 Medical Program.) You are responsible for paying any deductibles, coinsurance amounts, copayments, any pricing differences when applicable, and limited or non-covered services. No claim forms are required when you purchase your prescriptions at a network pharmacy.

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 Medical Program, 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 drug or other item from a nonparticipating (out-of-network) pharmacy and it is eligible for coverage as indicated in the first paragraph above, such as in an **emergency**, you must pay for the purchase in full and then submit a claim directly to the BCBSNM pharmacy benefit manager, Prime Therapeutics, at the address below (do not send to BCBSNM). In such cases, you will pay the difference in cost between the pharmacy's billed amount and the covered charge, in addition to your deductible, coinsurance, and/or copayment amount. If not included in your enrollment materials, you can obtain the necessary claim forms from a Customer Service Advocate or on the BCBSNM website (www.bcbsnm.com).

Prime Therapeutics
P.O. Box 14624
Lexington, KY 40512-4624

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) and 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.)

Finding a Retail Pharmacy

To find a participating pharmacy, you may log into the Blue Access for Members (BAM) page on the BCBSNM web site (or, for employees, you may link to that site directly from the LANS Intranet). After logging into BAM at www.bcbsnm.com, once you have created a BAM user ID and password by following on-line instructions, click on the My Coverage tab and choose the RX Drugs - Visit Prime Therapeutics option.

Note: You may also choose to create an additional log-in user ID and password for the Prime Therapeutics web site. However, if you choose this option, you must create a Blue Access member log-in before creating an additional Prime Therapeutics log-in.

If you use the Prime Therapeutics web site (www.myrxhealth.com), click on Find A Pharmacy. You will be asked to select from a list of BCBS plans. You must select Blue Cross and Blue Shield of New Mexico in order to obtain the correct list of participating pharmacies for this Medical Program. After you have selected Blue Cross and Blue Shield of New Mexico as your Medical Program administrator, you will be able to locate participating pharmacies throughout the United Stated, based on zip code or State name.

Supply Limitations

During any 30-day period, you can obtain up to a 30-day supply or 180 units (e.g., pills), whichever is less, of a single prescription drug or other item covered under this plan. If more than 180 units are needed to reach a 30-day supply, preauthorization is required. For oral contraceptives, the supply is limited to one menstrual cycle (normally 28 days). 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 percentage amount for a 30-day supply (usually one packaged item).

Mail Order Service

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. To use the Mail Order Service, follow the instructions outlined in the materials provided to you in your mail order brochure. (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.

IMPORTANT: Specialty drugs are not covered through the Mail Order Service. You must use the specialty pharmacy provider designated by BCBSNM in order to receive benefits for specialty drugs.

Supply Limitations

During any 90-day period, you can obtain up to a 90-day supply or 540 units (e.g., pills), whichever is less, of a single prescription drug or other item covered under the mail-order portion of this plan. If less than a 90-day supply is ordered, percentage amounts will still apply. If more than 540 are needed to reach a 90-day supply, preauthorization is required. 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 percentage amount for a 90-day supply (usually three packaged items).

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 (unless otherwise specified):

Program Type	Supply Maximum	Copay Requirement* (see note)
Nonprescription Nutritional Products	**30-day supply** during any 30-day period	One copayment as listed on Summary of Benefits
Retail Pharmacy and Specialty Pharmacy Provider	During each one-month period, a **30-day supply or 180 units** (e.g., pills) whichever is less	**One copayment** as listed on Summary of Benefits. If more than 180 units are needed to reach a 30-day supply, another copayment will apply to each additional 180 units (or portion thereof) purchased. For oral contraceptives, the supply is limited to one menstrual cycle (normally 28 days).
Mail Order Service	During each three-month period, a **90-day supply or 540 units** (e.g., pills) whichever is less	**Two copayments** as listed on Summary of Benefits. Orders of less than 60 days will not be covered through mail-order. If more than 540 units are needed to reach a 60-day or 90-day supply, 2 more copayments will apply to each additional 540 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 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.

No Coordination of Benefits

If you have other drug plan coverage that is primary over this Medical Program, this Medical Program will not coordinate benefits with the other drug plan coverage. You are responsible for paying the full amounts due under your primary drug plan coverage.

Drug Plan Exclusions

In addition to services listed as not eligible for coverage in the *General Limitations and Exclusion* section of this booklet, this drug plan provision of your health 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 manufactures).
- 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 intended for smoking or tobacco use cessation
- 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-enteric tube (e.g., nasogastric, nasoduodenal, or nasojejunal tube), unless the patient meets criteria for genetic inborn errors of metabolism and the product is **preauthorized** by BCBSNM); or nonprescription nutritional products that have not been preauthorized by BCBSNM (See *Section 4: Preauthorizations* for more information about preauthorization requirements.)
- 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
- infant formula, donor breast milk, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), or vitamins and oral minerals except when listed as covered due to being the sole source of nutrition or for treating a specific inborn error of metabolism

Note: Prescription contraceptive devices are payable under your medical/surgical plan benefit booklet in the "Family Planning" provision of the *Covered Services* section.

Brand-Name Exclusion

Some equivalent drugs are manufactured under multiple brand names. In such cases, the health care Medical Program may limit benefits to only one of the brand equivalents available. If you do not accept the brand that is covered under the Medical Program, the brand-name drug purchased will not be covered under any benefit level.

PREVENTIVE SERVICES

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

The services listed under this provision are not limited as to the number of times you may receive the service in any given period or as to the age of the patient (except when a service is inappropriate for the patient's age group, such as providing a pediatric immunization to an adult). You and your physician are encouraged to determine how often and at what time you should receive preventive tests and examinations and you will receive coverage according to the benefits and limitations of your health care plan. Preventive services are not subject to copayments, coinsurance, deducible, or benefit maximum when received from an in-network provider. (See your *Summary of Benefits* for specific cost-sharing details.) Out-of-network services for well baby care through age two is subject to out-of-network coinsurance and is not subject to deductible; all other out-of-network preventive services are subject to the usual out-of-network deductible, coinsurance, and out-of-pocket limit.

This Medical Program covers the following preventive services in accordance with national medical standards, The American Academy of pediatrics, and the U.S. Preventive Services Task Force, such as (but not limited to):

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

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

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

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

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

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

Covered preventive services **not** described in items "a" through "d" above may be subject to deductible, coinsurance, copayments, and/or dollar maximums. Allergy injections are **not** considered immunizations under the "Preventive Services" benefit. Examples of covered services include, but are not limited to:

- routine physical, breast, and pelvic examinations
- routine adult and pediatric immunizations
- 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
- periodic glaucoma eye tests
- vision and hearing screenings in order to detect the need for additional vision or hearing testing for members when received as part of a routine physical examination (A screening does *not* include an eye examination, refraction or other test to determine the amount and kind of correction needed.)
- health education and counseling services if recommended by your physician, including an annual consultation to discuss lifestyle behaviors that promote health and well-being, including smoking/tobacco use cessation counseling

Exclusions

This Medical Program does **not** cover:

- employment physicals, insurance examinations, or examinations at the request of a third party (the requesting party may be responsible for payment); premarital examinations; sports or camp physicals; any other nonpreventive physical examination
- routine eye examinations; eye refractions; or any related service or supply for members over the age of 18
- routine hearing examinations; hearing aids; or any related service or supply, unless otherwise specified in this section for members over the age of 18 (See "Hearing Aids/Related Services.")

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 Medical Program.

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.

Residential Treatment Centers

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

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

Preauthorization Requirements

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

If You Have Medicare - Certain provider types, such as licensed professional clinical mental health counselors (L.P.C.C.) and licensed marriage and family therapist (L.M.F.T) are not covered by Medicare. If you are covered as a retiree and are eligible for Medicare or if you have end-stage renal disease and have reached the end of the Medicare coordination time period, you must have preauthorization from the BCBSNM Behavioral Health Unit in order for services from these providers to be covered under this Plan. See Section 4 for more information.

Exclusions

This Medical Program does **not** cover:

- inpatient care that has not been preauthorized
- residential treatment for other than chemical dependency
- psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education
- services billed by a school, halfway house or group home, or their staff members; foster care; or behavior modification services
- maintenance therapy or care provided after you have reached your rehabilitative potential (See the "Long- Term or Maintenance Therapy" exclusion in the *General Limitations and Exclusions* section.)
- biofeedback, hypnotherapy, or behavior modification services
- religious or pastoral counseling
- custodial care (See the "Custodial Care" exclusion in *Section 6: General Limitations and Exclusions*.)
- hospitalization or admission to a skilled nursing facility, nursing home, or other facility for the primary purpose of providing custodial care service, convalescent care, rest cures, or domiciliary care to the patient
- services or supplies received during an inpatient stay when the stay is solely related to behavior, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of mental illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions)
- any care that is patient-elected and is not considered medically necessary
- care that is mandated by court order or as a legal alternative, and lacks clinical necessity as diagnosed by a licensed provider; services rendered as a condition of parole or probation
- special education, school testing and evaluations, counseling, therapy, or care for learning deficiencies or educational and developmental disorders; behavioral problems unless associated with manifest mental disorders or other disturbances
- non-national standard therapies, including those that are experimental as determined by the mental health professional practice
- the cost of any damages to a treatment facility
- residential treatment in excess of the lifetime maximum benefits specified on the *Summary of Benefits*

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

Cardiac and Pulmonary Rehabilitation

This Medical Program 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.** See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Congenital Heart Disease

Services covered under the congenital heart disease care program include any service listed as covered in this benefit booklet (such as office visits, diagnostic testing, etc.), but specifically target the following services for members with congenital health disease: congenital heart disease surgical interventions, interventional cardiac catheterizations, fetal echo cardiograms, and in-utero services and other **preauthorized** fetal interventions.

Blue Distinction Center for specialty care - while you are not required to use a Blue Distinction Center for treatment of congenital heart disease, you may choose a Blue Distinction Center and services are preauthorize by your BCBSNM case manager, you may be eligible for travel and lodging benefits described under Travel and Lodging later in this section, which applied to this treatment coverage for up to five days before a covered treatment and for one year following the date of the initial cardiac treatment.

Consult with your physician and/or with a BCBSNM care coordinator to determine which facility is best for you. You may view the entire list of Blue Distinction Center and review the criteria used in selection facilities for the designation at the Blue Cross and Blue Shield Association web site at www.bcbs.com.

Chemotherapy and Radiation Therapy

This Medical Program 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.** See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Cancer Clinical Trials

If you are a participant in an approved cancer clinical trial, you may receive coverage for certain routine patient care costs incurred in the trial. The trial must be conducted as part of a scientific study of a new therapy or intervention for the prevention of reoccurrence, early detection, or treatment of cancer. The persons conducting the trial must provide BCBSNM with notice of when the member enters and leaves a qualified cancer clinical trial and must accept BCBSNM's covered charges as payment in full (this includes the health care Medical Program's payment plus your share of the covered charge).

The routine patient care costs that are covered must be the same services or treatments that would be covered if you were receiving standard cancer treatment. Benefits also include FDA-approved prescription drugs that are not paid for by the manufacturer, distributor, or supplier of the drug. (Member cost-sharing provisions will apply to these benefits.)

Blue Distinction Center for specialty care - while you are not required to use a Blue Distinction Center for treatment of cancer, you may choose a Blue Distinction Center and services are preauthorize by your BCBSNM case manager, you may be eligible for travel and lodging benefits described under Travel and Lodging later in this section, which applied to this cancer treatment coverage for up to five days before a covered treatment and for one year following the date of the initial center 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 designed by their subspecialty for rate 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 web site. 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 Center and review the criteria used in selection facilities for the designation at the Blue Cross and Blue Shield Association web site at www.bcbs.com.

If you are a participant in an approved cancer clinical trial, you may receive coverage for certain routine patient care costs incurred in the trial. The trial must be conducted as part of a scientific study of a new therapy or intervention for the prevention of reoccurrence, early detection, or treatment of cancer. The persons conducting the trial must provide BCBSNM with notice of when the member enters and leaves a qualified cancer clinical trial and must accept BCBSNM's covered charges as payment in full (this includes the health care Medical Program's payment plus y our share of the covered charge).

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

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

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

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

Dialysis

This Medical Program covers the following services when received from a dialysis provider, or when **preauthorization** is received from BCBSNM, in your home (See *Section 4: Preauthorizations* for more information about preauthorization requirements.):

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

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

Preauthorization Required

To be covered, all **inpatient**, outpatient, office and home-based outpatient, short-term rehabilitation treatments, including skilled nursing facility and physical rehabilitation facility admissions, must receive **preauthorization** from BCBSNM and be received from a **preferred provider**. Short-term rehabilitation required due to reinjury or aggravation of an injury are also covered but must receive a separate **preauthorization** from BCBSNM, even if therapy was authorized for the original injury. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Covered Services

This Medical Program covers the following short-term rehabilitation services when rendered for the medically necessary treatment of accidental injury or illness:

- occupational therapy performed by a licensed occupational therapist
- physical therapy performed by a physician, licensed physical therapist, or other professional provider licensed as a physical therapist (such as a doctor of oriental medicine)

- joint and spinal manipulation services when administered by a licensed provider acting within the scope of licensure and when necessary for the treatment of accidental injury or medical condition
- speech therapy, including audio diagnostic testing, performed by a properly accredited speech therapist for the treatment of communication impairment or swallowing disorders caused by disease, trauma, congenital anomaly, or a previous treatment or therapy
- Preauthorized speech therapy for children when provided by a licensed speech therapist given to a child under the age of three whose speech is impaired due to one of the following conditions: (1) infantile autism, (2) developmental delay or cerebral palsy, (3) hearing impairment, or (4) major congenital anomalies that affect speech such as, but not limited to cleft lip and cleft palate.
- inpatient physical rehabilitation and skilled nursing facility services when **preauthorized** by BCBSNM

Benefit Limits

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

Conditions of Coverage

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

- services must be **preauthorized** by BCBSNM. See *Section 4: Preauthorizations* for more information about preauthorization requirements.
- there is a documented condition or delay in recovery that can be expected to measurably improve with therapy within two months of beginning active therapy. This period may be extended upon recommendation of the referring preferred physician, in consultation with BCBSNM.
- improvement would not normally be expected to occur without intervention.

Exclusions

This Medical Program does **not** cover:

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

SUPPLIES, EQUIPMENT AND PROSTHETICS

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

For diabetic supplies such as needles, syringes, glucose meters, and test strips, see "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.)

To be covered, items must be medically necessary and ordered by a health care provider. If you have a question about durable medical equipment, medical supplies, prosthetics or appliances not listed, please call the BCBSNM Health Services Department.

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** or more *(Total charges* means either the total purchase price of the item or total rental charges for the estimated period of use.)

If you do not receive preauthorizations for an item listed above, services may be **denied.** See "Preauthorizations" in *Section 4.*

Breast Pumps

This Medical Program covers the rental (but not to exceed the total cost) or purchase of manual, electric, or hospital grade breast pumps and supplies with a written prescription from a health care provider. The rental or purchase cost of manual, electric, or hospital grade breast pumps and supplies are not subject to coinsurance, deductible, copayment, or benefit maximums when received from an in-network provider (if your plan has out-of-network benefits for nonemergency services, out-of-network services are subject to the usual out-of-network deductible, coinsurance, and out-of-pocket).

Diabetic Supplies and Equipment

This Medical Program 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** or requiring long-term rental. See *Section 4: Preauthorizations* for more information about preauthorization requirements. For additional diabetic supply coverage, (e.g., insulin needle and syringes, autolet, glucose meters, test strips for glucose monitors, glucagon emergency kits), see "Prescription Drugs and Other Items."

Durable Medical Equipment and Appliances

This Medical Program covers the following items (**preauthorization is required for items costing over $500 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

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

Medical Supplies

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

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

Orthotics and Prosthetic Devices

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

- surgically implanted prosthetics or devices, including penile implants required as a result of illness or accidental injury, 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 prosthetics only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- breast prosthetics when required as the result of a mastectomy and mastectomy bras, which are limited to **three 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.)

- orthotics (e.g., collars, braces, molds) prescribed by an eligible provider to protect, restore, or improve impaired body function

When alternative prosthetic devices are available, the allowance for a prosthesis will be based upon the most cost-effective item. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Exclusions

This Medical Program 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 or devices used specifically as safety items or to affect performance in sports related activities
- 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
- external prosthetics that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing or devices used specifically as safety items or to affect performance in sports-related activities
- repair or rental costs that exceeds the purchase price of a new unit
- dental appliances (See “Dental-Related Services and Oral Surgery” for exceptions.)
- accommodative orthotics (deal with structural abnormalities of the foot, accommodate such abnormalities, and provide comfort, but do not alter function)
- orthopedic shoes, unless joined to braces (Diabetic members should refer to “Diabetic Supplies and Equipment” earlier in this section for information about covered podiatric equipment and orthopedic shoes.)
- equipment or supplies not ordered by a health care provider, including items used for comfort, convenience, or personal hygiene
- duplicate items; repairs to duplicate items; or the replacement of items because of loss, theft, or destruction
- stethoscopes or blood pressure monitors
- tubing, nasal cannulas, connectors, and masks, except when used with a covered piece of durable medical equipment
- 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
- 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 “Prescription Drugs and Other Items.”)
- items that can be purchased over-the-counter, including but not limited to dressings for wounds (i.e., bed sores) and burns, gauze, and bandages
- male contraceptive devices, including over-the-counter contraceptive products such as condoms; female contraceptive devices, including over-the-counter contraceptive products such as spermicide, when not prescribed by a health care provider. (See “Maternity/Reproductive Services and Newborn Care: Family Planning” for devices requiring a prescription.)
- items not listed as covered

SURGERY AND RELATED SERVICES

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

Surgeon's Services

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

Cochlear Implants

This Medical Program 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 Medical Program does **not** cover cochlear implant services without preauthorization. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Mastectomy Services

This Medical Program 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 Medical Program 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:

- 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 Medical Program 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.

Obesity Surgery

This Medical Program covers the surgical treatment of morbid obesity if treatment is preauthorized by BCBSNM before treatment begins and only when the member meets medical criteria established by BCBSNM. Medical policies are posted on BCBSNM's website (http://hcsc.com/medical_policies.html) and may change without notice. Check the website for the most current medical policy or call a Customer Service Advocate for assistance. **Benefits are not available without preauthorization, requested in writing.** *(Morbid obesity* means 45 kilograms or 100 percent over ideal body weight.)

Reconstructive Surgery

Reconstructive surgery improves or restores bodily function to the level experienced before the event that necessitated the surgery, or in the case of a congenital defect, to a level considered normal. Such surgeries may have a coincidental cosmetic effect. This Medical Program 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 be **denied.** (See *Section 4: Preauthorizations* for more information about preauthorization requirements.)

Exclusions

This Medical Program 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)
- any reconstructive procedure, orthognathic surgery when not related to TMJ/CMJ disorders, cochlear implant, breast reduction, or cosmetic breast surgery that has not received preauthorization from BCBSNM (See *Section 4: Preauthorizations* for more information about preauthorization requirements.)
- the insertion of artificial organs, or services related to transplants not specifically listed as covered under "Transplant Services"
- standby services unless the procedure is identified by BCBSNM as requiring the services of an assistant surgeon and the standby physician actually assists

Anesthesia Services

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

Exclusions

This Medical Program 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 Medical Program 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. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Facility Must Be in Transplant Network

Benefits for covered services will be approved only when the transplant is performed at a facility that contracts with BCBSNM, another Blue Cross Blue Shield (BCBS) Plan or the national BCBS transplant network, for the transplant being provided. Your BCBSNM case manager will assist your provider with information on the exclusive network of contracted facilities and required approvals. Call BCBSNM Health Services at (800) 325-8334 for information on these BCBSNM transplant programs.

Effect of Medicare Eligibility on Coverage

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

Organ Procurement or Donor Expenses

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

This Medical Program 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 Medical Program covers the following transplant procedures if **preauthorization** is received from BCBSNM (See *Section 4: Preauthorizations* for more information about preauthorization requirements.):

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

Cost-Sharing Provisions

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

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

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

In addition to the general provisions of this "Transplant Services" section, the following benefits, limitations, and exclusions apply to the above-listed transplants for **one year** following the date of the actual transplant or

retransplant. After one year, usual benefits apply and the services must be covered under other provisions of the Medical Program in order to be considered for benefit payment.

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

Blue Distinction Centers for Transplants

While you can select any in-network facility for your transplant, the Blue Distinction Center 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 (CKIBMR), the Scientific Registry of Transplant Recipients (SRTR) and the Foundation for Accreditation of Cellular Therapy (FACT), and is subject to periodical reevaluation as criteria continues 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; 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-dosed chemotherapy (**not** all bone marrow transplants are covered). Organ or tissue or multiple organ transplant 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 web site at www.bcbs.com.

Transplant Exclusions

This Medical Program does **not** cover:

- donor expenses after the donor has been discharged from the transplant facility
- transplant-related services for a transplant that did not receive **preauthorization** from BCBSNM (See *Section 4: Preauthorizations* for more information about preauthorization requirements.)
- any transplant or organ-combination transplant not listed as covered
- implantation of artificial organs or devices (mechanical heart, unless covered under BCBSNM medical policy)
- nonhuman organ transplants
- care for complications of noncovered transplants or follow-up care related to such transplants
- services related to a transplant performed in a facility not contracted directly or indirectly with BCBSNM to provide the required transplant (except cornea, kidney, or bone marrow)
- expenses incurred by a member of this plan for the donation of an organ to another person
- drugs that are self-administered or for use while at home (These services may be covered under "Prescription Drugs and Other Items.")

TRAVEL AND LODGING EXPENSES

This Medical Program covers the following travel and lodging benefits for patients receiving the following types of care:

- cancer care at a Blue Distinction Center for specialty care
- congenital heart disease treatment at a Blue Distinction Center for specialty care
- covered transplant at an in-network preferred provider facility (excluding cornea transplants which are covered as any other surgical procedure)

This coverage is available for up to five days before the patients initial treatment at the facility selected and for one year following the date of the initial treatment, transplant or retransplant. After one year, services are subject to usual Medical Program benefits and must be covered under other provisions of the standard Medical Program in order to be considered for benefit payment.

If a patient must temporarily relocate more than 50 miles outside his/her city of residence to receive treatment at an eligible facility (as described above), this Medical Program covers travel of the patient and one companion traveling on the same day(s) to and/or from the facility where the treatment will be received or the transplant will be performed. Travel is covered if needed for the purposes of an evaluation, to undergo the procedure or other treatment, and/or received necessary post-discharge follow-up.

If a patient needs a covered treatment at an eligible facility more than 50 miles form his/her home, a standard per diem benefit ($50) will be allocated for lodging expenses for the patient (while not confined) and another per diem benefit of $50 for one additional adult traveling with the patient (a combined per diem of $100). The patient is eligible for per diem allowance for outpatient therapy and pre- and post-operative care received on an outpatient basis. If the eligible patient is a covered child under the age of 18, this Medical Program covers travel and per diem expenses for two adults to accompany the child, but the daily per diem for lodging remains $100 for all three persons combined. Itemized receipts are **not** required, but you will need to indicate each day eligible for per diem reimbursement (for example, by sending a copy of your airline schedule showing your beginning and ending travel dates or hotel bill).

Travel expenses and standard per diem allowances for the patient and companion(s) are limited to a combined total lifetime maximum benefit of $10,000 per member for each of the three following treatment/program types (regardless of how many admission a or treatment the patent receives for each program type: caner care at a Blue Distinction Center for specialty care; congenital heart disease at a Blue Distinction Center for specialty care; and transplants at an in-network preferred provider facility.

Your Care Coordinator may approve travel and $50 or $100 per diem lodging allowances based upon the number of persons traveling and the total number of days of temporary relocation, up to the maximum $10,000 lifetime benefit for each of the three programs.

The following travel expenses are covered when supported by receipts (or, in the case of mileage reimbursement, a reasonable estimate of distance travels using a standard map or Internet available programs that provide users with destination maps and mileage estimates: automobile mileage, reimbursed a the standard IRS medical purpose rate; taxi fares; economy/coach airfare (anything other than economy or coach is **not** covered); parking and/or tolls; trains, boat, or bus fares.

Travel Exclusions

This Medical Program does **not** cover:

- you receive cancer care or treatment of congenital heart disease at a facility other than a Blue Distinction Center.
- you choose to travel to receive care for which travel is **not** considered medically necessary by the case manager
- automobile or rental or gasoline expenses.
- ambulance to facility (covered under standard Medical Program benefits and **not** reimbursed as travel expenses)
- lodging expenses in excess of the per diem allowance, if available, and food, beverage, or meal expenses
- incurred **more than five days before** or **more than one year following** the date of actual transplant or the start of cancer care or treatment of congenital heart disease
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; telephone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- expenses charged only because benefits are available under this provision (such as transportation received from a member of your family, or from any other person charging for transportation that does **not** ordinarily do so)

SECTION 6: GENERAL LIMITATIONS AND EXCLUSIONS

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

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

— Autism Spectrum Disorders

This Plan does not cover services related to autism spectrum disorders.

— Alternative Treatments

This Medical Program does not cover acupressure, aromatherapy, hypnotism, rolfing, naturopathy, holistic or homeopathic care, services of a naturalist, or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health. This Medical Program does not cover chelation therapy except to treat heavy metal poisoning. Exception: This Medical Program does cover medically necessary services of a Christian Science Practitioner or Christian Science Sanatorium as explained in *Section 5: Covered Services*

— Before Effective Date of Coverage

This Medical Program 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 Medical Program does not cover services related to biofeedback.

— Blood Services

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

— Commission of a Felony

This Medical Program does not cover treatment of injuries sustained by a member in the course of committing a felony. The Medical Program shall enforce this exclusion based upon reasonable information showing that this criminal activity took place.

— Complications of Noncovered Services

This Medical Program 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 Medical Program 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 Medical Program does not cover** cosmetic surgery, services, or procedures for psychiatric or psychological reasons, or to change family characteristics or conditions caused by aging. **This Medical Program does not cover** services related to or required as a result of a cosmetic service,

procedure, surgery, or subsequent procedures to correct unsatisfactory cosmetic results attained during an initial surgery.

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

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

— Custodial Care

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

— Dental-Related Services and Oral Surgery

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

— Domiciliary Care

This Medical Program 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 Medical Program 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 Medical Program will not cover** charges incurred after your effective date of coverage under this Medical Program that are covered under the prior plan's extension of benefits provision.

— Duplicate Testing

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

— Experimental, Investigational, or Unproven Services

This Medical Program 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 "Cancer Clinical Trials" in *Section 5: Covered Services*. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted when services were administered, the service is experimental and will not be covered. To be considered experimental, investigational, or unproven, one or more of the following conditions must be met:

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

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

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

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

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

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

— Food or Lodging Expenses

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

— Foot Care

This Medical Program does not cover:

- routine foot care (trimming, cutting, or debridement of corns, calluses, toenails) unless required as part of medically necessary diabetic disease management or severe systemic disease,
- treatment of bunions (except surgical treatment such as capsular or bone surgery)
- hygienic and preventive maintenance foot care (e.g., cleaning and soaking of the feet, applying skin creams in order to maintain skin tone)
- other services that are performed when there is not a localize sickness, injury or symptom involving the foot
- treatment of flat feet
- treatment of subluxation of the foot
- shoe orthotics except those that have been preauthorized for diabetic patients

— Genetic Testing or Counseling

This Medical Program does not cover tests such as amniocentesis or ultrasound to determine the gender of an unborn child. See "Maternity/Reproductive Services and Newborn Care" in *Section 5: Covered Services* for details.

— Hair Loss Treatments

This Medical Program 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 Medical Program does not cover audiometric (hearing) tests for members over the age of 18 **unless** 1) required for the diagnosis and/or treatment of an accidental injury or an illness, or 2) covered as a preventive *screening* service.

— 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 Medical Program does not cover hypnosis or services related to hypnosis, whether for medical or anesthetic purposes.

— Infertility Services/Artificial Conception

This Medical Program 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 Medical Program 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 Medical Program 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 Medical Program 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 Medical Program 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 Medical Program 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.

— Limited Services/Covered Charges

This Medical Program 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 Medical Program 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 Medical Program 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.)

This Medical Program 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 Medical Program does not cover** services that exceed maximum benefit limits.

— Medical Policy Determinations

Any technologies, procedures, or services for which medical policies have been developed by BCBSNM are either limited or excluded as defined in the medical policy. (See "Medical Policy" in *Section 10: Definitions).*

— Medically Unnecessary Services

This Medical Program 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" in *Section 5: Covered Services*).

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

— No Legal Payment Obligation

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

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

— Noncovered Providers of Service

This Medical Program 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
  - dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group
  - homeopathic or naturopathic provider

— Nonmedical Expenses

This Medical Program 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.)
- autopsies
- vocational or training services and supplies
- mailing and/or shipping and handling
- missed appointments; "get-acquainted" visits without physical assessment or medical care; provision of medical information to perform admission review or other preauthorizations; filling out of claim forms; copies of medical records; interest expenses
- modifications to home, vehicle, or workplace to accommodate medical conditions; voice synthesizers; other communication devices
- membership at spas, health clubs, or other such facilities
- personal convenience items such as air conditioners, humidifiers, exercise equipment, or personal services such as haircuts, shampoos, guest meals, and television rentals, Internet services
- personal comfort services, including homemaker and housekeeping services, except in association with respite care covered during a hospice admission
- immunizations or medications required for international travel
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; phone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- physicals or screening examinations and immunizations given primarily for insurance, licensing, employment, camp, weight reduction programs, medical research programs, sports, or for any nonpreventive purpose
- hepatitis B immunizations when required due to possible exposure during the member's work

- court- or police-ordered services unless the services would otherwise be covered or services rendered as a condition of parole or probation
- the cost of any damages to a treatment facility that are caused by the member

— Nonpreferred Provider Services

This Plan does not cover transplants when received from a nonpreferred 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 Medical Program, except during an emergency, if you do not first obtain preauthorization.

— Nonprescription Drugs

This Medical Program 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 under "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 Medical Program 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 Medical Program covers other nutritional products only under specific conditions set forth under "Prescription Drugs and Other Items."

— Post-Termination Services

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

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

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.

— Preauthorization Not Obtained When Required

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

— Private Duty Nursing Services

This Medical Program does not cover private duty nursing services.

— Psychotherapy (Mental Health and Chemical Dependency)

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

— Sex-Change Operations and Services

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

— Sexual Dysfunction Treatment

This Medical Program 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 Medical Program 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 Medical Program does not cover** services such as, but not limited to:

- recreational, sleep, crystal, primal scream, sex, and Z therapies
- self-help, stress management, weight-loss, and codependency programs
- smoking/tobacco use cessation counseling programs of providers that do not meet the standards described under "Cessation Counseling" in *Section 10: Definitions*
- services of a massage therapist or rolfing
- transactional analysis, encounter groups, and transcendental meditation (TM); moxibustion; sensitivity or assertiveness training
- vision therapy; orthoptics
- pastoral, spiritual, or religious counseling (This Medical Program also excludes such services even when rendered by a Christian Science Practitioner.)
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this Medical Program
- therapy for chronic conditions such as, but not limited to, cerebral palsy or developmental delay
- any therapeutic exercise equipment for home use (e.g., treadmill, weights)
- speech therapy for dysfunctions that self- correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic, other speech services that can be carried out by the patient, the family, or caregiver/teacher

— Thermography

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

— Transplant Services

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

— Travel or Transportation

This Medical Program 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 Medical Program 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 Medical Program 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 Medical Program 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 Medical Program does not cover** sunglasses, special tints, or other extra features for eyeglasses or contact lenses.

— War-Related Conditions

This Medical Program 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 Medical Program does not cover weight-loss or other weight-management programs, dietary control, or medical obesity treatment unless dietary advice and exercise are provided by a physician, nutritionist, or dietitian licensed by the approved agency and services are preauthorized by BCBSNM. Medical and surgical treatment of morbid obesity and covered weight management services are covered only when preauthorized by BCBSNM and only when the member has a body mass index (BMI = weight in kilograms divided by height in meters squared) of 40 or more. (Weight loss medications when preauthorized by BCBSNM, are covered only when medically necessary and for a BMI of 40 or more.)

— Work-Related Conditions

This Medical Program 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 Medical Program 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.

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 Medical Program 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 Medical Program.)

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

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

The following rules determine which coverage pays first:

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

Medicare — If the other valid coverage is Medicare and Medicare is not secondary according to federal law, Medicare pays first. You may not elect to change this Medical Program 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 as explained in *Section 8*. 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 (however, most providers will file claims for you or a "crossover" claim should automatically be sent by the Medicare Part B carrier or Part A intermediary to BCBSNM for secondary benefit determination).

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

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

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

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

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

— *Court-Decreed Obligations.* Regardless of which parent has custody, if a court decree specifies which parent is financially responsible for the child's health care expenses, the coverage of that parent pays first.

— *Custodial/Noncustodial.* The plan of the custodial parent pays first. The plan of the spouse of the custodial parent pays second. The plan of the noncustodial parent pays last.

— *Joint Custody.* If the parents share joint custody, and the court decree does not state which parent is responsible for the health care expenses of the child, the plans follow the rules that apply to children whose parents are not separated or divorced.

Active Member — If a member is covered as an active member under one coverage and as an inactive member under another, the coverage through active employment pays first. (Even if a member is covered as a family member under both coverages, the coverage through active retiree 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 Medical Program, 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 Medical Program, 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:

— **LANS** 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 **LANS** has provided benefits to you or your covered family members.

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

LANS 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 **LANS** 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 **LANS** 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. 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 preauthorization requirements or benefits may be reduced or denied as explained in *Section 4: Preauthorizations.* Covered services are the same services listed as covered in *Section 5: Covered Services* and all services are subject to the limitations and exclusions listed throughout this booklet.

IF YOU HAVE OTHER VALID COVERAGE

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

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

PARTICIPATING AND PREFERRED PROVIDERS

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

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

NONPARTICIPATING PROVIDERS

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

Payment normally is made to the provider. However, if you have already paid the provider for the services being claimed, your claim must include evidence that the charges were paid in full. Upon approval of the claim, BCBSNM will reimburse you for covered services, based on covered charges, less any required member copayment. You will be responsible for charges not covered by the Medical Program.

ITEMIZED BILLS

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

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

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

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

WHERE TO SEND CLAIM FORMS

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

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

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

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

Mental Health/Chemical Dependency Claims

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

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

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 Medical Program 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/already-a-member/coverage-home-and-away.html

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

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

BlueCard Worldwide Service Center
P.O. Box 261630
Miami, FL 33126 USA

IF YOU HAVE MEDICARE - FILING CLAIMS WHEN MEDICARE IS PRIMARY

If you have Medicare and Medicare is primary over this Medical Program (i.e., you are retired, a covered spouse or child 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 LANS Medical Program 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 and 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 received 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 Medical Program 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 and 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 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 the 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 the claim for services received from the hospital, along with Medicare's *Explanation of Medicare Benefits* form (EOMB), to the local BCBS Plan. (See instructions earlier 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 LANS Medical Program ID card to your provider, the Medicare Part B carrier will send an electronic copy of the claim to BCBSNM if services are received in New Mexico. If Medicare does not have your LANS Medical Program ID number, you must file a copy of the EOMB and all other required claim 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 form the hospital, along with Medicare's *Explanation of Medical Benefits* (EOMB) form, to the local BCBS Plan. (See instructions earlier 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 sent 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 you submitted the claim to Medicare for payment.)
- service received from licensed professional clinical mental health counselors (L.P.C.C.) and licensed marriage and family therapist (L.M.F.T.). (However, you will need preauthorization from BCBSNM in order to receive benefits for covered mental health services received from L.P.C.C and L.M.F.T. 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 not be covered under the Medical Program and if the services required 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 received benefits under the LANS Medical Program.

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 Marina 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 Web site to locate nearby participating physicians and hospitals.

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

CLAIMS PAYMENT PROVISIONS

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

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

If A Claim or Preauthorization Is Denied

If benefits are denied or only partially paid, BCBSNM will notify you of the determination. The notice to you will include: 1) the reasons for denial; 2) a reference to the health care plan provisions on which the denial is based; and 3) an explanation of how you may appeal the decision if you do not agree with the denial. (See "Complaints/Appeals Summary," later in this section. **You also have 180 days in which to appeal a decision.**

Covered Charge

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

Participating and Preferred Providers

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

Nonparticipating Providers

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

Accident-Related Hospital Services

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

Assignment of Benefits

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

Emergency Service Pricing

Notwithstanding anything in this booklet to the contrary, for out-of-network emergency care services, the covered charge shall be equal to at least the greatest of the following three amounts - not to exceed billed charges:

- the median amount negotiated with in-network providers for emergency care services furnished;
- the amount for the emergency care service calculated using the same method the Medical Program generally uses to determine payments for nonparticipating provider services but substituting the in-network provider cost-sharing provisions for the out-of-network cost-sharing provisions; or
- the amount that would be paid under Medicare for the emergency care service.

Each of these three amounts is calculated excluding any in-network copayment or coinsurance imposed with respect to the member.

Medicaid

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

Medicare

The drug covered provided under this Medical Program is creditable toward Medicare Part D drug coverage; therefore, persons covered under this Medical Program need not purchase Medicare Part D. However, if you are retired and eligible for Medicare, the PPO Medical Program provides benefits secondary to Medicare. In order to receive benefits under the Medical Program, you must be enrolled in both Parts A and B for Medicare. If you are a retiree or covered spouse or child of a retiree, see the LANS SPD for important information about how your decision to enroll or not into Medicare will affect your benefits and/or eligibility under this Medical Program. Also see *Section 3* for more information about how benefits are paid when Medicare is primary to this Medical Program.

Overpayments

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

Pricing of Noncontracted Provider Claims

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

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

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

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

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

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

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

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

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

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

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

BLUECARD® PROGRAM

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

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

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

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

For purposes of the Inter-Plan Arrangements described in this section, "covered charge" means the amount that BCBSNM determines is fair and reasonable for a particular covered and medically necessary service, as provided to

BCBSNM by a Host Blue. After the member's share of the covered charge is calculated, BCBSNM will pay the remaining amount of the covered charge up to the maximum benefit limitation, if any. For services received in foreign countries, BCBSNM will use the exchange rate in effect on the date of service in order to determine the covered charge.

Services Received from Contracted Providers Outside New Mexico

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

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

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

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

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

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

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

Services Received from a Noncontracted Provider Outside of New Mexico

If services are provided by a noncontracted provider, the provider may, but is not required to, submit claims on your behalf. A noncontracted provider has not negotiated his/her payments/rates with either the Host Blue or BCBSNM. If the noncontracted provider does not submit claims on your behalf, you will be required to submit the claims directly to the Host Blue. You will be subject to balance billing when you receive services from a noncontracted provider. This amount may be significant. "Balance billing" means that the noncontracted provider may require you to pay any amount that the provider bills that exceeds the sum of what BCBSNM pays toward a covered charge and your member share of the covered charge.

Member Liability Calculation

1. **In General**

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

2. **Exceptions**

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

MEMBER DATA SHARE

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

COMPLAINTS (GRIEVANCES) AND APPEALS: SUMMARY OF PROCEDURES

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

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

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

BCBSNM Contacts for Appeals

An appeal is an oral or written request for review of an "adverse benefit determination" or an adverse action by BCBSNM, its employees, or a participating provider. To file an appeal or for more information about appeals, contact:

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

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

LANS Administrative Errors and Eligibility Escalation Appeals Process

LANS is responsible for determining employee eligibility for coverage. If you have an administrative appeal about your eligibility, termination, contributions for coverage, or any other issue related to eligibility, please contact LANS or see the LANS SPD for details.

External Actions

Since the Medical Program is governed by the Employee Retirement Income Security Act of 1974 (ERISA), if you are still not satisfied after having completed the appeal process administrated by BCBSNM and described above, or if applicable, the eligibility and enrollment appeal process administrated by LANS and described in the LANS SPD you may have a right to bring a civil action under ERISA Section 502(a). You may not take legal action to recover benefits under this Medical Program until 60 days after BCBSNM has received the claim or preauthorization 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.

External Review Board

If you are still not satisfied after having completed the appeal process administered by BCBSNM and described above, or if applicable, the eligibility and enrollment appeal process administered by LANS and described in the LANS SPD, you have the right to request a hearing in front of an External Review Board. If you choose to request a hearing, you will be sent details on the process.

REQUEST FOR MEDICARE RECONSIDERATION

When Medicare Part A or B denies part or all of a claim, you can obtain from a local Social Security Office information on how to request reconsideration or review of denied Medicare claims and a description of your right to appeal Medicare claims decisions. If Medicare makes an additional payment after reconsideration, file the new *Explanation of Medicare Benefits* (EOMB) form to BCBSNM for additional reimbursement under this Medical Program.

SECTION 9: GENERAL PROVISIONS

AVAILABILITY OF PROVIDER SERVICES

BCBSNM does not guarantee that a certain type of room or service will be available at any hospital or other facility within the BCBSNM network, nor that the services of a particular hospital, physician, or other provider will be available.

CATASTROPHIC EVENTS

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

CHANGES TO THE BENEFIT BOOKLET

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

DISCLAIMER OF LIABILITY

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

Nothing in this benefit booklet is intended to limit, restrict, or waive any members rights under the law and all such rights are reserved to the individual.

DISCLOSURE AND RELEASE OF INFORMATION

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

EXECUTION OF PAPERS

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

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 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 file a complaint or appeal with BCBSNM and to receive an answer to those complaints within a reasonable time.
- 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.

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 Medical Program. You can inspect all records concerning your membership in this Medical Program during normal business hours given reasonable advance notice.

RESEARCH FEES

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

SENDING NOTICES

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

TRANSFER OF BENEFITS

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

SECTION 10: DEFINITIONS

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

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

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

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

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

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

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.

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

Biofeedback — Training and other necessary services (such as the use of special equipment) related to making certain bodily processes (e.g., heartbeats or brain waves) perceptible to the senses so they can be mentally controlled.

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

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

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

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

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

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

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

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

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

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

- is designed to build positive behavior change practices and provides counseling at a minimum on: establishment of reasons for quitting, understanding nicotine addiction, techniques for quitting, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse prevention information, and follow-up;
- operates under a written program outline that meets minimum requirements established by the Office of Superintendent of Insurance;

- employs counselors who have formal training and experience in tobacco cessation programming and are active in relevant continuing education activities; and
- uses a formal evaluation process, including mechanisms for data collection and measuring participant rate and impact of the program.

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

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

Child — See definition of "Eligible Family Member" in LANS Welfare Benefit Plan Summary Description.

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dependent — A person entitled to apply for coverage as specified in the LANS SPD. See "Eligible family member" below.

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

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

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

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

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

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

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

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

Eligible family members — See LANS SPD for description.

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.

EOMB — The "Explanation of Medicare Benefits" form that Medicare beneficiaries receive from Medicare explaining Medicare's payment or denial of a claim.

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

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

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

Genetic inborn error of metabolism — A rare, inherited disorder that is present at birth; if untreated, results in mental retardation or death, and requires that the affected person consume special medical foods.

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 Medical Program).

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

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

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

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

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

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

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

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

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

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

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

Inpatient services — Care provided while you are confined as an inpatient in a hospital or treatment center for at least 24 hours. Inpatient care includes partial hospitalization (a nonresidential program that includes from 5-12 hours of continuous mental health or chemical dependency care during any 24- hour period in a treatment facility).

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.

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

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

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

Maternity — Any condition that is related to pregnancy. Maternity care includes prenatal and postnatal care and care for the complications of pregnancy, such as ectopic pregnancy, spontaneous abortion (miscarriage), elective abortion or C-section. See "Maternity/Reproductive Services and Newborn Care" in *Section 5: Covered Services* for more information.

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

Medical detoxification — Treatment in an acute care facility for withdrawal from the physiological effects of alcohol or drug abuse. (Detoxification usually takes about three days in an acute care facility.)

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

Medical Program — The component of the LANS Health & Welfare Benefit Plan for Employees, ERISA Plan 501 or the LANS Health & Welfare Benefit Plan for Retirees, ERISA Plan 502 that provides coverage and/or reimbursements, as explained in this Medical Program Benefit Program Material, for specified medical, surgical,

mental health, chemical dependency, and prescription drug expenses. The Medical Program is a component of the overall plan.

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 Medical Program in accordance with the terms of the Administrative Services Agreement. Throughout this benefit booklet, the terms "you" and "your" refer to each member.

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

Naprapathy — Therapy employing manipulation of connective tissue and dietary measures for facilitating the recuperative and regenerative processes of the body.

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

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

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

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

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

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

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

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

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

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

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, coinsurance, and/or copayments for preferred provider services (In-Network) that you pay for most covered services in a calendar year. After an out-of-pocket limit is reached, this Medical Program pays **100 percent** of most of your preferred (In-Network) or nonpreferred provider (Out-of-Network) covered charges for the rest of that calendar year, not to exceed any benefit limits.

Outpatient services — Medical/surgical services received in the outpatient department of a hospital, observation room, emergency room, ambulatory surgical facility, freestanding dialysis facility, or other covered outpatient treatment facility.

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

Participating pharmacy — See the definition of "Provider."

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

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

Brand-name drug — A drug that is available from only one source or when available from multiple sources is protected with a patent.

Coinsurance — A **percentage** amount paid by you for each covered pharmacy prescription pharmacy provider.

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

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

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

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

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

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

Maintenance medications — Prescription drugs that are taken regularly to treat a chronic health condition such as high cholesterol, high blood pressure, or asthma. You are required to fill maintenance medications through the designated Mail Order Pharmacy provider as described later in this document. A list of maintenance medications is available on the BCBSNM website at www.bcbsnm.com. You may also contact a Customer Service Advocate for a copy.

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

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

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

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

Practice of pharmacy — The evaluation and implementation of a lawful order of a licensed practitioner: the dispensing of prescriptions; the participation in drug and device selection or drug administration that has been ordered by a licensed practitioner; drug regimen reviews and drug or drug-related research; the administering or prescribing of dangerous drug therapy; the provision of patient counseling and pharmaceutical care; the responsibility for compounding and labeling of drugs and devices; the proper and safe storage of drugs and devices; and the maintenance of proper records.

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

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

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

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

Physician — See definition of "Provider," below.

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

Plan — The LANS Welfare Benefit Plan for Employees, ERISA Plan 501 or the LANS Welfare Benefit Plan for Retirees, ERISA Plan 502. This Medical Program is a component of the overall Plan. Los Alamos National Security is the Plan Administrator and the Plan Sponsor of the Plan and of this Medical Program component of the Plan.

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

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

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

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

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

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

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 residential treatment center, a home health care agency, a diagnostic laboratory or imaging center, and a rehabilitation or other therapeutic health setting.
>
> **Physician:** A practitioner of the healing arts who is also a doctor of medicine (M.D.) or osteopathy (D.O.) and who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.
>
> **Professional provider:** A physician or health care practitioner, including a pharmacist, who is licensed, certified, or otherwise authorized by the state to provide health care services consistent with state law.

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

> **Preferred (PPO) Provider:** Health care professionals and facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, or another BCBS Plan, as "preferred" or "PPO" providers. These providers belong to the Preferred Provider Network.
>
> **Participating pharmacy:** A retail supplier that has contracted with BCBSNM or its authorized representatives to dispense prescription drugs and medicines, insulin, diabetic supplies, and nutritional products to members covered under the drug plan portion of this Medical Program and that has contractually accepted the terms and conditions as set forth by BCBSNM and/or its authorized representatives. Some participating pharmacies are contracted with BCBSNM to provide specialty drugs to members; these pharmacies are called "Specialty Pharmacy Providers" and some drugs must be dispensed by these specially contracted pharmacy providers in order to be covered.
>
> **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 Medical Program and that has contractually accepted the terms and conditions as set forth by BCBSNM and/or its authorized representatives. Some participating pharmacies are contracted with BCBSNM to provide specialty drugs to members; these

pharmacies are called "Specialty Pharmacy Providers" and some drugs must be dispensed by these specially contracted pharmacy providers in order to be covered.

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

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

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

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

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

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

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

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

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

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

Rolfing — Licensed service mark used for a system of muscle massage intended to serve both as physical and emotional therapy.

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

- routine hospital nursery services, including alpha-fetoprotein IV screening

- routine medical care in the hospital after delivery
- pediatrician
- services related to circumcision of a male newborn
- standby care at a C-section procedure

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

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

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

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

www.bcbsnm.com/health/know_your_numbers

Short-term rehabilitation — Inpatient, outpatient, office- and home-based occupational, physical, and speech therapy techniques that are medically necessary to restore and improve lost bodily functions following illness or accidental injury. (This does not include services provided as part of an approved home health or hospice admission, which are subject to separate benefit limitations and exclusions, and does not include alcohol or drug abuse rehabilitation.)

Skilled nursing care — Care that can be provided only by someone with at least the qualifications of a licensed practical nurse (L.P.N.) or registered nurse (R.N.).

Skilled nursing facility — A facility or part of a facility that:

- is licensed in accordance with state or local law; *and*
- is a Medicare-participating facility; *and*
- is primarily engaged in providing skilled nursing care to inpatients under the supervision of a duly licensed physician; *and*
- provides continuous 24-hour nursing service by or under the supervision of a registered nurse; *and*
- does **not** include any facility that is primarily a rest home, a facility for the care of the aged, or for treatment of tuberculosis, or for intermediate, custodial care or educational care.

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

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

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

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

Specialty pharmacy provider — See definition of "Participating Pharmacy."

Speech therapist — A speech pathologist certified by the American Speech and Hearing Association. A speech therapist assists patients in overcoming speech disorders.

Speech therapy — Services used for the diagnosis and treatment of speech and language disorders.

Subscriber — The individual whose employment or other status, except for family dependency, is the basis for enrollment eligibility, or in the case of an individual contract, the person in whose name the contract is issued.

Substances abuse — 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 substances. Substance abuse (also referred to as "chemical dependency," which includes alcoholism and drug abuse) may also be defined by significant risk of severe withdrawal symptoms if the use of alcohol, drugs, or other substance is discontinued.

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.

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

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

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.

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

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

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

Appendix: Notice - Inquiries/Complaints and Internal/External Appeals for Self- Funded Plans

This notice is made a part of your employer's self- funded health care plan benefit booklet, administered by Blue Cross and Blue Shield of New Mexico (BCBSNM). If you have a question about these procedures, please call a Customer Service Advocate at the phone number printed on the back of your identification card. NOTE: Whenever these procedures require that an action be taken by any party, including BCBSNM, within a certain period of time from receipt of a request or document, the request or document will be deemed to have been received within three working days of the date it was mailed.

Change in state or federal law or regulations, or interpretations thereof, may change the terms and conditions of coverage.

GENERAL INQUIRIES AND COMPLAINTS

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

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

The Claims Administrator, BCBSNM, has a team available to assist you with inquiries and complaints. To make an inquiry or complaint, contact a Customer Service Advocate at the phone number on the back of your ID card or by mail at the address on the inside front cover of your benefit booklet (inquiries about behavioral health services are directed to the Behavioral Health Unit; appeals are directed to the general BCBSNM Appeals Unit as indicated later in this appendix notice).

INITIAL INTERNAL REVIEW OF CLAIMS/PREAUTHORIZATION REQUESTS

When you or your treating health care professional requests a preauthorization or files a claim for a health care service, BCBSNM first determines whether the requested service is covered under your Plan. If the requested service is not covered, BCBSNM will not review for medical necessity, but will send you notice that there is no coverage for the requested service.

Only if the requested service is possibly covered, will BCBSNM review for medical necessity. If the requested service is approved as medically necessary, you will receive notice of that determination. An approval does not ensure that the service will be covered. For example, if you are not eligible for coverage at the time services are received, if the service you receive is different from the service authorized, or if your benefit plan changes or terminates before you receive the service in question, the service may still be denied.

Preauthorization - A decision by BCBSNM that a health care service has been reviewed and, based upon the information available, meets BCBSNM's requirements for coverage and medical necessity.

TIMING OF REQUIRED NOTICES AND EXTENSIONS

Separate schedules apply to the timing of required notices and extensions, depending on the type of claim. There are three types of claims as defined below.

— ***Urgent care clinical claim*** - Any pre- service claim that requires preauthorization, as described in the benefit booklet, for a benefit determination for medical care or treatment for which the application of regular notification time periods could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of the physician with knowledge of your medical condition, would subject you to severe pain that cannot adequately be managed without the care or treatment

— ***Post- service claim*** - A notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

— ***Pre-service claim*** - A request for preauthorization, which is any non-urgent request for a benefit or for a benefit determination for which the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. A voluntary request for advance determination of benefits is not a pre-service request for purposes of this provision.

URGENT CARE CLINICAL CLAIMS	
Type of Notice or Extension	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	**24 hours**
If you are notified that your claim is incomplete, you must then provide completed claim information to the Claims Administrator within:	**48 hours** after receiving notice
The Claims Administrator must notify you of the claim determination (whether adverse or not):	
if the claim is complete, as soon as possible (taking into account medical exigencies), but no later than:	**72 hours**
after receiving the completed claim (if the initial claim is incomplete), within:	**48 hours**

*You do not need to submit appeals of Urgent Care Clinical Claims in writing. You should call the Claims Administrator at the toll-free number listed on the back of your Identification Card as soon as possible to appeal an Urgent Care Clinical Claim.

PRE-SERVICE CLAIMS	
Type of Notice or Extension	**Timing**
If your claim is filed improperly, the Claims Administrator must notify you within:	**5 days**
If your claim is incomplete, the Claims Administrator must notify you within:	**15 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to the Claims Administrator within:	**45 days** after receiving notice
The Claims Administrator must notify you of the claim determination (whether adverse or not):	
if the claim is complete, within:	**15 days**
after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
If you require post-stabilization care after an emergency, within:	**the time appropriate to the circumstance not to exceed one hour after the time of request**

*This period may be extended one time by the Claims Administrator for up to 15 days, provided that the Claims Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

POST-SERVICE CLAIMS	
Type of Notice or Extension	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	**30 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to the Claims Administrator within:	**45 days** after receiving notice
The Claims Administrator must notify you of the claim determination (whether adverse or not):	
if the claim is complete, as soon as possible (taking into account medical exigencies), but no later than:	**30 days**
after receiving the completed claim (if the initial claim is incomplete), within:	**45 days**

*This period may be extended one time by the Claims Administrator for up to 15 days, provided that the Claims Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

Concurrent Care

For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your claim for benefits.

MANNER AND CONTENT OF CLAIM/PREAUTHORIZATION DENIAL NOTICES

On occasion, the Claim Administrator may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the *Explanation of Benefits* summary prepared by the Claim Administrator; then review the benefit booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to the Claims Administrator and request a review of the decision as described in Internal Appeal Procedures below.

If your preauthorization request or claim is denied in whole or in part, you will be notified in writing or by electronic means, within the time frames stated above, of the following:

- subject to privacy laws and other restrictions, if any, the identification of the claim, the date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- the specific reason(s) for determination;
- a reference to the specific health plan provision(s) on which the denial is based, or the contractual, administrative or protocol for the determination;
- the specific internal rule, guideline, protocol, or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request;
- an explanation of the scientific or clinical judgment relied on in the determination, if the denial was based on medical necessity, experimental treatment, or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- a description of additional information that may be needed to perfect the request or claim and an explanation of why such material is needed;
- a description of BCBSNM's internal review/appeals and external review procedures and time limits (and how to initiate a review/appeal or external review) including a statement of your right, if any, to pursue any state and, if

applicable, federal legal remedies, including bringing a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;

- in certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- in certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
- the right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;
- in the case of a denial of an urgent care clinical claim, a description of the expedited internal review procedure applicable to such claims (an urgent care claim decision may be provided orally, so long as written notice is furnished to you within three days of oral notification);
- contact information for applicable office of health insurance consumer assistance or ombudsman.

IMPORTANT: For *Adverse Benefit Determinations* that are related to any claim or preauthorization denial, reduction, termination, or failure to provide or make payment that is based on a **determination of eligibility** to participate in the Plan, including contributions for coverage, you must contact your **Employee Benefits Department at (505) 667-1806**.

INTERNAL APPEAL PROCEDURES

The following definitions apply to the Claims Administrator's internal appeal procedures (i.e., for issues not related to eligibility determinations):

Adverse Benefit Determination - A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment for a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claims Administrator or your employer and the Claims Administrator or your employer reduces or terminates such treatment (other than by amendment or termination of the employer's benefit plan) before the end of the approved treatment period; that is also an *Adverse Benefit Determination*. A rescission of coverage is also an *Adverse Benefit Determination*. A rescission of coverage does not include a termination of coverage for reasons related to nonpayment of premium.) In addition, an *Adverse Benefit Determination* also includes an Adverse Determination. For purposes of this Plan, BCBSNM will refer to both an "Adverse Determination" and an "Adverse Benefit Determination" as an "Adverse Benefit Determination," unless indicated otherwise.

Appeal - An oral or written request for review of an *Adverse Benefit Determination* or an adverse action by the Claims Administrator ("BCBSNM"), its employees, or a participating provider.

Final Internal Adverse Benefit Determination - An *Adverse Benefit Determination* that has been upheld by BCBSNM, at the completion of its internal appeal process or with respect to which the internal appeals process has been deemed exhausted.

Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An expedited clinical appeal is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, as well as continued hospitalization. Before authorization of benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, the Claims Administrator will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, the Claims Administrator will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Claims

Administrator shall render a determination on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by the Claims Administrator.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for preauthorization, or any other determination made by the Claim Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

An appeal of an *Adverse Benefit Determination* may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your ID card.

If you believe the Claim Administrator incorrectly denied all or part of your benefits, you may have your claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of an *Adverse Benefit Determination*, you may call or write to the Claim Administrator to request a claim review. The Claim Administrator will need to know the reasons why you do not agree with the *Adverse Benefit Determination*. You may contact the Claim Administrator at:

BCBSNM Appeals Unit
P.O. Box 27630
Albuquerque, NM 87125-9815
Telephone (toll-free): (800) 205-9926
FAX: (505) 816-3837

- In support of your Claim review, you have the option of presenting evidence and testimony to the Claim Administrator. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an *Adverse Benefit Determination* or at any time during the Claim review process.

The Claim Administrator will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of your Claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial *Adverse Benefit Determination*. Such new or additional evidence or rationale and information will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. The appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors, but who were not involved in making the initial denial of your claim. If the initial benefit determination regarding the claim is based in whole or in part on a medical judgment, the appeal determination will be made by a Physician associated or contracted with us and/or by external advisors, but who were not involved in making the initial denial of your claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator or your employer.

For non-eligibility issues, you or your authorized representative may request an appeal of a claims or preauthorization decision, orally or in writing, by contacting:

BCBSNM Appeals Unit
P.O. Box 27630
Albuquerque, NM 87125-9815
Telephone (toll-free): (800) 205-9926
FAX: (505) 816-3837

Timeframe for Completion of Internal Appeal

Upon receipt of a non-urgent pre-service appeal, the Claim Administrator shall render a determination of the appeal as soon as practical, but in no event more than 30 days after the appeal has been received by the Claim Administrator.

Upon receipt of a post-service appeal, the Claim Administrator shall render a determination of the appeal as soon as practical, but in no event more than 60 days after the appeal has been received by the Claim Administrator.

You have the right to request a postponement of the appeal review process by submitting your request in writing.

Manner and Content of Notification of Internal Appeal Decision

BCBSNM will provide you with written or electronic notice of the Internal Appeal Decision within the timeframes described above. You have the right to request, free of charge, reasonable access to and copies of all documents, records, and other information related to your appeal. If your appeal is denied in whole or in part, you will be notified in writing of the following:

- subject to privacy laws and other restrictions, if any, the identification of the claim, the date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- the specific reason(s) for the determination;
- the right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- an explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
- a description of the standard that was used in denying the Claim and a discussion of the decision;
- a description of BCBSNM's external review procedures and time limits including your right to pursue, if applicable, federal legal remedies including bringing a civil action under §502(a) of ERISA following a final adverse determination on external appeal;
- in certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- in certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
- contact information for applicable office of health insurance consumer assistance or ombudsman.

If the Claims Administrator's or your employer's decision is to continue to deny or partially deny your claim or preauthorization request or you do not receive a timely decision, you may be able to request an external review of your claim or preauthorization request by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the next section.

INDEPENDENT EXTERNAL REVIEW

For non-eligibility issues, you or your authorized representative may make a request for a standard external review or expedited external review of an *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* by an independent review organization (IRO). External review is available for an *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* that involves medical judgment (including, but not limited to, those based on requirements, for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational), as determined by the external reviewer. Rescissions are also eligible for external review.

1. Request for external review. Within four months after the date of receipt of a notice of an *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* from BCBSNM, you or your authorized representative must file your request for standard external review.

2. Preliminary review. Within five business days following the date of receipt of the external review request, BCBSNM must complete a preliminary review of the request to determine whether:

- You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
- The *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
- You have exhausted BCBSNM's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the "Exhaustion" section below for additional information about the exhaustion of the internal appeal process; and
- You or your authorized representative has provided all the information and forms required to process an external review.

You will be notified within one business day after BCBSNM completes the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, BCBSNM will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).

3. Referral to Independent Review Organization. When an eligible request for external review is completed within the time period allowed, BCBSNM or your employer will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, BCBSNM will take action against bias and to ensure independence. Accordingly, BCBSNM must contract with at least three IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

- Utilization of legal experts where appropriate to make coverage determinations under the plan.
- Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
- Within five business days after the date of assignment of the IRO, BCBSNM must provide to the assigned IRO the documents and any information considered in making the *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination*. Failure by BCBSNM to timely provide the documents and information must not delay the conduct of the external review. If BCBSNM fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination*. Within one business day after making the decision, the IRO must notify BCBSNM and you or your authorized representative.
- Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to BCBSNM. Upon receipt of any such information, BCBSNM may reconsider its *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* that is the subject of the external review. Reconsideration by BCBSNM must not delay the external review. The external review may be terminated as a result of the reconsideration only if BCBSNM decides, upon completion of its reconsideration, to reverse its *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* and provide coverage or payment. Within one business day after making such a decision, BCBSNM must provide

written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from BCBSNM.

- Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during BCBSNM's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
  - Your medical records;
  - The attending health care professional's recommendation;
  - Reports from appropriate health care professionals and other documents submitted by BCBSNM, you, or your treating provider;
  - The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
  - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
  - Any applicable clinical review criteria developed and used by BCBSNM, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
  - The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to BCBSNM and you or your authorized representative.
- The notice of final external review decision will contain:
  - A general description of the reason for the request for external review, including information sufficient to identify the claim;
  - The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
  - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
  - A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
  - A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either BCBSNM and you or your authorized representative;
  - A statement that judicial review may be available to you or your authorized representative; and
  - Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
- After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. Reversal of plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, BCBSNM immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

1. Request for expedited external review. BCBSNM must allow you or your authorized representative to make a request for an expedited external review with BCBSNM at the time you receive:

- An *Adverse Benefit Determination* if the *Adverse Benefit Determination* involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A *Final Internal Adverse Benefit Determination*, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the *Final Internal Adverse Benefit Determination* concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, BCBSNM must determine whether the request meets the reviewability requirements set forth in the "Standard External Review" section above. BCBSNM must immediately send you a notice of its eligibility determination that meets the requirements set forth in the "Standard External Review" section above.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, BCBSNM will assign an IRO pursuant to the requirements set forth in the "Standard External Review" section above. BCBSNM must provide or transmit all necessary documents and information considered in making the *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during BCBSNM's internal claims and appeals process.

4. Notice of final external review decision. BCBSNM's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the "Standard External Review" section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to BCBSNM and you or your authorized representative.

EXHAUSTION

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if BCBSNM waives the internal review process or has failed to comply with the internal claims and appeals process. If you have been deemed to have exhausted the internal review process due to BCBSNM's failure to comply with the internal claims and appeals process, you may also have the right to pursue any available remedies under 502(a) of ERISA or under state law.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

OTHER EXTERNAL ACTIONS

If you are still not satisfied after having completed BCBSNM's or, for eligibility and employee contribution issues, your employer's complaint, appeal, grievance, or reconsideration procedure, you may have the option of taking one of the following steps. No legal action at law or in equity may be taken or arbitration demand made earlier than 60 days

after the Claims Administrator 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 the Claims Administrator.

Additional Resources — If you need additional assistance, you may call the U.S. Department of Labor's Employee Benefits Security Administration (EBSA):

Call toll- free at (866) 444- EBSA (3272) or visit the EBSA Web site at www.askebsa.dol.gov

RETALIATORY ACTION

BCBSNM and your employer shall not take any retaliatory action against you for making a complaint, filing an appeal, or requesting external review under this health plan.

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

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 LANS Welfare Benefit Plan Summary Description.

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 Medical Program 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 Medical Program 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 Medical Program as an “eligible child”.

If the Medical Program 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 Medical Program, 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 Medical Program.

The Medical Program will offer COBRA continuation coverage to qualified beneficiaries only after the Medical Program administrator has been notified that a qualifying event has occurred.

The employer must notify the Medical Program 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 Medical Program administrator. The Medical Program requires you to notify the Medical Program 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 Medical Program 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 Medical Program 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 Medical Program 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 Medical Program 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 Medical Program 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 Medical Program as an eligible child.

In all of these cases, you must make sure that the Medical Program 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 Medical Program 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 Medical Program 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 Medical Program administrator.

PLAN CONTACT INFORMATION

Health Care Service Corporation
A Mutual Legal Reserve Company
P.O. Box 1180
Marion, IL 62959-7680
1-888-541-7107

Acceptance of coverage under this benefit booklet constitutes acceptance of its terms, conditions, limitations, and exclusions. Members are bound by all of the terms of this benefit booklet.

The legal agreement between **LANS** and Blue Cross and Blue Shield of New Mexico (BCBSNM) includes the following documents:

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

In addition, **LANS** has important documents that are part of the legal agreement:

- the Group Master Application; and
- the Administrative Services Agreement between BCBSNM and **LANS**

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

LANS reserves the right to amend, modify, or discontinue coverage provided for employees and their dependents. This benefit booklet is not an implied contract and does not guarantee benefits or employment.

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

BlueCross BlueShield of New Mexico

www.bcbsnm.com

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

44111.0313