Dear NMPSIA Member,

We are pleased to present the new health plan for eligible NMPSIA employees and their eligible family members. Your benefit plan is effective January 1, 2017.

This is a self-funded health plan. New Mexico Health Connections (NMHC) is the Claims Administrator for your plan. You will access the NMHC provider network just as if you were a fully insured NMHC member.

We want you to be a well-informed consumer of healthcare services. The information contained in this booklet will help you understand the details of your plan, reduce your out-of-pocket expenses, and get the most benefit from it. Please read it carefully. If you have questions about any of the plan benefits, you may call the Customer Service phone number listed in this booklet or speak with your NMPSIA Benefits Administrator.

NMPSIA reserves the right to terminate, discontinue, or change this health plan or any provision of this plan at any time – although we do not anticipate this happening. We will notify you as soon as possible about any mutually agreed-upon changes.

Thank you for selecting NMHC for your healthcare coverage.

Sincerely,

NMPSIA

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IMPORTANT PHONE NUMBERS AND ADDRESSES

Customer Service
Call our Customer Service Department. Our toll-free number is **1-877-210-8213.** We are available Monday through Friday, 8 a.m. to 5 p.m., Mountain Standard Time. If you need assistance outside normal business hours, you may call the Customer Service telephone number and leave a message. A Customer Service Representative will return your call by 5 p.m. the next business day.

Send all written inquiries to:	Physical address:
NMHC IBAC	2440 Louisiana Blvd. NE
P.O. Box 35100	Suite 601
Albuquerque, NM 87176	Albuquerque, NM 87110

New Mexico Health Connections Customer Care Center: **1-877-210-8213**.

- Spanish (español): Para obtener asistencia en español, llame al **1-877-210-8213**.
- Navajo (Diné): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-877-210-8213**.
- TTY services provided by A&T – TTY line: **1-800-659-8331**.

Express Scripts® Pharmacy Benefit Manager
Prescription drugs are administered by Express Scripts. For customer service, you can visit their website at www.express-scripts.com or call customer service at **1-800-498-4904**.

Prior Approvals
Call our Customer Service Department. Our toll-free number is **1-877-210-8213**. We are available Monday through Friday, 8 a.m. to 5 p.m., Mountain Standard Time.

NMHC Case Management department
Our toll-free number is **1-844-691-9984**. We are available Monday through Friday, 8 a.m. to 5 p.m., Mountain Standard Time.

Claims Submission
Please mail claim forms and itemized bills to:
Claims Department
New Mexico Health Connections
P.O. Box 3968
Corpus Christi, TX 78463-3968

Website
You may also visit our website for more information about your Benefits and services. Our web address is **www.mynmhc.org/nmpsia**.

WELCOME TO NEW MEXICO HEALTH CONNECTIONS

We are excited you have selected us as your Healthcare Insurer. At New Mexico Health Connections, your health is our priority. We believe that all New Mexicans should have access to quality and affordable healthcare services. It is our pleasure to provide you with access to excellent healthcare coverage through our statewide network of Providers.

New Mexico Health Connections is a non-profit, consumer-oriented and -operated (CO-OP) health plan organized under the Affordable Care Act and the laws of the State of New Mexico. In this document, we may call ourselves New Mexico Health Connections, or the Insurer, or "the Plan". When you see the words "we," "us," "our," and "NMHC" in this document, it is referring to New Mexico Health Connections.

New Mexico Health Connections offers insurance coverage to eligible people. The Benefits provided by your employer are described in this document, which we call a Benefit Booklet, as well as your Summary(ies) of Benefits and Coverage; Formulary Reference Guide; and Provider Directory. When you see the words "you" and "your" we are referring to people covered under by one of our insurance plans. Anyone receiving healthcare Benefits under your Plan may also be called Members, Enrollees, Covered Persons/Dependents, or Subscribers.

Please be sure to read this Benefit Booklet carefully and refer to the Summary of Benefits for your plan. The Summary of Benefits is a short, plain-language Summary of Benefits document that shows some specific Covered Benefits the Plan provides, your cost sharing amounts and the Coverage Limitations and Exclusions.

Understanding how this plan works can help you make the best use of your healthcare's Covered Benefits.

HOW TO USE THIS DOCUMENT

This Benefit Booklet is a legal document. This document is designed to help you understand your healthcare Benefits and the Services available to you. This Benefit Booklet, Summary(ies) of Benefits and Coverage, Formulary Reference Guide, and Provider Directory will guide you in using your Plan Benefits. They describe how the Plan works, the Services covered by the Plan, and who to contact if you need assistance with the Plan.

We encourage you to read these documents. It is important to understand what your Plan covers, and especially what it does not cover. Many sections of this Benefit Booklet refer to other sections of the document. You may not have all of the information you need by reading just one section or one document.

You are encouraged to keep this document and your Summary of Benefits, in addition to any other documents mentioned, as well as attachments or amendments to this Benefit Booklet that you may receive for your future reference. Your healthcare Providers do not have a copy of this document or the Summary of Benefits or other Plan documents and are not responsible for knowing your Plan Benefits.

The Plan

You have chosen New Mexico Health Connections to provide you and your covered Dependents coverage under a Health Maintenance Organization (HMO) Plan. You are required to see In-Network Providers. We have a statewide network of Providers and hospitals for your use.

By enrolling in this Plan, you have agreed to follow the rules of the Plan, which are outlined in this document, your Summary of Benefits and other documents mentioned earlier. We may change the Benefits described in this document. If that happens, you will be notified in writing of any changes that may affect you or your covered Dependents. Check NMPSIA.com for updates to your plan.

Contact our Customer Care Center if you need more information about your Plan or if you need copies of the benefit plan documents, such as this Benefit Booklet or your Summary of Benefits.

New Mexico Health Connections Customer Care Center: 1-877-210-8213

- Spanish (español): Para obtener asistencia en español, llame al 1-877-210-8213.
- Navajo (Diné): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-210-8213.
- TTY services provided by A&T – TTY Line: 1-800-659-8331 (711).

You may also visit our website at www.mynmhc.org/nmpsia for additional information about your Benefits and services.

You may visit or write to us about any questions or concerns at the following addresses:

Physical address:	Mailing address:
2440 Louisiana Boulevard,	NMHC IBAC
Suite 601	P.O. Box 35100
Albuquerque, NM 87176	Albuquerque, NM 87176

Interpreter Services

If you need assistance from an interpreter, we have services to assist you. If you would like access to these services, contact the Customer Care Center during business hours at 1-877-210-8213.

Entire Contract

This Benefit Booklet along with the Summary of Benefits and other documents specified, any amendments, and the Enrollment Application constitutes the Entire Contract between NMHC and the Subscriber; and as of the effective date of the Contract, supersede all other agreements between the parties. The Contract Year is the period of time for which the Agreement is in effect.

Amendments

The provisions of the Plan as outlined in this Benefit Booklet are subject to amendment; including benefit modifications, premium rate changes, or termination in accordance with their provisions or by mutual agreement in writing between the NMHC

and the employer group. By electing coverage and accepting Benefits under this Plan, all Planholders that are legally capable of contracting, agree to all terms, conditions, and provisions of the Plan. Premium rate changes shall not be effective without 60-) days' written prior notice to the Planholder.

Governing Law

This Benefit Booklet is made and shall be interpreted under the laws of the State of New Mexico and all applicable federal rules and regulations.

OTHER INSURANCE COVERAGE

Injuries Caused by Third Parties and Subrogation

This section will apply when another party is, or may be considered liable, for a Member's injury, sickness or other condition. This includes insurance carriers who are financially liable and for whom NMHC has made a payment for Benefits.

The Plan is subrogated to all of the rights of the Member against any party liable for the Member's injury or illness; or is or may be liable for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the value of the medical Benefits that may have been paid by NMHC. NMHC may assert this right without consent from the Member. This right includes, but is not limited to, the Member's rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, or other insurance; as well as the Member's rights under the Plan to bring an action to clarify his or her rights under the Plan. NMHC is not obligated in any way to pursue this right independently or on behalf of the Member, but may choose to pursue its rights to reimbursement at its sole discretion.

The Member is obligated to cooperate with NMHC and its agents in order to protect NMHC's subrogation rights. Cooperation with NMHC means you will:

- Provide NMHC or its agents with any relevant information requested;
- Sign and deliver such documents as reasonably requested to secure the subrogation claim;
- Obtain the consent of NMHC or its agents before releasing any party from liability for payment of medical expenses.

If the Member enters into litigation or settlement negotiations regarding the obligations of other parties, the Member must not prejudice the subrogation rights of NMHC. If a Member fails to obtain prior written consent from NMHC and agrees to a settlement or releases any party from liability for payment of medical expenses, or otherwise fails to cooperate with this provision, including executing any documents required herein, the Member will be required to repay NMHC for the value of any Benefits that were paid by NMHC. NMHC contracts with First Recovery Group, LLC, at the address listed below, to assist NMHC in its subrogation efforts. You or your provider may be contacted by First Recovery Group for information and assistance in investigating potential Third Party or Subrogation claims.

First Recovery Group, LLC
26899 Northwestern Highway, Suite 250
Southfield, MI 48033

Coordination of Benefits (COB)

Coordination of Benefits (COB) refers to Members who have coverage under more than one health insurance plan. A plan may be another group or individual health insurer or it may be another type of insurance, such as Medicaid or Medicare or certain types of automobile insurance. The insurance industry has developed "order of benefit determination rules" that govern the order in which each plan will pay a claim for Benefits. This ensures that plans will apply consistent rules and that the maximum amount will be paid under each applicable plan. The insurer that pays first is called the primary plan. The primary plan must pay Benefits in accordance with its Plan terms without regard to the possibility that another plan may cover some expenses. The insurance company that pays after the primary plan is the secondary plan. The secondary plan may reduce the Benefits it pays so that payments from all plan Benefits do not exceed 100% of the total Allowable Charge. (Note: In some cases, a Plan Member may be covered under three or more plans. In that case, Benefits can be coordinated among all the applicable plans to ensure that the maximum Benefits are paid by each plan).

Benefits under this Plan will pay after payment is made by a Health plan, group or individual automobile insurance Plan; or homeowner's or premises insurance, including medical payments, personal injury protection, or no-fault coverage.

In order to be able to coordinate Benefits with another insurance carrier, we must know what other health insurance coverage you have. This could reduce the out-of-pocket and/or "not covered" amounts for which you are liable. It is in your best interest to provide us with the most current information about other coverage that you and/or your dependents have. When your other health insurance coverage begins or ends, you should notify the Customer Care Center immediately at 1-877-210-8213.

RIGHTS AND RESPONSIBILITIES

As a Member of this Plan, you are entitled to certain rights when you access coverage. There are also certain responsibilities that you hold. It is important that you understand these rights and responsibilities.

As a Member of this Plan:

- **You have a right to information about member rights and responsibilities.**
- You have a right to detailed information about your Plan. This may include Covered Benefits and Services that are covered or excluded from the Plan, and all requirements that must be followed for Prior Approval and Utilization Review.
- You have a right to always have available and accessible services for Medically Necessary and covered services; including 24 hours per day, 7 days per week for urgent and emergency care services, and for other Covered Benefits and Services as defined by the Benefit Booklet or the Summary of Benefits.
- You have a right to information about your out-of-pocket expense limitations, and an explanation of your financial responsibility for Covered Services provided to you.
- You have a right to be treated in a manner that respects your privacy and dignity.
- You have a right to participate with your In-Network Providers in making decisions about your healthcare.
- You have a right to receive an explanation of your medical Condition, recommended treatment, risks of the treatment, expected results, and reasonable medical alternatives from your Participating Provider in a language that you understand, regardless of cost or your benefit coverage.
- You have a right to be informed about your treatment from your Participating Provider; to request your consent (agreement) to the treatment; to refuse treatment, including medication; and to be told of the possible consequences of refusing such treatment. This right exists even if treatment is not a Covered Benefit or Medically Necessary according to the Plan. The right to consent or agree to treatment may not be possible in a medical emergency where your life and health are in serious danger.
- You have a right to voice Complaints, Grievances or Appeals with NMHC or its regulatory bodies about NMHC and/or the Coverage that we provide.
- You have a right to make recommendations regarding Plan's Member Rights and Responsibilities policies.
- You have a right to receive assistance in a prompt, courteous and responsible manner.
- You have a right to the confidential handling of all communication and information maintained by NMHC. Your written permission will always be required for the release of medical and financial information, except:
    - When clinical data is needed by healthcare Providers for your care;
    - When NMHC is bound by law to release information;
    - When NMHC prepares and releases data but without identifying Members; and
    - When necessary to support NMHC's programs or operations, including for payment and to evaluate quality and service.
- You have a right to be promptly informed of termination or changes in Covered Benefits and Services or In-Network Providers.
- You have a right to know, upon request, of any financial arrangements or provisions between NMHC and its In-Network Providers, which may restrict referrals or treatment options or limit the Benefits or Services offered to you.
- You have a right to receive an explanation of why a Benefit is denied; the opportunity to Appeal the denial decision; the right to a second level of Appeal with NMHC; and the right to request help from the New Mexico Superintendent of Insurance.
- You have a right to adequate access to healthcare In-Network Providers near your home or work within the Plan's service area.
- You have a right to receive detailed information about requirements that you must follow for Prior Approval of certain Covered Benefits and Services.
- You have a right to have access to a current list of In-Network Providers in NMHC's network.
- You have a right to an example of the financial responsibility incurred by a Covered Person for Benefits and Services received from an Out-of-Network Provider.

You are responsible for learning how your Plan works. You should carefully read and refer to this Benefit Booklet, your Summary of Benefits, and other Plan documents. Contact the Customer Care Center if you have questions or Concerns about your Plan.

As a Member of the Plan, you have the following responsibilities:

- You have a responsibility to provide honest and complete information to NMHC and to your In-Network Providers.
- You have a responsibility to read and understand the information that you receive about your Plan.
- You have a responsibility to know how to properly access coverage and utilize your Plan.
- You have a responsibility to understand your health problems and participate in developing treatment goals that you agree to with your In-Network Providers.
- You have a responsibility to follow plans and instructions for care that you have agreed to with your In-Network Providers.
- You have a responsibility to present your Plan ID card before you receive care.
- You have a responsibility to promptly notify your Participating Provider if you will be delayed or unable to keep an appointment.
- You have a responsibility to pay your applicable Deductible, Copayment and Coinsurance amounts, including those for missed appointments.
- You have a responsibility to express your opinions, Concerns or Complaints in a constructive way to NMHC or to your Participating Provider.
- You have a responsibility to notify NMHC if you have any other insurance coverage.
- You have a responsibility to follow NMHC's Complaints and Appeals process when you are dissatisfied with NMHC or a Providers' actions or decisions.

ABOUT YOUR PLAN

Health Maintenance Organization

A Health Maintenance Organization or HMO plan gives you a network of In-Network Providers: physicians and other practitioners and hospitals that you must use for healthcare services.

In-Network Providers

As an HMO Plan Member, you can feel confident knowing that there is a New Mexico Health Connections' Participating Provider close to where you live or work. Our statewide network of physicians, hospitals and other medical service Providers means that you have access to In-Network providers throughout New Mexico.

When you or your covered Dependents see an In-Network Provider, we pay that Provider for Covered Benefits or Services that are covered under your Plan. You will be responsible for paying some charges such as your Deductible, Copayment and Coinsurance amounts. These amounts are due at the time that you receive services.

Prior Approval is required for some Covered Benefits and Services such as hospitalizations. If benefits and services require Prior Approval, your In-Network Provider must obtain authorization before providing these services to you.

Provider Directory

Our Provider Directory includes a list of physicians, hospitals, pharmacies, and other In-Network Providers that have contracted with us. The Provider network is subject to change as new Providers join our network and other Provider's leave. If a Provider is listed in the directory, it does not guarantee that the Provider is still contracted with New Mexico Health Connections, or that the Provider is accepting new patients.

Before joining our network, In-Network Providers must meet specific criteria through a process called credentialing. We regularly review our Providers' credentials to make sure that they continue to meet these standards.

If you would like to check the status of a Provider, you can access the Online Provider directory on our website at www.mynmhc.org. You can also contact our Customer Care Center to inquire about a Provider. The Customer Care Center can provide you with information about your Provider such as the medical school attended, residency completed, and Board Certification status. You may also contact our Customer Care Center to ask for a copy of our Provider Directory.

Service Area

NMHC's Service Area is the state of New Mexico.

Primary Care Practitioners (PCP)

PCPs are physicians and other qualified providers that manage your healthcare needs. It is our philosophy that a strong relationship with a Primary Care Practitioner will help you and your family navigate your health plan, as well as keep you healthy. PCPs provide services such as annual exams, routine immunizations, age appropriate preventive screening recommendations and treatment for illnesses and injuries.

Please select a PCP if you didn't do so at the time you completed your enrollment application. NMHC does not select a PCP for you. You can browse the provider directory by Participating Provider name or specialty. To do this, click on the "Find a Provider" button near the top of our homepage (www.mynmhc.org). After you have chosen a PCP, be sure to call his or her office and make sure they are accepting new patients. Although you are not required to select a PCP, if you do establish a relationship with one, it can be helpful to advise us of your choice in-order to better manage your care. You may do this in one of two ways:

- Call our Customer Service Department. Our toll-free number is 1-877-210-8213. We are available Monday through Friday, 8 a.m. to 5 p.m., Mountain Standard Time; or
- Log in to our Member Portal. You will find a link to the portal at the top right corner of our homepage.

Developing a relationship with a Primary Care Practitioner can help you stay well and avoid costly medical expenses in the future. NMHC's network of PCPs includes physicians practicing Family Medicine, Internal Medicine and Pediatrics, as well as Doctors of Oriental Medicine, Physician Assistants and Nurse Practitioners.

Specialty Care Practitioners
A Specialty Care Practitioner or Specialist is a Provider that treats a specific disease, medical Condition, or a specific part of the body. You do not need a referral to see a Specialist.

Some examples of Specialty Care Practitioners include cardiologists, orthopedists, neurologists, and endocrinologists. Doctors of Oriental Medicine may also be considered Specialty Care Practitioners as long as they have met NMHC's requirements for participation in the provider network.

Medical Emergencies
If you reasonably believe you have an Emergency Medical Condition, the initial treatment of that condition that prevents the member from seeking care from an Out-of-Network Provider will be covered by NMHC and paid at the In-Network benefit level. An Emergency medical condition means healthcare procedures, treatments, or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by 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 the person's health, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or disfigurement to the person.

Prior authorization is not required for emergency care. In addition, appropriate out-of-network emergency care shall be provided to a covered person without additional cost; whether out-of-network emergency care is appropriate shall be determined by the standards of Paragraph (4) Subsection D of 13.10.21.8 NMAC.

For follow-up care, which is no longer considered an Emergency, you or your family Member will need to select an In-Network Provider in order to receive In-Network benefits.

Medically Necessary Care Not Available in Service Area
If a Covered Benefit or Service is Medically Necessary and is not available from a Participating Provider, we will refer you to an Out-of-Network Provider. Before we refer you to an Out-of-Network Provider, we will ensure that your request is reviewed by a Specialist practicing in the field of medicine that would be familiar with your specific medical Condition. In these situations, NMHC will coordinate the referral. We will pay the Provider at a rate agreed upon between NMHC and the Out-of-Network Provider.

Receiving Care from an Out-of-Network Provider or Non-Participating Provider
Services and/or supplies received from an Out-of-Network Provider will not be covered unless Prior Approval is obtained from NMHC prior to receiving the services. If you do not receive Prior Approval you may be responsible for the charges resulting from failure to obtain Prior Approval for services provided by the Out-of-Network Provider

If you receive prior authorized care from an Out-of-Network Provider or Non-Participating Provider, you may be required to pay the charges in full to that Provider at the time of service. To be reimbursed for the charges you have paid, you will need to submit a Member Reimbursement form including an itemized statement with the diagnosis, the treatment received and an explanation for the services, the charges for the treatment, and the Member's identification information from your Plan ID card.

Generally, non-emergent care to an Out-of-Network Provider or Non-Participating Provider is not covered by this Plan.

However, there are certain situations in which we will pay for Covered Benefits and Services from Out-of-Network Providers, as explained below. If you have questions or need more information, please contact Customer Service at 1-877-210-8213.

Itemized bills must be submitted on billing forms or the Provider's letterhead or stationery and must include:
- The name and address of the Physician or other healthcare Provider;
- The full name of the patient receiving treatment or services; and
- The date, type of service, diagnosis, and charge for each service separately.

Canceled checks, balance due statements, cash register receipts or bills you prepare yourself are not acceptable. Please make a copy of all itemized bills for your records before you send them because the bills will not be returned to you. Itemized bills are necessary for your claim to be processed so that all Benefits or Services available under this Plan are provided.

If your itemized bill includes charges for services that were previously submitted to us, clearly identify the new charges that you are submitting for reimbursement. Medical records of the treatment or service may be required. You can get a Member Reimbursement form from our website at www.mynmhc.org or by calling the Customer Care Center at 1-877-210-8213.

Claims for Benefits or Services rendered by an Out-of-Network Provider must be submitted to NMHC within one year (365-days) from the date of service. If your Out-of-Network Provider does not file a claim for you, you are responsible for filing the claim within the one-year deadline. Claims submitted after the deadline are not eligible for reimbursement. If a claim is returned to you because we need additional information, you must resubmit it, with the information requested, within 90-days of receipt of the request. Services and/or supplies received from a Non-Participating Provider for which a Prior Approval was not obtained and was not for urgent/emergent care are not covered by the Plan and may result in denial of the claim reimbursement request.

Please mail the claim forms and itemized bills to:

Claims Department
New Mexico Health Connections
P.O. Box 3968
Corpus Christi, TX 78463-3968

Once received, reviewed and approved, NMHC will reimburse you for Covered Benefits and Services, less any required Deductibles and Coinsurance or Copayment amounts that you are required to pay as stated in the Summary of Benefits. You will be responsible for services not specifically covered by NMHC.

Usual, Customary and Reasonable Charges
This is an HMO plan. An HMO plan requires that you see an In-network provider to receive the In-Network benefit. Exceptions are Urgent Care, Emergency Services, or services otherwise pre-authorized.

Out-of-Network Providers are allowed to bill any amount they wish for healthcare services. The charges that they bill may be more than your Plan's Usual, Customary and Reasonable amount. Covered Benefits and Services received from Out-of-Network Providers are covered up to your Plan's Usual, Customary and Reasonable amount. The Usual, Customary and Reasonable amount is determined by the median rate paid for similar healthcare services within the surrounding geographic area in which the charges were incurred. The surrounding geographic area may be determined by the type of service and the access to that service in the geographic region.

When an Out-of-Network Provider charges more than the Usual, Customary and Reasonable amount, the payment to the provider will be based on the lesser of the billed charge or the Usual, Customary and Reasonable amount for the services rendered. Depending on the type of Benefit or Service received with the pre-authorized care, the Member will be responsible for the Plan Deductible and Coinsurance amounts.

Claims for Emergency Services Received Outside the United States
If you need Urgent or Emergency care from a Hospital or Physician when you are outside of the United States, claims should be handled the same way as described in the *Receiving Care from an Out-of-Network Provider* section of this Benefit Booklet. You will normally be required to pay the Provider at the time services are received and submit the claim to us for reimbursement. You are responsible for confirming that the claim and/or records are appropriately translated and that the monetary exchange rate is clearly identified when submitting the claim for the reimbursement. Medical records of the treatment or service may also be required.

Case Management
New Mexico Health Connections is committed to the delivery of high-quality case management programs to our members. We ensure members with healthcare needs and/or complex conditions have access to needed resources and services to assist them in better understanding and managing your chronic health condition(s). Members are guided into plans of care appropriate to their specific needs and designed to help them regain optimum health.

Members may be identified for case management through a variety of sources that include, but are not limited to:

- Claims or encounter data;
- Hospital admission and/or discharge data;
- Pharmacy data;
- Data collected through the utilization management (Prior Approval) process;
- Data collected from the health information line;
- Member data;
- Physician or provider data; and
- Purchaser supplied data.

Members may also be referred for case management from multiple sources including, but not limited to:
- Health information line;
- Disease Management programs;
- Discharge planners;
- Utilization Management teams;
- Member or caregiver; and
- A Provider/practitioner.

The NMHC Case Management program is available to all NMHC members. While NMHC monitors claims, utilization patterns and other health plan data, referrals into any level of case management are accepted from members, caregivers and providers.

Referral to a case management program can be initiated by contacting the NMHC Case Management department at 1-844-691-9984.

Disease Management
New Mexico Health Connections is committed to supporting our Members in the management of asthma and diabetes and other chronic diseases.

Asthma and diabetes are chronic diseases that can be controlled with education, medication management, and identification and elimination of triggers in the environment. NMHC's Asthma and Diabetes Management Programs are designed to identify and improve health outcomes for our Members by:
- Identifying members with asthma or diabetes;
- Analyzing risks factors to determine what level of intervention a Member needs;
- Outreaching, educating, and engaging asthmatic and/or diabetic Members and their families in activities to improve their health and develop self-management strategies;
- Facilitating communication, teamwork, coordination and management of necessary healthcare services; and
- Assisting members that may require community resources such as transportation or other assistance.

For more information or to refer yourself to a Disease Management program, contact the Customer Care Center at 1-877-210-8213.

Transition of Care
If you are receiving an ongoing course of treatment from an Out-of-Network Provider when you enroll in the Plan, or with a Participating Provider whose contract ends with NMHC during your treatment, you may be eligible to continue to receive services and they will be covered under the Plan. This is called a Transition of Care. Determinations for Transition of Care are made based on established medical criteria. The Transition of Care Period will be for a period of no less than thirty (30) days. Transition of Care also applies to members who have entered the third trimester of pregnancy, including post-partum care directly related to the delivery. For Members in the third trimester, the transitional period will continue through delivery, including post-partum care related to the delivery.

Treatment Refusal
A Member is allowed to refuse treatment that is recommended by a Participating Provider. If this happens, the Provider can decide not to continue their relationship with the Member because proper medical care is being disrupted. If the Provider feels there is no alternative care to the treatment that was refused, neither NMHC or the Provider will be held responsible for treating the Condition or for any complications that result from the Member refusing treatment. This is true as long as a Member refuses

treatment determined appropriate.

Customer Care Center
Our Customer Care Center staff will work with you to resolve any issues or answer any questions that you may have regarding your Plan. We resolve to answer your questions or concerns as quickly and as satisfactorily as possible.

Our Customer Care Center may assist you with the following:
- Provider information;
- Questions about Covered Benefits and Services;
- Procedures for obtaining care;
- Information about Prior Approvals;
- Status of claim payment;
- Appeals and Complaint procedures.

Online Member Options
Our interactive website is a valuable source of information. You can check your eligibility and claims status, send secure messages to the Customer Care Center, search for a Participating Provider, and more! Please visit our website at www.mynmhc.org/nmpsia for more information and to login to the member portal.

Where to Contact Us
If you have a question or concern about your Plan, you can contact the Customer Care Center at 1-877-210-8213. The Customer Care Center is open Monday through Friday from 8:00 a.m. to 5:00 p.m. Mountain Standard Time. Calls received after hours or on weekends will be directed to a voicemail messaging system that will be available 24-hours a day, 365-days a year, and calls will be returned on the next business day.

Language Line
We have translation services available. If you need translation services during a visit to your physician's office, contact the Customer Care Center for assistance.

Using Your ID Card
You have been issued a Plan ID card. Carry your Plan ID card with you at all times. A Provider will require you to show them your ID card when you receive healthcare services. Your ID card lists some of your Plan Benefits and Copayment or Coinsurance amounts. Additional Copayment and Coinsurance amounts, as well as contact information for the Customer Care Center and for Express Scripts® your Pharmacy Benefits Manager (PBM). Additional Copayment and Coinsurance amounts can be found in your Summary of Benefits. If you lose your ID card, or need additional cards, contact the Customer Care Center.

Do not allow a non-Member to use your Plan ID card. If this happens, you will be responsible for the cost of services provided to that person. Your membership and the membership of any covered Dependents will be terminated. Contact the Customer Care Center immediately if your Plan ID card is lost or stolen.

Identification (ID) Cards are issued by NMHC for identification purposes only. Possession of a Plan ID Card infers no rights to Covered Services and Benefits under your Plan. To be entitled to Services or Benefits, the cardholder must be the Member on whose behalf all applicable Plan premiums have been paid. If any Member allows the use of his/her ID card by a person other than him/herself, all rights of the Member and any dependents on the Plan will be immediately terminated at the discretion of NMPSIA.

When you receive Covered Services from a Participating Provider, your Provider will file your claims to us on your behalf. You must present your Plan ID card at the time of service to make sure that your claims are paid in a timely and accurately. You are expected to pay your Participating Provider for Copayments, Deductible and/or Coinsurance amounts as indicated in your Summary of Benefits Coverage and Plan ID card.

You will be responsible for any charges for missed appointments or appointments cancelled without adequate notice to your Participating Provider. If you believe you are being asked to pay an amount to a Participating Provider that you do not agree

with, you may contact the Customer Care Center for assistance. You are not responsible for any amounts owed to your Provider by NMHC.

Affirmation Statement

We make claims payment decisions based on the appropriateness of care, the services that are received, and the eligibility for coverage only. New Mexico Health Connections does not provide incentive payments to New Mexico Health Connections' Claims' Representatives, or make employment decisions based on the denial of member Benefits.

HOW TO GET CARE

This section explains how you can access care through a Participating Provider and how to make sure that the care you receive is covered under your Plan.

In order for us to provide your Plan Benefits in a timely fashion, you should follow these basic steps:

- Contact your physician or other Participating Provider when you have a healthcare need;
- Identify yourself as a Member. Have your Plan ID card on hand when making appointments;
- Upon arriving for a scheduled appointment, show your Plan ID card to the receptionist;
- Make sure Prior Approval has been obtained for the services described in the Prior Approval and What the Plan Covers sections of this Benefit Booklet;
- Notify NMHC of an Emergency admission within forty-eight (48) hours of being admitted to a hospital; and
- Call the Customer Care Center if you have a question, concern or complaint.

Medical Office Visits

Physicians and other In-Network Providers who you see in an office setting offer both primary and specialty care services. These Covered Services may include annual examinations, routine immunizations, and treatment of non-emergency/acute illnesses and injuries. For preventive, routine or specialty care, call or make an appointment with your physician or other Participating Provider. In-Network Providers will arrange for Prior Approval as necessary, as described in the Prior Approval section of this Benefit Booklet.

If you need a same day appointment or have an Urgent Illness, call your Provider's office to make an appointment. If your Provider is unable to see you, you may be able to see another physician or other practitioner in that office.

When you arrive for your appointment show your Plan I.D. card to the receptionist. If a particular benefit requires a Copayment, you must pay it before receiving services. If you are unable to keep an appointment, cancel as soon as possible.

Urgent Care

Urgent Care is for a situation that is not life threatening but requires medical care quickly, or after a Primary Care Practitioner's normal business hours. Urgent Care conditions are unexpected and arise due to illness or injury.

Some examples of Urgent Care situations are: a rising fever even after taking medication, an asthma attack where medications are not helping, an animal bite, an object in the eye or eye infection, a cut that may need stitches, a child with severe vomiting or diarrhea, a possible broken bone, shortness of breath, a sore throat, flu symptoms, a urinary tract infection, or a migraine headache where medicine is not helping.

If you need assistance finding the nearest In-Network Urgent Care facility, please contact the Customer Care Center, or refer to the Provider Directory. You can find a listing of Urgent Care centers on our website: www.mynmhc.org/find_a_doctor.aspx. You may want to call your Primary Care Practitioner for an appointment, before seeking care from another provider.

Emergency Services

Emergency Medical Conditions require quick action. An Emergency Medical Condition refers to the sudden onset of what reasonably appears to be a medical condition that manifests itself by 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 the person's health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part; or disfigurement to the person.

Examples of emergencies are severe bleeding, severe abdominal pain, a spinal cord or back injury, chest pain, a heart attack, a stroke, poisoning, a gunshot wound, a severe eye injury, or the sudden inability to breathe. There are many other acute conditions that NMHC considers an Emergency.

If you seek emergency care for an illness or injury that you believe requires immediate medical attention, the services will be covered by your Plan. Prior Approval is not needed for Emergency care. If your emergency results in you being admitted to the hospital, concurrent or retrospective Prior Approval will be required for the hospital Admission. If you are being admitted to an out-of-network hospital, you are responsible for contacting us to authorize your hospital stay once your emergency medical

Condition has been stabilized.

We will consider the following when determining whether a situation truly required emergency care:
- Would a reasonable person believe that the situation required immediate medical care and could not wait until the next working day or next available appointment with a PCP?
- What time of day was the care provided?
- What were the presenting symptoms?
- Are there any circumstances that prevented you from seeking emergency care from a Provider under established Plan guidelines?

You may have questions about acute illness other than an Emergency Medical Condition. You should contact your physician or other Provider before going to the emergency room, if possible.

What to Do in an Emergency
If you have an emergency, go to the nearest emergency room. Emergency Rooms are open twenty-four (24) hours a day, seven (7) days a week. If necessary, dial 911 for help. If you are able, tell the emergency room staff that you are a Plan Member and show them your ID Card. They can then contact us for you. In situations where you are unable to immediately notify NMHC, contact us as soon as you are able. We will provide direction and Prior Approval as needed.

Emergency Services at an Out-of-Network Provider or Facility
Emergency care should be obtained from the nearest available Provider or Facility, even if that Provider or Facility is not contracted with us. Emergency Services obtained from Out-of-Network Providers will be covered at your plans benefit level as if you had visited a Participating or In-Network Provider. Non-emergency services, such as follow-up care from a prior emergency require Prior Approval from NMHC. If you do not receive Prior Approval, NMHC may not pay for the services. If you are admitted to an Out-of-Network Facility, contact NMHC for Prior Approval. If you are not able to contact us, a family member or caregiver should contact us.

Some services NOT covered as Emergency Care from an Out-of-Network Provider include, but are not limited to:
- Elective or non-emergency care, including follow-up Care;
- Supplies, medications, and Durable Medical Equipment provided outside of the Service Area, except in an emergency or for an urgent illness, unless the need for care could not have been foreseen before leaving the Service Area;
- Care received after it is medically feasible to return to the Service Area.

If you are receiving Emergency care from an Out-of-Network Provider or Facility, you can transfer to an In-Network Facility or Provider to continue your care if it is safe for you to do so. Contact your Participating Provider to help make arrangements for a transfer.

Ambulance Service
If you need an ambulance, call 911 or your local ambulance service. Your Plan covers ambulance services for emergency services and Plan authorized medically necessary facility-to-facility transport if coordinated between NMHC and the provider. If ambulance services were used in a non-emergent situation and Prior Approval was not obtained from NMHC, you will be responsible for the charges.

PRIOR APPROVAL

Some services require NMHC's approval before care is received. The first step in the Prior Approval process is to confirm whether a treatment or service is a covered benefit under the Plan. If the service is not a covered benefit, the Prior Approval process cannot change this. You can confirm whether a treatment or service is covered by the Plan by reviewing this Benefit Booklet and your Summary of Benefits, or by contacting the Customer Care Center. Our Customer Care Center can answer questions that you or your provider may have regarding this process.

For covered Benefits and services that require approval, our Medical Management team will review your case and help determine whether the procedure, treatment or service being requested is Medically Necessary. Without Prior Approval, the services may not be covered.

Receiving Prior Approval for a service does not guarantee that the service will be paid for. For instance, if the number of services received exceeds the number of services approved in the Prior Approval or the Plan limits, services may not be covered. To ensure that the necessary Prior Approval is in place, contact the Customer Care Center before receiving services.

Who Obtains Approval from NMHC?

When a Participating Provider recommends care that requires Prior Approval, the Provider should contact us for approval. The Provider must submit information about your condition so we can review and determine whether the requested service is covered by the Plan, and if so, that it is Medically Necessary. We may need to talk to the Provider about the request.

To ensure that Prior Approval is in place, call the Customer Care Center before your scheduled service. Our Customer Care Center representatives can tell you which services require Prior Approval.

Failure to obtain Prior Approval may cause a delay of service or denial of claims.

How Does the Process Work?

NMHC requires Prior Approval for non-emergent hospital admissions and certain outpatient services. When we receive a request for Prior Approval, our Medical Management Department reviews the request using nationally recognized guidelines. These guidelines used by NMHC and practicing healthcare Providers are consistent with sound clinical principles. If guidelines do not exist for a certain service or treatment, resource tools based on clinical evidence are used.

Examples of services that require Prior Approval are:

- Non-emergent inpatient hospital admissions;
- Advanced imaging procedures, such as MRI, CT Scan, or PET Scans;
- Durable Medical Equipment (DME) and External Prosthetic Appliances (EPA) exceeding $1,000;
- Surgical Procedures;
- Specialty Treatments or Supplies; and
- Out-of-Network Services

Prior Approval Coverage Decisions

If we are not able to approve your Prior Approval request for clinical reasons, your case will be referred to a Medical Director before we notify you and your Provider of a disapproval. The Medical Director will consider your case and may speak with your Provider for more information. You and your Provider will be notified in writing if the request for Prior Approval cannot be approved based on the information we received, or if the Plan does not cover the service. If you disagree with the decision, you may appeal the decision through our formal Appeals Process, or have your Provider contact us to provide additional information.

When Does Prior Approval Review Occur?

Three types of Approval Review can occur:

- Prior Approval occurs when we receive a request before you receive care. Standard/Non-urgent service decisions are made within five (5) business days for all Standard/Non-urgent service decisions. We will send notice of the coverage decision to you and your Provider in writing.
- Concurrent review occurs when we receive a request for approval while you are receiving care; for example, in a hospital, skilled nursing facility or rehabilitation facility. Decisions are made within twenty-four (24) hours of receipt of the review

request. We will send notice of the coverage decision to you and your Provider in writing.

- Retrospective review occurs when we receive a request for approval after you have received care. Decisions related to these services are made within thirty (30) days of receiving all of the necessary information.

Prior Approval for Immediately Needed (Expedited) Care

If you have a medical Condition or situation that requires a Prior Approval decision to be made right away, we will perform an expedited review. For urgent or emergent situations, pre-service or concurrent review and determinations will be made within 24 hours of receiving the request.

WHAT IS COVERED BY THE PLAN?
Your Plan covers Medically Necessary healthcare services. Some services require Prior Approval. Please refer to the "Prior Approval" section in this Benefit Booklet or contact the Customer Care Center for questions regarding Prior Approval. Some services may also have limitations. Refer to your Summary of Benefits for dollar, visit, and/or Provider limitations.

As a member of NMHC, you are required to pay your Copayment, Coinsurance and Deductible amounts.

All services in this section are covered by the Plan. Please refer to other sections of this Benefit Booklet for information about other covered Benefits, for example, emergency and urgent care. Please also refer to your Summary of Benefits or call the Customer Care Center for more information.

Acupuncture
Acupuncture must be provided by a licensed Participating Provider unless covered services are unavailable in your area and a prior approval is received to see an out-of-network provider. Services must be appropriate for the treatment of a Condition that is covered by the Plan. Coverage is limited to 30-visits per Calendar year. This limit is combined with services received from Chiropractic provider, massage therapists and Rolfers. Please refer to your Summary of Benefits for your cost sharing (Deductible, Coinsurance, Copayment) amount.

Allergy Treatment
The Plan covers Benefits for direct skin (percutaneous and intradermal) and patch allergy tests and radioallergosorbent testing. Includes testing and sera. Prior Approval is required.

Alpha-fetoprotein IV Screening Test
The Plan will cover an alpha-fetoprotein IV screening test for pregnant women. The test screens for certain genetic abnormalities in the fetus. This test generally occurs between the sixteenth (16th) and twentieth (20th) week of pregnancy.

Ambulance Services
Ambulance transport is covered when it is necessary for an emergency. The Plan will review the ambulance and medical records to determine medical necessity. The use of an ambulance for non-emergent services requires Prior Approval from NMHC. If services were not Medically Necessary, or not approved by NMHC, you will be responsible for the charges.

Autism Spectrum Disorder
The Plan covers the diagnosis and treatment of Autism Spectrum Disorder for members up to age nineteen; or for members up to age twenty-two years if they are enrolled in high school. Coverage includes well-baby and well-child screenings for the diagnosis; treatment by means of speech, occupational, and physical therapy; and applied behavioral analysis. Coverage is limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan. A treatment plan developed by your provider must contain diagnosis, proposed treatment by types, the frequency and duration of treatment, anticipated outcomes stated as goals, the frequency with which the treatment plan will be updated, and the signature of the treating physician.

Care that is received under the Individuals with Disabilities Education Improvement Act of 2004 is not covered by this Plan. Special education and services that are the responsibility of the state and local school boards are not covered by this Plan. Speech, occupational and physical therapy, and applied behavioral analysis therapy require Prior Approval by NMHC.

Bariatric Surgery
Bariatric Surgery means surgery that modifies the gastrointestinal tract with the purpose of decreasing calorie consumption and therefore decreasing weight. Before pursuing bariatric surgery, a complete nutritional, behavioral and medical evaluation must be done. Indications include a Body Mass Index (BMI of 35kg/m2 or greater with other serious illnesses such as diabetes, high blood pressure or obstructive sleep apnea. **Prior Approval** is required and services must be performed at in In-network facility that is designated by NMHC.

Biofeedback
Biofeedback is a benefit when prescribed for the following physical conditions only: chronic pain treatment, Raynaud's Disease/Phenomenon, tension headaches, migraines, urinary incontinence and Craniomandibular Joint (CMJ) or

Temporomandibular Joint (TMJ) disorders. Biofeedback is a benefit only when provided by a Medical Doctor, a Doctor of Osteopathy, or a professional Psychologist**.**

Benefits for Covered biofeedback services, including office calls, are limited to the conditions listed above and require prior authorization.

Behavioral and Mental Health Services
Services for the treatment of behavioral/mental health are covered by the Plan on an outpatient basis for treatment, outpatient testing and assessment. Inpatient and partial hospitalization for psychiatric care are covered when Medically Necessary for the acute stabilization of a mental illness.

Providers or facilities offering Behavioral and Mental Health treatment must be qualified to treat mental illness. Some services require Prior Approval by NMHC.

Please refer to your Summary of Benefits for level of Covered Services.

Cancer Clinical Trials
The Plan provides coverage for Medically Necessary routine patient care at a New Mexico facility, incurred as a result of the Member's participation in a clinical trial if:

- The clinical trial is undertaken for the purpose of prevention, early detection or treatment of cancer for which no standard cancer treatment exists or more effective standard cancer treatment exists;
- The clinical trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology;
- The clinical trial is being provided in this state as part of a scientific study of a new therapy or intervention that is being conducted at an institution in this state and is for the treatment, palliation or prevention of cancer in humans with: specific goals; a rationale and back ground 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 that the treatment will be at least as efficacious as standard cancer treatment;
- The clinical trial is being provided as part of a clinical trial being conducted in accordance with a clinical trial approved by at least one of the following: (a) One of the federal National Institutes of Health; (b) A federal National Institute of Health Cooperative Group or center; (c) The United States Food and Drug Administration in the form of an investigational new drug application; (d) The United States Department of Defense; (e) The United States Department of Veteran Affairs; or (f) A qualified research entity that meets the criteria established by the federal National Institutes of Health for grant eligibility;
- The clinical trial or study has been reviewed and approved by an Institutional Review Board that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the federal National Institutes of Health;
- The personnel providing the clinical trial or conducting the study (a) Are providing the clinical trial or conducting the study within their scope of practice, experience and training and are capable of providing the clinical trial because of their experience, training and volume of patients treated to maintain their expertise; (b) Agree to accept reimbursement as payment in full from NMHC and that is not more than the level of reimbursement applicable to other similar services provided by the In-Network Providers within our provider network; (c) agree to provide written notification to the health plan when a patient enters or leaves a clinical trial;
- There is no non-investigational treatment equivalent to the clinical trial; and the available clinical or preclinical data provide a reasonable expectation that the clinical trial will be at least as efficacious as any non-investigational alternative; and there is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial will be at least as effective as any other medical treatment.

Pursuant to the patient informed consent document, no third party is liable for damages associated with the treatment provided during a phase of a clinical trial.

If a member is denied coverage of a cost and contends that the denial is in violation of NM law, the member may appeal the decision to deny the coverage of a cost to the Superintendent of Insurance and that appeal shall be expedited to ensure resolution of the appeal within no more than thirty 30-days after the date of the appeal to the Superintendent of Insurance.

For the purposes of this specific Covered Benefit and Service, the term "Routine Patient Care Cost" means:

- A medical service or treatment that is a benefit under the Plan that would be covered if the patient were receiving standard cancer treatment; or
- A drug provided to a patient during a clinical trial if the drug has been approved by the United States Food and Drug Administration, whether or not that organization has approved the drug for use in treating the patient's particular Condition, but only to the extent that the drug is not paid for by the manufacturer, distributor or Provider of the drug.

Routine Patient Care Cost does not include:

- The cost of an investigational drug, device or procedure;
- The cost of a non-healthcare service that the patient is required to receive as a result of participation in the clinical trial;
- Costs associated with managing the research that is associated with the clinical trial;
- Costs that would not be covered by the patient's if non-investigational treatments were provided; or
- Costs paid or not charged for by the clinical trial Providers.

Cardiac and Pulmonary Rehabilitation
This plan covers outpatient cardiac rehabilitation programs provided within six-months of a cardiac incident and outpatient pulmonary rehabilitation services. Prior authorization is required.

Childhood Immunizations
This Plan provides coverage for childhood immunizations, as well as coverage for Medically Necessary booster doses of all immunizing agents used in child immunizations, in accordance with the current schedule of immunizations recommended by the American Academy of Pediatrics.

Chiropractic Care
Chiropractic Care must be provided by a licensed Participating Provider unless covered services are unavailable in your area and a prior approval is received to see an out-of-network provider. Services must be appropriate for the treatment of a condition that is covered by the Plan. Coverage is limited to 30-visits per Calendar Year. This limit is combined with services received from Acupuncturists, massage therapists and Rolfers. Please refer to your Summary of Benefits for your Cost Sharing (Deductible, Coinsurance, Copayment) amount.

Circumcision of Newborn Males
The Plan will cover circumcision of newborn males whether the child is natural or adopted or in a "placement for adoption" status.

Colorectal Cancer Screening
The Plan will provide coverage for colorectal screenings to determine the presence of precancerous or cancerous conditions and other health problems.

Compression Garments
The Plan covers gradient or graduated compression garments as Medically Necessary when prescribed by a contracted physician for the treatment of a medical Condition. Such Conditions may be lymphedema, varicose veins, deep vein thrombosis or venous ulcers. The garments must be obtained from a Plan Participating Provider. Garments that are/or can be obtained over the counter, or without a prescription are not covered. Prior Authorization needed for services over $1,000. Replacement of a covered garment is limited to once every 6-months, except for support hose, which are limited to 12 pair (or 24 **hose**).

Consumable Medical Supplies
Consumable medical supplies are only covered during hospitalization, an office visit, or an approved home health visit. The Plan does not cover these supplies when used at other times by the Member or Member's family.

Consumable medical supplies are supplies that:

- Are usually disposable;
- Cannot be used repeatedly by more than one person;
- Are normally used for a medical purpose;
- Are generally useful only to a person who is ill or injured;

- Are ordered or prescribed by a licensed and qualified Provider.

Coverage for Individuals Participating in Approved Clinical Trials
Members are eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either (1) the referring healthcare professional is a participating provider and has concluded that the member's participation in such trial would be appropriate; or (2) the member provides medical and scientific information establishing that the member's participation in such a trial would be appropriate.

NMHC may not deny an eligible member's participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. NMHC may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial. NMHC may not discriminate against the individual on the basis of the individual's participation in the trial.

Craniomandibular Joint (CMJ) and Temporomandibular Joint (TMJ) Dysfunction Conditions
The Plan provides coverage for surgical and non-surgical treatment of temporomandibular joint disorders and craniomandibular disorders, subject to the same conditions, limitations, and prior review procedures that apply to treatment of any other joint. The Plan does not cover orthodontic treatment and appliances, crowns, bridges and dentures used for treatment of these disorders unless the disorder is caused by trauma. If caused by trauma, the member must receive initial treatment within 90-days of the accident and completion of treatment within 180 days. Subsequent covered treatment can be extended to 12 months from the accident date if it is determined to be medically necessary to occur within this time period.

Dental Services
This Plan will cover the following Medically Necessary dental services, when Prior Approval is obtained:
- An accidental injury from an outside force to sound, natural teeth, the jawbones or surrounding tissues. A sound tooth is a tooth that does not have significant decay or prior trauma; such as a filling, cap or crown. Any services required after the initial treatment must be associated with the initial accident in order to be covered (unless treatment must be delayed due to dental necessity as determined by NMHC).
- For coverage of accidental injury of the teeth, the member should receive initial treatment within 90-days of the accident and completion of treatment within 180 days. Subsequent covered treatment can be extended to 12 months from the accident date if it is determined to be medically necessary to occur within this time period.
- Treatment of tumors and cysts that require pathological examination of the jaws, cheeks, lips, tongue, or the roof and floor of the mouth.
- Hospitalization and general anesthesia for dental services provided in a hospital or ambulatory surgical center when Medically Necessary or:
    - The Member exhibits a physical, intellectual or medically compromising condition for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result, and for which dental treatment under general anesthesia can be expected to produce superior results;
    - Local anesthesia is ineffective for the Member due to an acute infection, anatomic variation or allergy;
    - The Member is a Covered dependent child age nineteen (19) or younger who is extremely uncooperative, fearful, anxious or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred, and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity;
    - The Member has extensive oral; facial; or dental trauma for which treatment under local anesthesia would be ineffective or compromised; or
    - Other dental procedures for which hospitalization or general anesthesia in a hospital or ambulatory surgical center is Medically Necessary.

Copayments, Coinsurance and Deductible amounts listed in your Summary of Benefits will apply. Routine dental care is not covered by your Plan.

Diabetes Supplies and Treatment
The Plan covers Diabetic Supplies and Treatment when used to treat insulin dependent diabetes, non-insulin dependent diabetes, or high blood glucose levels induced by pregnancy subject to Plan cost-sharing amounts. Examples of treatment and

supplies include:

- Insulin pumps and pump supplies
- Continuous blood glucose monitors
- Aids for the visually impaired;
- Podiatric appliances for the prevention of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; Podiatric appliances require prior Approval to determine medical necessity;
- Physician visits and post-diagnosis follow-up care;

The following Diabetic Supplies and Treatment are covered under Express Scripts. Call Express Scripts at 1-800-498-4904 for details.

- Syringes.
- Blood glucose monitors
- Test strips;
- Visual reading urine and ketone strips;
- Glucagon emergency kits;
- Insulin;
- Prescriptive oral agents;
- Injection aids
- Lancet and lancet devices;

When prescribed or diagnosed by a healthcare practitioner, all individuals with diabetes shall be entitled to self-management training provided by a certified, registered or licensed healthcare profession with recent education in diabetes management, limited to:

- Diabetes self-management training that shall be provided by a certified, registered or licensed healthcare professional with recent education in diabetes management, which shall be limited to:
    - Medically Necessary visits upon diagnosis of diabetes;
    - Visits following a physician diagnosis that represents a significant change in the patient's symptoms or condition that warrants changes in the patient's self-management;
    - Visits for re-education or refresher training is prescribed by a healthcare practitioner with prescribing authority and Medical nutrition therapy related to diabetes management.

Contact the Customer Care Center for questions regarding these requirements at 1-877-210-8213.

Diagnostic Services
Laboratory, x-ray and other diagnostic tests are covered when Medically Necessary. Some services require Prior Approval by NMHC.

Dialysis Services
The plan covers acute and chronic dialysis services including renal dialysis (hemodialysis) and continuous ambulatory peritoneal dialysis (CAPD) by approved dialysis providers. Services require prior authorization.

Durable Medical Equipment (DME)
DME is covered by NMHC. All DME exceeding $1,000 is subject to prior authorization.

Coverage includes the rental or purchase of DME, at our option. Examples of DME include, but are not limited to crutches, hospital beds, oxygen equipment, wheelchairs, and walkers.

Durable Medical Equipment should also be able to withstand repeated use; be reusable by other people; be used to serve a medical purpose; and not be generally useful to a person who is not ill or injured.

Some exclusions and limitations to DME coverage:

- Coverage is for medically appropriate equipment only, and does not include special features, upgrades or equipment

accessories unless Medically Necessary;
- The Plan covers the rental or purchase of Medically Necessary DME, including repair and adjustment of DME. We will not cover repairs that exceed the purchase price. Repair of DME or prosthetic or orthotic devices that were previously owned by the Member and not supplied to them through the Plan may be covered, except as defined under Diabetes Supplies and Treatment. Coverage for these repairs is be at the discretion NMHC;
- NMHC follows guidelines established by Medicare for the lifetime of DME. Equipment is expected to last at least five (5) years;
- Replacement due to loss, theft, misuse, abuse, or destruction is not covered. The Plan does not cover replacement in cases where the patient improperly sells or gives away the equipment;
- The Plan does not cover replacement of DME solely for warranty expiration, or new and improved equipment becoming available. The Plan does not cover duplicate or extra DME for the purpose of member comfort, convenience or travel. Surgically implantable devices and prostheses are covered under the surgery benefit as follows:
- Surgically implanted prosthetics or devices, including penile implants required as a result of illness or injury;
- Implantable mechanical devices such as cardiac pacemakers or defibrillators, insulin pumps, epidural pain pumps, and neurostimulators;
- Intra-ocular lenses;
- Teflon/dacron surgical grafts and meshes; and
- Artificial or porcine heart valves.

Enteral Nutrition Products
The Plan covers enteral nutrition products and related DME and supplies required to deliver the Medically Necessary enteral nutrition. The enteral nutrition must be prescribed by a physician; administered via tube feeding; and must be the primary source of nutrition for the member. The Plan does not cover oral nutrition products even when prescribed or administered by a physician.

Foods obtained from a grocery store or internet provider will not be covered as Special Medical Foods.

External Prosthetic Appliance (EPA)
The Plan covers EPA that is necessary to accomplish ordinary activities of daily living. EPA requires Prior Approval by NMHC. External Prosthetic Appliances are artificial substitutes worn on, or attached to the outside of the body; are used to replace a missing part (such as the leg, arm, or hand); or are needed to alleviate or correct an illness, injury, or congenital defect.

The following exclusions and limitations apply to EPA coverage:
- The Plan covers EPA for K1-3 ambulators. EPA for Level 0 or Level 4 ambulators are not covered;
- This Plan covers replacement of EPA if it is needed due to normal body growth or for changes due to illness or injury;
- The Plan follows Medicare guidelines to determine the lifetime of EPA;
- The Plan covers pre-fabricated EPA unless there is clinical documentation supporting that custom EPA is Medically Necessary. This includes upgrades or accessories that do not serve a therapeutic purpose;
- EPA for the purpose of being able to participate in recreational or leisure activities is not covered;
- EPA for the purpose of being able to play a sport is not covered;
- Repair or replacement of EPA is covered if it is Medically Necessary as determined by NMHC;
- Repair or replacement of EPA is not covered if due to loss, theft or destruction;
- The Plan does not cover duplicate or extra EPA for Member convenience or comfort.

Family Planning Services
Family Planning Services are covered by the Plan. Some covered services include contraceptive counseling and contraceptive drugs or devices approved by the Food and Drug Administration (FDA). Many FDA approved contraception methods are covered at no cost to you. NMHC must cover without cost sharing at least one form of contraception in each of the methods (currently 18) that the Food and Drug Administration has identified for women in its current Birth Control Guide. This coverage must also include the clinical services, including patient education and counseling, needed for provision of the contraceptive method.

Growth Hormone Therapy
Growth Hormone Therapy may be covered if an endocrinologist provides medical records that support the request for the

Growth Hormone Therapy. Therapy must be for a medical diagnosis covered by the Plan. This Plan does not cover growth hormone treatment for children with idiopathic short stature.

Habilitative Services
Healthcare services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Services require Prior Approval after ten (10) visits. Covered services are limited to treatment for Autism Spectrum Disorder.

Hearing Aids for Dependent Children
The Plan covers hearing aids and the evaluation for the fitting of Hearing Aids only for Dependent children up to age eighteen (18), or up to age twenty-one (21) if still attending high school up-to $2,200 every 36-months "per hearing impaired ear". After this, the member pays 90% coinsurance. Covered services include fitting and dispensing fees, and ear molds, as necessary to maintain optimal fit of the hearing aids. Services must be provided by an audiologist, hearing aid dispenser or physician. This benefit does include repair and replacement of hearing aids.

Hearing Aids for Adults
For those who are not within the above age-range, benefits are limited for each member to a maximum of $500 in benefit payments during any 36-months period. After this, the member pays 90% coinsurance. The 36-month period begins on the date you purchase your first hearing aid and ends three years later. This benefit includes repair and replacement of hearing aids. Routine hearing examinations and related services are not covered for members age 21 and older.

Hearing Care
Hearing exams are covered when they are used to diagnose and treat ear injuries or diseases of the ear. Routine hearing screenings from a Primary Care Practitioner are covered for Members up to age eighteen (18).

Home Health Care Services
Home Health Care services are covered for a member that is confined to the home, and that requires Skilled Care and is unable to receive medical care on an Ambulatory outpatient basis. Home Health Care services must be provided on the written order of a licensed physician, provided such order is renewed at least every sixty (60) days. Services must be delivered by a licensed and qualified Provider. Prior authorization is required.

Home Health Care services include:
- Visits from professional nurses including but not limited to registered nurses, licensed professional nurses, and other participating health professionals such as physical, occupational and respiratory therapists, speech pathologists, home health aides, social workers and dieticians;
- The administration or use of consumable medical supplies and DME by professional staff during an approved home health care visit;
- Covered Drugs prescribed by a Participating Provider for the duration of Home Health Care Services; and
- Laboratory services.

Physical, occupational, respiratory, and speech therapy provided in the home will be covered when Prior Approval is obtained from NMHC. These are limited to services provided on the written order of a Physician.

Home Health Care Services/Home Intravenous Services and Supplies
Private duty nursing is not Covered. Custodial Care needs that can be performed by non-licensed medical personnel to meet the normal activities of daily living do not qualify for Home Health Care Services and are not Covered. Examples of Custodial Care that are not Covered include, but are not limited to, bathing, feeding, preparing meals, or performing housekeeping tasks.

Hospice Care Services
Hospice services due to terminal illness are covered by the Plan. The services must be provided under a hospice care program and by a licensed and qualified Provider.

Services must be provided by an approved Hospice program during a Hospice benefit period and will not be Covered to the

extent that they duplicate other Covered Services available to you. Benefits that are provided for by a Hospice or other facility require approval by your Practitioner/Provider and our Prior Approval.

The Hospice benefit period is defined as follows:
- Beginning on the date your Practitioner/Provider certifies that you are terminally ill with a life expectancy of six months or less.
- Ending six months after it began, or upon your death.
- You must be a Covered Member throughout your Hospice benefit period.

The following services are Covered:
- Inpatient Hospice care
- Practitioner/Provider visits by Certified Hospice Practitioner/Providers
- Home Health Care Services by approved home health care personnel
- Physical therapy
- Medical supplies
- Bereavement counseling is limited to three sessions during the hospice benefit period.
- Prescription Drugs and Medication for the pain and discomfort specifically related to the terminal illness
- Respite care for a period **not to exceed ten continuous days** for **every 60-day** hospice benefit period and **no more than two respite care periods** during each hospice benefit period.

This Plan does not cover (Exclusions):
- Food, housing, or delivered meals
- Homemaker and housekeeping services
- Comfort items
- Private duty nursing
- Supportive services provided to the family of a Terminally Ill Patient when the members benefit has ended.

Where there is not a certified Hospice program available, regular Home Health Care Services benefits will apply.

Illness and Injury
The Plan will cover Primary care and Specialist services for the diagnosis and treatment of an illness or injury.

Implanted Medical Devices
Implanted medical devices must receive Prior Approval from NMHC. They must be ordered by an In-Network Provider. These devices include but are not limited to pacemakers, artificial hip joints, cochlear implants and cardiac stents.

Coverage consists of permanent or temporary internal aids and supports for defective body parts. The Plan will also cover the cost for repairs or maintenance of covered appliances.

Infertility Treatment
The Plan will cover the diagnosis and treatment of a physical condition causing infertility, with limitations. Please refer to the Exclusions section of the Benefit Booklet for more information regarding exclusions. Infertility services are covered only when provided by an In-Network, Participating Provider. Please refer to the Exclusions section of this Benefit Booklet for services that are not covered. Benefits related to infertility are limited to testing, diagnosis, and corrective procedures that only secondarily treat infertility, and are limited to:

- Surgical treatments such as opening an obstructed fallopian tube epididymis or vas deferens when the obstruction is not the result of a surgical sterilization
- Surgical treatment of abnormalities of the uterus that impair fertility
- 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 consider for benefit payment.

Diagnostic testing is covered only to diagnose the cause of infertility. Once the cause has been established and the treatment determined to be noncovered, no further testing is covered.

Inpatient Acute Care Hospital Services
Inpatient hospital services require Prior Approval from NMHC. Services include the treatment and evaluation of conditions for which outpatient care would not be appropriate.

Inpatient Long Term Acute Care Hospital Services
Long Term Acute Care hospitals provide longer-term inpatient care that cannot be treated at a facility with a lower level of care. Such services may include pulmonary care, advanced wound care, and critical care. Stays at a Long Term Acute Care (LTAC) hospital require Prior Approval from NMHC.

Inpatient Rehabilitation Hospital Services
Inpatient services at an acute rehabilitation facility are covered by the Plan. Services require Prior Approval from NMHC and must be rendered by a licensed and qualified Provider.

Internal Prosthetics
Internal prosthetics and/or medical appliances are covered when ordered by a Physician and require Prior Approval from NMHC.

Jaw or Facial Surgery
Surgery must be for the correction of a significant functional disorder. Skeletal deformities must be the result of an accidental injury, a congenital or developmental defect, or disease of the jaw and/or facial bones. Dental procedures, orthodontic braces, and surgery to improve appearance or other services determined to not be Medically Necessary are not covered under the Plan.

Massage Therapy
Only services administered by a Licensed Massage Therapist, licensed Physical Therapist, a medical doctor, a Doctor of Osteopathy, a Doctor of Oriental Medicine, or a Chiropractor operating under the scope of their license on an Outpatient basis are a Covered Service if necessary for treatment of an illness or Accidental Injury. Coverage is limited to 30-visits per Calendar Year. This limit is combined with services received from Acupuncturists, Chiropractors, and Rolfers. *No* benefits are paid for Maintenance Therapy.

Maternity Care
Your Plan covers maternity services, including pre and postnatal care. Care received during the postpartum period for a normal delivery, spontaneous abortion (miscarriage), and complications of pregnancy are also covered by the Plan. Coverage for the mother is for at least forty-eight (48) hours of inpatient care following a vaginal delivery and at least ninety-six (96) hours following a Cesarean section. A decision to reduce the period of inpatient care for the mother or the newborn child must be made by the attending physician, and in consultation with the mother. An extended newborn stay (non-routine) after the mother has been discharged, will require a separate authorization and applies a separate inpatient admission cost share.

If a decision is made to reduce the hospital stay to less than forty-eight (48) hours for a vaginal delivery, or less than ninety-six hours for a Cesarean section, the Plan provides coverage for at least three (3) home care visits. If the attending physician or home care provider and the mother agree that fewer visits are sufficient, the number of visits can be reduced. Home care may include parental education, assistance and training in breast and bottle-feeding, and the administration of any appropriate clinical tests.

Home births are only covered when performed by a licensed and certified midwife or birthing center.

Maternity Transport
The Plan covers ground and/or air transport to the nearest available and licensed Healthcare Facility for medically high-risk pregnant women with an impending delivery of a potentially viable infant. The Plan also covers transport to the nearest available tertiary care facility when it is necessary to protect the life of the infant.

Morbid Obesity Treatment
Morbid Obesity is defined as a condition of weighing 100 pounds over a person's ideal body weight (Body Mass Index (BMI of 35kg/m2 or greater with other serious illnesses such as diabetes, high blood pressure or obstructive sleep apnea).

The Plan covers surgical treatment for morbid obesity if it is Medically Necessary and if defined medical criteria are met. Criteria varies dependent upon the type of surgery. NMHC utilizes Interqual and Hayes Technology Manual for this criteria. Services require Prior Approval from NMHC. Treatment for the maintenance of, or Medically Necessary reversal of a previously obtained surgical procedure may be covered with Prior Approval from NMHC.

Naprapathy
Services must be provided by a License Naprapathist and are limited to $500 in Plan payments per Calendar Year.

Newborn and Adopted Children Coverage
Newly born and adopted children of a Member are covered from the moment of birth or adoption if the newborn or adopted child is enrolled on the Plan within 31-days of the birth or placement for adoption. Please refer to the Enrollment section of this Benefit Booklet for more information.

The Plan covers injury or sickness in a newborn child. The child can be natural or adopted or in a "placement for adoption" status. This includes circumcision for newborn males, and the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Ground or air transportation to the nearest available tertiary care facility is covered when necessary to protect the life of the infant.

Nutritional Evaluation
The Plan covers dietary evaluations and counseling for the medical management of a disease, including obesity. Services must be obtained from a licensed and qualified provider or a registered dietician. Refer to the Exclusions section of this Benefit Booklet for more information.

Orally Administered Anti-Cancer Medications
This Plan provides coverage for orally administered anti-cancer medication used to slow or kill the growth of cancerous cells. Coverage of these medications are subject to the same Prior Approval requirements as intravenously administered injected cancer medications covered by the Plan. Orally administered medications cannot cost more than intravenously injected equivalent and intravenously injected medications cannot cost more than orally administered medications.

Organ Transplant Services
The Plan covers human organ and tissue transplant services when Prior Approval is obtained from NMHC and services are received from recognized Centers of Excellence facilities within the United States.

The recipient of an organ transplant must be a Member at the time of services. Benefits are not available when the Member is a donor. Benefits are not available if the recipient is not a Member. The term recipient is defined to include a Member receiving approved transplant-related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Coverage is subject to the conditions and limitations outlined in the Summary of Benefits and in this Benefit Booklet.

Definition of Transplant Services
Transplant services include medical, surgical and hospital services for the recipient. This Plan also covers organ procurement needed for human-to-human organ or tissue transplant. The types of transplants covered include, but are not limited to, kidney, kidney/pancreas, cornea, bone marrow/stem cell, heart, heart/lung, liver and pancreas.

Prior Approval
Transplant services require Prior Approval from NMHC. Prior Approval is based on an evaluation conducted by a Plan-approved transplant facility and on the relevant evidence-based medical guidelines.

A member may seek approval from the health plan for dual transplant listing. The second listing must be within a separate or different Organ Procurement Organization. While dual listing is approved, payment will be made to only one facility for the actual

transplant event.

Organ Procurement Costs
The Plan covers costs directly related to the procurement of an organ from a cadaver or from a live donor. Surgery needed for organ removal; organ transit and the organ transportation; hospitalization and surgery of a live donor are also covered by the Plan. Compatibility testing that is done prior to procurement is covered if it is determined to be Medically Necessary by NMHC.

Transplant Travel
Travel expenses incurred in connection with a pre-approved transplant are covered up to $10,000 per lifetime. Benefits for transportation, lodging, and food are available to Members only if they are the recipient of a Prior-Approved organ/tissue transplant from a Plan-approved Provider. Transplant Travel requires Prior Approval from NMHC.

Covered Travel expenses for a Member receiving a transplant include charges for:
- Transportation to and from the transplant site, including charges for a rental car used during a period of care at the transplant facility;
- Lodging while at, or traveling to and from the transplant site;
- Food while at, or traveling to and from the transplant site.

The Plan will also cover travel expenses for one companion to accompany the patient as described above. Patients that are minors are allowed travel Benefits for themselves, one or both parents, or a parent and a designated companion. A companion may be a spouse, domestic partner, a family member, a legal guardian, or any person not related to the Member but actively involved in the Member's care.

The following are specific travel expenses travel expenses excluded from coverage:
- Travel costs incurred due to travel within 60-miles of the Member's home;
- Laundry bills;
- Telephone bills;
- Alcohol or tobacco products; and
- Charges for transportation that exceed coach rates.

Immunosuppressive Drugs for Organ Transplants
The Plan covers inpatient immunosuppressive drugs for organ transplants. Outpatient immunosuppressive Prescription Drugs may be covered. Please refer to your Summary of Benefits and Prescription Drug Formulary for information regarding your Outpatient Prescription Drug Benefits.

Outpatient Hospital or Ambulatory Surgical Procedures
Your Plan covers outpatient hospital and/or ambulatory surgical procedures including operating, recovery and other treatment rooms, physician and surgeon services, laboratory and pathology services, pre-surgical testing, anesthesia and medical supplies. Services must be prescribed by your Primary Care Practitioner or attending healthcare professional. Services may be provided at a hospital, a physician's office, or any other appropriately licensed facility. The provider delivering services must be licensed to practice, and must be practicing under authority of the Healthcare Insurer, the medical group, an independent practice association or other authority as applicable by New Mexico law. Prior Approval is required.

Prescription drugs obtained on an Outpatient basis are **not Covered** under the medical portion of this Plan. If you have questions about your other Outpatient prescription drug benefits, contact Express Scripts at 1-800-498-4904.

Physician Office Visits
Services received in a physician's office may include treatment of an injury or illness, and even some minor surgical procedures. These services may be provided by a Primary Care Practitioner or a Specialist.

Podiatry
Foot care, including all routine services such as the treatment of flat foot conditions, supportive devices, accommodative orthotics, orthopedic shoes unless jointed to braces, partial dislocations, bunions except capsular or bone surgery, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet and the trimming of corns, calluses, or toenails are not

covered by the Plan unless Medically Necessary due to diabetes or other significant peripheral neuropathies.

Preventive Care Services
Age and gender specific preventive care and periodic health exams are covered by the Plan. Some examples of preventive care services are adult and child immunizations; annual physicals for men, women and children, educational materials or consultations from providers to promote a healthy lifestyle, glaucoma (periodic) eye tests for all persons up to age thirty-five (35) years, hearing screenings (for Members through age nineteen [19] and under), limited laboratory tests, listed as an A or B recommendation by the U.S. Preventive Services Task Force colorectal cancer screenings, radiological (periodic) tests, vision screenings performed by a Primary Care Practitioner for Members through age nineteen [19], and well-baby and well-child care including immunizations.

Although the A or B recommendations by the U.S. Preventive Services Task Force are covered at no charge for Preventive Care services, you may be charged office visit cost-sharing for other services provided during your visit. NMHC may not impose cost-sharing with respect to anesthesia services performed in connection with a preventive colonoscopy if the attending provider determines that anesthesia would be medically appropriate for a member.

A member's attending provider may determine whether a sex-specific recommended preventive service that is required to be covered without cost-sharing, under the Affordable Care Act and its implementing regulations, is medically appropriate for a particular individual. For example, providing a mammogram or Pap smear for a transgender man who has residual breast tissue or an intact cervix (and the individual otherwise satisfies the criteria in the relevant recommendation or guideline as well as all other applicable coverage requirements), NMHC provides coverage for the recommended preventive service, without cost sharing, regardless of sex assigned at birth, gender identity, or gender of the individual otherwise recorded by NMHC.

For a complete list of Preventive Care services, please visit the U.S. Preventive Services Task Force website at www.uspreventiveservicestaskforce.org.

Reconstructive Surgery
This Plan will cover Medically Necessary reconstructive surgery when needed for the correction of a functional disorder resulting from accidental injury or from a congenital defects or disease. Services require Prior Approval, and an improvement in physiologic function must be reasonably expected.

Residential Treatment Centers
Residential Treatment Centers are covered for adults age 18 & older only. Coverage is limited to 60-days per calendar year and 30 days per admit. 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.

NMHC 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 NMHC as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Rolfing
Rolfing is limited to services provided by a certified Rolfer. Coverage is limited to 30-visits per Calendar Year. This limit is combined with services received from Acupuncturists, Chiropractors, and Massage Therapists. *No* benefits are paid for Maintenance Therapy.

Routine Physical Exams
Routine physical exams are covered one (1) time per year.

Second Opinions
Second Opinions are covered according to your Plan Benefits.

Short-Term Rehabilitation Therapy
Short-Term Rehabilitation Therapy may include physical, speech, occupational, cardiac and pulmonary therapy. These therapies are covered when NMHC has determined that they are expected to result in significant improvement of a Member's physical condition within two (2) months of beginning therapy. These services may be needed as a result of an injury, surgery, or an acute medical Condition. Related occupational therapy is provided for the purpose of training Members to perform the activities of daily living. Services require Prior Approval.

Smoking Cessation Treatment
Quitting smoking isn't easy, but we are here to help. If you want to quit smoking, call the state's Quit Line at 1-800-QUITNOW (1-800-784-8669). The Quit Line:

- Is open from 6 a.m. to 10 p.m., 7 days a week;
- Provides services in Spanish and English, with translation available for other languages;
- Provides services for youth and adults;
- Is free of charge; and
- Is staffed by cessation specialists trained in serving diverse populations.

Callers are offered:

- A self-paced guide to walk through the steps of quitting;
- Comprehensive information on methods to promote quitting success;
- An individualized quit plan;
- Free Quit Kits to help participants stay on track with their quit plan between calls; and
- Unlimited telephone support, including optional follow-up calls from help line specialists.

The Plan also covers with no charge:

- Services necessary to identify tobacco use, and use-related conditions, and dependence;
- For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
    - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
    - All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

Please talk to your Primary Care Practitioner about your desire to quit smoking.

Skilled Nursing
Inpatient services at a skilled nursing facility must be Prior Authorized and furnished by a licensed and qualified Provider. Covered Services are limited to 60-days/visits per year as stated in the Summary of Benefits and may include semi-private room and board, skilled and general nursing services, physician visits, limited Rehabilitative therapy, X-rays, and administration of covered drugs, medications, Biologicals and fluids.

Special Medical Foods for Genetic Inborn Errors of Metabolism
Special medical foods include nutritional substances that are:

- Intended for the medical and nutritional management of a patient with limited capacity to metabolize ordinary food;
- Specifically processed or formulated to be distinct in one or more nutrients that is present in natural foods;
- Formulated to be consumed or administered internally; and
- Essential for optimal growth, health and metabolic homeostasis.

Special medical foods must be obtained from a Plan Participating Vendor or Provider, and must be prescribed by a physician for the treatment of an inborn error of metabolism.

The Plan will cover enteral nutrition products and related DME and supplies required to deliver the Medically Necessary enteral nutrition. The enteral nutrition must be prescribed by a physician and administered via tube feeding, and must be the primary

source of nutrition for the member. The Plan does not cover oral nutrition products even when prescribed or administered by a physician.

Substance Abuse Services
Your Plan covers alcohol and substance abuse treatment. Covered services may include alcohol and drug abuse detoxification; partial hospitalization; and rehabilitation services. Except in a life threatening emergency, alcohol and substance abuse admissions must be Prior Authorized by NMHC. Lifetime max of two-courses of treatment for all services combined. Inpatient maximum of 30-days per calendar year combined with partial hospitalization.

Vision Care
Eye exams are covered to diagnose and treat eye injuries or disease. The Plan will pay for contact lenses when Medically Necessary for the treatment of keratoconus in adults and children. The Plan will also pay for the first pair of contact lenses after Medically Necessary cataract surgery.

Well-Child Care
Well-Child and well-baby medical care, including immunizations are covered by the Plan. These preventive care services are covered at no charge, however; if other services are received during an office visit in which well-child or well-baby care is administered, cost-sharing may apply.

Women's Healthcare
Some covered services related to women's healthcare include, but are not limited to:

- Prenatal care, including nutritional supplements that are Medically Necessary and prescribed by a Physician;
- Mammograms for screening and diagnosis. These services include but are not limited to low-dose mammography screenings performed at a designated imaging facility; and mammograms for screening and diagnostic purposes, including but not limited to low-dose mammography screenings performed at designated and approved imaging facility. At a minimum, the Plan shall cover one mammogram annually at no charge.
- Cytologic Screenings (Pap tests) for women ages eighteen (18) and older for determining the presence of precancerous or cancerous Conditions and other health problems, or where clinical conditions warrant, non-routine Pap testing in females under the age of 18;
- Screening and vaccine for Human papillomavirus (HPV). An HPV screening is allowed once every three (3) years for women age thirty (30) and older. The HPV vaccine is available for girls age nine (9) to fourteen (14) or older; and for women who are at risk of cancer, or at risk of other health Conditions that can be identified through a Cytological Screening;
- Services related to the diagnosis, treatment, and appropriate management of osteoporosis when Medically Necessary;
- Breast and Ovarian cancer genetic testing and genetic counseling based on family history;
- Screening for gestational diabetes;
- Counseling for HIV and sexually transmitted diseases;
- Screening and counseling for interpersonal and domestic violence and abuse;
- Forty-eight (48) hours of inpatient care following a mastectomy; and twenty-four (24) hours of inpatient care following lymph node dissection for the treatment of breast cancer;
- Mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts; prostheses; and complications resulting from a mastectomy, including lymphedema;
- Direct access to qualified obstetric and gynecological care for female Dependents age thirteen (13) or older; and
- Termination of pregnancy.

SERVICES YOUR PLAN DOES NOT COVER (EXCLUSIONS)

Services that are not described in the *What Is Covered by the Plan?* section may not be covered by this Plan. If services are Medically Necessary and you are unsure of Plan coverage, contact the Customer Care Center at 1-877-210-8213.

Services and Benefits excluded from coverage under this Plan are listed below.

Amniocentesis, ultrasound, or any other procedures requested solely to determine the gender of a fetus, unless Medically Necessary to determine the existence of a gender-linked genetic disorder, are not covered by the Plan.

Any treatments, procedures, services, equipment, drugs, drug usage, devices or supplies that NMHC Medical Director determines are not Medically Necessary unless Prior Approval is obtained from NMHC are not covered.

Assistance in the activities of daily living, such as eating, bathing, and dressing are not covered by the Plan.

Autopsies and/or transportation costs for deceased Members are not covered by the Plan.

Benefits and services not specified in the *What This Plan Covers* section of this Benefit Booklet or in your Summary of Benefits are not covered by the Plan.

Care related to complications for a non-covered surgery in general, are not covered by the Plan.

Certain Services related to the treatment of mental illness and substance abuse conditions are not covered by the Plan. These excluded services include, but are not limited to, the following:

- Any court-ordered treatment or therapy, or any treatment or therapy ordered as a Condition of parole, probation or custody or visitation evaluations unless Medically Necessary and covered under the Services and Benefits section of this Benefit Booklet;
- Treatment of organic mental disorders associated with permanent dysfunction of the brain; developmental disorders, including but not limited to, developmental reading disorders, developmental delay and articulation disorder;
- Treatment, therapies, counseling, programs or activities of an educational nature;
- Treatment, therapies, counseling, programs and activities for borderline intellectual functioning;
- Treatment, therapies, counseling, programs and activities for occupational problems or vocational or religious counseling;
- Treatment, therapies, counseling, programs and activities related consciousness raising;
- Intelligence Quotient (I.Q.) testing;
- Group Home, Treatment Foster Care (TFC), Day Treatment, Multisystemic Therapy (MST), Family Stabilization (FST) and Comprehensive Community Support Services (CCSS);
- Services that are considered experimental and/or are not generally accepted by the medical community or proven to be safe and effective;
- Therapeutic schools and programs, including, but not limited to wilderness and other experimental programs; and
- Psychological testing on children requested by or for a school system, unless Medically Necessary.

Conditions for which state or local law mandates treatment in a public facility, or court-ordered services are not covered by the Plan. These are not covered unless they are ordered by the treating physician and approved by the Plan.

Cosmetics and health and beauty aids are not covered by the Plan.

Cosmetic therapy, drugs/medications or procedures for the purpose of changing appearance are not covered by the Plan. Examples of these services are:

- Surgical excision or reformation of sagging skin on any part of the body including, but not limited to, eyelids, face, neck, abdomen, arms, lips, or buttocks, unless medically necessary;
- Services for the enlargement, reduction, implantation or change in appearance of a part of the body, for instance, the breast, face, lips, jaw, chin, nose, ears or genitals;
- Hair transplantation;
- Chemical or laser face peels or abrasions of the skin;
- Removal of hair by electrolysis or other methods including lasers; and

- Any other surgical or non-surgical procedures that are primarily for the purpose of altering appearance and not performed for the purpose of correcting functional disorders resulting from accidental injury or from congenital defects or disease.

Custodial and domiciliary care are not covered by the Plan.

Dental Care: Dental x-rays, routine dental care including exams, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion are not covered by the Plan, except as otherwise described in the *"What Is Covered by the Plan?"* section of the Benefit Booklet regarding Dental Services and Craniomandibular Joint (CMJ) and Temporomandibular Joint (TMJ) Dysfunction Conditions. In the case of CMJ and TMJ Dysfunction Conditions, the Plan does not cover orthodontic treatment and appliances, crowns, bridges and dentures used for treatment of these disorders unless the disorder is caused by trauma. associated with the initial accident. For coverage of accidental injury, the patient should receive initial treatment within 90-days of the accident and completion of treatment within 180-days. Subsequent covered treatment can be extended to 12-months from the accident date if it is determined to be medically necessary to occur within this time period. Coverage for services will not be extended beyond 12-months from the accident date.

Diapers and incontinence supplies are not covered by the Plan.

Dietary supplements and nutritional formulae taken by mouth or feeding tubes are not covered by the Plan, except as otherwise described in the "What Is Covered by the Plan?" section under Enteral Nutrition Products.

Equipment that serves the comfort or convenience of the Member or the person caring for the Member is not covered by the Plan.

Infertility services are excluded from coverage including, but not limited to:
- In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and variations of these procedures;
- Surrogacy services, including the medical care of the surrogate mother, and the medical care of the surrogate mother's newborn child, unless and until that child becomes an eligible Dependent of the Subscriber as provided in the "Who May Enroll" section of this Benefit Booklet;
- Reversal of sterilization;
- Any costs associated with the collection, preparation or storage of sperm for artificial insemination, including donor fees, donor egg or sperm retrieval; and
- Infertility injectable and suppository medications are not covered by the Plan.

Fees for television, telephone, newborn infant photographs, and other such articles are not covered by the Plan.

Foot care including all routine services such as the treatment of flat foot conditions, supportive devices, accommodative orthotics, orthopedic shoes unless jointed to braces, partial dislocations, bunions except capsular or bone surgery, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet, and the trimming of corns, calluses, or toenails are not covered by the Plan unless Medically Necessary Due to diabetes or other significant peripheral neuropathies.

Homemaker services and non-skilled nursing care are not covered by the Plan.

Home Health Care Services does not cover Private duty nursing and Custodial Care needs that can be performed by non-licensed medical personnel to meet the normal activities of daily living. Examples of Custodial Care that are not Covered include, but are not limited to, bathing, feeding, preparing meals, or performing housekeeping tasks.

Infant or baby food, formula or breast milk or other regular grocery products that can be processed for oral feedings are not covered by the Plan.

Injuries sustained in the course of committing a criminal act are not covered by the Plan.

Medical and hospital care and related costs for the infant child of a Dependent, unless the infant child is otherwise eligible for coverage under the Plan, are not covered by the Plan.

Medical, surgical or other healthcare procedures and treatments that are experimental, unproven, ineffective or investigational treatment as determined by the Medical Director and in accordance with peer-reviewed published medical and scientific literature and the practice of the national medical community are not covered by the Plan. See Cancer Clinical Trials in this Benefit Booklet for exceptions to this exclusion.

This exclusion is for:

- Any procedures or treatments that are not recognized as conforming to accepted medical practice;
- Any procedures or treatments in which the scientific assessment of the technique, or its application for a particular Condition, has not been completed or its effectiveness has not been established;
- Any procedures or treatments for which the required approval of a governmental agency has not been granted at the time the services are given;
- Cancer chemotherapy or other types of therapy that are subject to ongoing phase I, II or III clinical trials, except when the chemotherapy is prescribed under medical research protocol and submitted to regional and national databases; and
- Therapy administered under experimental protocols.

Membership costs or fees associated with health clubs and loss clinics, physical conditioning programs, exercise programs or equipment, personal trainers, software designed to promote good health and activity, and the use of club swimming pools for therapy are not covered by the Plan.

Modifications or installations to building and related structures and vehicles are not covered by the Plan. Some examples are stairway lifts, ceiling-mounted lifts, and wheelchair lifts.

Non-emergency care when traveling outside the United States of America is not covered by the Plan.

Non-medical ancillary services such as vocational or educational rehabilitation, behavioral training, sleep therapy, job counseling, psychological counseling and training, or educational therapy for learning disabilities or mental impairment are not covered by the Plan.

Non-medical, non-approved expenses for personal services or comfort items are not covered by the Plan. Examples of these services are charges for legal counsel, hotel accommodations, meals, telephone charges and reimbursement for lost wages.

Non-Prescription formulas for food allergies or food intolerances are not covered by the Plan.

Nursing home care, except for those services with Prior Approved by the Plan and is provided in a skilled nursing facility, is not covered by the Plan.

Penile implants are not covered by the Plan, unless the result of accidental injury or illness. Prior authorization is required.

Personal or comfort items such as personal care kits provided at a hospital, are not covered by the Plan.

Private hospital rooms and/or private duty nursing, unless determined to be Medically Necessary by NMHC Medical Director, are not covered by the Plan.

Replacement of Durable Medical Equipment due to loss, theft, misuse, abuse, destruction, warranty expiration, new/improved equipment availability, or sale of the equipment is not covered by the Plan.

Routine refractions, eyeglasses, corrective lenses, other eye appliances, and eye exercises are not covered by the Plan.

Services and/or supplies received prior to and after dates of coverage under the Plan are not covered by the Plan.

Services for which other coverage is required to provide or reimburse; including but not limited to Workers' Compensation, automobile insurance or similar coverage; is not covered by the Plan.

Services from a Provider that are not within his or her scope of practice, are not covered by the Plan.

Services and/or supplies received from an Out-of-Network Provider for which a Prior Approval was not obtained and are not for urgent/emergent care, are not covered by the Plan.

Services not generally recognized as Medically Necessary, such as:
- HCG (Human Chorionic Gonadotrophin) injections to increase ovulation;
- Hair analysis; and
- Reversal of voluntary sterilization are not covered by the Plan.

Services not primarily medical in nature, or supplies or equipment that are primarily and customarily used for a non-medical purpose as determined by the Plan Medical Director, are not covered by the Plan.

Services that are primarily for rest, domiciliary or convalescent care, are not covered by the Plan.

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

Surgical treatments for the correction of a refractive error, including radial keratotomy, and laser vision correction; or the fitting of eyeglasses are not covered by the Plan.

Travel, lodging and other related expenses, except as defined in this Benefit Booklet, are not covered by the Plan.

Treatment for sexual dysfunction, including but not limited to medications, counseling and clinics, is not covered by the Plan.

Treatment of an immediate family member, or engagement in self-treatment absent an emergency or a short-term situation involving a minor problem in which a qualified physician is not available, is not covered by the Plan.

Treatment or services provided in connection with, or to comply with, police detention, court orders or other similar arrangements are not covered by the Plan.

Treatment that results from an injury or illness that arises out of, or as the result of employment for wage or profit, regardless of whether such treatment is covered by any Workers' Compensation or other similar coverage or if covered, whether such treatment is found compensable thereunder, is not covered by the Plan.

If you are uncertain about a treatment or service and whether or not it is excluded, contact the Customer Care Center before the treatment or service is provided. Services Benefits that are not described in this Benefit Booklet and/or the Summary of Benefits are not covered by the Plan.

MEMBER COST-SHARING REQUIREMENTS

Cost-sharing amounts include deductibles, coinsurance, copayments and any other expense required of a Member. Cost-sharing amounts listed in your Summary of Benefits. Your cost-sharing amounts will vary depending on the type of service you receive.

Copayments

A Copayment, or copay, is a fixed dollar amount that you must pay each time you obtain a particular Covered Service. After you pay your Copay, NMHC pays the rest of the charges. Your Summary of Benefits contains your Plan's Copayment amounts, if any.

Coinsurance

Coinsurance is a percentage of charges that is paid partially by NMHC and partially by the Member. Coinsurance amounts continue to be the responsibility of the member after the Plan Deductible has been met. Your Summary of Benefits contains your Coinsurance amounts, if any.

Coinsurance is due after services have been provided and the claim has been processed. Coinsurance is calculated based on the total amount of the claim paid. It is your responsibility to pay your Provider the Coinsurance amount and keep receipts as your proof of payment.

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.

Annual Deductibles

Your Annual Deductible is the amount that you are required to pay for certain services before Benefits are paid by NMHC. Please refer to your Summary of Benefits for your Deductible amount. Services that have a Copayment do not apply toward your Deductible. Your Annual Deductible runs on a 12-month period per your employer's agreement with NMHC with a Calendar Year Accumulation.

Individual Deductible

Your Annual Deductible is the amount that you are required to pay for certain services before Benefits are paid by NMHC. The deductible amounts are indicated on your *Summary of Benefits.*

Family Deductible

An entire family meets the applicable annual deductible when the total deductible amount reaches two times the amount specified as being "Individual" on the *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.

Annual Out-of-Pocket Maximums

Your Plan has an Annual Out-of-Pocket Maximum to protect you from the high cost of a catastrophic illness. Having an Out-of-Pocket Maximum means that you will not pay more than a specified amount each year in Deductible, Copayment and Coinsurance charges. Refer to your Summary of Benefits for your Plan's Out-of-Pocket Maximum amount. Your Annual Out-of-Pocket Maximum runs on a 12-month period per your employer's agreement with NMHC on a Calendar Year Accumulation.

Some expenses, such as charges above Usual, Customary and Reasonable amounts, do not apply to your Out-of-Pocket Maximum.

Once the In-Network Out-of-Pocket Maximum has been met, we will pay 100% of the Allowable Charges for Covered Services received from In-Network Providers. Plan benefit maximums will still apply.

Individual Out-of-Pocket Maximums

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

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

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

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

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

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

SUMMARY OF HEALTH INSURANCE GRIEVANCE PROCEDURES

If you have an inquiry or a concern about any preauthorization request, claims payment, claims that have been denied or only partially paid, the quality of care you receive, the cancellation of your coverage, or any other review decisions made by NMHC, call the NMHC NM Public Schools Insurance Customer Care Center toll-free at 1-877-210-8213. Many complaints or problems can be handled informally by calling, writing, or e- mailing the NMHC Public Schools Insurance Designated Service Unit. If you are not satisfied with the initial response, you can request internal review as described below.

Summary of Health Insurance Grievance Procedures

This is a summary of the process you must follow when you request a review of a decision by your insurer. You will be provided with detailed information and complaint forms by your insurer at each step. In addition, you can review the complete New Mexico regulations that control the process under the Legal tab on the Office of Superintendent of Insurance (OSI) website, located at www.osi.state.nm.us. You may also request a copy from your insurer at: 2440 Louisiana Blvd NE, Suite 601, Albuquerque, NM 87110 or from OSI by calling 1-505 827-4601 or toll-free at 1-855-427-5674.

What types of decisions can be reviewed?

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

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

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

Review of an Adverse Determination

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

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

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

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

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

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

How long does initial certification take?

Standard decision: The insurer must make an initial decision within 5 working days. However, the insurer may extend the review period for a maximum of 10 calendar days if it:

- Can demonstrate reasonable cause beyond its control for the delay;
- Can demonstrate that the delay will not result in increased medical risk to you; and
- Provides a written progress report and explanation for the delay to you and your provider within the original 5 working day review period.

What if I need services in a hurry?

Urgent care situation: An **urgent care situation** is a situation in which a decision from the insurer is needed quickly because:

- Delay would jeopardize your life or health;
- Delay would jeopardize your ability to regain maximum function;
- Your provider **reasonably** requests an expedited decision;
- The physician with knowledge of your medical condition, believes that delay would subject you to severe pain that cannot be adequately managed without the requested care or treatment; or
- The medical demands of your case require an expedited decision.

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

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

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

If the initial request is approved, the insurer must notify you and your provider within 2 working days after the decision, unless an urgent matter requires a quicker notice. If the insurer denies certification, the insurer must notify you and the provider within 24 hours after the decision.

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

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

Telephone: 1-877-210-8213

Email: nmpsia@mynmhc.org

Written requests for review must be submitted to:
Address: NMHC, Attn: Appeal & Grievance Department
P.O. Box 36719, Albuquerque, NM 87176

Fax: 1-800-747-9132

Email: NMHC-Member-A-and-G@mynmhc.org

You may also contact the Managed Health Care Bureau (MHCB) at OSI for assistance with preparing the written request for a review at:
Telephone: (505) 827-4601 or toll-free at 1-855-427-5674

Address:
Office of Superintendent of Insurance – MHCB
P.O. Box 1689, 1120 Paseo de Peralta
Santa Fe, NM 87504-1689

Fax: (505) 827-4734, Attn: MHCB

Email: mhcb.grievance@state.nm.us

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

Appealing an adverse determination – first level review
If you are dissatisfied with the initial decision by your insurer, you have the right to request that the insurer's decision be reviewed by its medical director or appropriate designee. The medical director or appropriate designee may make a decision based on the terms of your policy, may choose to contact a specialist or the provider who has requested the service on your behalf, or may rely on the insurer's standards or generally recognized standards.

How much time do I have to decide whether to request a review?
You must notify the insurer that you wish to request an internal review within **180 days** after the date you are notified that the initial request has been denied.

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

How long does a first level internal review take?
Expedited review. If a review request involves an urgent care situation, your insurer must complete an expedited internal review as required by the medical demands of the case, but in no case later than 72 hours from the time the internal review request was received.

Standard review. If the request for internal review is made before you receive the health care service ("Pre- Service Request") Your insurer must complete both the medical director's or appropriate designee's review and (if you then request it) the insurer's internal panel review within 30 days after receipt of your request for review. The medical director's review generally takes only a few days. If the request for internal review is made after you receive the health care service ("Post- Service Request"), the entire internal review shall be completed within 60 days of the request for internal review.

The medical director or appropriate designee denied my request - now what?
If the NMHC medical director or the appropriate designee upholds the adverse determination, you may request a panel review by NMHC. If you ask to have your request reviewed by the insurer's panel, you have the right to appear before the panel in person or by telephone or have someone, (including your attorney), appear with you or on your behalf. You may submit information that you

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

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

The insurer's internal panel must complete its review within the 30 day or 60-day time period previously discussed, following your original request for an internal review. You will be notified within 2 days after the panel decision. If you fail to provide records or other information that the insurer needs to complete the review, you will be given an opportunity to provide the missing items, *but the review process may take much longer and you will be forced to wait for a decision.*

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

If you remain dissatisfied after NMHC's internal review, you may file a complaint with NM Public Schools Insurance Authority within 30 days after NMHC's internal review decision. (Note: You may contact NMPSIA at any time during the internal review process.) Upon receipt of your complaint, the NM Public Schools Insurance Authority will review the case and respond to the parties involved within 30 days. If your situation requires expedited review, a response will be provided within 48 hours of receipt by NM Public Schools Insurance Authority of the complaint. Your complaint should be submitted to:

Executive Director, NMPSIA
410 Old Taos Highway
Santa Fe, NM 87501
1-800-548-3724
Fax: 505-983-8670

Review by the Superintendent of Insurance
If you remain dissatisfied after the NMHC internal review decision and the NM Public Schools Insurance Authority decision, you have the right to request an external review by the New Mexico Office of the Superintendent of Insurance by filing a written request within 120 calendar days after your receipt of the decision unless your claim meets the criteria for expedited review as discussed above. You will have the right to submit additional information to support your request and you may choose to attend the hearing and speak. You may also ask other persons to testify at the hearing. The Superintendent may appoint independent co-hearing officers to hear the matter and to provide a recommendation.

The co-hearing officers will provide a recommendation to the Superintendent within 20 days after the hearing is complete. The Superintendent will then issue a final order.

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

You can submit your request by mail to:
Office of the Superintendent of Insurance
Attention: Managed Health Care Bureau – External Review Request
P.O. Box 1689
Santa Fe, New Mexico 87504-1689 or
1120 Paseo de Peralta, Room 428 Santa Fe, NM 87504- 1269

Toll- free phone number: 1-855-427- 5674 or (505) 827- 4601

Fax to: **Managed Health Care Bureau – External Review Request at (505) 827-4734**

Email to: **mhcb.grievance@state.nm.us (subject: External Review Request)**

Online at: **www.OSI.state.nm.us**

Review of an Administrative Decision
How long do I have to decide if I want to appeal and how do I start the process?
If you are dissatisfied with an initial administrative decision made by your insurer, you have a right to request an internal review within **180 days** after the date you are notified of the decision. The insurer will notify you within 3 days after receiving your request for a review and will review the matter promptly. You may submit relevant information to be considered by the reviewer.

How long does an internal review of an Administrative Decision take?
The insurer will mail a decision to you within 15 days after receiving your request for a review of an administrative decision, unless NMHC must delay the decision in order to obtain additional information. The decision will be binding unless you request reconsideration of the internal review within 20 days of your receipt of the initial decision.

Can I appeal the decision from the internal reviewer?
Yes. You have **20 days** to request that the insurer form a committee to reconsider its administrative decision.

What does the reconsideration committee do? How long does it take?
When the insurer receives your request, it will appoint two or more members to form a committee to review the administrative decision. The committee members must be representatives of the company who were not involved in either the initial decision or the internal review. The committee will meet to review the decision within 15 days after the insurer receives your request. You will be notified at least 3 days prior to the committee meeting so that you may provide information, and/or attend the hearing in person or by telephone.

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

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

How can I request an external review?

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

Executive Director, NMPSIA
410 Old Taos Highway
Santa Fe, NM 87501
1-800-548-3724
Fax: 505-983-8670

If you are dissatisfied with NMHC's internal review decision or the NM Public Schools Insurance Authority decision, you have the right to request an external review by the New Mexico Office of the Superintendent of Insurance by filing a written request within 120 calendar days after your receipt of the decision unless your claim meets the criteria for expedited review as discussed above.

You may submit the request to OSI using forms that are provided by your insurer. Forms are also available on the OSI website located at www.osi.state.nm.us. You may also call OSI to request the forms at (505) 827-4601 or toll-free at 1-855-427-5674.

How does the external review work?
Upon receipt of your request, the Superintendent will request that both you and the insurer submit information for consideration. The insurer has 5 days to provide its information to the Superintendent, with a copy to you. If your matter qualifies for external

review, you may also submit additional information including documents and reports for review by the Superintendent. The Superintendent will review all of the information received from both you and the insurer and issue a final decision within 45 days. If you need extra time to gather information, you may request an extension of up to 90 days. Any extension will cause the review process and decision to take more time.

General Information

Confidentiality

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

Special needs and cultural and linguistic diversity

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

Reporting requirements

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

The preceding summary has been provided by the Office of Superintendent of Insurance. This is not legal advice, and you may have other legal rights that are not discussed in these procedures.

OTHER PLAN PROVISIONS

Age Limits
If the Plan contains an age limit or a date after which coverage provided by the Plan will not be effective, and if such date falls within a period for which premium is accepted by NMHC or if NMHC accepts a premium after such date, the Plan will remain in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured the coverage provided by the Plan would not have become effective or would have ceased prior to the acceptance of such premium or premiums, then the liability of the Plan shall be limited to the refund, upon request, of all premiums paid for the period not covered by the Plan.

Assignment of Benefits
NMHC specifically reserves the right to pay the Subscriber directly and to refuse to honor an assignment of Benefits in any circumstances. If a medical provider or another party receives written or verbal permission from a Member to receive payment for Covered Benefits and Services directly from NMHC, NMHC is not bound to honor the agreement and may make payment to the Member. No person may execute any power of attorney to interfere with NMHC's right to pay the Subscriber or Plan Member instead of another entity.

Circumstances Beyond NMHC's Control
If faced with a disaster such as an earthquake, war or riot, we will make a good faith effort to help Members get Covered Services, and we will remain responsible for payment of Covered Services. NMHC will not be liable for damages resulting from delays in service, or failure due to a lack of facilities or personnel.

Claim Forms and Proof of Loss
A written receipt, claim form or proof of loss must be furnished to NMHC in accordance with the claim procedures specified in this Benefit Booklet. Electronic submission of proof of loss is as acceptable as submission on paper. All submissions must be made to NMHC within 365-days of the occurrence or start date of the loss on which claim is based. If notice is not provided during that time, the claim will not be invalidated, denied or reduced if it is shown that written notice was given as soon as reasonably possible. When a request for a claim form or the notice of a claim is provided to NMHC, we will provide the claimant or Planholder the claim forms that we require for filing. If the claimant does not receive these claim forms within 15-days after NMHC receives notice of claim or the request for a claim form, the claimant will be considered to meet the proof of loss requirement of the Plan. Foreign claims must be translated in U.S. currency prior to being submitted to NMHC for payment.

Disclaimer of Liability
NMHC has no control over the diagnosis; treatment; care; or other service provided to a Member by any facility or Provider, whether the Provider is a Participating or Out-of-Network Provider. NMHC is not liable for loss or injury caused by any healthcare Provider by reason of negligence or otherwise.

Evaluating New Technology for Inclusion as a Covered Benefit
The Plan excludes coverage of healthcare services that are considered to be experimental or investigational in nature or the use of technology that is for an off-label use. NMHC has a process to evaluate health services and new technology that might be considered experimental or investigational. If NMHC determines the procedure or service to be experimental or investigational, the service will not be covered by this Plan. If you agree to receive these services, you may be responsible for the charges.

The NMHC Medical Director will verify whether or not there is support for a particular healthcare service and will make the coverage determination. This support will generally be in the form of prospective, randomized, controlled clinical trials that support the safety and effectiveness of the healthcare service in question.

In addition, the new technology must be as beneficial as any established alternative and the outcomes must be attainable outside of investigational settings. If the Medical Director is unable to locate support, he/she may consult with an outside vendor that NMHC uses to help us evaluate new technologies.

Freedom of Choice of Hospital or Practitioner
Within the area and coverage limits of the Plan, an insured person has the right to exercise full freedom of choice in the selection of a hospital, practitioner of the healing arts, optometrist, psychologist, podiatrist, physician assistant, certified nurse-

midwife, registered lay midwife, registered nurse in expanded practice, or independent social worker as defined in the *Glossary* of this Benefit Booklet. Treatment of an illness or injury within the provider's scope of practice shall not be restricted under any new health insurance contract or healthcare Plan. A person insured under a health insurance Plan providing coverage for payment of Benefits for the treatment or cure or correction of any physical or mental condition shall be deemed to have complied with the requirements of the Plan by submission of a proof of loss, or upon submitting written proof supported by the certificate of the provider or independent social worker.

Fraud and Abuse
Our Fraud and Abuse Program works to investigate and prevent all forms of suspicious activity related to health insurance fraud and/or abuse.

Definitions of Fraud and Abuse
Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or another person. It includes any act that constitutes fraud under applicable federal or state law.

Abuse is when a person is involved in practices that are inconsistent with sound, fiscal business or medical practices. These practices may result in an unnecessary cost to a health plan or in reimbursement for services that are not Medically Necessary or that do not meet professionally recognized standards for healthcare.

Reporting Potential Fraud, Abuse, or Suspicious Activity
If you think that insurance fraud, abuse, or other suspicious activity has occurred, may be occurring, or is going to occur, please report it immediately. You can report this activity by:

- Calling the Fraud and Abuse Telephone Hotline at 855-882-3903 or (505) 492-2056, extension 156;
- Faxing the information to the Fraud and Abuse Department at 866-231-1344; or
- Mailing the information to:

New Mexico Health Connections
Attn: Fraud and Abuse Department
P.O. Box 36719 Albuquerque, NM 87176

If you report suspicious or fraudulent activity, be sure to include as much detail as possible with your report so we can investigate the issue. Reports can be made anonymously. All reports are treated as confidential and will be investigated. We may refer the activity to law enforcement or to the appropriate regulatory body. Members or Providers that are found to be engaging in suspicious activity, fraud or abuse are subject to removal from the Plan and recovery of any overpayments.

Payment of Claims
Claims submitted by a Member for services received by a deceased Member will be payable in accordance with the beneficiary designation and the provisions respecting such payments. If no such designation or provision is provided, claims will be payable to the estate of the insured. Any other claims unpaid at the Member's death may, at our option, be paid to the beneficiary. All other claims will be payable to the Member or to the Provider, at the option of NMHC.

Recovery of Excess Benefit Overpayments
An "excess benefit" overpayment is a service or benefit not required by this Plan, but that has been paid by NMHC. We have the right to recover any overpayments that we make. If the excess benefit is a service, recovery shall be based upon the usual rate for that service. If the excess benefit is a payment, recovery shall be based on the payment made. Recovery may be sought from one or more of the following: any person to, for, or with respect to whom such services were provided or such payments were made, any insurance company, any healthcare plan or other organization.

The right of recovery belongs to NMHC alone. It is used at NMHC's sole discretion. If we notify you, or your legal representative if you are a minor or legally incompetent, that we are pursuing the recovery of these Benefits, we ask that you cooperate with us to secure these recovery rights.

The Rights of Custodial Parents
When a child has coverage under a non-custodial parent, or a parent that does not have primary custody of the child, NMHC will

provide information to the custodial parent, as necessary, for the child to obtain Benefits; permit the custodial parent or the provider to submit claims for covered services without the approval of the noncustodial parent; and make payments on claims submitted in accordance with New Mexico law directly to the custodial parent, the provider or the state Medicaid agency.

The Rights of Non-Custodial Parents
NMHC acknowledges the rights of the Non-Custodial Parents of children who are covered under a Custodial Parent's Plan, unless these rights have been rescinded per court order or divorce decree. Non-Custodial parents are able to contact NMHC to obtain and provide necessary information including but not limited to Provider information, claim information, claims payment, and Benefits or services information for the child

Reimbursement of Claims to Member
To be reimbursed for the charges you have paid, you will need to submit a Member Reimbursement form including an itemized statement with the diagnosis, the treatment received and an explanation for the services, the charges for the treatment, and the patient's identification information from your Plan ID card.

Itemized bills must be submitted on billing forms or the Provider's letterhead or stationery and must include:
- The name and address of the Physician or other healthcare Provider;
- The full name of the patient receiving treatment or services; and
- The date, type of service, diagnosis, and charge for each service separately.

Canceled checks, balance due statements, cash register receipts or bills you prepare yourself are not acceptable. Please make a copy of all itemized bills for your records before you send them because the bills will not be returned to you. Itemized bills are necessary for your claim to be processed so that all Benefits available under this Plan are provided.

If your itemized bill includes charges for services that were previously submitted to us, clearly identify the new charges that you are submitting for reimbursement. Medical records of the treatment or service may be required. You can get a Member Reimbursement form from our website at www.mynmhc.org or by calling the Customer Care Center at 1-855-7MY-NMHC (1-855-769-6642).

Claims for services rendered by an Out-of-Network Provider must be submitted to NMHC within one year 365-days from the date of service. If your Out-of-Network Provider does not file a claim for you, you are responsible for filing the claim within the one-year deadline. Claims submitted after the deadline are not eligible for benefit payment or reimbursement. If a claim is returned to you because we need additional information, you must resubmit it, with the information requested, within 90-days of receipt of the request. Please mail the claim forms and itemized bills to:

Claims Department
New Mexico Health Connections
P.O. Box 3828
Corpus Christi, TX 78463

Once received, reviewed and approved, NMHC will reimburse you for Covered Services, less any required Deductibles and Coinsurance or Copayment amounts that you are required to pay as stated in the Summary of Benefits. You will be responsible for charges not specifically covered by NMHC within 45-business days.

Time Limit on Certain Defenses
As of the date of issue of this Plan, no misstatements, except willful or fraudulent misstatements, made by the Subscriber in the application for this Plan shall be used to void the Plan or to deny a claim for loss incurred or disability, as defined in the Plan.

In the event a misstatement in an application is made that is not fraudulent or willful, NMHC may prospectively rate and collect from the insured the premium that would have been charged to the insured at the time the Plan was issued had such misstatement not been made.

NOTICE OF PRIVACY PRACTICES (HIPAA)

New Mexico Health Connections is committed to maintaining and protecting your privacy. We are required to protect the privacy of your individually identifiable health information, genetic information and other personal information and to send you this Notice about our policies, safeguards and practices. When we use or disclose your Protected Health Information (PHI), we are bound by the terms of this Notice.

How We Protect Your Privacy

We will not disclose your Protected Health Information (PHI) without your authorization unless it is necessary to provide your health Benefits, administer your benefit Plan, support Plan programs or services, or as required or permitted by law. If we need to disclose your PHI, we will follow the policies described in this Notice to protect your privacy.

New Mexico Health Connections protects your PHI by following processes and procedures for accessing, labeling and storing confidential records. Access to our facilities is limited only to authorized personnel. Internal access to your PHI is restricted to Plan employees who need the information to conduct Plan business. We train our employees on policies and procedures designed to protect you and your privacy. Our Privacy Officer monitors the policies and procedures and ensures that they are being followed.

How We Use and Disclose Your Confidential Information

We will not use your PHI or disclose it to others without your authorization, except for the following purposes:

- **Treatment**. We may disclose your PHI to your healthcare Provider for Plan coordination, or management of your healthcare and related services;
- **Payment**. We may use and disclose your PHI to obtain payment of Premiums for your coverage and to determine and fulfill our responsibility to provide your Plan Benefits. However, we are prohibited from using or disclosing genetic information to make any coverage determinations, such as eligibility or rate setting. We may also disclose your PHI to another health plan or a healthcare Provider for its payment activities;
- **Healthcare Operations**. We may use and disclose your PHI for our healthcare operations. We may also disclose your PHI to another health plan or a Provider who has a relationship with you, so that it can conduct quality assessment and improvement activities;
- **Appointment Reminders and Treatment Alternatives.** We may use and disclose your PHI for appointment reminders or send you information about treatment alternatives or other health-related Benefits and services. You will have an opportunity to opt out of future communications;
- **Disclosure to Plan Vendors and Accreditation Organizations**. We may disclose your PHI to companies with whom we contract if they need the information to perform the services they provide to us. We may also disclose your PHI to accreditation organizations such as the National Committee for Quality Assurance (NCQA) when the NCQA auditors collect Health Employer Data and Information Set (HEDIS) data for quality measurement purposes. When we enter into these types of arrangements, we obtain a written agreement to protect your PHI;
- **Public Health Activities**. We may use and disclose your PHI for public health activities authorized by law, such as preventing or controlling disease, reporting child or adult abuse or neglect to government authorities. PHI information to close friends or family members who are involved in or help pay for your care. We may also advise your family members or close friends about your condition or location, such as that you are in the hospital;
- **Health Oversight Activities**. We may disclose your PHI to a government agency that is legally responsible for oversight of the healthcare system or for ensuring compliance with the rules of government benefit programs, such as Medicare or Medicaid, or other regulatory programs that need health information to determine compliance;
- **For Research**. We may disclose your PHI for research purposes, subject to strict legal restrictions;
- **To Comply with the Law**. We may use and disclose your PHI as required by law;
- **Judicial and Administrative Proceedings**. We may disclose your PHI in response to a court or administrative order and, under certain circumstances, a subpoena, warrant, discovery request or other lawful process;
- **Law Enforcement Officials**. We may disclose your PHI to the police or other law enforcement officials, as required by law in compliance with a court order, warrant or other process or request authorized by law to report a crime or as otherwise permitted by law;
- **Health or Safety**. We may disclose your PHI to prevent or lessen a serious and imminent threat to your health or safety or the health and safety of the general public or other person;
- **Government Functions**. Under certain circumstances, we may disclose your PHI to various departments of the government such as the U.S. military or the U.S. Department of State;

- **Workers' Compensation**. We may disclose your PHI when necessary to comply with Workers' Compensation laws. State law may further limit the permissible ways we use or disclose your PHI. If an applicable state law imposes stricter restrictions, we will comply with that state law.

Uses and Disclosures with Your Written Authorization
We will not use or disclose your PHI for any purpose other than the purposes described in this Notice without your written authorization. The written authorization to use or disclose health information shall remain valid, which in no event shall be for more than twenty-four (24) months. You can revoke the authorization at any time.

Your Individual Privacy Rights
- **Right to Request Additional Restrictions.** You may request restrictions on our use and disclosure of your PHI for the treatment, payment and healthcare operations purposes explained in this Notice. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction.
- **Right to Receive Confidential Communications.** You may ask to receive communications of your PHI from us by alternative means of communication or at alternative locations, if you believe that communication through normal business practices could endanger you. While we will consider reasonable requests carefully, we are not required to agree to all requests. Your request must specify how or where you wish to be contacted.
- **Right to Inspect and Copy your PHI.** You may ask to inspect or to obtain a copy of your PHI that is included in certain records we maintain. Under limited circumstances, we may deny you access to a portion of your records. If you request copies, we may charge you copying and mailing costs consistent with applicable law. If your information is stored electronically and you request an electronic copy, we will provide it to you in a readable electronic form and format.
- **Right to Amend your Records.** You have the right to ask us to amend your PHI that is contained in our records. If we determine that the record is inaccurate, and the law permits us to amend it, we will correct it. If your physician or another practitioner or person created the information that you want to change, you should ask that person to amend the information.
- **Right to Receive an Accounting of Disclosures.** Upon request, you may obtain an accounting of disclosures we have made of your PHI, except for disclosures made for treatment, payment or healthcare operations, disclosures made earlier than six years before the date of your request, and certain other disclosures that are exempted by law. If you request an accounting more than once during any 12-month period, we may charge you a reasonable fee for each accounting statement after the first one.
- **Right to Receive Paper Copy of this Notice.** You may contact Customer Care at the number on your Plan ID card to obtain a paper copy of this Notice.

If you wish to make any of the requests listed above under "*Your Individual Privacy Rights*", you must notify NMHC in writing.

For More Information or Complaints
If you want more information about your privacy rights, do not understand your privacy rights, are concerned that NMHC has violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact our Privacy Officer. If we discover a breach involving your unsecured PHI, we will notify you of the breach by letter or other method permitted by law. You may also file written complaints with the Secretary of U.S. Department of Health and Human Services (www.hhs.gov/ocr/privacy). Please contact our Privacy Officer to obtain the correct address for the Secretary. We will not take any action against you if you file a complaint with the Secretary or us.

Privacy Officer
You may contact our Privacy Officer at:

New Mexico Health Connections
P.O. Box 36719 Albuquerque, NM 87176 (505) 633-8020

We may change the terms of this Notice at any time. If we change this Notice, we may make the new Notice terms effective for all of your PHI that we maintain, including any information we created or received before we issue the new Notice.

PROTECTING YOUR CONFIDENTIALITY (GRAHAM, LEACH, BLILEY ACT)

We are committed to keeping your personal and sensitive information confidential. We must follow state and federal laws regarding confidentiality. We have safeguards in place to protect the privacy and security of your personal information. You can trust us to collect and maintain the information we need to administer your Plan in a way that protects your privacy. Below are answers to some common questions about our confidentiality policies.

What Types of Information Do We Receive?

We receive information that we need to administer your Plan. This may include information from Members who apply for coverage; submit a claim; and information from medical Providers.

How Do We Protect Your Oral, Written, and Electronic Personal Information?

Employees and/or organizations that act on our behalf are required to keep your personal information confidential. Here is a list of things that we do to help ensure our policies are followed:

- Our Compliance Department monitors our confidentiality policies, and educates our employees on this topic;
- If possible, we provide only aggregate information that doesn't identify a person. If we need to share individually identifiable information, we have policies that protect confidentiality;
- Our employees may not disclose information to other employees unless it is needed to conduct Plan business;
- We require a written agreement from companies and/or organizations that receive confidential information from us. These partners agree that they will use any individually identifiable information only to administer the benefit plan in accordance with applicable laws;
- We may require your written authorization before we disclose your confidential information. For example, if we receive a request from a research organization or from an attorney, we would require an authorization to be signed before we release any information. Requests for confidential information for a minor, or for an adult who is unable to exercise rational judgment or give informed consent, require authorization from the Member's parent or legal guardian;
- We protect the confidentiality of former Members just as we do for current Members;

We have taken the following steps to make sure our facilities protect your confidential information:

- Facility access is limited to authorized personnel only;
- We maintain procedures for accessing, labeling and storing confidential records, including electronic records.

What Types of Information Do We Disclose and to Whom?

We will not release confidential information unless it is necessary to administer the plan, or to support NMHC programs or services. We may disclose information relating to claims and the processing of claims to:

- Providers, Plan Sponsors, and insurers that provide reinsurance;
- Plan affiliated companies, such as contracted entities providing medical services for Members;
- Regulatory agencies such as the Office of the Superintendent of Insurance (OSI); and Centers for Medicare and Medicaid Services (CMS); and accreditation organizations such as the National Committee for Quality Assurance;
- Courts or attorneys who serve us with a subpoena;
- New insurers or claims administrators who assume responsibility for administering the benefit plan;
- Companies that assist us in recovering overpayments;
- Companies that pay claims or perform Utilization Review services for us;
- Companies that assist us in recovering Benefits that were paid for claims incurred as a result of third-party negligence; and
- Companies not affiliated with NMHC that perform other types of services for us.

How Can Members Access Their Confidential Information?

All Members have a right to review their medical records. If you wish to review yours, you can submit a written request to your physician or healthcare Provider. We strive to make sure that the information we keep is accurate and complete. If a Member finds an error and wishes to correct it, he or she can contact the Provider who created the record.

Notice of Confidentiality of Domestic Abuse Information

There is a State confidentiality law that protects Member's confidential information if they have been involved in domestic abuse. In processing your application for insurance or a claim for insurance Benefits, we may receive confidential domestic abuse information from sources other than you. If this happens, we are prohibited from using it or any other confidential abuse information, or your status as a victim of domestic abuse as a basis for denying, refusing to insure, renew or reissue, cancel, or

otherwise terminate your healthcare coverage. We also are prohibited from restricting or excluding coverage, or charging a higher premium for health coverage based on domestic abuse information.

As a health plan Member, you have the right to access and correct all confidential domestic abuse information that we may have about you. A full or more comprehensive notice and explanation of confidential domestic abuse information practices, as required by law, will be provided to you upon your request. If you are or have been a victim of domestic abuse, you have the right to inform us of your wish to be designated as a protected person. As a protected person, confidential information including your address and telephone number will remain confidential, and will be disclosed and transferred only in accordance with state and federal laws.

If you wish to be designated as a protected person, please contact NMHC at (505) 633-8020 or 1-855-7MY-NMHC (1-855-769-6642).

GLOSSARY

When used in this Benefit Booklet, the following terms are defined as follows:

An **Administrative Grievance or Complaint** means an oral or written complaint submitted by or on behalf of a grievant regarding any aspect of a health Benefits plan other than a request for healthcare services, including but not limited to:

1. Administrative practices of the Healthcare Insurer that affects the availability, delivery, or quality of healthcare services;
2. Claims payment, handling or reimbursement for healthcare services; and
3. Terminations of coverage;

Adverse Determination means any of the following: any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time), a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payments, that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Adverse Determination Grievance means an oral or written complaint submitted by or on behalf of a grievant regarding an adverse determination.

Agreement refers to the Health Insurance Contract and its Attachments. The Agreement is a contract between New Mexico Health Connections and the Subscriber or Employer Group for the provision of healthcare coverage.

An **Allowable Charge** is the amount NMHC will use to calculate payment to an In-Network Provider for a Covered Service. In-Network Providers are not allowed to bill more than the Allowable Charge.

Ambulatory Services are healthcare services delivered at a physician's office, clinic, medical center or outpatient facility in which the patient’s stay does is no longer than 24 hours.

The **Annual Deductible** is the amount a Member must pay for Covered Services before health Benefits are paid by NMHC. It is also referred to as a “Deductible.”

The **Annual Out-of-Pocket Maximum** is the highest dollar amount a Member will pay in Deductible, Coinsurance and Copayment amounts for Covered Services. Plan maximums, exclusions and limitations of this Plan will apply. It is also referred to as the “Out-of-Pocket Maximum.”

An **Appeal of Adverse Determination** is something you do if you disagree with our decision to deny a request for coverage of healthcare services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we do not pay for a drug, item, or service you think you should be able to receive.

Autism Spectrum Disorder is a condition that meets the diagnostic criteria for the pervasive developmental disorders published in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision, also known as DSM-IV- TR, published by the American psychiatric association, including autistic disorder, Asperger's disorder, pervasive development disorder not otherwise specified, Rett's disorder, and childhood disintegrative disorder.

Biologicals are medical compounds that are prepared from living organisms and/or their products.

A **Calendar Year** is the period of time beginning January 1 and ending December 31 of any given year.

Certification means a decision by a Healthcare Insurer that a healthcare service requested by a provider or grievant has been reviewed and, based upon the information available, meets the Healthcare Insurer’s requirements for coverage and medical necessity, and the requested healthcare service is therefore approved.

A **Certified Nurse Midwife** is any person who is licensed by the board of nursing as a registered nurse and who is licensed by the New Mexico Department of Health as a Certified Nurse Midwife.

A **Certified Nurse Practitioner** is a registered nurse endorsed by the Board of Nursing for the expanded practice as a certified nurse practitioner. A Certified Nurse Practitioner's name and pertinent information is entered on the list of certified nurse practitioners maintained by the New Mexico Board of Nursing.

Coinsurance is the percentage of allowable charges that you must pay for Covered Services after the Deductible has been met. The Coinsurance will be applied to the total allowable charges for the service. Refer to your Summary of Benefits to see what your Coinsurance amounts are.

A **Concern or Complaint** is made when a Member calls the Customer Care Center to express dissatisfaction with coverage or Benefits under the Plan.

A **Condition** is a group of related diagnoses dealing with the same organ, system or disease process.

Continuous Quality Improvement is the effort to measure, evaluate, and improve a managed healthcare plan's processes. The purpose of the effort is to continually improve the quality of healthcare services provided to Plan Members.

The **Contract Year** is the period of time for which the Agreement is in effect.

A **Copayment** is a dollar amount that is the Member's share of the fee for Covered Services, as described in the Summary of Benefits or Rider, if applicable, which is payable at time of service.

Covered Benefit or **Covered Services are** general terms we use to refer to all of the healthcare services and supplies that are covered by the Plan.

A **Covered Person** is a person that is entitled to receive healthcare Benefits provided by a health benefit plan.

Culturally and Linguistically Appropriate Manner of notice means a notice that meets the following requirements:

- The Healthcare Insurer must provide oral language services, such as a telephone customer assistance hotline, that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals, including external review, in any applicable non-English language;
- The Healthcare Insurer must provide, upon request, a notice in any applicable non-English language;
- The Healthcare Insurer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Healthcare Insurer; and
- For purposes of this definition, with respect to an address in any New Mexico county to which a notice is sent, a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county is literate only in the same non-English language, as determined by the department of health and human services (HHS); the counties that meet this ten percent (10%) standard, as determined by HHS, are found at http://cciio.cms.gov/resources/factsheets/clas-data.html and any necessary changes to this list are posted by HHS annually.

A **Cytological Screening** is a pelvic exam for female patients. The exam includes a Papanicolauo test (Pap smear) or liquid based cervical cytopathology and a human papillomavirus (HPV) test, whether or not symptoms are present.

The **Deductible** is the amount a Member must pay for Covered Services before health Benefits are paid by NMHC. It is also referred to as an "Annual Deductible."

A **Dependent** is the spouse, domestic partner or natural, step-child, adopted, or foster child of a Subscriber of the Plan.

A **Doctor of Oriental Medicine (DOM)** is one that is licensed and approved to practice acupuncture and oriental medicine.

An **Emergency Medical Condition** is one in which a prudent layperson with an average knowledge of health and medicine would believe that symptoms require immediate medical attention to help prevent the loss of life, the loss of a limb, or the loss of function of a limb. Symptoms may be due to an illness, injury, severe pain, or a medical Condition that is quickly getting worse.

Emergency Care or **Emergency Services** are covered services that are furnished by a Provider who is qualified to provide emergency services. The services are needed to evaluate or stabilize an Emergency Medical Condition.

Where applicable, **Employer Group** is the employer or Agreement holder.

An **Enrollee** is a Covered Person who receives healthcare Benefits under this Plan.

Benefit Booklet refers to this document, along with any riders or other optional coverage selected; which explains your coverage, what we must do, your rights, and what you have to do as a member of the Plan.

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

- A technology must have final approval from the appropriate regulatory government bodies;
- The scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and
- The improvement must be attainable outside the Investigational settings. The **FDA** is the United States Food and Drug Administration.

Follow-up Care is the contact with, or re-examination of a patient at prescribed intervals following diagnosis or during a course of treatment.

A **Grievance** is a type of complaint you make about the Plan or one of our providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Grievant means any of the following:

- A Planholder, subscriber, enrollee, or other individual, or that person's authorized representative or provider, acting on behalf of that person with that person's consent, entitled to receive healthcare Benefits provided by the healthcare plan;
- An individual, or that person's authorized representative, who may be entitled to receive healthcare Benefits provided by the healthcare plan;
- Medicaid recipients enrolled in a Healthcare Insurer's Medicaid plan; or
- Individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase healthcare Benefits pursuant to the New Mexico Healthcare Purchasing Act.

Habilitative Services Healthcare services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Benefits Plan means a health plan or a Plan, contract, certificate or agreement offered or issued by a Healthcare Insurer or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of healthcare services; this includes a traditional fee-for-service health Benefits plan.

A **Healthcare Facility** is a place that provides healthcare services. This may include a hospital or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing center, a home health agency, a diagnostic, laboratory or imaging center, and a rehabilitation or other therapeutic health setting.

The **Healthcare Insurer** is the insurance provider. The insurance provider must have a valid certificate of authority in good standing under the Insurance Code.

A **Healthcare Professional** is a person that is licensed or otherwise authorized under state law to deliver medical services within the scope of his/her license.

Healthcare Services include services, supplies, procedures for diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease; and includes, to the extent offered by the health Benefits plan, physical and mental health services, including community-based mental health services, and services for developmental disability services or developmental delay.

A **Health Maintenance Organization (HMO)** is a person or company that provides or arranges for the delivery of healthcare services to its Members on a prepaid basis; except for the Covered Persons responsibility for copayments, coinsurance or deductibles.

Hearing Officer, Independent Co-Hearing Officer or ICO means a healthcare or other professional licensed to practice medicine or another profession who is willing to assist the superintendent as a hearing officer in understanding and analyzing medical necessity and coverage issues that arise in external review hearings.

An **Independent Quality Review Organization** is one that is appointed to review a Plan's practices. The organization performs external quality audits of the managed healthcare plan and reports its findings to NMHC and to the OSI. The review helps NMHC improve and enhance their operations and improve their quality of healthcare.

An **Independent Social Worker** means a person licensed as an independent social worker by the board of social work examiners, pursuant to the Social Work Practice Act.

In-Network Provider is the term we use for physicians, other healthcare professionals, hospitals, and other healthcare facilities that are licensed or certified to provide healthcare services. We call them "In-Network Providers" when they have an agreement with NMHC to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of the Plan. NMHC pays network providers based on the agreements we have with the providers or if the providers agree to provide you with Plan-covered services.

Managed Care is a system or technique used by third party payors or their agents to affect access to, and control payment for Healthcare services. Managed care techniques most often include: (1) prior, concurrent and retrospective review of the medical necessity and appropriateness of services or site of services; (2) contracts with selected healthcare Providers; (3) financial incentives or disincentives for Covered Persons to use specific Providers, services, prescription drugs or service sites; (4) controlled access to and coordination of services by a case manager; and/or (5) payor efforts to identify treatment alternatives and modify benefit restrictions for high cost patient care.

A **Managed Care Health Plan (MHCP)** is a Plan, contract, certificate, or agreement offered or issued by a Healthcare Insurer, Provider service network, or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of Healthcare services. A MHCP either requires a Covered person to use healthcare Providers that are managed, owned, under contract with or employed by the Healthcare Insurer, Provider service network, or plan administrator. A MHCP does not include a traditional fee-for-service indemnity health benefit plan or a health benefit plan that covers only short-term travel, accident-only, limited benefit, an indemnity, PPO dental or non-profit dental benefit plan, student health plan, or specified disease policies.

A **Medical Director** is a physician of NMHC that serves to manage the provision of healthcare services to Plan Members.

Medicaid is a grant to a state for medical assistance programs.

Medical Necessity or Medically Necessary means healthcare services determined by a provider, in consultation with the Healthcare Insurer, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies,

boards and associations, or any applicable clinical protocols or practice guidelines developed by the Healthcare Insurer consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease.

Medicare is the Federal health insurance program for people 65-years of age or older; some disabled people under age 65; and people with End-Stage Renal Disease.

A **Member** is any Subscriber or Dependent who elects the Plan coverage and for whom the required Premium has been received by NMHC. A Member must meet all the enrollment and eligibility requirements as defined.

Morbid Obesity is defined as a condition of weighing 100 pounds over a person's ideal body weight.

New Technology is technology that must be approved by the appropriate government regulatory bodies, and for which scientific evidence must permit conclusions about the effect of the technology on health outcomes. The technology must improve the net health outcomes. The technology must be as beneficial as any established alternatives. The improvement must be attainable outside of the setting in which investigation of the technology occurs.

An **Out-of-Network Provider** is a physician, facility or ancillary Provider that is not contracted with NMHC and has not agreed to a pre-determined reimbursement schedule for the services that they provide.

A **Non-Specialist** or **Primary Care Practitioner (PCP)** is a doctor that provides general medical services. Primary Care Practitioners are able to take care of basic services such as behavioral health, preventive care, chronic disease, OB/GYN care, orthopedic, and dermatology services.

An **Obstetrician/Gynecologist (OB/GYN)** is a physician that is board eligible or certified by the American Board of Obstetricians and Gynecologists, or by the American College of Osteopathic Obstetricians and Gynecologists.

OSI refers to the **Office of the Superintendent of Insurance**.

Other In-Network or **Participating Healthcare Facility** is any facility, other than a participating medical hospital; which is operated by or has an agreement with NMHC to provide services to our Members.

An **Out-of-Network Provider** is a physician or other practitioner or facility that is not contracted with NMHC to provide services to Members of the Plan for a pre-determined cost.

A **Participating Provider** is the term we use for a physician, other healthcare professionals, hospitals, and other healthcare facilities that are licensed or certified to provide healthcare services. We call them "In-Network Providers" when they have an agreement with NMHC to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of the Plan. NMHC pays network providers based on the agreements we have with the providers or if the providers agree to provide you with plan-covered services.

A **Physician** is a licensed doctor of medicine and/or surgery or Practitioner of the Healing Arts.

A **Physician Assistant** is a person who has graduated from a nationally-recognized physician assistant or assistant surgeon program; or who is currently certified by the national commission of Physician Assistants. A Physician Assistant must be licensed in the State of New Mexico to practice medicine under the supervision of a licensed physician.

The **Plan** is the health insurance plan available from New Mexico Health Connections and selected by the Subscriber to provide Covered Benefits and Services to the Subscriber and eligible dependents.

A **Policy** is a contract (generally a standard form contract) between the insurer and the Subscriber, known as the policyholder, which determines the claims that the insurer is legally required to pay.

Planholder is the Subscriber to whom the Plan is issued.

The **Preferred Drug List** is a listing of approved drug products. These drugs and medications have been approved in accordance with parameters established by NMHC. The list is subject to periodic review and is amended as required.

The **Premium** is the sum of money paid to NMHC by the Subscriber for the receipt of services and Benefits associated with the Plan.

Prescription Drugs are drugs for which sale or legal dispensing requires the order of a physician.

A **Primary Care Practitioner (PCP)** is the physician or other person you see first for most health problems. A PCP coordinates, supervises, provides, and maintains the continuity of care.

Primary Care Services are services provided by a PCP or primary provider of healthcare services.

Prior Approval is approval from NMHC in advance for certain services or drugs that may or may not be on our formulary. Some services and medications are only covered if your doctor or other network provider receives Prior Approval from NMHC.

A **Prospective Enrollee** is an individual eligible for enrollment; or a person who has expressed interest in purchasing coverage and is eligible for coverage through NMHC.

A **Provider** or **Practitioner** is a licensed hospital, physician or other healthcare provider that is authorized to render health services within the scope of their license.

The **Provider Network** means the physicians, pharmacies, facilities and other healthcare providers and practitioners that have contracted with NMHC.

A **Qualified Medical Child Support Order** is an order from a State or Federal government agency or court. It requires a person to provide health insurance coverage for specific dependents.

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

A **Rider** is an addition that is made to the Plan that refers to Benefits not noted in the Summary of Benefits. It is a part of the Plan and subject to the same general conditions of the regular Plan. It is not a separate Plan. It contains information regarding Benefits in addition to those in the Summary of Benefits. Lastly, it is paid for by an addition to the basic premium.

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

A **Screening Mammography** is a radiologic examination designed to detect breast cancer at an early stage in a person that has no symptoms. The exam includes an x-ray of the breast using equipment specific for mammography. The x-ray has an average radiation exposure delivery of less than one radiation mid-breast. It includes two views for each breast, as well as the professional interpretation of the film. It does not include diagnostic mammography.

The **Service Area** is the state of New Mexico.

Skilled Nursing Care refers to services ordered by a physician that require the skills of professional personnel such as a registered nurse or licensed practical nurse. Skilled Care is provided directly by or under the supervision of such personnel to a patient who needs those services twenty-four (24) hours a day, along with other treatment, for recovery from illness or injury. Skilled Care does not include custodial nursing care.

A **Specialist** is a physician that is certified to provide services for a specific type of medicine.

A **Subscriber** is a person to whom a Plan is issued. A Subscriber must meet the established eligibility requirements and is entitled to enroll in the Plan on his or her own behalf, and not as the dependent of another person.

The **Summary of Benefits** is a document that describes Plan Benefits such as Copayments, Coinsurance and Deductible amounts. The Summary of Benefits is a supplement to this Benefit Booklet.

The **Termination Date** is midnight of the date on which a Member's coverage ends.

Termination of Coverage means the cancellation or non-renewal of coverage provided by a Healthcare Insurer to a grievant but does not include a voluntary termination by a grievant or termination of a health Benefits plan that does not contain a renewal provision.

A **Tertiary Care Facility** is a hospital that provides specialized care for high-risk patients. The facility provides and coordinates transport, communication, education and data analysis systems for the geographic area that it serves. Patients of these facilities need high-risk perinatal care and intensive intrapartum care.

Traditional Fee-For-Service Indemnity Benefit means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage grievants to utilize preferred providers, to follow pre-authorization rules, to utilize prescription drug formularies or other cost-saving procedures to obtain prescription drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services.

Uniform Standards means all generally accepted practice guidelines, evidence-based practice guidelines or practice guidelines developed by the federal government or national and professional medical societies, boards and associations, and any applicable clinical review criteria, policies, practice guidelines, or protocols developed by the Healthcare Insurer consistent with the federal, national, and professional practice guidelines that are used by a Healthcare Insurer in determining whether to certify or deny a requested healthcare service.

Urgent Care is care for a condition that is not an emergency; but is an unforeseen medical illness, injury, or condition that requires immediate care when NMHC's network of providers is unavailable or inaccessible.

An **Urgent Illness** is a non-life-threatening illness that requires prompt medical attention. Some examples of urgent situations are sprains, strains, vomiting, cramps, diarrhea, bumps, bruises, cold, fever, small lacerations, and minor burns.

Usual, Customary and Reasonable Charges is the amount NMHC will pay for care given to a Member by an Out-of- Network Provider. Usual, Customary and Reasonable rates are healthcare services, medical supplies and payment rates for healthcare services provided by a healthcare practitioner are at or near the median rate paid for similar healthcare services within a surrounding geographic area where the charges were incurred. The surrounding geographic area may be determined by the type of service and access to that service in the geographic area.

Utilization Review or **Utilization Management** is the process of reviewing and managing a Member's medical Conditions so the Member receives the right care, by the right Provider, at the right time. This process maximizes Plan Benefits and ensures quality healthcare.

A **Women's Healthcare Provider** is certified healthcare provider that specializes in women's health.

Workers' Compensation Policy or Plan refers to the workers' compensation plan of the 50 United States, the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands; as well as the systems provided under the Federal Employees' Compensation Act and the Longshoreman's and Harbor Workers' Compensation Act; and any other federal, state, county, or municipal workers' compensation; occupational disease or other employer liability laws; or other legislation of similar purpose or intent.

SUMMARY OF ENROLLMENT AND ELIGIBILITY INFORMATION

PROVIDED BY YOUR EMPLOYER PARTICIPATING UNDER THE NEW MEXICO PUBLIC SCHOOLS INSURANCE AUTHORITY

This is a summary of NMPSIA rules. The NMPSIA rules, found at NMPSIA.com, supersede any information contained in this summary.

Eligible Employee

You are eligible to participate in the New Mexico Public Schools Insurance Authority (NMPSIA) Employees Benefits Program if you are actively at work and work the minimum qualifying number of hours established by your employer. (In most cases, employees qualify for basic life insurance coverage because they work 15 hours or more per week. In most cases, employees qualify for all other lines of coverage because they work a minimum of 20 or more hours per week. If you work fewer than 20 hours per week but at least 15 hours per week, you may also be eligible to participate if your employer has passed a part-time employee resolution which has been approved by the NMPSIA Board of Directors).

If you are eligible, you may participate only in the lines of NMPSIA employee benefits coverage offered by your employer. Independent contractors (with the exception of one-bus owner operators) and fleet bus drivers are not eligible to participate in the NMPSIA Employee Benefits Program.

Your employer determines the rate of basic life insurance coverage ($10,000, $25,000, or $50,000) for its eligible employees. If you are eligible for this basic life insurance coverage, it will be provided to you by your employer at no charge. This coverage goes into effect on the first day of the month following your hire date provided you are actively at work on the day your basic life coverage is scheduled to go into effect.

You have 31 days from your date of hire to apply for all other lines of coverage. We will consider that you have applied when you complete, sign, and turn in your application to your employer's benefits office, or when you or your employer enter your enrollment on the NMPSIA online benefit system at https://nmpsiaonline.nmpsia.com. NMPSIA does not accept retroactive effective dates, so please apply for coverage prior to the effective date being requested.

In most cases, all other lines of NMPSIA coverage will become effective on the first day of the month following the day you apply provided you are actively at work on your effective date of coverage (and your premium is withheld and/or adjusted from your payroll check). Your effective date of coverage is determined by your employer based on your payroll deductions, but this coverage can never go into effect retroactively and never any sooner than the first day of the month FOLLOWING your first day actively at work. (For example, if your date of hire is August 2, September 1 is the soonest your coverage can go into effect.)

If you are a variable hour or seasonal employee (or a substitute), your employer determines if you are eligible for medical coverage under the Affordable Care Act guidelines. (This classification of employees is only eligible for medical coverage).

Board Member

Actively serving (publicly elected) board members of participating school districts or colleges/universities are eligible to enroll to the NMPSIA benefit plans (except for basic life and long term disability coverage) offered to the employees at the entity they represent. Board members have 31 days from being sworn into office to apply for benefits. The additional life insurance amount available is equal to the basic life insurance amount offered to the employees at the entity. Charter school board members are not eligible to enroll for NMPSIA Benefits.

Eligible Dependents

You may apply to enroll your eligible dependents (spouse and children) to your NMPSIA Group coverage if your dependents meet NMPSIA's eligibility requirements. You will be required to present the original supportive documentation to your employer's benefits office to prove that your dependents meet NMPSIA's eligibility requirements. A copy of the appropriate supportive documentation must accompany your application or change card (or be presented to your employer, or uploaded, prior to your coverage going into effect); otherwise your dependents will experience a delayed effective date of coverage.

As a new hire, you are granted 61 days from the day your coverage goes into effect to provide the appropriate supportive documentation proving that your dependents are eligible for NMPSIA coverage. In cases of changes in status, you are granted 61 days from the qualifying event to provide the appropriate supportive documentation. In either case, coverage for your

dependents will go into effect the first day of the month following the day you turn in the appropriate supportive documentation to your employer's benefits office, or uploaded, (provided you applied timely and meet the 61-day timeline for supportive documentation). The effective date of coverage for your dependents will not be made retroactive to your effective date of coverage, except for newborns and adopted children who are enrolled timely. See details:

The following is a list of dependents that are eligible to participate in your NMPSIA Group coverage. This list also specifies the supportive documentation required to prove your dependent's eligibility:

Eligible Dependent Supportive Documentation Required

- Legal Spouse: Original official state publicly filed marriage certificate from the County Clerk's Office or from the Bureau of Vital Statistics (chapel certificate is also acceptable)
- Domestic Partner (Only if Employer has elected this option): Notarized affidavit of domestic partnership
- Child under the age of 26 as follows:
    - Natural Child or Stepchildren
    - Legally adopted child or a child for whom the eligible employee is the legal guardian and who is primarily dependent on the eligible employee for maintenance and support
    - Child for whom you have legal guardianship

Original official state publicly filed birth certificate from the Bureau of Vital Statistics (hospital birth registration form is also acceptable)

Evidence of placement by a state licensed agency, governmental agency or a court order/decree (notarized statement and power of attorney are not acceptable)

Legal Guardianship Document (notarized statement and power of attorney documents are not acceptable)

Eligible Dependent Supportive Documentation Required

- Foster child living in the same household as a result of placement by a state licensed placement agency, provided that the foster home is appropriately licensed
- Dependent child with qualified medical child support order Placement order AND foster home license

Medical Child Support Order

Child enrolled in the NMPSIA Group Plan who reaches age 26 while covered under the NMPSIA Group Plan, who is wholly dependent on the eligible employee for maintenance and support, who is incapable of self-sustaining employment because of mental or physical impairment: Evidence of incapacity and dependency in the form of a physician statement indicating diagnosis and prognosis and application must be provided 31 days before the child reaches age 26 or within 31-days from the date the child becomes incapacitated while covered under the NMPSIA Group Plan (final determination is made by the insurance carrier).

Ineligible Dependents

- The following ARE NOT ELIGIBLE for NMPSIA Group Coverage:
- Ex-spouses (even if stipulated in a final divorce decree)
- Common law relationships of the same or opposite sex which are not recognized by New Mexico Law unless domestic partner benefits are offered by your employer
- Dependents while in active military service
- Children left in the care of an eligible employee without evidence of legal guardianship
- Parents, aunts, uncles, brothers, sisters, or any other person not defined as eligible dependent under NMPSIA Rules
- Domestic partners unless your employer has elected this option

Enrollment Requirements

You are required to provide Social Security numbers for you and your dependents to enroll in the NMPSIA Group Plan. If you are in the process of applying for a social security number, you may turn in this proof to your employer's benefits office.
You may choose to apply to enroll in single coverage. If you choose to apply to enroll one eligible dependent, you must enroll ALL eligible dependents unless one of the following applies:

1. The eligible dependent for which you are requesting to exclude from a particular line of NMPSIA coverage is covered for that particular line of coverage under another plan (individual, group, Medicaid, Medicare, VA, Indian Health Services, etc.);
2. Your enrollment is due to a special event defined under the Special Enrollments Provision; or
3. A divorce decree states that the ex-spouse is to provide a particular coverage for your dependent child.

Supportive documentation in the form of a letter from the other plan or employer verifying other coverage is required when No. 1 applies. (A current insurance identification card is an acceptable form of supportive documentation if it lists the dependent's name and the type of his or her coverage.)

Supportive documentation as determined by NMPSIA is required when No. 2 or No. 3 applies (i.e., evidence of involuntary loss of coverage that specifies who lost what coverage, on what date and why the coverage was lost; original official state publicly filed birth certificate or marriage certificate; divorce decree; etc.).

Deadlines for Employee and Dependent Enrollment
You may apply to enroll yourself and your eligible dependents for NMPSIA employee benefits within 31 days from your date of hire (first day you report to work) or within 31 days from a qualifying event that changes your status. If you are an actively serving board member, you must apply to enroll within 31 days from the date you are sworn into office.
If you miss the 31-day enrollment period or decline coverage, the following will apply:

- You may apply during the established open enrollment period in the fall, and your coverage will go into effect January 1 (coverage may begin sooner if you have a qualifying or special event occur and you apply within 31 days from the event).
- You have 60 days from the date of involuntary loss of Medicaid coverage or the Children's Health Insurance Program (CHIP) coverage to apply.
- You may apply during the established open enrollment period in the fall, and your coverage will go into effect January 1 (coverage may begin sooner if you have a qualifying event occur and you apply within 31 days from the event).
- You may apply during the established open enrollment period in the fall, and your coverage will go into effect January 1 (coverage may begin sooner if you have a qualifying event occur and you apply within 31 days from the event). There is no open enrollment for these coverages. You may apply for ADL and LTD coverage (or increase your ADL coverage) through the evidence of insurability process (children are exempt from going through evidence of insurability). The Life and LTD Insurance Carrier will review your health statement and may request medical records in order to make a final decision on your application.

Evidence of insurability does not apply if you are promoted to a new job classification with a salary increase or if your part-time employment status changes to full-time with a salary increase provided you apply within 31 days from this qualifying event. If you are enrolled for ADL and your spouse involuntarily loses other life insurance coverage, you may apply for spouse ADL within 31 days from this qualifying event (provided you provide proof of the involuntary loss timely).

Change of Status
If you (or in some cases, your dependents) have a change of status due to the following qualifying events, you must report this change in status by completing, signing, and turning a change card to your employer's benefits office within 31-days from the qualifying event (or when you and your employer enter your enrollment on the NMPSIA online benefit system at https://nmpsiaonline.nmpsia.com):

- Birth
- Marriage
- Adoption of a child or child placement order in anticipation of adoption
- Incapacity of a child covered under the NMPSIA Group Plan
- Legal guardianship of a child
- Promotion to a new job classification with a salary increase, or employment status change from a part-time position to a full-time position with a salary increase (provided you are fulfilling the actively-at-work requirement)
- Divorce or Annulment (not a legal separation)
    - You cannot cancel a spouse when a divorce is in progress.
    - You are required to cancel an ex-spouse effective on the last day of the month your divorce becomes final (you will be required to provide certain pages of your final divorce decree or proof the divorce became final).
    - If you lose other health insurance coverage as a result of divorce, you may apply to enroll in the coverage(s) lost by providing the appropriate supportive documentation listed under the next bullet point.

    - Involuntary loss of group or individual coverage through no fault of the person having the group or individual insurance coverage (This may include an involuntary loss of medical insurance, dental insurance, vision insurance, exhaustion of COBRA, etc.
    - You will be required to provide your employer's benefits office with a loss of coverage letter specifying who lost coverage, what type of coverage was lost, what day coverage was lost, and why coverage was lost. If the letter does not address each of these factors, we cannot determine the loss of coverage to be an involuntary loss of coverage and your enrollment may not be accepted.)
- Loss of employment (including retirement)
- Establishment of termination through affidavit terminating domestic partnership
- Establishment of an affidavit of domestic partnership (If this option is available through your employer and provided all requirements listed in the affidavit apply.)
- Death

Special Enrollment Events for Medical Coverage Only
Special enrollment events mandated by state and federal laws permit you to apply to enroll in medical coverage within 31 days from the occurrence of a special event.

If you meet eligibility requirements for medical coverage and are not enrolled in the NMPSIA Medical Plan, you may enroll yourself only, or yourself and one or more eligible dependents for NMPSIA medical coverage within 31 days from the occurrence of the following special events:

- You suffer an involuntary loss of coverage because coverage of your spouse (or domestic partner, if applicable) or child under another plan is terminated as a result of divorce, death, termination of employment, reduction in hours, legal separation, or termination of employer contributions
- You get married or you establish domestic partnership by affidavit (if your employer participates in offering domestic partnership coverage)
- A child is born to you or your spouse
- You adopt a child or a child is placed for adoption in your family
- You or any eligible dependent suffer an involuntary loss of Medicaid or CHIP coverage (you have 60 days from date of this type of loss to apply; and proof is required)

To report your change of status due to a qualifying event or a special enrollment event you are required to complete, sign and turn in a change card and supportive documentation, or you and your employer may enter your change and upload the supportive documentation on the NMPSIA online enrollment system at https://nmpsiaonline.nmpsia.com within 31 days from the date of your qualifying or special event. If you do not meet this 31-day deadline, you may apply for coverage during the established open enrollment in the fall with an effective date of January 1.

Further, if you do not report a change of status that causes your spouse or child to become ineligible either within 60 days from the qualifying event or within 60 days from the day coverage would end; your spouse or child will not be eligible for COBRA continuation coverage under the NMPSIA Group Plan. When a spouse or child becomes ineligible, coverage under NMPSIA Group Plan ends for him/her on the last day of the month for which he/she becomes ineligible. (Even though you have 60 days to report this change as it pertains to COBRA continuation coverage, NMPSIA Rules require that you report this change of status within 31-days from the qualifying event. This alerts NMPSIA to notify the carriers about your spouse's ineligibility to avoid unnecessary claim payments. This also allows your employer to make the necessary premium adjustments, if any, to your payroll check.) NMPSIA will retract or collect claim overpayments from you (the employee) when you are late in reporting an ineligible spouse or ineligible dependent.

Example: You divorce (or terminate your domestic partnership) on July 12; this causes your ex-spouse (or ex-domestic partner) to become ineligible effective July 31. You should immediately visit your employee benefits office to drop your ex-spouse (or ex-domestic partner) and any enrolled step-children (or your domestic partner's children), if applicable, from the NMPSIA Group Plan. Provide your employee benefits office with a copy of your divorce decree (or termination of domestic partner affidavit) and a "signed" record change card. Your ex-spouse (or ex-domestic partner) may apply for COBRA continuation coverage provided that you report this change of status within the timeframe listed above. (REMINDER: Review your beneficiary designation and make any changes you wish. Life insurance proceeds may not be payable to an ex-spouse unless the ex-spouse is re-designated as beneficiary after the divorce becomes final.)

When you are electing NMPSIA Group coverage, you will be required to complete, sign, and turn in the appropriate application, or you and your employer may enter your enrollment and upload the supportive documentation on the NMPSIA online benefit system at https://nmpsiaonline.nmpsia.com. In the event of a dependent enrollment, your employer's benefits office is required to view the supportive documentation you have presented. Without the appropriate supportive documentation, your dependent's effective date of coverage will be delayed. If supportive documentation is not provided by the established deadline (61 days from your effective date or 61 days from the qualifying event), your dependent will not be eligible for coverage until January 1.

Address and Phone Number Changes
In order for each insurance carrier affiliated with your NMPSIA coverage to process your address and/or phone number changes, you must report address and phone number changes directly to your employer's benefits office on the appropriate form, or you may enter these changes online at https://nmpsiaonline.nmpsia.com.

Beneficiary Changes
You may change your beneficiary (as often as you wish) for your basic life insurance coverage and your additional life insurance coverage. Contact your employer's benefits office for a "Beneficiary Designation Form". Once you complete, sign, and turn in this form to your employer's benefits office, the form will be forwarded to NMPSIA's Eligibility/Enrollment Administrative Office. When a life claim is filed, the life insurance carrier verifies the latest beneficiary information in your membership file. (Be sure to designate a beneficiary for your basic life insurance coverage even if you decline or are not eligible to participate in the additional life coverage.) Visit https://go.standard.com/eforms/17041.pdf to view frequently asked questions about naming a beneficiary.

Termination of Coverage Effective Dates
Coverage terminates for NMPSIA Group participation as follows:

- Coverage terminates at the end of the period for which deductions are made from your payroll check.
- This termination date is determined by your employer.
- Coverage terminates on the last day of the month in which the board member's term expires.
- Coverage terminates on the last day of the month in which the eligible dependent becomes ineligible (i.e., coverage for an ex-spouse and step-children or the ex-domestic partner's children terminates on the last day of the month in which the divorce becomes final or domestic partnership terminates; coverage for any other dependent child ends on the last day of the month in which the child reaches the limiting age of 26).
- Your employer determines when your coverage ends under the active plan. Your employer's policy may allow you to remain on the active plan for up to one year from the date your LOA was approved, so be sure to contact your employer's benefit office one month prior to reaching this 12- month period to discuss your coverage options. ALSO, be sure to contact your employer's benefits office WITHIN 31 DAYS from returning from your LOA to discuss your benefits or premiums that may have been suspended while you were on LOA. (Further, if you are on LOA due to disability, be sure to review information regarding benefits you may be eligible for under your life or disability coverage provided by The Standard.)

General Information

- Once enrolled in vision, you may not drop vision until you and each of your covered dependents have been enrolled two years.
- NMPSIA offers open enrollment each fall for medical, dental, and vision coverage. Once you apply (prior to January 1), the change becomes effective on January 1.
- NMPSIA offers switch enrollment each fall for medical coverage and for dental coverage.
- Once you apply (prior to January 1) to switch plans, the change becomes effective on January 1.
- If both of you and your spouse work for a NMPSIA employer, you and your spouse may not enroll each other as a spouse, nor may you both cover your children. If your child is also an employee of a NMPSIA participating entity and enrolled for employee coverage, you may not cover your child as a dependent for the lines of coverage your child is enrolled as an employee. Double coverage outside of the NMPSIA Group Plan is allowed.
    - NMPSIA's Eligibility/Enrollment Administrative Office will mail or email you a Confirmation of Enrollment (or a Notice of Incomplete Enrollment if you are missing information or documentation). Review these notices carefully and report any discrepancies to your Employee Benefits office. Failure to act may cause coverage to be postponed or denied.
    - Check your enrollment online at https://nmpsiaonline.nmpsia.com.

Federal and State Insurance Laws Will Apply
Under NMPSIA Rules and Regulations, anyone who knowingly or willfully makes any false or fraudulent statement or representation shall forfeit all employee and dependent rights to coverage or benefits. In the event of prohibited actions by an official or employee of a participating school district or other educational entity, the employer shall take the appropriate disciplinary action against the offending official or employee. If such appropriate disciplinary action is not so taken, NMPSIA reserves the right to terminate coverage for the participating school district or other education entity.

IF YOU HAVE ANY QUESTIONS ABOUT THE NMPSIA ELIGIBILITY RULES, CONTACT YOUR EMPLOYER'S BENEFITS OFFICE OR NMPSIA AT 1-800-548-3724, or contact NMPSIA's ENROLLMENT/ELIGIBILITY ADMINISTRATIVE OFFICE at 1-800-233-3164.

Notice of Non-Discrimination and Accessibility

The following is a statement outlining nondiscrimination for NMHC and the services it provides to its clients and members:

- We do not discriminate on the basis of race, color, national origin, age, disability, or gender in our health programs or activities.
- We provide assistance free of charge to people with disabilities or whose primary language is not English. To request a document in another format such as large print or to get language assistance such as a qualified interpreter, please call NMHC Customer Service at 1-855-769-6642, TTY services 1-800-659-8331, Monday through Friday, 8:00 a.m. to 5:00 p.m.
- If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can send a complaint to:

  NMHC Compliance Hotline
  2440 Louisiana Blvd. NE, Suite 601
  Albuquerque, NM 87110
  Phone: 1-855-882-3904
  Fax: 1-866-231-1344

You also have the right to file a complaint directly with the U.S. Dept. of Health and Human services online, by phone, or by mail:

- **Online:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- **Phone:** Toll-free: 1-800-368-1019, TDD: 1-800-537-7697
- **Mail:** U.S. Dept. of Health & Human Services, 200 Independence Ave. SW, Room 509F, HHH Bldg., Washington, DC 20201

new mexico health connections

English
You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

Spanish
Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711.

Navajo
T'áá jíík'eh doo bąąh 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit[‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77 bik11’ b44sh bee hane’7 t’11 j77k’eh bee hane’7 bik1’7g77 bich’8’ hodíilnih dóó 0 bił 'adidíílchił. TTY 711.

Vietnamese
Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phj dành cho hội viên được nêu trên thẻ ID chương trinh bảo hiểm y tế của quý vị, bấm số 0. TTY 711.

German
Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711.

Chinese
你不花钱得到帮助和信息在你的语言的权利。要请求翻译，打电话给你的健康计划的身份证上列出的免费电话员的电话号码，请按 0 TTY711。

Arabic
جردملا ءاضعلأاب صاخلا يناجملا فتاهلا مقرب لصتا ،يروف مجرتم بلطل .ةفلكت يأ لمحت نود كتغلب تامولعملاو ةدعاسملا بلع لوصحلا يف يصنلا فتاهلا .0 بلع طغضاو ،ةيحصلا كتطخب ةصاخلا ةيوضعلا فرّ عمُ ةقاطبب)TTY(قحلا كل 711

Korean
귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID 카드에 기재된 무료 회원 전화번호로 전화하여 0 번을 누르십시오. TTY 711.

Tagalog
May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711.

Japanese
ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳 をご希望の場合は、医療プランの ID カードに記載されているメンバー用のフリーダイヤルまでお電話の 上、0 を押してください。TTY 専用番号は 711 です。

French
Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.

Italian
Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711.

Russian
Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711

Hindi
आप के पास अपनी भाषा में सहायता एवं जानकारी नन:शुल्क प्राप्त करने का अधिकार है। दभु ाषषए के लिए अनुरोि करने के लिए, अपने हैल्थ प्ि ान ID कार्ड पर सूचीबद्ध टोि-फ्र नंबर पर फ़ोन करें, 0 दबाएं। TTY 711

Persian-Farsi
هدش دیق ناگیار نفلت هرامش اب یهافش مجرتم تساوخرد یارب .دییامن تفایرد ناگیار روط مب ار دوخ نابز مب تاعلاطا و کمک مک دیهد راشف ار 0 و هدومن لصاح سامت دوخ یتشادهب ممانرب ییاسانش تراک رد. TTY 711 دیراد قح امش

Thai
คุณมีสิทธิที่จะไดร้ ับความช่วยเหลือและขอ้ มูลในภาษาของคุณไดโ้ ดยไม่มีค่าใชจ้ ่าย หากตอ้ งการขอล่ามแปลภาษา โปรดโทรศพั ทถ์ ึงหมายเลขโทรฟรีที่อยบู่ นบตั รประจา ตวั สา หรับแผนสุขภาพของคุณ แลว้ กด 0 สา หรับผทู้ ีม่ีความบกพร่องทางการไดย้ นิ หรือการพดู โปรดโทรถึงหมายเลข 711