

# Your Health Care Benefits Program



## New Mexico Public Schools Insurance Authority (NMPSIA)

*A Guide To Your Group Preferred Provider Option (PPO) Health Care Plan*

Administered by:



205500 (July 1, 2016)

## CUSTOMER ASSISTANCE

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

**Street address:** 4373 Alexander Blvd. NE

**Toll-free telephone number:** 1-888-966-7742

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

Blue Cross and Blue Shield of New Mexico

P.O. Box 27630

Albuquerque, New Mexico 87125-7630

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

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

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

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

**Send claims\* to:**

Claims, Behavioral Health Unit

P.O. Box 27630

Albuquerque, New Mexico 87125-7630

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

**[www.bcbsnm.com](http://www.bcbsnm.com)**

**Prescription Drugs** - Prescription drugs are administered by Express Scripts. For customer service, you can visit their website at [www.express-scripts.com](http://www.express-scripts.com) or call customer service at 1-800-498-4904.

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

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

A message from

## **New Mexico Public Schools Insurance Authority (NMPSIA)**

Welcome to the PPO health care benefit plan for eligible employees of **New Mexico Public Schools Insurance Authority (NMPSIA)** and their eligible family members. Blue Cross and Blue Shield of New Mexico (BCBSNM), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, and an Independent Licensee of the Blue Cross and Blue Shield Association is pleased to serve as the Claims Administrator for the **NMPSIA** self-funded health care benefit plan. You will be accessing the BCBS Preferred Provider network as if you were insured by BCBSNM.

Please take some time to get to know your health care benefit plan coverage, including its benefit limits and exclusions, by reviewing this important document and any enclosures. Learning how this plan works can help make the best use of your health care benefits.

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

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

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

**Note: Preferred Provider Option (PPO) -** Under the PPO Plan, you are not restricted to using certain network providers exclusively, but may also choose to receive most services outside the network at a reduced benefit level. (This network is one of the largest in the state of New Mexico and you will be able to take advantage of the many preferred provider contracts that other Blue Cross Blue Shield Plans have throughout the United States.)

Sincerely,

**NMPSIA**

<b>Revision History:</b> group renewal with all applicable updates 7/16
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## SECTION 1: HOW TO USE THIS BENEFIT BOOKLET

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

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

### DEFINITIONS

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

### SUMMARY OF BENEFITS AND COVERAGE (SBC)

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

### IDENTIFICATION (ID) CARD

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

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

### PROVIDER NETWORK DIRECTORY

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

### DRUG PLAN BENEFITS

In addition to your benefit booklet, you will be sent a separately issued important information about your drug plan benefits or you can contact Express Scripts customer service at 1-800-498-4904 or website at [www.express-scripts.com](http://www.express-scripts.com) for more information.

### BLUECARD® BROCHURE

As a member of a PPO health plan administered by BCBSNM, you take your health plan benefits with you – across the country and around the world. The BlueCard Program gives you access to preferred providers almost everywhere you travel or live. Almost 90 percent of physicians in the United States contract with Blue Cross and Blue Shield (BCBS)

Plans. You and your eligible family members can receive the Preferred Provider level of benefits – even when traveling or living outside New Mexico – by using health care providers that contract as preferred providers with their local BCBS Plan. You should have received a brochure describing this program in more detail. It’s a valuable addition to your health care plan coverage. Instructions for locating a preferred provider outside New Mexico are in the brochure or can be found on the BCBSNM website at [www.bcbsnm.com](http://www.bcbsnm.com).

## LIMITATIONS AND EXCLUSIONS

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

## PREFERRED PROVIDER BENEFIT ONLY

Some services are eligible for benefits **only** when received from preferred providers. Refer to your *Summary of Benefits* for specific details.

## PREAUTHORIZATION REQUIRED

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

### Emergency/Maternity Admission Notification

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

### Written Request Required

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

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

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

## PREAUTHORIZATION OF BEHAVIORAL HEALTH CARE

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

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

## PREAUTHORIZATION AND COMPLAINT/APPEAL PROCEDURES

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

## **CUSTOMER SERVICE**

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

Customer Service representatives can help with the following:

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

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

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

**Website: [www.bcbsnm.com](http://www.bcbsnm.com)**

### **Behavioral Health Customer Service**

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

**Toll-free: 1-888-898-0070**

### **Deaf and Speech Disabled Assistance**

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

### **Translation Assistance**

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

### **After Hours Help**

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

- leave a message for BCBSNM to call you back on the next business day
- leave a message saying you have a complaint or appeal

### **Special Beginnings®**

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

**Toll-free: 1-888-421-7781**

## **BLUE ACCESS FOR MEMBERS**<sup>SM</sup>

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

If you need help accessing the BAM site, call:

**BAM Help Desk (toll-free): 1-888-706-0583**

**Help Desk Hours: Monday through Friday 6 A.M. - 9 P.M., Mountain Standard Time**

**Saturday 6 A.M. - 2:30 P.M. Mountain Standard Time.**

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

## **HEALTH CARE FRAUD INFORMATION**

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

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

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



## **SECTION 2: ENROLLMENT AND TERMINATION INFORMATION**

Information provided by NMPSIA is located in the back of this booklet.

## SECTION 3: HOW YOUR PLAN WORKS

### BENEFIT CHOICES

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

#### Your Choices

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

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

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

### PREFERRED PROVIDERS VERSUS NONPREFERRED PROVIDERS

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

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

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

## Covered Charges

\*For covered charges related to claims from providers that contract directly with BCBSNM, see “Covered Charges” in *Section 8: Claims Payments and Appeals*.

\*For covered charges related to claims from out-of-network providers, see “Exceptions for Non-preferred Providers” later in this *Section 3: How Your Plan Works*.

\*For covered charges related to claims from providers outside New Mexico, see “BlueCard” in *Section 8: Claims Payments and Appeals*.

## PROVIDER DIRECTORY AND ONLINE PROVIDER FINDER®

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

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

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

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

### Web-Based BCBSNM Provider Finder

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

**[www.bcbsnm.com](http://www.bcbsnm.com)**

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

### Paper Provider Network Directory

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

### Providers Outside New Mexico

Out-of-state providers that contract with their local Blue Cross and/or Blue Shield Plan and international providers that contract with the Blue Cross and Blue Shield Association as **Preferred Providers** are also eligible for the

“Preferred Provider” level of benefits for covered services, including fixed-dollar copayment amounts listed on the *Summary of Benefits*. **Note:** Providers who have a “participating-only” contract are **not** preferred providers and you will not receive the Preferred Provider benefit level when receiving services from participating-only providers. You must use **preferred providers** in order to obtain the higher benefit (unless listed under “**Benefit Level Exceptions**,” later in this section).

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

### **BCBSNM Website**

If you have an Internet connection, go to the BCBSNM website at [www.bcbsnm.com](http://www.bcbsnm.com), click on “Provider Finder<sup>®</sup>” and then select the line entitled “Providers located outside New Mexico.” You will then be linked to the Blue Cross Blue Shield Association’s BlueCard Doctor and Hospital Finder.

**BCBSNM website: [www.bcbsnm.com](http://www.bcbsnm.com)**

### **National Website**

Visit the Blue Cross and Blue Shield Association website at [www.bcbs.com](http://www.bcbs.com) and click on the national “BlueCard Doctor and Hospital Finder,” then select “Find a Doctor or Hospital.” Follow the instructions.

**Blue Cross and Blue Shield Association website:  
[www.bcbs.com](http://www.bcbs.com) (or [www.bluecares.com](http://www.bluecares.com))**

### **National Phone Number**

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

**1-800-810-BLUE (2583)**

### **International Assistance**

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

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

## **CALENDAR YEAR**

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

## **BENEFIT LIMITS**

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

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

## COST-SHARING FEATURES

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

## YOUR DEDUCTIBLE

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

### Individual Deductible

The deductible amounts indicated on your *Summary of Benefits*. Once a member's deductible payments has reached the deductible amount, this Plan will begin paying its share of that member's covered preferred provider charges.

Covered charges for preferred provider services are applied to the nonpreferred provider deductible and covered charges for nonpreferred providers are applied to the preferred provider deductible.

### Family Deductible

An entire family meets the applicable annual deductible when the total deductible amount reaches three 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.

### What Is Not Subject to the Deductible

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

- charges covered under pharmacy plan
- PPP office visit copayments
- the following services when received from preferred providers: MRIs, PET scans, and CT scans
- hearing aids and ear molds for members under the age of 21

### Admissions Spanning Two Calendar Years

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

### Timely Filing Reminder

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

## COPAYMENTS

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

## Office Visit Copayment

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

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

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

## COINSURANCE

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

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

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

### Preferred Providers

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

### Nonpreferred Providers

When you receive covered services from a nonpreferred provider, you have a higher deductible amount to meet each year and you must pay a higher percentage of covered charges for nonpreferred provider services. If the covered charge is less than the billed charge, you will also be responsible for paying the difference when you receive services from a nonpreferred provider. See *Section 8: Claims and Appeals*, “Provider Payment Example,” for more information.

## OUT-OF-POCKET LIMIT

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

The out-of-pocket amounts for preferred provider services are **not** applied to the Nonpreferred Provider out-of-pocket limit. In addition, the out-of-pocket amounts for nonpreferred provider services are not applied to the Preferred Provider out-of-pocket limit.

### Individual Limits

Once your coinsurance 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 Limits**

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.)

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

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

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

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

### **CHANGES TO THE COST-SHARING AMOUNTS**

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

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

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

### **BENEFIT LEVEL EXCEPTIONS**

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

#### **Emergency Care**

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

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

#### **Transition of Care**

If your health care provider leaves the BCBSNM provider network (for reasons other than medical competence or professional behavior) or if you are a new member and your provider is not in the provider network when you enroll, BCBSNM may authorize you to continue an ongoing course of treatment with the provider for a transitional period of time of not less than 30 days. (If necessary and ordered by the treating provider, BCBSNM may also

authorize transitional care from other out-of-network providers.) The period will be sufficient to permit coordinated transition planning consistent with your condition and needs. Special provisions may apply if the required transitional period exceeds 30 days. If you have entered the third trimester of pregnancy at the effective date of enrollment, the transitional period shall include post-partum care directly related to the delivery. Call the BCBSNM Customer Service department for details.

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

### **Unsolicited Providers**

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

### **Ancillary Provider**

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

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

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



## SECTION 4: PREAUTHORIZATIONS

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

In order to receive benefits:

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

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

**Medically Necessary/Medical Necessity** is defined as health care services determined by a provider, in consultation with BCBSNM, 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 BCBSNM 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.

### **Please note:**

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

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

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

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

### **How the Preauthorization Procedure Works**

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

## **BCBSNM PREFERRED PROVIDERS**

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

- when recommending any nonemergency admission, readmission, or transfer

- when a covered newborn stays in the hospital longer than the mother
- before providing or recommending a service listed under “Other Preauthorizations,” later in this section

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

## NONPREFERRED PROVIDERS OR PROVIDERS OUTSIDE NEW MEXICO

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

## INPATIENT PREAUTHORIZATION

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

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

### Penalty for Not Obtaining Inpatient Preauthorization

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

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

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

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

## OTHER PREAUTHORIZATIONS

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

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

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

- **air ambulance** services (unless during a medical emergency)
- **cardiac or pulmonary** rehabilitation
- **chemotherapy** (high-dose)
- **dental-related services** in a hospital or other facility (the procedure may not be covered even if benefits for the hospitalization are approved as medically necessary; see *Section 5: Covered Services*); oral/maxillofacial surgery procedures; treatment of accidental injuries to teeth (except initial treatment); orthognathic surgery; and treatment of orthognathism
- **PET scans; cardiac CT scans; MRIs**
- **enteral nutritional products, special medical foods, and certain drugs** covered
- extended care for skilled nursing, inpatient rehabilitating, and short-term rehabilitation
- **home health care**
- **home dialysis**
- **home infusion therapy (HIT)**, excluding antibiotics
- **hospice**
- certain **injections**, including but not limited to **intravenous immunoglobulin (IVIG)**
- **psychological testing; neuropsychological testing; electroconvulsive therapy (ECT)**; repetitive transcranial magnetic stimulation; and **intensive outpatient program (IOP)** treatment
- **surgery** including, but not limited to, cochlear implants, reconstructive surgery, and cosmetic breast surgery services
- **transplant procedures** including pretransplant evaluations
- transplant procedures **travel expenses**
- **weight management** services including obesity surgery

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

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

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

### **Preauthorization of Mental Health/Chemical Dependency Services**

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

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

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

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

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

<b>Summary of Contact Information for Preauthorization, Customer Service, Claim Submission, and Appeal (or Reconsideration) Processes for Medical/Surgical and Behavioral Health Services:</b>			
<b>Process:</b>	<b>Type of Service:</b>	<b>Phone:</b>	<b>Send to:</b>
<b>Request preauthorization</b>	Medical/surgical	1- 800- 325- 8334	Send to P.O. number listed on inside cover.
	Mental health/chemical dependency	1- 888- 898- 0070	BH Unit P.O. Box 27630, Albuquerque, NM 87125- 7630
<b>Customer Service Inquiry</b>	Medical/surgical	1- 800- 432- 0750	Send to P.O. number listed on inside cover.
	Mental health/chemical dependency	1- 888- 898- 0070	BH Unit P.O. Box 27630 Albuquerque, NM 87125- 7630
<b>Submit claim</b> (post- service)	Medical/surgical		Send claim to P.O. number listed on inside cover.
	Mental health/chemical dependency		BH Unit P.O. Box 27630 Albuquerque, NM 87125- 7630
Request <b>appeal</b> or reconsideration of <b>claim</b> or <b>preauthorization</b> decision	Medical/surgical	1- 800- 205- 9926	BCBSNM Appeals Unit P.O. Box 27630 Albuquerque, NM 87125- 9815
	Mental health/chemical dependency	1- 888- 898- 0070	BCBSNM Appeals Unit P.O. Box 27630 Albuquerque, NM 87125- 9815
<b>Grievance Assistance</b> - Office of Superintendent of Insurance (OSI), Managed Health Care Bureau	Medical/surgical; Mental health/chemical dependency	1- 855- 427- 5674	OSI P.O. Box 1689 Santa Fe, NM 87504- 1689

## **ADVANCE BENEFIT INFORMATION/PREDETERMINATION**

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

## **UTILIZATION REVIEW/QUALITY MANAGEMENT**

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

## SECTION 5: COVERED SERVICES

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

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

### MEDICALLY NECESSARY SERVICES

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

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

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

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

### AMBULANCE SERVICES

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

#### Air Ambulance

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

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

#### Exclusions

This Plan does **not** cover:

- commercial transport, private aviation, or air taxi services
- services not specifically listed as covered, such as private automobile, public transportation, or wheelchair ambulance

- services ordered only because other transportation was not available, or for your convenience

## **AUTISM SPECTRUM DISORDERS**

For a member **19 years old or younger** (or, if enrolled in high school, 22 years old or younger), this Plan covers the habilitative and rehabilitative treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy, and applied behavioral analysis (ABA). Providers must be credentialed to provide such therapy.

Treatment must be prescribed by the member's treating physician in accordance with a treatment plan. Treatment must be **preauthorized** by BCBSNM to determine that the services are to be performed in accordance with such a treatment plan; if services are received but were not approved as part of the treatment plan, benefits for services will be denied. Services not preauthorized by BCBSNM must be performed in accordance with a treatment plan and must be medically necessary or benefits for such services will be denied. Once maximum functionality has been reached and no additional improvement is expected, no therapies are covered unless required to maintain that member's current functionality (that is, in the absence of additional treatment, the patient would suffer a setback). **No benefits are available for any treatments not shown to be habilitative or rehabilitative.** See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Services are subject to usual member cost-sharing features such as deductible, coinsurance, copayments, and out-of-pocket limits - based on place of treatment, type of service, and whether preauthorization was obtained from BCBSNM. All services are subject to the *General Limitations and Exclusions* except where explicitly mentioned as being an exception. This benefit is subject to the other general provisions of the health plan, including but not limited to: coordination of benefits, participating provider agreements, restrictions on health care services, including review of medical necessity, case management, and other managed care provisions.

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

### **Exclusions**

This Plan does **not** cover:

- any experimental, long-term, or maintenance treatments unless listed above
- medically unnecessary or nonhabilitative services under any circumstance
- any services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children 3 to 22 years old who have autism spectrum disorder
- services not in accordance with a treatment plan
- respite services or care
- Sensory Integration Therapy (SIT) or Auditory Integration Therapy (AIT)
- music therapy, vision therapy, or touch or massage therapy
- floor time
- facilitated communication
- elimination diets; nutritional supplements; intravenous immune globulin infusion; secretin infusion
- chelation therapy
- hippotherapy, animal therapy, or art therapy

## **DENTAL-RELATED SERVICES AND ORAL SURGERY**

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

## Dental and Facial Accidents

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

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

## Facility Charges

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

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

## Oral Surgery

This Plan covers the following oral surgical procedures only:

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

## TMJ/CMJ Services

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

## Exclusions

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

- surgeon’s or dentist’s charges for noncovered dental services
- hospitalization or general anesthesia for the patient’s or provider’s convenience
- any service related to a dental procedure that is not medically necessary
- any service related to a dental procedure that is excluded under this Plan for reasons other than being dental-related, even if hospitalization and/or general anesthesia is medically necessary for the procedure being received (e.g., cosmetic procedures, experimental procedures, services received after coverage termination, work-related injuries, etc.)
- nonstandard services (diagnostic, therapeutic, or surgical)
- removal of tori, exostoses, or impacted teeth
- procedures involving orthodontic care, the teeth, dental implants, periodontal disease, noncovered services, or preparing the mouth for dentures
- duplicate or “spare” appliances



- personalized restorations, cosmetic replacement of serviceable restorations, or materials (such as precious metals) that are more expensive than necessary to restore damaged teeth
- dental treatment or surgery, such as extraction of teeth or application or cost of devices or splints, unless required due to an accidental injury and covered under “Dental and Facial Accidents” or “TMJ/CMJ Services”
- dentures, artificial devices and/or bone grafts for denture wear, including implants

## DIABETIC SERVICES

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

*For insulin and over-the-counter diabetic supplies, including glucose meters, contact Express Script for more information.*

*For durable medical equipment, see “Supplies, Equipment and Prosthetics.”*

*For educational services and diabetes management services, see “Physician Visits/Medical Care.”*

## EMERGENCY CARE AND URGENT CARE

### Emergency Care

This Plan covers medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to his/her health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part, or disfigurement. (In addition, services must be received in an emergency room, trauma center, or ambulance to qualify as an emergency.) Examples of emergency conditions include, but are not limited to: heart attack or suspected heart attack, coma, loss of respiration, stroke, acute appendicitis, severe allergic reaction, or poisoning.

### Emergency Room Services

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

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

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

### Emergency Admission Notification

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

### Follow-Up Care

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

## Urgent Care

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

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

## HEARING AIDS/RELATED SERVICES FOR CHILDREN UNDER AGE 21

This Plan covers the cost of hearing aids, the fitting and dispensing fees for hearing aids and ear molds, **limited to two hearing aids every 36 months** for members under 21 years old. This 36-month benefit period begins on the date the first covered hearing aid-related service is received and payable under this provision and ends 36 months later. The next benefit period begins 36 months after the first hearing aid-related service (e.g., fitting cost, ear mold, etc.) OR on the date the next hearing aid-related service, whichever length of time is greater. Adult hearing aids are available up to the first \$500; thereafter, the member will pay 90% in any 36 month period .

Benefits for hearing aid-related services will be provided at **100 percent** of the covered charges. (Other covered services, such as hearing examinations and audiometric testing related to a hearing aid need for members under 21 years old are subject to the usual plan coinsurance provisions for office services and diagnostic testing. Benefits for these additional services are not applied to the 36-month maximum benefit available for hearing aids.) **Routine hearing examinations and related services are not covered for members age 21 and older.**

## HOME HEALTH CARE/HOME I.V. SERVICES

### Conditions and Limitations of Coverage

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

### Preauthorization Required

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

### Covered Services

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

- skilled nursing care provided on an intermittent basis by a registered nurse or licensed practical nurse
- physical, occupational, or respiratory therapy provided by licensed or certified physical, occupational, or respiratory therapists
- speech therapy provided by a speech pathologist or an American Speech and Hearing Association certified therapist
- intravenous medications and other prescription drugs ordinarily not available through a retail pharmacy if **preauthorization** is received from BCBSNM (If drugs are not provided by the home health care agency, contact Express Scripts for more information.)
- drugs, medicines, or laboratory services that would have been covered during an inpatient admission
- enteral nutritional supplies (e.g., bags, tubing) (For enteral nutritional formulas, contact Express Scripts for more information.)
- medical supplies
- skilled services by a qualified aide to do such things as change dressings and check blood pressure, pulse, and temperature

## Exclusions

This Plan does **not** cover:

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

## HOSPICE CARE SERVICES

### Conditions and Limitations

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

### Covered Services

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

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

## Exclusions

This Plan does **not** cover:

- food, housing, or delivered meals
- medical transportation
- homemaker and housekeeping services
- comfort items
- private duty nursing

- supportive services provided to the family of a terminally ill patient when the patient is not a member of this Plan
- care or services received after the member's coverage terminates

## HOSPITAL/OTHER FACILITY SERVICES

### Blood Services

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

### Inpatient Services

#### Preauthorization Required

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

#### Covered Services

For acute inpatient medical or surgical care received during a covered hospital admission, this Plan covers room and board and other medically necessary services provided by the facility.

#### Medical Detoxification

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

### Exclusions

This Plan does **not** cover:

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

### Outpatient or Observation Services

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

## LAB, X-RAY, OTHER DIAGNOSTIC SERVICES

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

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

- x-ray and radiology services, ultrasound, and imaging studies
- laboratory and pathology tests

- EKG, EEG, and other electronic diagnostic medical procedures
- genetic testing (Tests such as amniocentesis or ultrasound to determine the gender of an unborn child are not covered; see “Maternity/Reproductive Services and Newborn Care.”)
- infertility-related testing (See “Maternity/Reproductive Services and Newborn Care.”)
- PET (Positron Emission Tomography) scans, cardiac CT scans
- MRIs
- psychological or neuropsychological testing with **preauthorization** from BCBSNM
- audiometric (hearing) and vision tests for the diagnosis and/or treatment of an accidental injury or an illness

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

## MATERNITY/REPRODUCTIVE SERVICES AND NEWBORN CARE

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

### Family Planning and Infertility-Related Services

*For oral contraceptive coverage and contraceptive devices purchased from a pharmacy, contact Express Scripts for more information..*

#### Family Planning

Covered family planning services include:

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

For these following covered family planning services, no coinsurance, deductible, copayment, or benefit maximums will apply when received from a provider in the preferred or participating provider network. When these services are received from an out-of-network provider, if your plan has out-of-network benefits for nonemergency services, the usual out-of-network deductible, coinsurance, and out-of-pocket will apply.

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

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

## Infertility-Related Services

This Plan covers the following infertility-related treatments. (**Note:** the following procedures only *secondarily* treat infertility):

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

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

Diagnostic *testing* is covered only to diagnose the cause of infertility. Once the cause has been established and the treatment determined to be noncovered, no further testing is covered. For example, this Plan will cover lab tests to monitor hormone levels following the hormone replacement treatment listed as covered above. However, daily ultrasounds to monitor ova maturation are **not** covered since the testing is being used to monitor a noncovered infertility treatment.

## Exclusions

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

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

## Pregnancy-Related/Maternity Services

If you are pregnant, you should call BCBSNM before your maternity due date, soon after your pregnancy is confirmed. BCBSNM must be notified as soon as possible if the mother's stay is greater than **48 hours** for a routine delivery or greater than **96 hours** for a C-section delivery. If no notified, benefits for covered facility services may be reduced by \$300.

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

### Covered Services

Covered pregnancy-related services include:

- hospital or other facility charges for room and board and ancillary services, including the use of labor, delivery, and recovery rooms (This Plan covers all medically necessary hospitalization, including at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a C-section delivery. **Note:** Newborns who are not eligible for coverage under this Plan will not be covered beyond the 48 or 96 hours required under federal law.)
- routine or complicated delivery, including prenatal and postnatal medical care of an obstetrician, certified nurse-midwife or licensed midwife (Expenses for prenatal and postnatal care are included in the total covered charge for the actual delivery or completion of pregnancy.) **Note:** Home births are not covered unless the provider has a preferred provider contract with his/her local BCBS Plan and is credentialed to provide the service.

- pregnancy-related diagnostic tests, including genetic testing or counseling (Services must be sought due to a family history of a gender-linked genetic disorder or to diagnose a possible congenital defect caused by a present, external factor that increases risk, such as advanced maternal age or alcohol abuse. For example, tests such as amniocentesis or ultrasound to determine the gender of an unborn child are **not** covered.)
- necessary anesthesia services by a provider qualified to perform such services, including acupuncture used as an anesthetic during a covered surgical procedure and administered by a physician, a licensed doctor of oriental medicine, or other practitioner as required by law
- when necessary to protect the life of the infant or mother, coverage for transportation, including air transport, for the medically high-risk pregnant woman with an impending delivery of a potentially viable infant to the nearest available tertiary care facility for newly born infants (See “Ambulance Services” for details.)
- services of a physician who actively assists the operating surgeon in performing a covered surgical procedure when the procedure requires an assistant
- elective, spontaneous, or therapeutic termination of pregnancy prior to full term

### Special Beginnings

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

**1-888-421-7781**

### Newborn Care

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

#### Newborn Eligibility

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

#### Routine Newborn Care

If both the mother’s charges and the baby’s charges are eligible for coverage under this Plan, no additional deductible for the newborn is required for the facility’s initial routine nursery care if the covered newborn is discharged on the same day as the mother. If baby is NOT discharged with mother, then the baby will be charged for his/her own deductible or copay (whichever is applicable).

The 48/96 mandate is intended as a rule for length of stay rather than for insurance coverage. However, Legal recommends that at the present time, we approve and pay claims for routine newborn care for the first 48/96 hours after birth even if the insurance policy only provides for single (and not family) coverage (reference Newborn benefits under Information Provided by your Employer). This recommendation is due to the specific language that the OSI required BCBSNM include in our benefits booklets. We are exploring options for changing the language in our booklets in the future.

#### Covered Services

Covered services for initial routine newborn care include:

- routine hospital nursery services, including alpha-fetoprotein IV screening
- routine medical care in the hospital after delivery

- pediatrician standby care at a C-section procedure
- services related to circumcision of a male newborn

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

### **Extended Stay Newborn Care**

A newborn who is enrolled for coverage within the time limits specified in *Section 2: Enrollment and Termination Information* is also covered if he/she stays in the hospital longer than the mother. The baby's services will be subject to a separate deductible, coinsurance and out-of-pocket limit

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

## **PHYSICIAN VISITS/MEDICAL CARE**

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

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

### **Office Visits and Consultations**

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

### **Allergy Care**

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

### **Breastfeeding Support and Services**

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

### **Diabetes Self-Management Education**

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

- medically necessary visits upon the diagnosis of diabetes
- visits following a physician diagnosis that represents a significant change in your symptoms or condition that warrants changes in your self-management



- visits when re-education or refresher training is prescribed by a health care provider
- medical nutrition therapy related to diabetes management

Contact Express Scripts for more information for benefits for insulin and oral agents to control blood glucose levels, glucose meters, needles, syringes, and test strips; see “Supplies, Equipment and Prosthetics” for other covered supplies and equipment required due to diabetes.

### Genetic Inborn Errors of Metabolism

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

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

### Injections and Injectable Drugs

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

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

### Mental Health Evaluation Services

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

### Inpatient Medical Visits

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

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

## PREVENTIVE SERVICES

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

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

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

- a. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
- b. immunizations for routine use that have in effect a recommendation by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
- c. evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents;
- d. with respect to women, to the extent not described in item "a" above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.

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

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

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

- routine physical, breast, and pelvic examinations
- routine adult and pediatric immunizations
- an annual routine gynecological or pelvic examination and low-dose mammogram screenings
- papilloma virus screening and cytologic screening (a Pap test or liquid-based cervical cytopathology)
- human papillomavirus vaccine (HPV) for members ages 9 - 26 years old
- periodic blood hemoglobin, blood pressure and blood glucose level tests
- periodic colorectal screening tests
- periodic blood cholesterol or periodic fractionated cholesterol level including a low-density lipoprotein (LDL) and a high-density lipoprotein (HDL) level; periodic stool examination for the presence of blood
- periodic left-sided colon examination of 35 to 60 centimeters or colonoscopy
- well-child care, including well-baby and well-child screening for diagnosing the presence of autism spectrum disorder
- periodic glaucoma eye tests

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

## Exclusions

This Plan does **not** cover:

- employment physicals, insurance examinations, or examinations at the request of a third party (the requesting party may be responsible for payment); premarital examinations; sports or camp physicals; any other nonpreventive physical examination
- routine eye examinations; eye refractions; or any related service or supply
- routine hearing examinations; hearing aids; or any related service or supply, unless otherwise specified in this section (See “Hearing Aids/Related Services for Children Under Age 21.”)

## PSYCHOTHERAPY (MENTAL HEALTH AND CHEMICAL DEPENDENCY)

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

### Medical Necessity

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

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

### Covered Services/Providers

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

### Residential Treatment Centers

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

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

## Preauthorization Requirements

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

## Exclusions

This Plan does **not** cover:

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

## REHABILITATION AND OTHER THERAPY

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

## **Acupuncture and Spinal Manipulation**

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

## **Cardiac and Pulmonary Rehabilitation**

This Plan covers outpatient cardiac rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services.

## **Chemotherapy and Radiation Therapy**

This Plan covers the treatment of malignant disease by standard chemotherapy and treatment of disease by radiation therapy.

### **Cancer Clinical Trials**

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

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

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

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

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

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

## **Dialysis**

This Plan covers the following services when received from a dialysis provider:

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

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

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

### **Preauthorization Required**

To be covered, all **inpatient**, short-term rehabilitation treatments, including skilled nursing facility and physical rehabilitation facility admissions, must receive **preauthorization** from BCBSNM. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

### **Covered Services**

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

- occupational therapy performed by a licensed occupational therapist
- physical therapy performed by a physician, licensed physical therapist, or other professional provider licensed as a physical therapist (such as a doctor of oriental medicine)
- speech therapy, including audio diagnostic testing, performed by a properly accredited speech therapist for the treatment of communication impairment or swallowing disorders caused by disease, trauma, congenital anomaly, or a previous treatment or therapy
- inpatient physical rehabilitation and skilled nursing facility services when **preauthorized** by BCBSNM

### **Benefit Limits**

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

### **Exclusions**

This Plan does **not** cover:

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

## **SUPPLIES, EQUIPMENT AND PROSTHETICS**

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

## Breast Pumps

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

## Diabetic Supplies and Equipment

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

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

**Reminder:** For additional diabetic supply coverage, (e.g., insulin needle and syringes, autolet, glucose meters, test strips for glucose monitors, glucagon emergency kits), contact Express Scripts for more information.

## Durable Medical Equipment and Appliances

This Plan covers the following items:

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

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

## Medical Supplies

This Plan covers the following medical supplies, not to exceed a **34-day supply** purchased during any 34-day period, unless otherwise indicated:

- colostomy bags, catheters
- gastrostomy tubes
- hollister supplies
- tracheostomy kits, masks

- lamb’s wool or sheepskin pads
- ace bandages, elastic supports when billed by a physician or other provider during a covered office visit
- slings
- support hose prescribed by a physician for treatment of varicose veins (limit of twelve pair per calendar year)

## **Orthotics and Prosthetic Devices**

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

- surgically implanted prosthetics or devices, including penile implants required as a result of illness or accidental injury
- externally attached prostheses to replace a limb or other body part lost after accidental injury or surgical removal; their fitting, adjustment, repairs and replacement
- replacement of prosthetics only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- breast prosthetics when required as the result of a mastectomy and mastectomy bras, which are limited to **six bras** per calendar year
- functional orthotics only for patients having a locomotive problem or gait difficulty resulting from mechanical problems of the foot, ankle, or leg (A functional orthotic is used to control the function of the joints and prescribed by a physician or podiatrist.)
- orthotics (e.g., collars, braces, molds) prescribed by an eligible provider to protect, restore, or improve impaired body function

When alternative prosthetic devices are available, the allowance for a prosthesis will be based upon the most cost-effective item.

## **Exclusions**

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

- air conditioners, biofeedback equipment, humidifiers, purifiers, self-help devices, or whirlpools
- items that are primarily nonmedical in nature such as Jacuzzi units, hot tubs, exercise equipment, heating pads, hot water bottles, or diapers
- nonstandard or deluxe equipment, such as motor-driven wheelchairs, chairlifts or beds; external prosthetics that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing
- repairs to items that you do not own
- comfort items such as bedboards, beds or mattresses of any kind, bathtub lifts, overbed tables, or telephone arms
- repair or rental costs that exceeds the purchase price of a new unit
- dental appliances (See “Dental-Related Services and Oral Surgery” for exceptions.)
- accommodative orthotics (deal with structural abnormalities of the foot, accommodate such abnormalities, and provide comfort, but do not alter function)
- orthopedic shoes, unless joined to braces (Diabetic members should refer to “Diabetic Supplies and Equipment” earlier in this section for information about covered podiatric equipment and orthopedic shoes.)
- equipment or supplies not ordered by a health care provider, including items used for comfort, convenience, or personal hygiene
- duplicate items; repairs to duplicate items; or the replacement of items because of loss, theft, or destruction
- stethoscopes or blood pressure monitors
- voice synthesizers or other communication devices



- eyeglasses or contact lenses or the costs related to prescribing or fitting of glasses or contact lenses, unless listed as covered; sunglasses, special tints, or other extra features for eyeglasses or contact lenses
- hearing aids or ear molds, fitting of hearing aids or ear molds, or related services or supplies for persons 21 or older or, if under age 21, in excess of the maximum benefit described in this section (For surgically implanted devices for the profoundly hearing impaired, see “Surgery and Related Services” below.)
- syringes or needles for self-administering drugs (Coverage for insulin needles and syringes and other diabetic supplies not listed as covered in this section is described under your pharmacy plan, contact Express Scripts for more information)
- items that can be purchased over-the-counter, including but not limited to dressings for wounds (i.e., bed sores) and burns, gauze, and bandages
- male contraceptive devices, including over-the-counter contraceptive products such as condoms; female contraceptive devices, including over-the-counter contraceptive products such as spermicide, when not prescribed by a health care provider. (See “Maternity/Reproductive Services and Newborn Care: Family Planning” for devices requiring a prescription.)
- items not listed as covered

## **SURGERY AND RELATED SERVICES**

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

### **Surgeon’s Services**

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

#### **Cochlear Implants**

This Plan covers cochlear implantation of a hearing device (such as an electromagnetic bone conductor) to facilitate communication for the profoundly hearing impaired, including training to use the device.

#### **Mastectomy Services**

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

This Plan also covers reconstructive breast surgery following a covered mastectomy. Coverage is limited to:

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

This Plan does **not** cover subsequent procedures to correct unsatisfactory cosmetic results attained during the initial breast/nipple surgery or tattooing, or breast surgery.

#### **Obesity Surgery**

This Plan covers the surgical treatment of morbid obesity if treatment meets medical criteria established by BCBSNM. Medical policies are posted on BCBSNM’s website ([http://hcsc.com/medical\\_policies.html](http://hcsc.com/medical_policies.html)) and may change without notice. Check the website for the most current medical policy or call a Customer Service Advocate for assistance. (*Morbid obesity* means 45 kilograms or 100 percent over ideal body weight.)

#### **Reconstructive Surgery**

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

- an accidental injury

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

Cosmetic procedures and procedures that are **not medically necessary**, including all services related to such procedures, will be **denied**.

### **Exclusions**

This Plan does **not** cover:

- cosmetic or plastic surgery or procedures, such as breast augmentation, rhinoplasty, and surgical alteration of the eye that does not materially improve the physiological function of an organ or body part (unless covered under “Mastectomy Services”)
- procedures to correct cosmetically unsatisfactory surgical results or surgically induced scars
- refractive keratoplasty, including radial keratotomy, or any procedure to correct visual refractive defect
- unless required as part of medically necessary diabetic disease management, trimming of corns, calluses, toenails, or bunions (except surgical treatment such as capsular or bone surgery)
- sex change operations or complications arising from transsexual surgery
- subsequent surgical procedures needed because you did not comply with prescribed medical treatment or because of a complication from a previous noncovered procedure (such as a noncovered organ transplant, sex change operation or previous cosmetic surgery)
- the insertion of artificial organs, or services related to transplants not specifically listed as covered under “Transplant Services”
- standby services unless the procedure is identified by BCBSNM as requiring the services of an assistant surgeon and the standby physician actually assists

### **Anesthesia Services**

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

### **Exclusions**

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

### **Assistant Surgeon Services**

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

### **Exclusions**

This Plan does **not** cover:

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

## TRANSPLANT SERVICES

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

If you are approved as a transplant recipient candidate, you must ensure that **preauthorization** for the actual transplant is also received. None of the benefits described here are available unless you have this preauthorization. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

### Facility Must Be in Transplant Network

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

### Effect of Medicare Eligibility on Coverage

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

### Organ Procurement or Donor Expenses

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

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

### Bone Marrow, Cornea or Kidney

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

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

### Cost-Sharing Provisions

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

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

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

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

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

### **Recipient Travel and Per Diem Expenses**

If BCBSNM requires you (i.e., the transplant recipient) to temporarily relocate outside of your city of residence to receive a covered transplant, travel to the city where the transplant will be performed is covered. A standard per diem benefit (**\$50**) will be allocated for lodging expenses for the recipient and one additional adult traveling with the transplant recipient. If the transplant recipient is an eligible child under the age of 18, benefits for travel and per diem expenses for **two adults** to accompany the child are available.

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

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

### **Transplant Exclusions**

This Plan does **not** cover:

- transplant-related services for a transplant that did not receive **preauthorization** from BCBSNM (See *Section 4: Preauthorizations* for more information about preauthorization requirements.)
- any transplant or organ-combination transplant not listed as covered
- implantation of artificial organs or devices (mechanical heart, unless covered under BCBSNM medical policy)
- nonhuman organ transplants
- care for complications of noncovered transplants or follow-up care related to such transplants
- services related to a transplant performed in a facility not contracted directly or indirectly with BCBSNM to provide the required transplant (except cornea, kidney, or bone marrow)
- expenses incurred by a member of this plan for the donation of an organ to another person
- drugs that are self-administered or for use while at home (These services may be covered under your pharmacy plan.)
- donor expenses after the donor has been discharged from the transplant facility
- lodging expenses in excess of the per diem allowance, if available, and food, beverage, or meal expenses
- travel or per diem expenses:
  - incurred **more than five days before** or **more than one year following** the date of transplantation
  - if the recipient's case manager indicates that travel is not medically necessary
  - related to a bone marrow or kidney transplant
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; telephone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- expenses charged only because benefits are available under this provision (such as transportation received from a member of your family, or from any other person charging for transportation that does not ordinarily do so)

## SECTION 6: GENERAL LIMITATIONS AND EXCLUSIONS

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

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

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

### — **Before Effective Date of Coverage**

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

### — **Biofeedback**

Biofeedback is covered **ONLY** when administered by a licensed MD, DO, or a Board Certified Biofeedback Therapist. To be covered, diagnosis must be chronic pain, tension headache, migraine, Reynaud's syndrome, urinary incontinence, TMJ disorder, or craniomandibular disorder. Pre-Cert is required or benefits will be denied for self-coordinated services. If the diagnosis is "smoking cessation," a different benefit applies.

### — **Blood Services**

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

### — **Complications of Noncovered Services**

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

### — **Convalescent Care or Rest Cures**

**This Plan does not cover** convalescent care or rest cures.

### — **Cosmetic Services**

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

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

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

## — Custodial Care

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

## — Dental-Related Services and Oral Surgery

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

## — Domiciliary Care

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

## — Duplicate (Double) Coverage

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

## — Duplicate Testing

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

## — Experimental, Investigational, or Unproven Services

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

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

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

*Reliable evidence* means only published reports and articles in authoritative peer-reviewed medical and scientific literature; the written protocol or protocols used by the treating facility, or the protocol(s) of another facility

studying substantially the same medical treatment, procedure, device, or drug; or the written informed consent used by the treating facility or by another facility studying substantially the same medical treatment, procedure, device, or drug. *Experimental or investigational* does not mean cancer chemotherapy or other types of therapies that are the subjects of ongoing phase IV clinical trials.

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

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

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

#### — **Food or Lodging Expenses**

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

#### — **Genetic Testing or Counseling**

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

#### — **Hair Loss Treatments**

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

#### — **Hearing Examinations, Procedures and Aids**

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

#### — **Home Health, Home I.V. and Hospice Services**

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

#### — **Hypnotherapy**

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

#### — **Infertility Services/Artificial Conception**

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

**Plan does not cover** the cost of donor sperm, costs associated with the collection, preparation, or storage of sperm for artificial insemination, or donor fees.

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

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

#### — **Late Claim Filing**

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

#### — **Learning Deficiencies/Behavioral Problems**

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

#### — **Limited Services/Covered Charges**

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

#### — **Local Anesthesia**

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

#### — **Long-Term and Maintenance Therapy**

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

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

#### — **Medical Policy Determinations**

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



## — **Medically Unnecessary Services**

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

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

## — **No Legal Payment Obligation**

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

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

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

## — **Noncovered Providers of Service**

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

- member of your immediate family or a person normally residing in your home
- physician, other person, supplier, or facility (including staff members) that are not specifically listed as covered in this benefit booklet, such as a:
  - health spa or health fitness center (whether or not services are provided by a licensed or registered provider)
  - school infirmary
  - halfway house
  - massage therapist
  - private sanitarium
  - extended care facility or similar institution
  - dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group
  - homeopathic or naturopathic provider

## — **Nonemergency Services**

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

## — **Nonmedical Expenses**

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

- adoption or surrogate expenses

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

### — Nonparticipating Provider Services

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

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

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

### — **Nonpreferred Provider Services**

**This Plan does not cover** the following services when received from a nonpreferred provider: acupuncture, spinal manipulation, outpatient cardiac and pulmonary rehabilitation, inpatient or outpatient physical therapy, speech therapy, occupational therapy, skilled nursing facility services, and transplants.

**This Plan does not cover** transplants when received from a nonpreferred provider.

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

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

### — **Nonprescription Drugs**

**This Plan does not cover** nonprescription or over-the-counter drugs, medications, ointments, or creams, including herbal or homeopathic preparations, or prescription drugs that have over-the-counter equivalents, except for those products specifically listed as covered in your pharmacy plan (contact Express Scripts for more information) This exclusion includes nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum.

### — **Nutritional Supplements**

**This Plan does not cover** vitamins, dietary/nutritional supplements, special foods, formulas, mother's milk, or diets, unless prescribed by a physician. Such supplements require a prescription to be covered under the "Home Health Care/Home I.V. Services" in *Section 5: Covered Services*. This Plan covers other nutritional products only under specific conditions set forth under your pharmacy plan (contact Express Scripts for more information)

### — **Post-Termination Services**

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

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

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

You should have received information from your pharmacy plan that explains your benefits for these items. All general limitations and exclusions listed in this *Section 6*. Contact Express Scripts for more information.

### — **Preauthorization Not Obtained When Required**

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

### — **Private Duty Nursing Services**

**This Plan does not cover** private duty nursing services.

— **Psychotherapy (Mental Health and Chemical Dependency)**

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

— **Sex-Change Operations and Services**

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

— **Sexual Dysfunction Treatment**

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

— **Supplies, Equipment and Prosthetics**

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

— **Surgery and Related Services**

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

— **Therapy and Counseling Services**

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

- recreational, sleep, crystal, primal scream, sex, and Z therapies
- self-help, stress management and codependency programs
- smoking/tobacco use cessation counseling programs that do not meet the standards described under “Cessation Counseling” in *Section 10: Definitions*
- services of a massage therapist or rolfing when not administered by a licensed rolfer
- transactional analysis, encounter groups, and transcendental meditation (TM); moxibustion; sensitivity or assertiveness training
- vision therapy; orthoptics
- pastoral, spiritual, or religious counseling
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this Plan
- therapy for chronic conditions such as, but not limited to, cerebral palsy or developmental delay and described in *Section 5* under “Autism Spectrum Disorders”
- any therapeutic exercise equipment for home use (e.g., treadmill, weights)
- speech therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic, other speech services that can be carried out by the patient, the family, or caregiver/teacher

— **Thermography**

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

## — Transplant Services

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

## — Travel or Transportation

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

## — Veteran’s Administration Facility

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

## — Vision Services

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

## — War-Related Conditions

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

## — Work-Related Conditions

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

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

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

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

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

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

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

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

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

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

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

### **The following rules determine which coverage pays first:**

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

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

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

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

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

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

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

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

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

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

### **Responsibility For Timely Notice**

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

### **Facility of Payment**

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

### **Overpayments - Right of Recovery**

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

## **REIMBURSEMENT**

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

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

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

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

## SECTION 8: CLAIMS PAYMENTS AND APPEALS

### FILING CLAIMS

You must submit claims **within 12 months** after the date services or supplies were received. If a claim is returned for further information, resubmit it **within 45 days**. **Note:** If there is a change in the Claims Administrator, the length of the timely filing period may also change.

### IMPORTANT NOTE ABOUT FILING CLAIMS

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

### IF YOU HAVE OTHER VALID COVERAGE

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

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

### PARTICIPATING AND PREFERRED PROVIDERS

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

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

### NONPARTICIPATING PROVIDERS

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

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



## ITEMIZED BILLS

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

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

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

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

## WHERE TO SEND CLAIM FORMS

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

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

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

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

### Mental Health/Chemical Dependency Claims

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

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

### Drug Plan Claims

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

your enrollment materials, you can obtain the name and address of the pharmacy benefit manager and the necessary claim forms from a Customer Service Advocate or on the BCBSNM website at [www.bcbsnm.com](http://www.bcbsnm.com).

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

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

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

**[www.bcbs.com/already-a-member/coverage-home-and-away.html](http://www.bcbs.com/already-a-member/coverage-home-and-away.html)**

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

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

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

### **CLAIMS PAYMENT PROVISIONS**

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

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

#### **If A Claim or Preauthorization Is Denied**

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

## **Covered Charge**

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

## **Participating and Preferred Providers**

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

## **Nonparticipating Providers**

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

## **Accident-Related Hospital Services**

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

## **Assignment of Benefits**

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

## **Emergency Service Pricing**

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

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

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

## **Medicaid**

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

## **Medicare**

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

## Overpayments

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

## Pricing of Noncontracted Provider Claims

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

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

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

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

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

- covered services required during an emergency and received in a hospital, trauma center, or ambulance
- for PPO health plans, services from noncontracted providers that satisfy at least one of the three conditions below and, as a result, are eligible for the Preferred Provider benefit level of coverage
  - covered services from noncontracted providers within the United States that are classified as "unsolicited" as explained earlier in *Section 3: How Your Plan Works* and as determined by the member's Host Plan while outside the service area of BCBSNM
  - preauthorized** transition of care services received from noncontracted providers
  - covered services received from a noncontracted anesthesiologist, pathologist, or radiologist while you are a patient at a **contracted** facility receiving covered services or procedures that have been preauthorized, if needed

BCBSNM will use essentially the same claims processing rules and/or edits for noncontracted provider claims that are used for contracted provider claims, which may change the covered charge for a particular service. If BCBSNM does not have any claim edits or rules for a particular covered service, BCBSNM may use the rules or edits used by

Medicare in processing the claims. Changes made by CMS to the way services or claims are priced for Medicare will be applied by BCBSNM within 90-145 days of the date that such change is implemented by CMS or its successor.

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

### Provider Payment Example

The two examples below demonstrate the difference between your liability for services from a nonpreferred provider (when such services are **preauthorized** and **not** eligible for 100 percent coverage of billed charges, such as during an emergency) versus a preferred provider. Both examples are for a plan that pays 80 percent of covered charges with the remaining 20 percent of covered charges paid by the member.

*Example 1.* Preferred Provider Claim Payment (Plan pays 80 percent; deductible is met):

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

*Example 2.* Nonpreferred Provider Claim Payment (Plan pays 80 percent; deductible is met):

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

### BLUECARD® PROGRAM

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

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

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

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

For purposes of the Inter-Plan Arrangements described in this section, “covered charge” means the amount that BCBSNM determines is fair and reasonable for a particular covered and medically necessary service, as provided to BCBSNM by a Host Blue. After the member’s share of the covered charge is calculated, BCBSNM will pay the remaining amount of the covered charge up to the maximum benefit limitation, if any. For services received in foreign countries, BCBSNM will use the exchange rate in effect on the date of service in order to determine the covered charge.

### **Services Received from Contracted Providers Outside New Mexico**

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

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

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

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

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

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

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

## **Services Received from a Noncontracted Provider Outside of New Mexico**

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

## **Member Liability Calculation**

### **1. In General**

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

### **2. Exceptions**

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

## **MEMBER DATA SHARE**

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

## **COMPLAINTS (GRIEVANCES) AND APPEALS: SUMMARY OF PROCEDURES**

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

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

Many complaints or problems can be handled informally by calling, writing, or e-mailing BCBSNM Customer Service. If you are not satisfied with the initial response, you can also request internal and external review as described in the detailed *Appendix: Notice - Claim Determinations, Inquiries, Grievances and External Review* included in the back of your booklet.

### **BCBSNM Contacts for Appeals**

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

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

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

### **Appeals to Superintendent**

If you are still not satisfied after having **completed** the BCBSNM inquiry, complaint, and appeal procedures, you may have the decision reviewed by the Superintendent of Insurance in New Mexico by filing a written request **to the Superintendent within four months** of receipt of the written decision from BCBSNM. **You must first exhaust all of the appeal procedures offered by BCBSNM in your case.**

### **External Actions**

If you are still not satisfied after having completed the BCBSNM complaint, appeal, grievance, or reconsideration procedure, you may have the option of taking other steps, as outlined in the *Inquiries/Complaints and Internal/External Appeals* notice applicable to your health plan. No legal action may be taken or arbitration demand made earlier than **60 days** after BCBSNM has received the claim for benefits or preauthorization request, or later than **three years** after the date that the claim for benefits should have been filed with BCBSNM.



## **SECTION 9: GENERAL PROVISIONS**

### **AVAILABILITY OF PROVIDER SERVICES**

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

### **CATASTROPHIC EVENTS**

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

### **CHANGES TO THE BENEFIT BOOKLET**

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

### **DISCLAIMER OF LIABILITY**

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

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

### **DISCLOSURE AND RELEASE OF INFORMATION**

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

### **EXECUTION OF PAPERS**

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

### **INDEPENDENT CONTRACTORS**

The relationship between BCBSNM and its network providers is that of independent contractors; physicians and other providers are not agents or employees of BCBSNM, and BCBSNM and its employees are not employees or agents of any network provider. BCBSNM will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any network provider.

The relationship between BCBSNM and the group is that of independent contractors; the employer is not an agent or employee of BCBSNM, and BCBSNM and its employees are not employees or agents of the group.

### **MEMBER RIGHTS**

All members have these rights:

- The right to available and accessible services, when medically necessary, as determined by your primary care or treating physician in consultation with BCBSNM, 24 hours per day, 7 days a week, or urgent or emergency care services, and for other health services as defined by your benefit booklet.
- The right to be treated with courtesy and consideration, and with respect for your dignity and your need for privacy.

- The right to have their privacy respected, including the privacy of medical and financial records maintained by BCBSNM and its health care providers as required by law.
- The right to be provided with information concerning BCBSNM's policies and procedures regarding products, services, providers, and appeals procedures and other information about the company and the benefits provided.
- The right to receive from your physician(s) or provider, in terms that you understand, an explanation of your complete medical condition, recommended treatment, risk(s) of treatment, expected results and reasonable medical alternatives, irrespective of BCBSNM's position on treatment options. If you are not capable of understanding the information, the explanation shall be provided to your next of kin, guardian, agent or surrogate, if able, and documented in your medical record.
- The right to file a complaint or appeal with BCBSNM and to receive an answer to those complaints within a reasonable time.
- The right to detailed information about coverage, maximum benefits, and exclusions of specific conditions, ailments or disorders, including restricted prescription benefits, and all requirements that you must follow for preauthorization and utilization review.
- The right to make recommendations regarding BCBSNM's member rights and responsibilities policies.
- The right to a complete explanation of why care is denied, an opportunity to appeal the decision to BCBSNM's internal review and the right to a secondary appeal.

## **MEMBER RESPONSIBILITIES**

As a member enrolled in a managed health care plan administered by BCBSNM, you have these responsibilities:

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

## **MEMBERSHIP RECORDS**

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

## **RESEARCH FEES**

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

## **SENDING NOTICES**

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

## **TRANSFER OF BENEFITS**

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

## SECTION 10: DEFINITIONS

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

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

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

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

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

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

**Adverse determination** — A decision made either pre-service or post-service by BCBSNM that a health care service requested by a provider or member has been reviewed and based upon the information available does not meet the requirements for coverage or medical necessity and the requested health care service is either denied, reduced, or terminated.

**Alcohol abuse** — Conditions defined by patterns of usage that continue despite occupational, social, marital, or physical problems related to compulsive use of alcohol. Alcohol abuse may also be defined by significant risk of severe withdrawal symptoms if the use of alcohol is discontinued.

**Alcohol abuse treatment facility, alcohol abuse treatment program** — An appropriately licensed provider of medical detoxification and rehabilitation treatment for alcohol abuse.

**Ambulance** — A specially designed and equipped vehicle used **only** for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an ambulance.

**Ambulatory surgical facility** — An appropriately licensed provider, with an organized staff of physicians, that meets all of the following criteria:

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis; *and*
- provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility; *and*
- does not provide inpatient accommodations; *and*
- is not a facility used primarily as an office or clinic for the private practice of a physician or other provider.

**Appliance** — A device used to provide a functional or therapeutic effect.

**Applied behavioral analysis (ABA)** — Services that include behavior modification training programs that are based on the theory that behavior is learned through interaction between an individual and the environment. The goal of behavior management is to reinforce and increase desirable, functional behaviors while reducing undesirable, “maladaptive” behaviors.

**Autism spectrum disorder** — A condition that meets the diagnostic criteria for the pervasive developmental disorders published in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision, also known as *DSM-IV-TR*, published by the American Psychiatric Association, including autistic disorder; Asperger’s disorder; pervasive development disorder not otherwise specified; Rhett’s disorder; and childhood integrative disorder.

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

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

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

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

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

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

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

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

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

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

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

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

- is designed to build positive behavior change practices and provides counseling at a minimum on: establishment of reasons for quitting, understanding nicotine addiction, techniques for quitting, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse prevention information, and follow-up;
- operates under a written program outline that meets minimum requirements established by the Office of Superintendent of Insurance;
- employs counselors who have formal training and experience in tobacco cessation programming and are active in relevant continuing education activities; and
- uses a formal evaluation process, including mechanisms for data collection and measuring participant rate and impact of the program.

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

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

**Child** — See definition of “Eligible Family Member” in *Section 2: Enrollment and Termination Information*.

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

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

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

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

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

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

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

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

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

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

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

**Covered charge** — The amount that BCBSNM allows for covered services using a variety of pricing methods and based on generally accepted claim coding rules. The covered charge for services from “contracted providers” is the amount the provider, by contract with BCBSNM (or another entity, such as another BCBS Plan), will accept as payment in full under this health plan. For information about pricing of noncontracted provider claims, see “Pricing of Noncontracted Provider Claims” in *Section 8: Claim Payments and Appeals*.

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

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

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

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

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

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

**Creditable coverage** — Health care coverage through an employment-based group health care plan; health insurance coverage; Part A or B of Title 18 of the Social Security Act (Medicare); Title 19 of the Social Security Act (Medicaid) except coverage consisting solely of benefits pursuant to section 1928 of that title; 10 USCA Chapter 55 (military benefits); a medical care program of the Indian Health Service or of an Indian nation, tribe, or pueblo; the NM

Medical Insurance Pool (NMMIP) Act, or similar state sponsored health insurance pool; a health plan offered pursuant to 5 USCA Chapter 89; a public health plan as defined in federal regulations, whether foreign or domestic; any coverage provided by a governmental entity, whether or not insured, a State Children's Health Insurance Program; or a health benefit plan offered pursuant to section 5(e) of the federal Peace Corps Act.

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

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

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

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

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

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

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

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

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

**Drug List** — A list of prescription drugs that are preferred for use retail and mail-order pharmacy benefits. The list is subject to periodic review and change. If you need a list of commonly prescribed drugs on the BCBSNM Drug List, request it from customer service or visit the pharmacy website. Your drug plan may or may not use a Drug List. Contact Express Scripts for more information.

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

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

**Eligible family members** — See "Eligible Family Members" in *Section 2: Enrollment and Termination Information* for more information about eligible family members.

**Emergency, emergency care** — Medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to his/her health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part, or disfigurement. In addition, services must be received in an emergency room, trauma center, or ambulance to qualify as an emergency. Examples of emergency conditions include, but are not limited to: heart attack or suspected heart attack, coma, loss of respiration, stroke, acute appendicitis, severe allergic reaction, or poisoning.

**Employee probationary period** — The number of months or days of continuous employment beginning with the employee's most recent date of hire and ending on the date the employee first becomes eligible for coverage under the employer's group. Your employer determines the length of the probationary period based on the NMPSIA Rules and Regulations at [nmpsia.com](http://nmpsia.com).

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

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

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

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

**Governmental plan** — That term as defined in Section 3(32) of the federal Employee Retirement Income Security Act of 1974 and includes a federal governmental plan (a governmental plan established or maintained for its employees by the United States government or an instrumentality of that government).

**Group** — A bonafide employer covering employees of such employer for the benefit of persons other than the employer; or an association, including a labor union, that has a constitution and bylaws and is organized and maintained in good faith for purposes other than that of obtaining insurance.

**Group health care plan** — An employee welfare benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care and includes items and services paid for as medical care (directly or through insurance, reimbursement, or otherwise) to employees or their eligible family members (as defined under the terms of the Plan).

**Habilitative treatment** — Treatment programs that are necessary to: 1) develop, 2) maintain, and 3) restore to the maximum extent practicable the functioning of an individual. All three conditions must be met in order to be considered habilitative.

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

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

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



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

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

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

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

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

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

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

**Initial enrollment eligibility date** — A member's effective date of coverage or the first day of any employee probationary period imposed on the member by the employer, whichever is earlier. For a late applicant or for a person applying under a special enrollment provision, the initial enrollment eligibility date is his/her effective date of coverage.

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

**Intensive outpatient program (IOP)** — Distinct levels or phases of treatment that are provided by a certified/licensed chemical dependency or mental health program. IOPs provide a combination of individual, family, and/or group therapy in a day, totaling nine or more hours in a week.

**Investigational drug or device** — For purposes of the "Cancer Clinical Trial" benefit described in *Section 5: Covered Services* under "Rehabilitation and Other Therapy," an "investigational drug or device" means a drug or device that has not been approved by the federal Food and Drug Administration.

**Involuntary loss of coverage** — As applied to special enrollment provisions, loss of other coverage due to legal separation, divorce, death, moving out of an HMO service area, termination of employment, reduction in hours or termination of employer contributions (even if the affected member continues such coverage by paying the amount previously paid by the employer). A loss of coverage may also occur if your employer ceased offering coverage to the particular class of workers or similarly situated individuals to which you belonged or terminated your benefit package option and no substitute Plan was offered. If the member is covered under a state or federal continuation policy due to prior employment, involuntary loss of coverage includes exhaustion of the maximum continuation time period.

Involuntary loss of coverage does not include a loss of coverage due to the failure of the individual or member to pay premiums on a timely basis or termination of coverage for good cause.

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

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

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

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

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

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

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

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

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

**Medical supplies** — Expendable items (except prescription drugs) ordered by a physician or other professional provider, that are required for the treatment of an illness or accidental injury.

**Medically necessary, medical necessity** — See “Medically Necessary Services” in *Section 5: Covered Services*.

**Medicare** — The program of health care for the aged, end-stage renal disease (ESRD) patients and disabled persons established by Title XVIII of the Social Security Act of 1965, as amended.

**Member** — An enrollee (the subscriber or any eligible family member) who is enrolled for coverage and entitled to receive benefits under this Plan in accordance with the terms of the Administrative Service Agreement. Throughout this benefit booklet, the terms “you” and “your” refer to each member.

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

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

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

**Noncontracting allowable amount**— See definition of “Covered charge” earlier in this section.

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

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

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

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

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

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

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

**Other providers** — Clinical psychologists and the following masters-degreed psychotherapists (an independently licensed professional provider with either an M.A. or M.S. degree in psychology or counseling): licensed independent social workers (L.I.S.W.); licensed professional clinical mental health counselors (L.P.C.C.); masters-level registered nurse certified in psychiatric counseling (R.N.C.S.); licensed marriage and family therapist (L.M.F.T.). For chemical dependency services, a provider also includes a licensed alcohol and drug abuse counselor (L.A.D.A.C.).

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

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

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

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

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

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

**Physician** — See definition of “Provider,” below.

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

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

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

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

**Preferred provider** — See definition of “Provider,” below.

**Pregnancy-related services** — See definition of “Maternity,” earlier in the section.

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

**Primary Preferred Provider (PPP)** — See definition of “Provider.”

**Probationary period** — The amount of time an employee must work before becoming eligible for any health care coverage offered by the employer sponsoring this plan. Your employer determines the length of the probationary period.

**Prosthetics or prosthetic device** — An externally attached or surgically implanted artificial substitute for an absent body part; for example, an artificial eye or limb.

**Provider** — A duly licensed hospital, physician, or other practitioner of the healing arts authorized to furnish health care services within the scope of licensure.

**Health care facility:** An institution providing health care services, including a hospital or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing facility, a residential treatment center, a home health care agency, a diagnostic laboratory or imaging center, and a rehabilitation or other therapeutic health setting.

**Physician:** A practitioner of the healing arts who is also a doctor of medicine (M.D.) or osteopathy (D.O.) and who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

**Professional provider:** A physician or health care practitioner, including a pharmacist, who is licensed, certified, or otherwise authorized by the state to provide health care services consistent with state law.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**[www.bcbsnm.com/health/know\\_your\\_numbers](http://www.bcbsnm.com/health/know_your_numbers)**

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

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

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

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

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

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

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

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

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

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

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

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

**Surgical services** — Any of a variety of technical procedures for treatment or diagnosis of anatomical disease or accidental injury including, but not limited to: cutting; microsurgery (use of scopes); laser procedures; grafting, suturing, castings; treatment of fractures and dislocations; electrical, chemical, or medical destruction of tissue; endoscopic examinations; anesthetic epidural procedures; other invasive procedures. Benefits for surgical services also

include usual and related local anesthesia, necessary assistant surgeon expenses, and pre- and post-operative care, including recasting.

**Temporomandibular joint (TMJ) syndrome** — A condition that may include painful temporomandibular joints, tenderness in the muscles that move the jaw, clicking of joints, and limitation of jaw movement.

**Terminally ill patient** — A patient with a life expectancy of **six months or less**, as certified in writing by the attending physician.

**Tertiary care facility** — A hospital unit that provides complete perinatal care (occurring in the period shortly before and after birth) and intensive care of intrapartum (occurring during childbirth or delivery) and perinatal high-risk patients. This hospital unit also has responsibilities for coordination of transport, communication and data analysis systems for the geographic area served.

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

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

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



## APPENDIX A: CONTINUATION COVERAGE RIGHTS UNDER COBRA

This notice contains important information about your possible right to COBRA continuation coverage, which is a temporary extension of coverage under this group health care plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), for certain larger group employers. COBRA continuation coverage may be available to you and to other members of your family who are covered under the health care plan when you would otherwise lose your group health coverage. Contact your employer to determine if you or your group are eligible for COBRA continuation coverage.

This notice generally explains:

- COBRA continuation coverage;
- when it may become available to you and your family if your group is subject to the provisions of COBRA; and
- what you need to do to protect your right to receive it.

This notice gives only a summary of COBRA continuation coverage rights. For more information about the rights and obligations under the Plan and under federal law, contact the Plan administrator or see *Section 2: Enrollment and Termination Information* of this benefit booklet.

The Plan administrator of the Plan is named by the employer or by the group health plan. Either the Plan administrator or a third party named by the Plan administrator is responsible for administering COBRA continuation coverage. Contact your Plan administrator for the name, address, and telephone number of the party responsible for administering your COBRA continuation coverage.

### COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of health care plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the health care plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and eligible children of employees may be qualified beneficiaries. Under the Plan, generally most qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Contact the employer and/or COBRA administrator for specific information for your Plan.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- your hours of employment are reduced; or
- your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- your spouse dies;
- your spouse’s hours of employment are reduced;
- your spouse’s employment ends for any reason other than his or her gross misconduct;
- your spouse becomes enrolled in Medicare (Part A, Part B or both); or
- you become divorced or legally separated from your spouse.

Your eligible children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens and if your group is subject to the provisions of COBRA:

- the parent-employee dies;
- the parent-employee’s hours of employment are reduced;
- the parent-employee’s employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes enrolled in Medicare (Part A, Part B or both);

- the parents become divorced or legally separated; or
- the child stops being eligible for coverage under the Plan as an “eligible child”.

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage of any retiree covered under the Plan, the retiree is a qualified beneficiary with respect to the bankruptcy. The retiree’s spouse, surviving spouse and eligible children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan administrator has been notified that a qualifying event has occurred.

The employer must notify the Plan administrator **within 30 days** when the qualifying event is:

- the end of employment;
- the reduction of hours of employment;
- the death of the employee;
- with respect to a retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
- the enrollment of the employee in Medicare (Part A, Part B or both).

For the other qualifying events (divorce or legal separation of the employee and spouse or an eligible child losing eligibility for coverage as an eligible child), you must notify the Plan administrator. The Plan requires you to notify the Plan administrator **within 60 days** after the qualifying event occurs. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

Once the Plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage may last for up to 36 months when the qualifying event is:

- the death of the employee;
- the enrollment of the employee in Medicare (Part A, Part B or both);
- your divorce or legal separation; or
- an eligible child losing eligibility as an eligible child.

When the qualifying event is the end of employment or reduction in hours of employment, COBRA continuation coverage lasts for **up to 18 months**. There are two ways in which this 18-month period of COBRA continuation can be extended:

### **Disability Extension of 18-month Period of Continuation Coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during **the first 60 days** of COBRA continuation coverage and you notify the Plan administrator in a timely fashion, you and your entire family can receive **up to an additional 11 months** of COBRA continuation coverage, **for a total maximum of 29 months**. You must make sure that your Plan administrator is notified of the Social Security Administration’s determination **within 60 days** of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

### **Second Qualifying Event Extension of 18-Month Period of Continuation Coverage**

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and eligible children in your family can get additional months of COBRA continuation coverage, **up to a maximum of 36 months**. This extension is available to the spouse and eligible children if the former employee dies, enrolls in

Medicare (Part A, Part B or both), or gets divorced or legally separated. The extension is also available to an eligible child when that child stops being eligible under the Plan as an eligible child.

In all of these cases, you must make sure that the Plan administrator is notified of the second qualifying event **within 60 days** of the second qualifying event. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

## **IF YOU HAVE QUESTIONS**

If you have questions about COBRA continuation coverage, contact the Plan administrator or the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

In order to protect your family's rights, you should keep the Plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Plan administrator.

## **PLAN CONTACT INFORMATION**

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

## Appendix: Notice - Claim Determinations, Inquiries, Grievances and External Review

### Claim Determinations - Timeframes

Blue Cross and Blue Shield of New Mexico (BCBSNM) will provide notice of its benefit determination on a claim that is received after the services have been provided to you (Post-Service Claim) within **30 working days** after the receipt of the claim. BCBSNM may extend this period for up to 15 additional days for matters beyond its control. BCBSNM will provide you with written notice if an extension is needed. If an extension is needed because you did not submit all information needed to decide your claim, the notice of extension will describe the missing information and you will have 45 days from receipt of the notice to provide the requested information.

### TIMEFRAME FOR NOTICE OF PRE-SERVICE CLAIM DETERMINATIONS

BCBSNM will provide notice of its initial determination as follows:

**Standard Pre-Service Determination** - BCBSNM will make its decision as to whether to approve or deny a pre-service request for services (Pre-Service Claim) within **five working days** of receiving the request, unless earlier notice is required (see Expedited Pre-Service Determination, below.) BCBSNM may extend the review period for up to **10 working days** if BCBSNM can show there is a cause beyond its control for the delay and that the delay will not result in increased medical risk to you. BCBSNM will provide you with written notice if an extension is needed and will send you a written progress report and explanation for the delay within the original five-day period. If a service is approved, you and the provider will be notified within **two working days** of the date of the service was approved, unless earlier notice is required by the medical exigencies of the case. **Note: An approval of a pre-service request does not insure that the service will be covered.** For example, if you are not eligible for coverage at the time the services were received, if the services you received are different from the services that were initially approved, or if your benefit plan changes or terminates before you receive the service(s) in question, the service may still be denied.

If a service is not approved, you and your provider will be notified of the adverse determination by telephone within **24 hours** of making the decision. You and your provider will also be notified of the adverse benefit determination by written or electronic means sent within **one working day** of the telephone notice.

**Expedited Pre-Service Determination** - BCBSNM will make its decision within **24 hours** of written verbal receipt of the request for an expedited decision when the medical exigencies of the case require an expedited decision including when any delay in making the decision could:

- seriously jeopardize your life or health or your ability to regain maximum function or,
- in the opinion of the physician with knowledge of your medical condition, delay in making a decision would subject you to severe pain that cannot be adequately managed without the care or treatment being requested.

### Concurrent Care Decisions

If BCBSNM has approved an ongoing course of treatment to be provided over a period of time or a number of treatments and decides to reduce or terminate the course of treatment, BCBSNM will notify you and your provider. The notice will be given in advance to allow you enough time to request internal review before the services are reduced or terminated.

Any request to extend an ongoing course of treatment will be decided by BCBSNM and notice will be provided to you within **24 hours** after receipt of the request, provided that your request for extending the ongoing course of treatment was received within at least **24 hours** before the expiration of the approved period of time or number of treatments.

Note: You may also request Expedited External Review by the Superintendent of Insurance at the same time you request expedited internal review. (See External Review later in this section.)

### NOTICE OF ADVERSE BENEFIT DETERMINATION

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

- the specific reason(s) for determination;

- a reference to the specific health plan provision(s) on which the denial is based, or the contractual, administrative or other protocol relied on for the determination;
- a description of additional information which may be needed to perfect an internal review and an explanation of why such material is necessary;
- subject to privacy laws and other restrictions, if any, the identification of the claim, the date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- an explanation of the internal review and external review processes and how to initiate internal or external review, and a statement of your right, if any, to pursue any state and, if applicable, federal legal remedies, including bringing a civil action under Section 502(a) of ERISA;
- in certain situations, a statement in non-English language(s) that indicates how to access the language services provided by BCBSNM;
- your right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;
- any internal rule, guideline, protocol, or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge upon request;
- an explanation of the scientific or clinical judgment relied on in the determination, if the denial was based on medical necessity, experimental treatment, or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- the right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;
- a description of the applicable Expedited Review process for urgent care claims and;
- contact information for applicable office of health insurance consumer assistance or ombudsman.

## **GENERAL INQUIRIES AND COMPLAINTS**

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

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

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

## **GRIEVANCES/INTERNAL REVIEW**

If you make an oral grievance, a BCBSNM NM Public Schools Insurance Designated Service Unit Advocate will assist you. The Managed Health Care Bureau of the Office of Superintendent of Insurance is also available to assist you with grievances, questions, or complaints. Call:

**Toll Free 1-855-427-5674**

You may designate a representative to act for you in the internal review. Your designation of a representative must be in writing in order to protect against disclosure of information about you except to your authorized representative. You, your guardian or representative, or a provider acting on your behalf can contact a BCBSNM NM Public Schools Insurance Designated Service Unit Advocate in person, by letter, by e-mail, or by telephone if you have an inquiry or complaint about a preauthorization request, a claim payment or denial, or any other issue. If you make an inquiry or complaint or file a grievance under the following procedures, you will not be subject to retaliatory action by

BCBSNM. Note: This is a summary of the procedures. You may request a more detailed written explanation of these procedures by calling the BCBSNM NM Public Schools Insurance Authority Designated Service Unit.

You may request internal review, orally or in writing, by contacting:

**NMPSIA Designated Service Unit, Grievance Coordinator**

**Mailing Address: P.O. Box 27630**

**Albuquerque, New Mexico 871255-7630**

**Telephone: 1-888-966-7742**

**Email: [nmpstadsu@bcbsnm.com](mailto:nmpstadsu@bcbsnm.com)**

**Fax: (505) 837-8509**

## **GRIEVANCE PROCEDURES (INTERNAL REVIEW PROCESS)**

If you are not satisfied with the initial decision made by BCBSNM, you can request internal review. Within **180 days** after you receive notice of a BCBSNM decision (payment, denial, or partial denial) on a claim or a preauthorization request, call or write the BCBSNM Designated Service Unit and explain your reasons for disagreeing with the decision. If you do not submit the request for internal review within the **180 day period**, you waive your right to internal review, unless you can demonstrate that circumstances beyond your control prevented you from requesting internal review within **180 days** after your receipt of the initial notice. You may request copies of relevant documents, submit written information, comments, and additional medical information and provide telephonic, or in-person testimony as part of the internal review. You may also designate, in writing, an authorized representative to act on your behalf in the Internal Review Process.

You should include the following items, if applicable, with your request for internal review:

- a copy of the Explanation of Benefits (EOB) and/or denial letter;
- copies of related medical records from your provider; and
- any additional information in support of your request.

Right to a Full and Fair Review - You have the right to a full and fair review, which includes the following:

- You may submit any additional documents, evidence, and provide telephonic, written or in-person testimony.
- BCBSNM will provide you with any new or additional evidence relied upon or generated in connection with the claim sufficiently in advance of the final decision to allow you a reasonable time to respond.
- Your review will be handled in a manner that ensures the independence and impartiality of the persons involved.
- The review will take into account all comments, documents, records, and testimony provided by you.
- The review will not give deference to the initial adverse determination and will be conducted by BCBSNM personnel who were not involved in the initial determination.
- If the adverse benefit determination was based on medical judgment, including a determination with regard to whether the requested service is experimental, investigational, or not medically necessary or appropriate, BCBSNM will consult with a health care professional who has appropriate training and expertise in the field of medicine involved. The health care professional will not have been involved in the initial determination and will not be a subordinate to any individual who made the initial determination.
- No fewer than three working days prior to the date scheduled for a panel review or at such earlier time as you may request it, BCBSNM will provide to you, at no charge, all documentation and information relevant to your request, including copies of your pertinent medical records; a copy of your health benefit plan; BCBSNM's notice of adverse determination; uniform standards relevant to your medical condition used in the review; questions sent to or reports received from any medical consultants; and all other evidence or documentation relevant to reviewing the adverse determination.

**Adverse Determination Grievance** - This is a summary of the internal review procedure that applied to "adverse determinations" made by BCBSNM regarding a request for a health care service.

**Adverse Determination** - An adverse determination regarding a benefit request means a decision made by BCBSNM either pre- service or post- service, that a health care service requested by a provider or member has been reviewed and, based upon the information available, does not meet the requirements for coverage or medical necessity and the requested health care service is either denied, reduced, or terminated.

It also includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment for a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by BCBSNM and BCBSNM reduces or terminates such treatment before the end of the approved treatment period, that is also an “adverse determination”. A rescission of coverage is also an “adverse determination”. Rescission of coverage does not include termination of coverage for nonpayment of premium.

If your request for a health care service has been denied in whole or in part, you may request internal review of the adverse determination. The internal review will be either “expedited” or “standard.”

If required by the medical exigencies of the request, BCBSNM will conduct an “Expedited Review” and will render a decision as soon as practicable, but not later than **72 hours** from receipt of the request. “Expedited Review” will be conducted if the application of “Standard Review” time periods would result in your life, health, or ability to regain maximum function being jeopardized, or in the opinion of a physician with knowledge of your medical condition, you would be subjected to severe pain that cannot be adequately managed without the requested service. If your request satisfied the criteria for “Expedited Review” you may also request Expedited External Review at the same time you request Expedited Internal Review.

If not medically exigent, BCBSNM will conduct a “Standard Review.” If the request for internal review is made before you receive the health care service (“Pre- Service Request for Review”), the entire internal review process shall be completed within **20 working days** of receipt of the request for internal review.

If the request for internal review is made **after** you receive the health care service (“Post-Service Request for Review”), the entire internal review shall be completed within **40 working days** of the request for internal review.

Please note that BCBSNM may extend the review period for up to **10 working days** for Pre- Service Requests and up to **20 working days** for Post- Service Requests, if BCBSNM can demonstrate that the delay is beyond its control, the delay will not result in increased medical risk to you and BCBSNM provides you with a written progress report and explanation of the delay within the original review period.

If the BCBSNM medical director or the appropriate designee of the medical director upholds the adverse determination, BCBSNM will notify you of that decision by telephone (if available) and by mail and will ask whether you want to pursue an “internal panel review” of the decision. If you elect to pursue internal panel review, BCBSNM will notify you of the date, time, and location that the panel will convene and you can participate in person or by phone. BCBSNM will not unreasonably deny your request for a postponement. The internal panel decision will be provided to you by telephone and in writing within the time frames set forth above, subject to any extensions or postponements.

**Administrative Grievance** - This is a summary of the internal review procedure followed by BCBSNM for any oral or written complaint about any aspect of the benefit plan other than a request for health care service including, without limitation:

- administrative practices of BCBSNM that affect the availability, delivery or quality of health care services;
- claims payment, handling, or reimbursement for health care services; and
- termination of coverage.

If you are dissatisfied with a decision, action, or inaction of BCBSNM, you have the right to request an initial internal review orally or in writing. A BCBSNM representative will complete the internal review and mail a written decision to you within **15 working days** of receipt of the administrative grievance unless BCBSNM 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 working days** of your receipt of the initial decision. BCBSNM may extend the review period when

there is a delay in obtaining documents or records necessary for the review, provided that BCBSNM notifies you in writing of the need for the extension and the expected date of resolution.

Upon receipt of your request for reconsideration of the internal review, BCBSNM will appoint a reconsideration committee to schedule and hold a hearing. You may participate in the hearing in person or by telephone. The hearing shall be held within **15 working days** after receipt of your request for reconsideration, unless BCBSNM has approved a request made by you to postpone the hearing. The decision of the committee will be provided to you in writing within **7 working days** after the hearing. BCBSNM will not unreasonably deny your request for a postponement.

BCBSNM Contacts - For more information, contact:

**BCBSNM Appeals Unit**  
**P.O. Box 27630**  
**Albuquerque, NM 87125- 9815**  
**Telephone (toll-free): (800) 205-9926**  
**E-mail: see website at [www.bcbsnm.com](http://www.bcbsnm.com)**  
**Fax: (505) 816-3837**

## **EXTERNAL REVIEW**

If you are still not satisfied after having completed the internal review, you have the option of taking one or more of the following steps.

### **NMPSIA Grievance Review Procedures**

If you are not satisfied with BCBSNM's internal review decision, you may file a complaint with NM Public Schools Insurance Authority within 30 days after BCBSNM'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**

### **External Review by the NM Superintendent of Insurance**

If you are dissatisfied BCBSNM'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 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: (855) 427-5674**  
**or (505) 827-4601**

Fax to:

**Managed Health Care Bureau - External Review Request at (505) 827-4734**



E-mail to:

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

Online at:

**www.OSI.state.nm.us**

If required by the medical exigencies of the case, by telephone at (505) 827-4601 or toll-free at (855) 427-5674.

You will need to provide a copy of the BCBSNM and/or the NM Public Schools Insurance Authority decision; a fully executed release form authorizing the Superintendent to obtain any necessary medical records from BCBSNM or other health care providers and any other supporting documentation. You may contact the Managed Health Care Bureau to assist you in this process by calling toll-free at the number above.

If your request for external review concerns an administrative grievance, the Superintendent may conduct an investigation or inquiry or consult with you, as appropriate, and will issue a written decision to the parties. If your request for external review concerns an adverse determination grievance and the Superintendent determines that your request is appropriate for external review, the Superintendent will schedule the matter for informal hearing and provide notice to you and BCBSNM at least eight working days prior to the hearing date. The hearing will be conducted by hearing officers appointed by the Superintendent.

The Superintendent is not bound by BCBSNM's determination. The external review decision is binding on the parties, but there may be additional state or federal remedies available.

## **RETALIATORY ACTION**

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

## **CATASTROPHIC EVENTS**

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

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Acceptance of coverage under this benefit booklet constitutes acceptance of its terms, conditions, limitations, and exclusions. Members are bound by all of the terms of this benefit booklet.

The legal agreement between **New Mexico Public Schools Insurance Authority** and Blue Cross and Blue Shield of New Mexico (BCBSNM) includes the following documents:

- this benefit booklet and any amendments, riders, or endorsements;
- the enrollment/change form(s) for the subscriber and his/her dependents;
- the members' identification cards; and
- the *Summary of Benefits*

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

- the Benefit Program Application from the employer; and
- the Administrative Services Agreement between BCBSNM and **New Mexico Public Schools Insurance Authority**.

The above documents constitute the entire legal agreement between BCBSNM and **New Mexico Public Schools Insurance Authority**. No agent or employee of BCBSNM has authority to change this benefit booklet or waive any of its provisions. You will be notified of any changes to this benefit booklet at least 30 days before the changes become effective.

**New Mexico Public Schools Insurance Authority** reserves the right to amend, modify, or discontinue coverage provided for employees and their dependents. This benefit booklet is not an implied contract and does not guarantee benefits or employment.

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

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**Information Provided by your  
Employer**



## EMPLOYEE BENEFITS RULES AND REGULATIONS 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.)*

**NOTE:** 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:



## EMPLOYEE BENEFITS RULES AND REGULATIONS SUMMARY

NEWBORN	CHILDREN PLACED FOR ADOPTION OR ADOPTED
<p>You are granted 61 days from the first of the month following your newborn's birth to provide appropriate supportive documentation to your employer's benefits office.</p>	<p>You are granted 61 days from the first of the month following your child's date of placement for adoption or adoption (<i>whichever comes first</i>) to provide appropriate supportive documentation to your employer's benefits office.</p>
<p>Coverage for a newborn begins on the newborn's date of birth, provided that you are enrolled in NMPSIA family medical coverage. Any claims associated with your newborn, cannot be processed until you apply to enroll your newborn.</p>	<p>Coverage for an adopted child begins on date of placement or adoption (<i>whichever comes first</i>) provided that you are enrolled in NMPSIA family medical coverage. Any claims associated with your adopted child, or child placed for adoption cannot be processed until you apply to enroll your child.</p>
<p>If you are not enrolled in NMPSIA family medical coverage, your newborn will not be automatically covered from date of birth. You must apply to enroll your newborn within 31 days from the newborn's date of birth. If you miss this 31-day enrollment period, your newborn will not be eligible for coverage until January 1.</p>	<p>If you are not enrolled in NMPSIA family medical coverage, your adopted child or child placed for adoption will not be automatically covered from date of adoption or placement. You must apply to enroll your child within 31 days from date of placement or adoption (<i>whichever comes first</i>) in order for your child's coverage to be effective from date of placement or adoption. If you miss this 31-day enrollment period, your child will not be eligible for coverage until January 1.</p>

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
<ul style="list-style-type: none"> <li>• <b>Legal Spouse</b></li> </ul>	<p>Original official state publicly filed marriage certificate from the County Clerk's Office or from the Bureau of Vital Statistics (<i>chapel certificate is also acceptable</i>)</p>
<ul style="list-style-type: none"> <li>• <b>Domestic Partner</b> (<i>Only if Employer has elected this option</i>)</li> </ul>	<p>Notarized affidavit of domestic partnership</p>
<ul style="list-style-type: none"> <li>• <b>Child under the age of 26 as follows:</b> <ul style="list-style-type: none"> <li>o Natural Child or Stepchildren</li> <li>o 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</li> <li>o Child for whom you have legal guardianship</li> </ul> </li> </ul>	<p>Original official state publicly filed birth certificate from the Bureau of Vital Statistics (<i>hospital birth registration form is also acceptable</i>)</p> <p>Evidence of placement by a state licensed agency, governmental agency or a court order/decreed (<i>notarized statement and power of attorney are not acceptable</i>)</p> <p>Legal Guardianship Document (<i>notarized statement and power of attorney documents are not acceptable</i>)</p>



## EMPLOYEE BENEFITS RULES AND REGULATIONS SUMMARY

ELIGIBLE DEPENDENT	SUPPORTIVE DOCUMENTATION REQUIRED
<ul style="list-style-type: none"> <li>o 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</li> <li>o Dependent child with qualified medical child support order</li> </ul>	<p>Placement order AND foster home license</p> <p>Medical Child Support Order</p>
<ul style="list-style-type: none"> <li>• <b>Child enrolled in the NMPSIA Group Plan who reaches age 26 while covered under the NMPSIA Group Plan</b>, 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</li> </ul>	<p>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 <b>while covered under the NMPSIA Group Plan</b> (<i>final determination is made by the insurance carrier</i>).</p>

### 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 #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 #2 or #3 apply (*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.*).



## EMPLOYEE BENEFITS RULES AND REGULATIONS SUMMARY

### 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:

- **Medical/Prescription Coverage** – 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*). **Exception:** You have 60 days from the date of involuntary loss of Medicaid coverage or the Children’s Health Insurance Program (CHIP) coverage to apply.
- **Dental Coverage** – 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*).
- **Vision Coverage** – 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*).
- **Long Term Disability Coverage (LTD) and/or Additional Life Coverage (LTD)** – 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>*):

#### Qualifying Events:

- 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*)
  - o You cannot cancel a spouse when a divorce is in progress.
  - o 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*).
  - o 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.



## EMPLOYEE BENEFITS RULES AND REGULATIONS SUMMARY

- o 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. **IMPORTANT:** 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.*)
- o Loss of employment (*including retirement*)
- o Establishment of termination through affidavit terminating domestic partnership
- o Establishment of an affidavit of domestic partnership (*If this option is available through your employer and provided all requirements listed in the affidavit apply.*)
- o 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 #1:** You divorce (or terminate your domestic partnership) on July 12th; this causes your ex-spouse (or ex-domestic partner) to become ineligible effective July 31st. 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.)





## EMPLOYEE BENEFITS RULES AND REGULATIONS SUMMARY

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:

- **Employees** – 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.
- **Actively Serving Board Members** – Coverage terminates on the last day of the month in which the board member's term expires.
- **Dependents (spouse/domestic partner and dependent child)** – 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*).
- **Employees on an extended leave of absence (LOA)** – 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.*)



New Mexico  
Public Schools  
Insurance  
Authority

## EMPLOYEE BENEFITS RULES AND REGULATIONS SUMMARY

### GENERAL INFORMATION

- **The Two Year Vision Rule** – Once enrolled in vision, you may not drop vision until you and each of your covered dependents have been enrolled two years.
- **Open Enrollment** – 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.
- **Switch Enrollment** – 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.
- **The No NMPSIA Double Coverage Rule** – 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.
- **Confirmation of Enrollment** –
  - o 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.
  - o Check your enrollment online at <https://nmpsiaonline.nmpsia.com>.

**INSURANCE FRAUD** (*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 you may contact NMPSIA'S  
ENROLLMENT/ELIGIBILITY ADMINISTRATIVE OFFICE at 1-800-233-3164.**

**The NMPSIA Rule and Regulations at [www.nmpsia.com](http://www.nmpsia.com) supersede any information contained in this Summary or Frequently Asked Questions Section on page 16. You may also log on to [www.nmpsia.com](http://www.nmpsia.com) to find the links to contact NMPSIA staff.**





**BlueCross BlueShield of New Mexico**



[www.bcbsnm.com](http://www.bcbsnm.com)

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