



Administered by:



**BlueCross BlueShield
of New Mexico**

University of New Mexico Student Health Plan Benefit Booklet

Account #:190482

BluePPO EvolutionsSM

A Guide to Your Group Preferred Provider (PPO) Health Care Plan



CUSTOMER ASSISTANCE

MEDICAL BENEFITS

Call **1-844-866-2224**

UNM Team Health Customer Care Center Monday through Friday from 8 A.M. - 5 P.M. Mountain Time. If you call after normal Customer Care hours, you will be asked to leave a message.

PRIOR AUTHORIZATION

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

For **Prior Authorization** 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.

Send all written inquiries/**Prior Authorization** requests and submit medical/surgical **Claims*** to:

Blue Cross and Blue Shield of New Mexico

P.O. Box 660058
Dallas, TX 75266

24/7 NURSELINE

Call **1-800-973-6329**

The 24/7 Nurseline can help when you have a health problem or concern. The 24/7 Nurseline is staffed by **Registered Nurses** who are available 24 hours a day, 7 days a week.

ENROLLMENT

Call Academic HealthPlans, Inc

1-855-865-0352

BEHAVIORAL HEALTH & CHEMICAL DEPENDENCY

For inquiries or **Prior Authorization** 24 hours/day, 7 days/week

Call **1-888-898-0070**

Send Behavioral Health & **Chemical Dependency Claims*** to:

Blue Cross Blue Shield of New Mexico

Claims, Behavioral Health Unit

P.O. Box 660058 Dallas, TX 75266

WEBSITES

For **Provider** network information, BCBSNM **Drug List**, **Claim** forms, and other information:

UNM.myahpcare.com

or

www.bcbsnm.com

Academic HealthPlans

BCBSNM

Academic HealthPlans, Inc. (AHP) is an independent company that provides program management and administrative services for the **Student** Health Plan that Blue Cross and Blue Shield of NM administers.

*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. **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

University of New Mexico Student Health

Welcome to the PPO health care benefit plan for eligible **Students** of the **University of New Mexico** 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 UNM Student Health Plan 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 UNM Student Health Plan (your **Group**) may change the benefits described in this **Benefit Booklet**. If that happens, BCBSNM or UNM Student Health Plan will notify you of those mutually agreed upon changes.

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

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) - The **Student Health Plan** is a **Preferred Provider Organization (PPO)** plan. You should seek treatment from Student Health and Counseling Center (SHAC), the UNM Health Network or the BCBSNM **Preferred Provider Organization (PPO)** Network, which consists of **Hospitals**, doctors, and ancillary and other health care **Providers** who have contracted with UNM Health and BCBSNM for the purpose of delivering covered health care services at negotiated prices, so you can maximize your benefits under this plan. A list of **Network Providers** can be found online at unm.myahpcare.com by clicking on the "Find a Doctor or **Hospital**" link under "Benefits," or by calling (844) 866-2224.

Sincerely,

UNM Student Health Plan

Revision History: Renewal 07/26 with all applicable benefit updates
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SECTION 1: HOW TO USE THIS BENEFIT BOOKLET

This **Benefit Booklet** describes the medical/surgical, **Prescription Drug**, and behavioral 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 UNM Team Health Customer Care. See details in *Section 3: How Your Plan Works*.
- Call BCBSNM (or the Behavioral Health Unit) for **Prior Authorization**, if necessary. The phone numbers are on your Plan ID card. See *Section 4: Prior Authorizations* for details about the **Prior Authorization** 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

The defined terms in this **Benefit Booklet** are capitalized and shown in the appropriate provision in the **Benefit Booklet** or in *Section 10: Definitions*. Whenever these terms are used, the meaning is consistent with the definition given. Terms in italics may be section headings describing provisions or they may be defined terms.

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. The **Summary of Benefits** may not be available in this booklet. For a current copy please contact a UNM Team Health Customer Care (Customer Care) whose phone number is at the bottom of each page of this **Benefit Booklet**. You may also log on to UNM.myahpcare.com.

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 UNM Team Health Customer Care.

Provider Network Directory

The **Provider** network directory is available through the BCBSNM website at www.bcbsnm.com. It lists all **Providers** in the UNM Health Network and the **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 UNM Customer Care. 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 UNM Team Health Customer Care or visit the BCBSNM website.

Drug Plan Benefits

BCBSNM has contracted with a separate **Pharmacy** benefit manager to administer your outpatient drug plan benefits. In addition to your **Benefit Booklet**, you will be sent important information about your drug plan benefits. For information specific to your drug plan coverage, see "Prescription Drugs and Other Items" in *Section 5: Covered Services*.

BlueCard®

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. It's a valuable addition to your health care plan coverage. Instructions for locating a **Preferred Provider** outside New Mexico can be found on the BCBSNM website at 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 UNM Health Providers or BCBS **Preferred Providers**. Refer to your **Summary of Benefits** for specific details.

Prior Authorization Required

To receive full benefits for some nonemergency **Admissions** and certain medical/**Surgical Services**, you or your **Provider** must call BCBSNM **before** you receive treatment. Call Monday through Friday, 8 A.M. to 5 P.M., Mountain Time. See *Section 4: Prior Authorizations* for details. After hours calls will be answered but inquiries may be handled the next business day.

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 UNM Team Health Customer Care, Monday through Friday, 8 A.M. to 5 P.M., Mountain Time. Also, if you have a routine delivery and stay in the **Hospital more than 48 hours**, or if you have a C-section delivery and stay in the **Hospital more than 96 hours**, you must call BCBSNM for **Prior Authorization** before you are discharged.

Written Request Required

If a **written request** for **Prior Authorization** 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 660058

Dallas, TX 75266

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.

Prior Authorization of Behavioral Health Care

Prior Authorization must be obtained for all inpatient and specified outpatient behavioral health and **Chemical Dependency** services by contacting the Behavioral Health Unit (BHU) at the phone number below (also listed on the back of your ID card). For services requiring **Prior Authorization**, 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 Prior Authorization 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

Prior Authorization 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 Care Advocate.

Customer Care

If you have any questions about your coverage, call UNM Team Health Customer Care. UNM Team Health Customer Care is available Monday through Friday from 8 A.M. - 5 P.M., Mountain Time. If you need assistance outside normal business hours, you may call the Customer Care telephone number and leave a message. UNM Team Health Customer Care will return your call by 5 P.M. the next business day.

Customer Care representatives can help with the following:

- Answer questions about your benefits
- Assist with **Prior Authorization** 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 care 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 UNM Team Health Customer Care at:

UNMHealthCustomerCare@unmmg.org

In addition to accepting e-mail inquiries, the UNM Team Health website contains valuable information about the UNM Health and BCBSNM **Provider** networks, and other Plan benefits.

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, BCBSNM Behavioral Health Unit (BHU) offers multi language interpreters for **Members** who call Customer Service.

After-Hours Help

If you need or want help to file a complaint outside normal business hours, you may call BCBSNM Behavioral Health Unit (BHU). Your call will be answered:

- You may be asked to leave a message for UNM Team Health to call you back on the next business day.
- Talk to a nurse at the 24/7 Nurseline right away if you have a health problem.

24/7 Nurseline

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

Toll-free: 1-800-973-6329

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

Blue Access For Members

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

If you need help accessing the **BAM** site, call:

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

Help Desk Hours: Monday through Friday 6 A.M. - 9 P.M., Mountain Time Saturday 6 A.M. - 2:30 P.M. Mountain Time.

Note: Depending on your **Group's** coverage, you may not have access to all online features. Check with your benefits administrator or call Customer Service at the number on the back of your ID card. BCBSNM 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 UNM Team Health Customer Care.
- 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

Who Is Eligible

Eligibility: The following types of **Students** will be automatically enrolled in the Plan unless a waiver and proof of coverage under another plan is submitted and approved by the waiver deadline:

- Medical Health Professional, Medical Doctorate, Pharmacy Doctorate (Pharm D), Physician's Assistant, Master of Science in Anesthesia, and Graduate Nursing (DNP, PhD, and Post-Graduate Certificate Program) **Students** enrolling (and not receiving a tuition refund), paying fees and actively attending classes each semester for six (6) or more credit hours or for three (3) or more hours in the summer; and
- Graduate **Students** holding a Teaching Assistantship (TA), Graduate Assistantship (GA), Research Assistantship (RA), or Project Assistantship (PA), enrolled for six (6) or more graduate credit hours throughout the semester and working 25% FTE or higher (Contact the Office for Academic Personnel at 505-277-4528 for additional eligibility information regarding assistantships).
- Graduate Fellowship holders (Contact the Office of Graduate Studies at 505-277-2711 for additional eligibility information regarding fellowships).

These **Students** will be automatically enrolled unless an opt-out waiver and proof of coverage under another Plan is submitted and approved prior to the waiver deadline. The medical policy and additional information can be found at unm.myahpcare.com and hr.unm.edu/benefits/student-health-plan.

The University of New Mexico maintains its right to investigate **Student** status and attendance records to verify that the eligibility requirements have been met. If The University of New Mexico discovers the eligibility requirements have not been met, the only obligation is refund of premium.

No eligibility rules or variations in premium will be imposed based on a **Student's** health status, medical condition, **Claims** experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status factor. A **Student** will not be discriminated against for coverage under this Policy on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Variations in the administration, processes or benefits of this Policy that are based on clinically indicated, reasonable management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

Discontinuance of Insurance Termination Date of Insurance

A **Student's** coverage will end on the earliest of the date:

- The Policy terminates
- The **Student** is no longer eligible or
- The period ends for which premium is paid

A **Dependent's** coverage will end on the earliest of the date:

- He or she is no longer a **Dependent**
- The **Student's** coverage ends or
- The period ends for which premium is paid or
- The Policy terminates

Refund of Premium

A pro-rata refund of premium will be made only in the event:

- Of a Covered Person's death or
- The Covered Person enters full-time active duty in any Armed Forces and we receive proof of such active-duty service

Eligible Family Members

Eligible **Students** who enroll may also insure their **Dependents**. **Dependent** enrollment must take place at the initial time of **Student** enrollment (or within 30 days, if the premium is billed on the **Student's** tuition); exceptions to this rule are made for newborn or adopted children, or for **Dependents** who become eligible for coverage as the result of a qualifying event. (Please see "Qualifying Events," page 3, for more details.) "**Dependent**" means an **Student's** lawful spouse including domestic partner; or an **Student's Child**, stepchild, **Child** of a covered person's domestic partner, foster **Child**, a grandchild for whom the **Student** or **Student's** spouse has legal guardianship; or a **Child** who is adopted by the **Student** or placed for adoption with the **Student**, or for whom the **Student** is a party in a suit for the adoption of the Child; or a **Child** whom the **Student** is required to insure under a medical support order issued or enforceable by the courts. Any such **Child** must be under age 26.

Coverage will continue for a **Child** who is 26 or more years old, chiefly supported by the **Student** and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the **Child's** condition and dependence must be submitted to the University of New Mexico within 31 days after the date the **Child** ceases to qualify as a **Dependent**, under this plan, for the reasons listed above. During the next two years, the University of New Mexico may, from time to time, require proof of the continuation of such condition and dependence. After that, the University of New Mexico may require proof no more than once a year.

Dependent coverage is available only if the **Student** is also insured. **Dependent** coverage must take place within the exact same coverage period as the **Student's**; therefore, it will expire concurrently with the **Student's** plan.

A newborn **Child** will be covered, provided the covered **Student**:

- 1) Enrolls the **Child** within 31 days of birth and
- 2) Pays any required additional premium

Eligible Child - The following family members of the **Student** through the end of the month during which the **Child** turns age 26:

- Natural or legally adopted **Child** of the **Student**
- **Child** placed in the **Student's** home for purposes of adoption (including a **Child** for whom the **Student** is a party in a suit in which the adoption of the **Child** by the **Student** is being sought)
- Stepchild of the **Student** (or otherwise eligible **Child** of a domestic partner, if domestic partners are covered under your benefit plan)
- **Child** for whom the **Student** must provide coverage because of a court order or administrative order pursuant to state law

A **Child** meeting the criteria above is an “eligible **Child**” whether or not the **Student** is the custodial or noncustodial parent, and whether or not the “eligible **Child**” is claimed on income tax, employed, married, attending school or residing in the **Student’s** home, **except** that:

- Once the **Student** is no longer a legal guardian of a **Child** or there is no longer a court order to provide coverage to a **Child**, the **Child** must be eligible as a natural **Child**, legally adopted **Child**, or stepchild of the **Student** in order to retain eligibility as a family member under this health plan.

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

- Shares your permanent residence and has resided with you for no less than one year
- Is not less than 18 years of age
- Is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner’s will; assignment of a durable power of attorney or health care power of attorney; shared household expenses
- Is not a blood relative any closer than would prohibit legal marriage and
- Has signed jointly with you, a notarized affidavit which must be submitted to the UNM Benefits Office.

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

- Has signed a domestic partner affidavit or declaration with any other person within 12 months prior to designating each other as domestic partners hereunder
- Is currently legally married to another person nor
- Has any other domestic partner, spouse, or spouse equivalent of the same or opposite sex

You and your domestic partner must qualify for and be recognized as domestic partners by the University of New Mexico (See UNM Policy #3790 for additional information on Domestic Partner eligibility). The UNM Student Health Plan, will require a notarized *Affidavit of Domestic Partnership* (available at <http://hr.unm.edu/docs/benefits/affidavit-of-domestic-partnership.pdf>) and at least one corroborating documents:

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

Within 31 days of the Effective Date of Coverage, you must submit all required forms to your UNM Benefits Department administrator. Once you have made an election during your initial enrollment period of 31 days from your date of hire, you are locked into that decision until the next open enrollment period.

UNM Student Health Plan will require acceptable proof (such as copies of income tax forms, legal adoption or legal guardianship papers, or court orders) that an individual qualifies as an **Eligible Family Member** under this coverage.

Unless listed as an **Eligible Family Member**, no other family member, relative or person is eligible for coverage as a family member. Common-law spouses are **not** considered legal spouses; in order to be considered eligible for coverage, a common-law spouse must meet the definition of “domestic partner.”

Information for Noncustodial Parents

When a **Child** is covered by the Plan through the **Child’s** noncustodial parent, then UNM Student Health Plan will:

- Provide such information to the custodial parent as may be necessary for the **Child** to obtain benefits through the Plan
- Permit the custodial parent or the **Provider** (with the custodial parent’s approval) to submit **Claims** for **Covered Services** with the approval of the noncustodial parent and
- Make payments on **Claims** submitted in accordance with the above provision directly to the custodial parent, the **Provider**, or the state **Medicaid** agency as applicable

Applying for Coverage

An eligible person can apply for coverage, for his/her **Eligible Family Members**, by enrolling online at unm.myahpcare.com **within 31 days** after becoming eligible according to the terms of the **Administrative Services Agreement**. **Note:** UNM Student Health Plan cannot use genetic information or require genetic testing in order to determine or to limit or deny coverage.

When Coverage Begins

UNM Student Health Plan will determine your Effective Date of Coverage according to the provisions of the **Administrative Services Agreement**.

This Plan does not cover any service received before your Effective Date of Coverage (which, for **Eligible Family Members**, may be later than the **Student’s** effective date). Also, if your prior coverage has an extension of benefits provision, this Plan will not cover those charges incurred after your effective date that are covered under the prior benefit plan.

Changes to Coverage

After initial enrollment, you may need to add **Eligible Family Members** to, or remove them from your coverage, update your address, or switch from Individual to Family coverage, or vice versa.

Your ability to change coverage types (e.g., from Family to Individual coverage, etc.) will depend on the rules and regulations set forth by the University of New Mexico. Please contact Academic HealthPlans at 1-(855) 865-0352 to find out when you can change your coverage type or remove a person from your coverage.

Adding a Family Member to Coverage

A **Student** may apply for coverage of an **Eligible Family Member** (such as a new spouse or a newborn **Child**). **Within 31 days** of acquiring the newly **Eligible Family Member**, the **Student** must:

- Notify Academic HealthPlans of the change
- Submit all necessary information and legal documentation of proof of dependency and
- Pay any additional premium for coverage

Adding a Spouse or a Domestic Partner

If a **Student** adds coverage for a spouse **within 31 days** of marriage, the effective date of the new **Eligible Family Member's** coverage will be no later than the first of the month following the date your **Group** received all requested information. If the **Student** does not 1) provide the necessary information and documentation to his/her benefits administrator or to Academic HealthPlans, and if required, 2) change from Individual (or **Student + Child(ren)** coverage, if applicable) to Family coverage **within 31 days** of marriage, then the spouse may not be added to coverage except as a **Late Applicant** (or as specified under "**Special Enrollment**" later in this section). You may also have the option of applying for a Two-Person (**Student + Spouse**) coverage type. Ask Academic HealthPlans which coverage types are available to you. For example, if you are applying for coverage for a new spouse and his/her eligible **Child(ren)**, you will have to change to Family coverage. See "Adding an Eligible **Child**," below.

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

Adding an Eligible Child

If you do not submit an application for an eligible **Child** or add additional coverage, if required, within the time frames below, the **Child** will be considered a **Late Applicant**, except as specified under "**Special Enrollment**."

Newborn Children

You must add coverage for the newborn **within 31** days of the birth in order for newborn care to be covered beyond **48 hours** for a routine delivery or greater than **96 hours** for a C - section delivery. If the application is not received **within 31** days and additional premium or other **Student** contributions for coverage, if any, are not paid, the newborn is considered a **Late Applicant**.

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

Adopted Children

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

Note: An adopted **Child** who is not enrolled within 31 days of adoption or placement in the home will be considered a **Late Applicant** unless the **Child** was previously enrolled in a **Student** health plan or other **Creditable Coverage** within 30 days of his/her adoption or placement for adoption and has had prior **Creditable Coverage** since that date with no significant lapse (i.e., 63 or more days).

Legal Guardianship

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

Stepchild

Application for coverage must be made for a stepchild **within 31 days** of the marriage to the stepchild's biological parent.

Court Ordered Coverage for Children

When a **Student** or university is required by a court or administrative order to provide coverage for an eligible **Child**, the eligible **Child** may be enrolled in the **Student's** Family coverage, or **Student/Children** coverage, if available and will **not** be considered a **Late Applicant**. (If the **Student** has Individual or Two-Person coverage, he/she may be required to pay additional premium in order for the eligible **Child** to be added.) If not specified in the court or administrative order, the eligible **Child's** Effective Date of Coverage will be the date the order has been filed as public record with the State or the effective date of Family coverage, or **Student/Children** coverage, if available, whichever is later. UNM Student Health Plan must receive a copy of the court or administrative order.

Late Applicant

Unless eligible for a **Special Enrollment**, applications from the following enrollees will be considered late:

- Anyone not enrolled **within 31 days** of becoming eligible for coverage under this Plan (e.g., a newborn **Child** added to coverage more than 31 days after birth when, for example, Family coverage (or **Student/Children** coverage, if available) is not already in effect, a **Child** added more than 31 days after legal adoption, or a new spouse or stepchild added more than 31 days after marriage)
- Anyone enrolling on the **Group's** initial BCBSNM enrollment date who was not covered under the **Group's** prior plan (but who was eligible for such coverage)
- Anyone eligible but not enrolled during the **Group's** initial enrollment
- Anyone who voluntarily terminates his/her coverage and applies for reinstatement of such coverage at a later date (except as a **Provider** under USERRA of 1994)

Application for coverage from **Late Applicants** will be accepted only during your **Group's** open enrollment period, except as described under "Special Enrollment for **Students** and Their Eligible Family Members" and under "Switch Enrollment and Changes in Plan," provisions of this Section 2.

Enrollment

Students are automatically enrolled and it is the **Student's** responsibility to waive out of coverage each semester if they have other coverage.

Special Enrollment

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

Note: There are no **Special Enrollments** for persons applying for any continuation coverage if offered under your Plan. You must enroll in these coverages timely.

Qualifying Events

The four instances of **Special Enrollment** are:

Loss of Prior Coverage

An eligible **Student** who declined coverage when initially eligible because of having other comprehensive medical coverage and who later *involuntarily* loses the other coverage (or who reaches a lifetime maximum under the prior benefit plan), may apply for coverage for himself/herself and **Eligible Family Members**. (The **Eligible Family Members** need not have been covered under the prior benefit plan when the **Student** has been granted a **Special Enrollment** under this provision.) Currently enrolled **Students** may also add **Eligible Family Members** to coverage under this provision if the **Eligible Family Member** had prior **Creditable Coverage** that was involuntarily lost or had reached lifetime benefit maximum under the other carrier's benefit plan. (See definition of "**Involuntary Loss of Coverage**" in *Section 10: Definitions*.)

If all necessary information and documentation is received **within 31 days** of losing the other coverage (or **within 31 days** of receiving the first denial notice informing the **Student** or **Eligible Family Member** that he/she had reached a lifetime limit), the applicant(s) will **not** be considered late.

Documentation from the prior carrier - supporting the fact that the person had prior **Creditable Coverage** that was lost involuntarily - may be submitted at a later date, but the **Student** must submit all other necessary information and documentation **within 31 days** of the loss of coverage (or denial notice). **Note:** Enrollment changes cannot be processed until **all documentation** is provided.

If the **Student** lost prior coverage, **Special Enrollment** is available to the **Student** and any **Eligible Family Members** of the **Student** (including spouse). If an **Eligible Family Member** of the **Student** lost prior coverage, **Special Enrollment** is available for the affected **Eligible Family Member** and the **Student** (not other **Eligible Family Members**). The choice to quit paying premiums, for example, because the **Student** or one family member under the other carrier's benefit plan reaches a lifetime benefit maximum is not an example of **Involuntary Loss of Coverage** for the entire family. However, in the case of one **Eligible Family Member** losing prior coverage, although all family members may not be eligible for a "special" enrollment, **Eligible Family Members** may be enrolled at the same time as the special enrollee, subject to **Late Applicant** provisions. Also, in order to be eligible for a **Special Enrollment** due to loss of prior coverage, the declining person must have completed a waiver of coverage statement when first eligible to enroll, and the reason stated for declining coverage must have been due to having other coverage. If a **Student** requests a **Special Enrollment** for self only, **Eligible Family Member(s)** only, or both, Academic HealthPlans may require proof of loss of coverage or proof of the date of the event.

Change in Family Status

A **Student** who acquires a new **Eligible Family Member** due to marriage, birth, adoption, or placement for adoption may apply for a **Special Enrollment** in this Plan for himself/herself and other family members who are eligible for coverage under this Plan. Application for **Special Enrollment** of the **Student** and his/her **Eligible Family Members** will **not** be considered late if submitted **within 31 days** of the marriage, birth, adoption, or placement of the eligible **Child** in the **Student's** home. If submitted more than 31 days following the change in family status, **Special Enrollment** is not available.

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

This right to Special Enrollment upon a change in family status applies to the Student and to all Eligible Family Members.

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

Loss of Medicaid/SCHIP Eligibility

If an eligible **Student** or his/her **Eligible Family Member** is not currently enrolled in the Plan and loses eligibility under **Medicaid** or under a State Child Health Plan (SCHIP), the person losing such coverage may enroll in the Plan without being considered a **Late Applicant**. To be eligible for **Special Enrollment**, the person must apply for coverage under the **Student** health plan no later than **60 days** after the date of termination of **Medicaid** or SCHIP coverage. (In order for an **Eligible Family Member** to be eligible for **Special Enrollment**, the **Student** must be covered under the **Student** health plan. If the **Student** is not enrolled in the Plan when the **Eligible Family Member** becomes eligible for assistance, the **Student** must enroll into the Plan at the same time as the **Eligible Family Member**.) Documentation from the state - supporting the fact that the person had **Medicaid**/SCHIP coverage that was lost involuntarily - may be submitted at a later date with the university’s approval, but the **Student** must submit all necessary information and documentation within **60 days** of the loss of coverage. **Note:** Enrollment changes cannot be processed until **all documentation** is provided to the University.

If the Student lost Medicaid/SCHIP coverage, Special Enrollment is available to the current Student and any Eligible Family Members of the Student (including spouse). If an Eligible Family Member of the current Student lost Medicaid/SCHIP coverage, Special Enrollment is available for the affected Eligible Family Member and the Student (not other Eligible Family Members).

Medicaid/SCHIP Student Health Plan Premium Assistance Eligibility

A state may offer premium subsidies through **Medicaid** or a State Child Health Plan (SCHIP) to low-income children and their families for qualified University-sponsored coverage. This includes premium assistance for continuation coverage under federal or state law. Therefore, if an eligible **Student** or an **Eligible Family Member** is not enrolled in the Plan and later becomes eligible for **Student** health plan premium assistance under **Medicaid** or under SCHIP, the eligible person may enroll in the Plan without being considered a **Late Applicant**. To be eligible for **Special Enrollment**, the affected person must apply for coverage through the University no later than **60 days** after becoming eligible for premium assistance. (In order for a family member to be eligible for **Special Enrollment**, the **Student** must be covered under the University’s health plan. If the **Student** is not enrolled in the Plan when the **Eligible Family Member** becomes eligible for assistance, the **Student** must enroll in to the Plan at the same time as the **Eligible Family Member**.)

Documentation from the state - supporting the fact that the person is eligible for premium assistance from **Medicaid** or SCHIP - may be submitted at a later date with the University’s approval, but the **Student** must submit all necessary information and documentation **within 60 days** of the affected person’s premium assistance eligibility date. **Note:** Enrollment changes cannot be processed until **all documentation** is provided to the University.

The current Student who is eligible but not enrolled for coverage under the terms of the Student Health Plan (or a Dependent of such a Student who is eligible but not enrolled for Student Health Plan coverage under such terms) may enroll in the Student Health Plan upon becoming eligible for a state premium assistance subsidy under Medicaid or SCHIP if Special Enrollment is requested in a timely manner.

Applying for Special Enrollment

Application for **Special Enrollment** must be made **within the time period specified for each of the qualifying events above** in order to qualify you and/or your **Eligible Family Member(s)** for a **Special Enrollment** right. Please contact Academic HealthPlans for details about **Special Enrollment** privileges that apply to you and your **Eligible Family Members**.

Waiving Coverage

Students who do NOT want the UNM Student Health Plan will need to purchase an acceptable insurance plan on their own and log in to the UNM Student Health Plan website at: <https://unm.myahpcare.com>, enter their insurance information in English and apply to “Waive” (NOT PAY FOR) the UNM Student Health Plan by the waiver deadline as determined by the University of New Mexico.

Coverage Effective Date

Insurance for an Eligible Person who enrolls during the program’s enrollment period, as established by the school, is effective on the latest of the following dates:

- Policy Effective Date
- Date We receive the completed enrollment form
- Date the required premium is paid and
- Date the **Student** enters the Eligible Class

Coverage for a **Student’s** eligible **Dependent** who enrolls:

- During the enrollment period established by the Policyholder or
- Within 31 days after the **Student** acquires a new **Dependent** or
- Within 31 days after a Dependent terminates coverage under another Health Care Plan, is effective on the latest of the following dates:
 - First day of the Coverage Period
 - Date the **Student** enters the Eligible Class
 - Date we receive the completed enrollment form
 - Date the required premium is paid

After the time periods described above, the **Student** or **Dependent** must wait until the next enrollment period, except for a newborn or a newly adopted **Child** or if there is an **Involuntary Loss of Coverage** under another Health Care Plan.

Notification of Eligibility and Address Changes

The **Student** must notify **Academic HealthPlans** **within 31 days** following any changes that may affect his/her or a family member’s eligibility, including a change to a covered family member’s name or address, by indicating such changes on the **Academic HealthPlans** web portal. You can obtain this form at Academic HealthPlan’s website: [UNM.myahpcare.com](https://unm.myahpcare.com) or by calling Academic HealthPlans at 1- (855) 865-0352.

Coverage Termination Date of Insurance

An **Student’s** coverage will end on the earliest of the date:

- Date the Policy terminates
- Date the **Student** is no longer eligible
- Date the period ends for which premium is paid
- Date the Policy Effective Date of the renewal of this Policy if a **Student** decides to renew coverage under this Policy, and the Policy Effective Date of the renewal of this Policy becomes effective before this Policy terminates

A **Dependent's** coverage will end on the earliest of the date:

- He or she is no longer a **Dependent**
- The **Student's** coverage ends
- The period ends for which premium is paid
- The Policy terminates

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 the Student Health and Counseling Center (SHAC), a UNM Health Provider or a BCBS **Preferred 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 unless otherwise specified in the Plan. Services obtained from **Nonpreferred Providers** (any **Provider** outside the UNM Health Network or BCBSNM PPO Network) will not be paid EXCEPT for **Ambulance** and **Emergency** services.

Hearing Aid

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 **Nonpreferred Providers**, see "Benefit Level Exceptions" 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 UNM Health Provider or **Primary Preferred Provider (PPP)** or other **Preferred Provider** in your area. You can also access behavioral 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 UNM Team Health Customer Care. It is also a good idea to speak with a **Provider's** office staff directly to verify whether or not they belong to the BCBS **Preferred Provider** network before making an appointment.

Web-Based BCBSNM Provider Finder

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

www.bcbsnm.com

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

Paper Provider Network Directory

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

Finding a Pharmacy

To find a **Participating Pharmacy**, visit the Prime Therapeutics website at:

www.MyPrime.com

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

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

Go to the BCBSNM website at www.bcbsnm.com, click on “Find Care.”. On the following page, you will either be able to log into your **BAM** account or you can search as a “Guest.” You will then need to enter the “City, State or Zip” code of the location in which you are searching for **Providers**. **BCBSNM website: www.bcbsnm.com**

National Website

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

Blue Cross and Blue Shield Association website:

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

National Phone Number

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

1-800-810-BLUE (2583)

International Assistance

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

Plan Year

Your **Benefit Period** is as follows:

- Medical & Pharmacy Doctorate **Students**: July 1, 2026 – June 30, 2027
- Physician’s Assistants (New): August 10, 2026 – July 15, 2027
- Physician’s Assistants (Returning): July 1, 2026 – July 15, 2027
- GA/Fellowship/Medical Health Professionals: August 10, 2026 – July 15, 2027
- Master of Science in Anesthesia July 27, 2026 – July 1, 2027
- Graduate Nursing (DNP, PhD, and Post-Graduate Certificate Program) August 10, 2026 – July 15, 2027

Benefit Limits

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

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

Cost-Sharing Features

For some services, you will pay only a fixed-dollar amount **Copayment** for **Covered Charges**. In other cases, you will have to meet a **Deductible** and pay a percentage of the **Covered Charge** (**Preferred Providers** will not bill you for amounts in excess of the **Covered Charge**). When you receive a number of services during a single visit or procedure, you may have to pay both a **Copayment** and a **Deductible** (if applicable) plus a percentage of the **Covered Charges** that are not included in the **Copayment**. Refer to your **Summary of Benefits** for details.

Your Deductible

Your **Deductible** (if applicable) is the amount of **Covered Charges** that you must pay in a **Plan Year** before this Plan begins to pay its share of the applicable (**Preferred** or **Nonpreferred Provider**) **Covered Charges** you incur during the same **Plan Year**. If the **Deductible** amount remains the same during the **Plan Year**, you pay it only once each **Plan Year**, and it applies to all **Preferred** or **Nonpreferred Provider Covered Services** you receive during that **Plan Year**.

Individual Deductible

The individual **Deductible** amounts indicated on your **Summary of Benefits** apply to the UNM Health and BCBSNM network benefits. Once a **Member's Deductible** payments for the UNM Health or the BCBSNM **Preferred Provider** services reach the individual **Deductible** amount, this Plan will begin paying its share of that **Member's** covered **Preferred Provider** charges. Services performed at the Student Health and Counseling Center (SHAC) are not subject to the individual **Deductible**.

Family Deductible

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

What Is Not Subject to the Deductible

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

- Charges covered under "Prescription Drugs and Other Items"
- **Primary Preferred Provider** office visit **Copayments**
- The following services when received from **Preferred Providers**: preventive care, routine diagnostic tests, (excluding MRIs, PET scans, and CT scans)

Admissions Spanning Two Plan Years

If a **Deductible** has been met while you are an inpatient and the **Admission** continues into a new **Plan Year**, no additional **Deductible** is applied to that Admission's **Covered Services**. However, all other services received during the new **Plan Year** are subject to the **Deductibles** for the new **Plan 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 UNM Health Provider or 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**, which can be obtained by contacting a UNM Team Health Customer Care Customer or by logging on to UNM.myahpcare.com.

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**.

Drug Plan Copayment

When you purchase covered **Prescription Drugs** and other items through the drug plan, your responsibility may be either a fixed-dollar amount or a percentage of the **Covered Charge**. (You may also have to pay the difference between the cost of a **Brand-Name Drug** and its generic equivalent.) In either case, drug plan **Copayments** are **not** subject to the **Deductible** or **Out-of-Pocket Limit** provisions. See "Prescription Drugs and Other Items" for more information about the drug plan.

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**.

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**.

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 **Plan Year**. After the **Out-of-Pocket Limit** is reached, this Plan pays 100 percent of most of your **Preferred Provider Covered Charges** for the rest of the **Plan Year**, not to exceed any benefit limits.

Individual Limits

Once your **Coinsurance** amounts for **Preferred Provider** services in a **Plan 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 **Plan Year**.

Family Limits

An entire family meets the **Out-of-Pocket Limit** during a **Plan 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)

See the **Summary of Benefits** which can be obtained by contacting a UNM Team Health Customer Care Customer or by logging on to UNM.myahpcare.com 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 **Plan 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 year, the new amounts must be met during the same **Plan 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, benefits are not available 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, UNM Health 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**, UNM Health may also authorize transitional care from other **Nonpreferred 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 UNM Customer Care for details.

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 **Prior Authorization** 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 all associated charges.

Note: Except as described above, the Preferred Provider benefit level will not apply to nonemergency services when received from a Nonpreferred Provider.

SECTION 4: PRIOR AUTHORIZATIONS

You or your **Provider** must obtain **Prior Authorization** *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.

Prior Authorization determines only the **Medical Necessity** of a specific service and/or an **Admission** and an allowable length of stay. **Prior Authorization 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 behavioral health condition, illness, injury, or disease.

Please note:

Prior Authorization 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.

For specific details about the Prior Authorization requirement for the above referenced Outpatient Services, please call Customer Service at the number on the back of your Identification Card

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

Most **Prior Authorization** 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 **Prior Authorization** is not obtained before the service is received.

How the Prior Authorization Procedure Works

When you or your **Provider** call BCBSNM a 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) of the status of the **Prior Authorization** requested for benefits for the proposed hospitalization or other services. If **Prior Authorization** is not obtained for the **Admission** or other services 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 **Prior Authorization** is not your responsibility — it is the **Provider's**. **Preferred Providers** contracting with BCBSNM must obtain **Prior Authorization** 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 Prior Authorizations,” later in this section.

Note: Providers that contract with other Blue Cross and Blue Shield Plans are not familiar with the **Prior Authorization** 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 **Prior Authorization** 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 **Prior Authorization**, the **Provider** is **not** obligated to obtain the **Prior Authorization** for you. In such cases, it is **your** responsibility to ensure that **Prior Authorization** is obtained. If authorization is **not** obtained **before** services are received, **your benefits for Covered Services will be denied and you will be entirely responsible for the charges**. The **Provider** may call on your behalf, but it is **your responsibility** to ensure that BCBSNM has authorized those services.

Inpatient Prior Authorization

Prior Authorization 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).

Type of Inpatient Admission, Readmission, or Transfer:	When to obtain inpatient Admission Prior Authorization:
Non-Emergency	Before the patient is admitted.
Emergency, non-Maternity	Within 48 hours of the Admission. If the patient's condition makes it impossible to call within 48 hours, call as soon as possible.
Maternity-related (including eligible newborns when the mother is not covered)	Before the mother's Maternity due date, soon after pregnancy is confirmed. BCBSNM must be notified as soon as possible if the mother's stay is greater than 48 hours for a routine delivery or greater than 96 hours for a C- section delivery.
Extended stay, newborn (an eligible newborn stays in the Hospital longer than the mother)	Before the newborn's mother is discharged.

Not Obtaining Inpatient Prior Authorization

If you or your **Provider do not receive Prior Authorization** for inpatient benefits, but you choose to be hospitalized anyway, **no** benefits may be paid as indicated in the table below:

If, based on a review of the Claim:	Then:
The Admission was not for a Covered Service .	Benefits for the Facility and all related services will be denied.*
The Admission was for an item listed under " Other Prior Authorizations ," (e.g., elective admissions).	Benefits for the Facility and all related services will be denied.*
The Admission was for any other Covered Service but hospitalization was not Medically Necessary .	Benefits will be denied for room, board, and other charges that are not Medically Necessary.*
The Admission was for a Medically Necessary Covered Service .	Benefits for the Facility's Covered Services may be denied.

Inpatient **Prior Authorization** 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 Prior Authorizations

In addition to **Prior Authorization** review for all nonemergency **Inpatient Services**, **Prior Authorization** is required for the services listed below. Most **Prior Authorizations** 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 **Prior Authorization**. 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 **Prior Authorizations** for you. (See "Inpatient **Prior Authorization**" for further information regarding inpatient **Prior Authorization** requirements.)

If **Prior Authorization** 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 Prior Authorization Received	Claim Disposition: In-Network	Claim Disposition: Out-of-Network
Service is Medically Necessary	Claim is paid based on Member's benefit plan	Claim is paid based on Member's benefit plan
Service is not Medically Necessary	Claim is denied; Member held harmless	Claim is denied; Member is held harmless

Other services that require Prior Authorization includes but not limited to:	Outpatient Medical / Surgical Services
• Dialysis obtained from an Nonpreferred-Provider* • Home Health Services including but not limited to home private duty nursing (PDN) and home infusion therapy (HIT)* • Home Hospice* • Home Infusion Therapy (HIT)* • Home Hemodialysis* • Non-Emergent Air Ambulance* • Transplant Evaluations and Transplants • Out-of-Network/Out-of-Plan Services* • Outpatient elective surgery received in an out-of-network Hospital or ambulatory surgical center	• Advanced Imaging / Radiology • Molecular Genetic Lab Testing • Musculoskeletal – Joint, Spine Surgery • Musculoskeletal – Pain • Radiation Therapy / Radiation Oncology • Sleep • Other Outpatient Services ○ Cardiology – Lipid Apheresis ○ Ear, Nose and Throat ○ Gastroenterology ○ Neurology ○ Outpatient Surgery (Breast, Deactivation of Headache Triggers, Jaw) ○ Pain Management ○ Wound Care • Behavioral Health and Substance Use Disorder Services ○ Applied Behavioral Analysis (ABA) ○ Electroconvulsive Therapy (ECT) ○ Intensive Outpatient Treatment (IOP) ○ Partial Hospitalization ○ Psychological Testing/Neuropsychological Testing ○ Repetitive Transcranial Magnetic Stimulation

For specific details about the Prior Authorization requirement for the above referenced Outpatient Services, please call Customer Service at the number on the back of your Identification Card. BCBSNM reserves the right to no longer require **Prior Authorization** during the **Plan Year**. Updates to the list of services requiring **Prior Authorization** may be confirmed by calling UNM Team Health Customer Service.

All services, including those for which **Prior Authorization** 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 Prior Authorization may not be approved for payment** (for example, due to being **Experimental, Investigational, Unproven**, or not **Medically Necessary**). The complete list of services requiring **Prior Authorization** is subject to review and change by BCBSNM.

The **Prior Authorization** 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.

Prior Authorization of Behavioral Health/Chemical Dependency Services

Prior Authorization must be obtained for all inpatient behavioral health and **Chemical Dependency** services. **Prior Authorization** may be requested by contacting the BCBSNM Behavioral Health Unit (BHU) at the phone number listed on the back of your ID card. **Prior Authorization** is also required for outpatient psychological testing, neuropsychological testing, **Intensive Outpatient Program (IOP)** treatment, Applied Behavior Analysis (ABA) Therapies, and electroconvulsive therapy (ECT) for treatment of **Mental Disorder** and/or **Chemical Dependency**. **Prior Authorization** 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 **Prior Authorization**, 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 **Prior Authorization** 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 **Prior Authorization** of nonemergency **Inpatient Services**, benefits for covered, **Medically Necessary** inpatient **Facility** care may be reduced by an amount that is equal to the **Prior Authorization** (or **Admission** review) penalty, if any, indicated for medical/surgical **Admissions**. If **Inpatient Services** received without **Prior Authorization** 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 **Prior Authorization** 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 **Prior Authorization** for **Outpatient Services** *before* you start treatment.

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

Summary of Contact Information for Prior Authorization, Customer Service, Claim Submission, and Appeal (or Reconsideration) Processes for Medical/Surgical and Behavioral Health Services:			
Process:	Type of Service:	Phone:	Send to:
Request Prior Authorization	Medical/surgical	1-505-291-3585 or 1-844-866-2224	Send to P.O. number listed on inside cover. Attn: Health Services Department
	Behavioral Health/ Chemical Dependency	1-888-898-0070	Send to P.O. number listed on inside cover. Attn: BH Unit
Customer Service Inquiry	Medical/surgical	1-844-866-2224	Send to P.O. number listed on inside cover.
	Behavioral Health/ Chemical Dependency	1-888-898-0070	Send to P.O. number listed on inside cover. Attn: BH Unit
Submit Claim (post-service)	Medical/surgical		Send Claim to P.O. number listed on inside cover.
	Behavioral Health/ Chemical Dependency		Send to P.O. number listed on inside cover. Attn: BH Unit
Request appeal or reconsideration of Claim or Prior Authorization decision	Medical/surgical	1-800- 205- 9926 or 1-844- 866- 2224	Send to P.O. number listed on inside cover. Attn: Appeals Unit or Contact UNM Team Health Customer Care Center for assistance.
	Behavioral Health/ Chemical Dependency	1- 888- 898- 0070	Send to P.O. number listed on inside cover. Attn: Appeals Unit or Contact UNM Team Health Customer Care Center for assistance.

If Your Prior Authorization Request Is Denied

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

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

If you have an inquiry or a concern about any **Prior Authorization** request, call your UNM Team Health Customer Service Advocate for assistance at 1844-866-2224. Many complaints or problems can be handled informally by calling or writing UNM Team Health Customer Service. If you make an oral complaint, a UNM Team Health Customer Service Advocate will assist you.

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 **Student** health 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. **To be covered, services must be Medically Necessary or listed as a Covered Service below. If a service is not listed as a Covered Service, it will be covered as long as that service is Medically Necessary and is not specifically excluded in this Benefit Booklet.**

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 the following definition:

Medically Necessary 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 behavioral health condition, illness, injury, or disease.

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.

Prior Authorizations are a requirement that you or your **Provider** must obtain authorization 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.

Prior Authorization determines only the **Medical Necessity** of a specific service and/or an **Admission** and an allowable length of stay. **Prior Authorization 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 not **Medically Necessary** will be denied.

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 **Prior Authorization** 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

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. **Prior Authorization** for the treatment must be requested by contacting BCBSNM. BCBSNM may 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. If **Prior Authorization** is not obtained from BCBSNM, which will determine if the services will be performed in accordance with a treatment plan and are **Medically Necessary**, prior to having the services 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: Prior Authorizations* for more information about **Prior Authorization** requirements. Please review the **Short-Term Rehabilitation: Occupational, Physical, Speech Therapy** section of this Policy for more specific information about how visit maximums for Occupational, Physical and Speech Therapy services apply to benefits for **Autism Spectrum Disorder**.

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 **Prior Authorization** 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**). This also includes services or supplies provided for the treatment of an **Accidental Injury** resulting from an act of domestic violence or a medical condition. 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 inpatient **Hospital** services for dental-related and oral surgery services must have **Prior Authorization** from BCBSNM. **Note:** The **Dentist's** services for the procedure will not be covered unless listed as eligible for coverage in this section.

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, see *“Prescription Drugs and Other Items.”*

For **Durable Medical Equipment**, see *“Supplies, Equipment and Prosthetics.”*

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

Emergency Care And Urgent Care

Emergency Care

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.

If you disagree with the **Claim Administrator’s** determination in processing your benefits as nonemergency care instead of **Emergency Care**, you may call the **Claim Administrator** at the number on the back of your ID card. Please review the *Section 8: Claims Payment and Appeals* provision of this **Benefit Booklet** for specific information on your right to seek and obtain a full and fair review of your **Claim**.

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 disagree with the **Claim Administrator’s** determination in processing your benefits as nonemergency care instead of **Emergency Care**, you may call the **Claim Administrator** at the number on the back of your **Identification Card**. Please review *Section 8: Claims Payments and Appeals* section of this Policy for specific information on your rights to seek and obtain a full and fair review of your **Claim**.

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 will not be covered for **Noncontracted Providers**.

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

This Plan covers the cost of hearing aids, the fitting and dispensing fees for hearing aids and ear molds.

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.

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 **Prior Authorization** is received from BCBSNM (If drugs are not provided by the **Home Health Care Agency**, see “Prescription Drugs and Other Items.”)
- Drugs, medicines, or laboratory services that would have been covered during an inpatient **Admission**
- Enteral nutritional supplies (e.g., bags, tubing) (For enteral nutritional formulas, see “Prescription Drugs and Other Items.”)
- **Medical Supplies**

- Skilled services by a qualified aide to do such things as change dressings and check blood pressure, pulse, and temperature

Exclusions

This 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 with **Prior Authorization** from 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, see "Prescription Drugs and Other Items.")
- Medical social services provided by a qualified individual with a degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training and experience (Such services must be recommended by a **Physician** to help the **Member** or his/her family deal with a specified medical condition.)
- Services of a home health aide under the supervision of a **Registered Nurse** and in conjunction with **Skilled Nursing Care**
- Nutritional guidance and support, such as intravenous feeding and hyperalimentation
- Respite care 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

Prior Authorization Required

If hospitalization is recommended by a **Nonpreferred Provider** or you are outside New Mexico, **you are responsible** for obtaining **Prior Authorization**. If you do not follow the inpatient **Prior Authorization** procedures, benefits for covered **Facility** services will be **reduced** or **denied** as explained in *Section 4: Prior Authorizations*.

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. **Prior Authorization** is required for all inpatient hospitalizations. See "Psychotherapy (Behavioral Health and **Chemical Dependency**)" for information about benefits for **Chemical Dependency** rehabilitation. See *Section 4: Prior Authorizations* for more information about **Prior Authorization** 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**”).

Infusion Therapy

Some outpatient infusion services for routine **Maintenance Medications** have been identified as capable of being administered, outside of an outpatient **Hospital** setting. **Member** out-of-pocket expenses may be lower when services are provided by a **Professional Provider** in an **Infusion Suite**, a home or an office, instead of a **Hospital**. Non-maintenance outpatient infusion therapy services will be covered the same as any other illness.

For more information, you may contact UNM Team Health Customer Care at the toll-free number on your **Identification Card**.

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 **Prior Authorization** from BCBSNM
- Audiometric (hearing) and vision tests for the diagnosis and/or treatment of an **Accidental Injury** or an illness
- Sleep studies

Note: All services, including those for which **Prior Authorization** 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 Prior Authorization will not be approved for payment.**

Maternity/Reproductive Services and Newborn Care

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

Family Planning and Infertility-Related Services

For oral contraceptive coverage and contraceptive **Devices** purchased from a **Pharmacy**, see “*Prescription Drugs and Other Items.*”

Family Planning

Covered family planning services include:

- Health education
- The following categories of FDA-approved contraceptive drugs, **Devices**, and services, subject to change a 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.

- 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 (<https://www.bcbsnm.com/nm/documents/rx-drugs/member-contraceptive-list-nm.pdf>), 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
- At least one **Generic Drug** or therapeutic equivalent in each category of contraception approved by the FDA
- Up to a 6-month supply of contraceptives is available, if prescribed by your **Physician** and are self-administered

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**. If benefits for contraceptive coverage is denied, you or your representative may contact Customer Service at the toll-free number on the back of your ID card to request an expedited review.

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:

- 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 UNM Team Health Customer Care before your **Maternity** due date, soon after your pregnancy is confirmed. UNM Team Health Customer Care must be notified as soon as possible if the mother's stay is greater than **48 hours** for a routine delivery or greater than **96 hours** for a C-section delivery. If not notified, benefits for covered **Facility** services may be reduced by **\$300**.

A covered daughter also has coverage for **Pregnancy-Related Services**. However, if the parent of the newborn *is* a covered **Child** of the **Student** (i.e., the newborn is the **Student'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

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 **Student** (i.e., the newborn is the **Student’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.

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

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**.

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

This plan, it 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

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

Genetic Inborn Errors of Metabolism

This Plan covers **Medically Necessary** expenses related to the diagnosis, monitoring and control of Genetic Inborn Errors of Metabolism as defined in *Section 10: Definitions*. **Covered Services** include:

- Medical assessment, including clinical services,
- Biochemical analysis,
- **Medical Supplies**,
- **Prescription Drugs** (see “Prescription Drugs and Other Items”),
- Corrective lenses for conditions related to the **Genetic Inborn Error of Metabolism**,
- Nutritional management and **Special Medical Foods** which have **Prior Authorization**(as defined and described in “Prescription Drugs and Other Items”).

In order to be covered, services cannot be excluded under any other provision of this **Benefit Booklet** and are paid according to the provisions of the Plan that apply to that particular type of service (e.g., **Special Medical Foods** are covered under “Prescription Drugs and Other Items,” medical assessments under “Physician Visits/Medical Care” and corrective lenses under “Supplies, Equipment and Prosthetics”).

To be covered, the **Member** must be receiving medical treatment provided by licensed health care professionals, including **Physicians**, 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.

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 UNM Team Health Customer Care if you have any questions about this policy.

Behavioral Health Evaluation Services

This Plan covers medication checks and intake evaluations for **Mental Disorders**, Alcohol, and **Drug Abuse**. See “Psychotherapy (Behavioral 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.)

Prescription Drugs and Other Items

Covered Medications and Other Items

Members are encouraged to use **Participating Pharmacies** under the **Retail Pharmacy Program** or **Specialty Pharmacy Drug Program** to make the most of their **Prescription Drug** benefits. **Members** who utilize nonparticipating Pharmacies will still receive coverage at the in-network allowable rate and subject to any applicable copays. The plan covers the following drugs, supplies and other products through this drug plan provision:

- **Prescription Drugs**, prenatal vitamins, and medicines, unless listed as an exclusion (covered drugs/items include insulin, glucagon, prescriptive oral agents for controlling blood sugar levels and **Prescription** contraceptive **Devices** and medications purchased from a **Participating Pharmacy**) **Note: Prescription** contraceptive **Devices** fitted or inserted by, and purchased directly from a **Physician** are payable under the "Family Planning" benefit, if any, of your medical/surgical Plan.
- Specialty drugs such as, but not limited to, self-administered injectable drugs such as growth hormone, Copaxone, Avonex. (Some self-administered drugs, whether injectable or not, are identified as specialty drugs and must be acquired through a **Participating Specialty Pharmacy Provider** in order to be covered.)
- Vaccinations for flu or pneumonia, or Zostavax® vaccinations when received from certain Participating Pharmacies (For a list of pharmacies that are contracted with BCBSNM to provide this service, go to the BCBSNM website at www.bcbsnm.com.)
- Insulin needles, syringes, glucose meters, and other diabetic supplies (e.g., glucagon emergency kits, autolets, lancets, lancet **Devices**, blood glucose and visual reading urine and ketone test strips). (A separate **Copayment** amount applies for each item purchased.) These items are **not** covered as a medical supply or medical equipment expense under any medical or surgical provisions of this **Benefit Booklet**. See "Supplies, Equipment, and Prosthetics" later in this section for a list of diabetic equipment that is covered under the medical/surgical portion of your health plan.
- Nonprescription **Enteral Nutritional Products** and **Special Medical Foods** only with **Prior Authorization** and either: 1) delivered through a **Medically Necessary** enteral access tube that has been surgically placed (e.g., gastrostomy, jejunostomy) or 2) meeting the definition of **Special Medical Foods** (These products must be ordered by a **Physician** and **Prior Authorization** received from BCBSNM in order to be covered.) See *Section 4: Prior Authorizations* for more information about **Prior Authorization** requirements.

- **Two 90-day courses** of treatment with FDA-approved **Prescription Drugs** and **Prior Authorization** to assist you with quitting tobacco use or smoking. (Starting any course of **Prescription Drug** therapy counts as one entire course of drug therapy - even if you discontinue or fail to complete the course. Therefore, if you purchase a one-month supply of a **Prescription Drug** for smoking cessation and do not continue the drug beyond the one month, you have used up one entire 90-day course of treatment with the 30-day supply.).

Prior Authorizations

Certain **Prescription Drugs** and specialty **Pharmacy** drugs may require **Prior Authorization** from BCBSNM. A list of drugs requiring **Prior Authorization** is available on the BCBSNM website at <https://unm.myahpcare.com/>. Your **Physician** can request the necessary **Prior Authorization**. See *Section 4: Prior Authorizations* for more information about **Prior Authorization** requirements.

Member Copayments

For covered **Prescription Drugs** (including specialty drugs), insulin, diabetic supplies, and nutritional products, you pay a **Copayment**, not to exceed the actual retail price, for each **Prescription** filled or item purchased (not to exceed supply limitations described in this section). **Copayments** are included in the **Out-of-Pocket Limit**, and are eligible for reimbursement once the **Out-of-Pocket Limit** is reached. You may also have to pay the difference in cost between the **Brand-Name Drug** and its generic equivalent (see below). The **Copayments** are listed on the **Summary of Benefit**, which can be obtained by contacting a UNM Team Health Customer Care Customer or by logging on to [UNM.myahpcare.com](https://unm.myahpcare.com).

Brand-Name vs. Generic Drug Costs

If you or the **Provider** requests the **Brand-Name Drug** when there is an FDA-approved generic equivalent available, **you must pay the difference in cost between the Brand-Name and its Generic equivalent**, plus the applicable **Copayment** and/or **Coinsurance** amount after your **Deductible** based on current tier of brand name drug. Any “differences” between the cost of the Generic equivalent and the cost of the Brand Name Drug will not apply to the **Deductible** and out-of-pocket maximum and will continue to be applicable after the Out-of-Pocket Maximum is met.

Retail Pharmacy Program

All items covered under this provision must be purchased from a participating retail **Pharmacy** unless there is an **Emergency**. **Some drugs may have to be purchased from a participating Specialty Pharmacy Provider in order to be covered.** (See your **Provider** Directory, call a Customer Service Advocate or visit the BCBSNM website at www.bcbsnm.com for a list of **Participating Pharmacies** and **Specialty Pharmacy Providers**.)

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

You must present your BCBSNM Identification (ID) Card to the pharmacist at the time of purchase to receive your drug benefits. (You do not receive a separate **Prescription** ID card; use your BCBSNM ID card to receive all your medical/surgical and **Prescription Drug** services covered under this Plan.) You are responsible for paying any **Deductibles**, **Coinsurance** amounts, **Copayments**, any pricing differences when applicable, and limited or non-Covered Services. No **Claim** forms are required when you purchase your **Prescriptions** at a **Participating Pharmacy**.

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

If you do not have your ID card with you or if you purchase your drug or other item from a nonparticipating (out-of-network) **Pharmacy** and it is eligible for coverage as indicated in the first paragraph above, such as in an **Emergency**, you must pay for the purchase in full and then submit a **Claim** directly to the BCBSNM **Pharmacy** benefit manager, Prime Therapeutics, at the address below (do not send to BCBSNM). In such cases, you will pay the difference in cost between the **Pharmacy's** billed amount and the **Covered Charge**, in addition to your **Deductible**, **Coinsurance**, and/or **Copayment** amount. You can obtain the necessary **Claim** forms from UNM Team Health Customer Care.

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

If you are leaving the country or need an extended supply of medication, call Customer Service **at least two weeks** before you intend to leave. (Extended supplies or vacation overrides may be approved only through the Retail Pharmacy Program. In some cases, you may be asked to provide proof of continued enrollment eligibility under the Retail Pharmacy Program.)

IMPORTANT: You must use the Specialty Pharmacy Provider designated by BCBSNM in order to receive benefits for specialty drugs.

Cost-Sharing Features

For covered **Prescription Drugs** (including specialty **Pharmacy** drugs), insulin, diabetic supplies, **Enteral Nutritional Products** and **Special Medical Foods**, you pay a percentage amount (not to exceed supply limitations described below). The **Coinsurance** you pay has a minimum amount you may be charged, but you will never pay more than the actual retail price. **Coinsurance** amounts are subject to the overall Plan **Deductible** and the **Out-of-Pocket Limit** provisions (see **Summary of Benefits**, *which can be obtained by contacting a UNM Team Health Customer Care Customer or by logging on to UNM.myahpcare.com.*). Once your **Coinsurance** amounts reach the **Out-of-Pocket Limit**, items covered under this Plan will be payable at **100 percent** for the rest of the **Plan Year**.

Supply Limitations

For each **Copayment** listed on the **Summary of Benefits**, you can obtain the following supply of a single covered **Prescription Drug** or other item (unless otherwise specified):

Program Type	Supply Maximum	Copay Requirement* (see note)
Nonprescription Nutritional Products	30-day supply during any 30-day period	50 percent of Covered Charges (includes Prescriptions for Enteral Nutritional Products and Special Medical Foods as described under "Covered Drugs and Other Items")
Retail Pharmacy and Specialty Pharmacy Provider	During each one month period, a 30-day supply	One Copayment for a 30-day supply.
Retail Pharmacy Supply	During each three - month period, a 90-day supply	One Copayment for each 30-day supply up to 90-day supply.
Self-Administered Prescription Contraceptives	During each six month period, a 180-day supply	No Copayment

NOTE: For commercially packaged items (such as an inhaler, a tube of ointment or a blister pack of tablets or capsules), you will pay the applicable **Copayment** for each package, **regardless of the number of days supply the package represents**.

Drug Plan Exclusions

In addition to services listed as not eligible for coverage in the *General Limitations and Exclusion* section of this booklet, this drug plan provision of your health plan does **not** cover:

- Nonprescription and over-the-counter drugs unless specifically listed as covered, including herbal or homeopathic preparations and Nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum, or **Prescription Drugs** that have over-the-counter equivalents This exclusion includes Nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum.
- Compounded medications, regardless of whether or not one or more ingredients in the compound requires a **Prescription** (Compounds are those made by mixing or reconstituting ingredients in a manner or ratio that is inconsistent with United States Food and Drug Administration-approved indications provided by the ingredients' manufacturers.)
- **Prescriptions** or other covered items purchased from a nonparticipating **Pharmacy**, nonparticipating **Specialty Pharmacy Provider** or other **Provider** unless eligible for benefits in an **Emergency** situation
- Refills before the normal period of use has expired, in excess of the number specified by the **Physician** or requested more than one year following the **Physician's** original order date (Some **Prescriptions** may be subject to a shorter refill window. Please call customer service for details.)
- Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced
- Infertility medications
- Drugs or other items for the treatment of sexual or erectile dysfunction
- Therapeutic **Devices** or **Appliances**, including support garments and other nonmedicinal substances

- Medications or preparations used for **Cosmetic** purposes (such as preparations to promote hair growth or medicated cosmetics), including tretinoin (sold under such brand names as Retin-A) for **Cosmetic** purposes
- Nonprescription **Enteral Nutritional Products** that are taken by mouth or delivered through a temporary naso-enteric tube (e.g., nasogastric, nasoduodenal, or nasojejunal tube), unless the patient meets criteria for Genetic Inborn Errors of Metabolism and the product has **Prior Authorization** from BCBSNM); or Nonprescription nutritional products that do not have not been **Prior Authorization** from BCBSNM (See *Section 4: Prior Authorizations* for more information about **Prior Authorization** requirements.)
- Shipping, handling or delivery charges
- **Prescription Drugs** required for international travel or work
- Appetite suppressant or diet aids; weight reduction drugs food or diet supplements and medication prescribed for body building or similar purposes

Note: **Prescription** contraceptive **Devices** are payable under your medical/surgical plan **Benefit Booklet** in the “Family Planning” provision of the **Covered Services** section.

Brand-Name Exclusion

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

Preventive Services

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

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

- This Plan covers the following **Preventive Services** not subject to **Coinsurance, Deductible, Copayment**, or benefit maximums when received from an **In-Network Provider**. 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”);
- 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;
- 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;

With respect to women, to the extent not described in item the first bullet above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.

The **Preventive Services** described in items “a” through “d” above may change as USPSTF, CDC, and HRSA guidelines are modified. For more information, you may visit the BCBSNM website at www.bcbsnm.com or contact Customer Service at the toll-free number on your BCBSNM health plan **Identification Card**.

Covered **Preventive Services not** described in items “a” through “d” above may be subject to **Deductible, Coinsurance, Copayments**, and/or dollar maximums. Allergy injections are **not** considered immunizations under the “**Preventive Services**” benefit. Examples of **Covered Services** include, but are not limited to:

- Routine physical, breast, and pelvic examinations
- Routine adult and pediatric immunizations
- An annual routine gynecological or pelvic examination and low-dose mammogram screenings
- Papilloma virus screening and cytologic screening (a Pap test or liquid-based cervical cytopathology)
- Human papillomavirus vaccine (HPV) for **Members** ages 9 - 26 years old
- Periodic blood hemoglobin, blood pressure and blood glucose level tests
- Periodic colorectal screening tests
- Periodic blood cholesterol or periodic fractionated cholesterol level including a low-density lipoprotein (LDL) and a high-density lipoprotein (HDL) level; periodic stool examination for the presence of blood
- Periodic left-sided colon examination of 35 to 60 centimeters or colonoscopy
- Well-child care, including well-baby and well-child screening for diagnosing the presence of **Autism Spectrum Disorder**
- Periodic glaucoma eye tests
- Vision and hearing screenings in order to detect the need for additional vision or hearing testing for **Members** when received as part of a routine physical examination (A screening does *not* include an eye examination, refraction or other test to determine the amount and kind of correction needed.)
- Health education and counseling services if recommended by your **Physician**, including an annual consultation to discuss lifestyle behaviors that promote health and well-being, including smoking/tobacco use **Cessation Counseling**

Exclusions

This 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 non preventive physical examination
- Routine eye examinations; eye refractions; or any related service or supply

Psychotherapy (Behavioral Health and Chemical Dependency)

Note: You do not receive a separate behavioral health/**Chemical Dependency** ID card; use your BCBSNM ID card to receive all medical/surgical and behavioral 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 behavioral health services (including individual and group psychotherapy) received in a **Psychiatric Hospital**, an **IOP (Intensive Outpatient Program)**, or an alcoholism treatment program that complies with applicable state laws and regulations, and services rendered by psychiatrists, licensed psychologists, and Other **Providers** as defined in *Section 10: Definitions*. See your BCBSNM **Provider Directory** for a list of contracting **Providers** or check the BCBSNM website at www.bcbsnm.com.

Residential Treatment Centers

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

BCBSNM requires that any behavioral 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.

Prior Authorization Requirements

All inpatient behavioral health and **Chemical Dependency** services must have **Prior Authorization** from the Behavioral Health Unit which can be reached at the phone number listed on the back of your ID card. **Prior Authorization** is also required for outpatient psychological testing, neuropsychological testing, **Intensive Outpatient Program (IOP)** treatment, electroconvulsive therapy (ECT), and repetitive transcranial magnetic stimulation for treatment of mental illness and/or **Chemical Dependency**. **Prior Authorization** 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 **Prior Authorizations** section, earlier. In such cases, you may be responsible for all charges, so please ensure that you or your **Provider** have received **Prior Authorization** 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
- Biofeedback, hypnotherapy, or behavior modification services
- Religious or pastoral counseling
- Custodial Care
- 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 behavioral 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 behavioral health professional practice
- The cost of any damages to a treatment **Facility**

Habilitation/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**, limited to one visit per day 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.

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 connection with phases I through IV of a cancer trial when approved by the federally funded agencies listed in 42 USC 300gg-8. 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 "Prescription Drugs and Other Items" will apply to these benefits.)

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:

- An agency of the National Institute of Health (NIH); or
- Centers for Medicare and Medicaid Services; or
- Agency for Healthcare Research and Quality; or
- NIH cooperative Group which is a formal network of facilities that collaborates on research projects and has an established NIH approved peer review program operating within the group, including the National Cancer Institute Clinical Cooperative Group and the National Cancer Institute Community Clinical Oncology Program; or
- The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (DHHS); or
- The U.S. Food and Drug Administration; or
- The U.S. Department of Defense or Veterans Affairs; or
- A qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants or the DOD, VA or Department of Energy if the study has been reviewed and approved through a peer review system; or
- An institutional review board of an institution in Mexico that has a multiple project assurance contract approved by the Office of Human Research Protections of the U.S. DHHS.
- A clinical trial conducted under an FDA investigational new drug application; or
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

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)

Prior Authorization Required

To be covered, all **inpatient, Short-Term Rehabilitation** treatments, including **Skilled Nursing Facility** and physical rehabilitation **Facility Admissions**, must receive **Prior Authorization** from BCBSNM. See *Section 4: Prior Authorizations* for more information about **Prior Authorization** 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 **Prior Authorization** has been **obtained** from BCBSNM

Benefit Limits

Benefits are limited, if applicable, as specified in the **Summary of Benefits**. Benefits for **Autism Spectrum Disorder** will not apply toward, and are not subject to, any **Occupational Therapy, Physical Therapy** or **Speech Therapy** visits. **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

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

This plan, it 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 non-Emergency services, out-of-network services are subject to the usual out-of-network Deductible, Coinsurance, and out-of-pocket). Electric breast pumps are limited to 1 per Calendar Year 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), see “Prescription Drugs and Other Items.”

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.

Some **Durable Medical Equipment** may be obtained at the Student Health and Counseling Center (SHAC).

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 (six pair per policy 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 **four bras** per policy 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 bed boards, 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
- Syringes or needles for self-administering drugs (Coverage for insulin needles and syringes and other diabetic supplies not listed as covered in this section is described under “Prescription Drugs and Other Items.”)
- Items that can be purchased over-the-counter, including but not limited to dressings for wounds (i.e., bed sores) and burns, gauze, and bandages
- Male contraceptive **Devices**, including over-the-counter contraceptive products such as condoms; female contraceptive **Devices**, including over-the-counter contraceptive products such as spermicide, when not prescribed by a health care **Provider**. (See “Maternity/Reproductive Services and Newborn Care: Family Planning” for **Devices** requiring a **Prescription**.)
- Items not listed as covered

SURGERY AND RELATED SERVICES

To be covered, Prior Authorization from BCBSNM must be received for all inpatient surgical procedures. See “Prior Authorizations” 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.

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)

- 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** or previous **Cosmetic** surgery)
- Obesity treatment, including the surgical treatment of morbid obesity
- 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

Prior Authorization, requested in writing, must be obtained from BCBSNM **before** a pretransplant evaluation is scheduled. A pretransplant evaluation is **not** covered if **Prior Authorization** 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 **Prior Authorization** for the actual **Transplant** is also received. None of the benefits described here are available unless you have this **Prior Authorization**. See *Section 4: Prior Authorizations* for more information about **Prior Authorization** 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 **Prior Authorization** is received from BCBSNM (See *Section 4: Prior Authorizations* for more information about **Prior Authorization** 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**. **Prior Authorization** must be obtained 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: Prior Authorizations* for more information about **Prior Authorization** 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 (**\$150**) 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 **Prior Authorization** from BCBSNM (See *Section 4: Prior Authorizations* for more information about **Prior Authorization** requirements.)
- Any **Transplant** or organ-combination **Transplant** not listed as covered
- Implantation of artificial organs or devices (mechanical heart, unless covered under BCBSNM **Medical Policy**)
- Nonhuman organ **Transplants**
- Care for complications of noncovered **Transplants** or follow-up care related to such **Transplants**
- Services related to a **Transplant** performed in a **Facility** not contracted directly or indirectly with BCBSNM to provide the required **Transplant** (except cornea, kidney, or bone marrow)
- Expenses incurred by a **Member** of this plan for the donation of an organ to another person
- Drugs that are self-administered or for use while at home (These services may be covered under "Prescription Drugs and Other Items.")
- 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:

— Aerial Vehicle Accidents

This Plan does not cover nor provide benefits for loss or expenses incurred as a result of an accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as fare-paying passenger in an aircraft operated by a commercial scheduled airline. Handled by subrogation.

— Assault, Felony, Riots, and Civil Commotion

This Plan does not cover nor provide benefits for loss or expenses incurred as a result of committing or attempting to commit an assault or felony or participation in a riot or civil commotion.

— Before Effective Date of Coverage

This Plan does not cover any service received, item purchased, **Prescription** filled, or health care expense incurred before your **Effective Date of Coverage**. If you are an inpatient when coverage either begins or ends, benefits for the **Admission** will be available only for those **Covered Services** received on and after your **Effective Date of Coverage** or those received before your termination date.

— Biofeedback

This Plan does not cover services related to biofeedback.

— Blood Services

This Plan does not cover directed donor or autologous blood storage fees when the blood is used during a 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 **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, **Prior Authorization**, requested in writing, must be obtained from BCBSNM for such services. Also, **Reconstructive Surgery**, which may have a coincidental **Cosmetic** effect, may be covered when required as the result of **Accidental Injury**, illness, or congenital defect.

— Custodial Care

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

— Dental-Related Services and Oral Surgery

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

— Domiciliary Care

This 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.

— Elective Treatment and Elective Surgery

This Plan does not cover nor provide benefits for loss or expenses incurred for elective treatment or elective surgery, except as specifically provided in the Plan.

— 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.

— Government Hospital Treatment

This Plan does not cover nor provide benefits for loss or expenses incurred for treatment provided in a government **Hospital** unless there is a legal obligation to pay such charges in the absence of insurance.

— 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.

— 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 *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 **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

This Plan does not cover any technologies, procedures, or services for which medical policies have been developed by BCBSNM that 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*.)

— Motor Vehicle Accidents

This Plan does not cover nor provide benefits for loss or expenses incurred as a result of Injuries sustained as the result of a motor vehicle accident to the extent provided for any loss or any portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. Handled by subrogation.

— 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 (except massage therapist services performed at SHAC)
 - Private sanitarium
 - 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**

— Non-Eligible Expenses

This Plan does not cover nor provide benefits for loss or expenses incurred for treatment, services or supplies that are not deemed to be an eligible expense.

— 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 **Prior Authorizations**; filling out of **Claim** forms; copies of medical records; interest expenses
- Modifications to home, vehicle, or workplace to accommodate medical conditions; voice synthesizers; other communication devices
- Membership at spas, health clubs, or other such facilities
- Personal convenience items such as air conditioners, humidifiers, exercise equipment, or personal services such as haircuts, shampoos, guest meals, and television rentals, Internet services
- Personal comfort services, including homemaker and housekeeping services, except in association with respite care covered during a **Hospice Admission**
- Immunizations or medications required for international travel
- Moving expenses or other personal expenses (e.g., laundry or dry-cleaning expenses; phone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- Physicals or screening examinations and immunizations given primarily for insurance, licensing, employment, camp, weight reduction programs, medical research programs, sports, or for any non-preventive 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**

— 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 under “Prescription Drugs and Other Items.” This exclusion includes Nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum.

— Nutritional Supplements

This 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 “Prescription Drugs and Other Items.”

— Obesity Surgery

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

— Out-of-Network Services

This Plan does not cover out-of-network services are **NOT AVAILABLE EXCEPT** Emergency services including ER visits, emergency admissions, urgent care centers and ambulance services.

— Post-Termination Services

This Plan does not cover any service received or item or drug purchased after your coverage is terminated, even if: 1) **Prior Authorization** 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.

— Prior Authorization Not Obtained When Required

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

— Preventive Treatment, Testing, Medicines, Serums, Vaccines, Vitamins and Contraceptive

This Plan does not cover nor provide benefits for loss or expense incurred for preventive treatment, testing, medicines, serums, vaccines, vitamins or contraceptive except as specifically provided in the Plan. This exclusion does not apply to **Preventive Services** mandated by the Patient Protection and Affordable Care Act.

— Private Duty Nursing Services

This Plan does not cover private duty nursing services.

— Psychotherapy (Behavioral Health and Chemical Dependency)

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

— 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, crystal, primal scream, sex, and Z therapies
- Self-help, stress management, weight-loss, 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
- 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*.

— Travel as a Team Member

This Plan does not cover nor provide benefits for loss or expenses incurred for injury resulting from: the practicing for, participating in, or traveling as a team member to and from intercollegiate, professional and semi-professional sports; hang gliding; sky diving; glider flying; sail planing. This exclusion does not apply to injuries sustained while participating in the UNM intramural Plan or UNM Club Sport Plan or activities, which are not under auspices of the UNM Athletic Department but are conducted under the jurisdiction of the policyholder.

— 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.

— Viscosupplementation

This Plan does not cover viscosupplementation (intra-articular hyaluronic acid injection), except for individuals currently receiving maintenance therapy.

— Vision Services

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

— War-Related Conditions

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

— Weight Management

This Plan does not cover weight-loss or other weight-management programs, dietary control, or medical obesity treatment, other than counseling programs as required under federal law unless dietary advice and exercise are provided by a **Physician**, nutritionist, or dietitian licensed by the appropriate agency. Call a Customer Service Advocate for assistance.

— 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.)

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

The rules establishing the order of benefit determination between this Plan and any other Health Care Plan covering you on whose behalf a Claim is made are as follows:

NOTE: The University of New Mexico does not allow Students or their Dependents to have dual coverage under the University of New Mexico or University of New Mexico Student Health plans. In the event of dual coverage under these plans, The University of New Mexico reserves the right to determine the appropriate plan coverage and may discontinue the other coverage.
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**, then **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.

Student/Family Member — If the **Member** who received care is covered as an employee, retiree, or other policy holder (i.e., as the **Student**) 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 **Student**) 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 both parents have the same birthday, the Health Care Plan that has covered the parent the longest is the primary plan. If the **Other Valid Coverage** does not follow this rule, the father’s coverage pays first.

Child, Parents Separated, Divorced, or Not Living Together — For a **Dependent Child** whose parents are divorced, separated, or not living together, whether or not they have ever been married:

— *Court-Decreed Obligations*. Regardless of which parent has custody,

- if a court order states that one of the parents is responsible for the **Dependent Child’s** health care expenses or health care coverage and the Health Care Plan of that parent has actual knowledge of

those terms, that Health Care Plan is primary. This rule applies to **Plan Years** commencing after the Health Care Plan is given notice of the court decree.

- if a court order states that both parents are responsible for the **Dependent Child's** health care expenses or health care coverage, the plans follow the rules that apply to children whose parents are not separated or divorced
 - — *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 third. The plan of the spouse 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:

- UNM Student Health Plan 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 UNM Student Health Plan has provided benefits to you or your covered family members.

- UNM Student Health Plan is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits UNM Student Health Plan provided for that sickness or injury.

UNM Student Health Plan 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 UNM Student Health Plan 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 UNM Student Health Plan 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 **Prior Authorization** requirements or benefits may be reduced or denied as explained in *Section 4: Prior Authorizations*. **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 university or any **Member** for a service if the **Provider** does not meet the filing limit for that service and the **Claim** for that service is denied due to timely filing limitations.

Nonparticipating Providers

A **Nonparticipating Provider** is one that has neither a **Preferred** or a **Participating Provider** agreement. If your **Nonparticipating Provider** does not file a **Claim** for you, submit a separate **Claim** form for each family member as the services are received. Attach itemized bills and, if applicable, your **Other Valid Coverage's** payment

explanation, to a *Member Claim Form*. (Forms can be printed from the BCBSNM website at www.bcbsnm.com or requested from a Customer Service Advocate.) Complete the **Claim** form using the instructions on the form. (See special **Claim** filing instructions for out-of-country **Claims** under “Where to Send Claim Forms” later in this section.)

Payment normally is made to the **Provider**. However, if you have already paid the **Provider** for the services being claimed, your **Claim** must include evidence that the charges were paid in full. Upon approval of the **Claim**, BCBSNM will reimburse you for **Covered Services**, based on **Covered Charges**, less any required **Member Copayment**. You will be responsible for charges not covered by the 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 **Student’s** name and address
- **Member’s** date of birth and relationship to the **Student**
- 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 660058
Dallas, TX 75266

Behavioral Health/Chemical Dependency Claims

Claims for covered behavioral health and **Chemical Dependency** services received in New Mexico should be submitted to:

BCBSNM, BH Unit
P.O. Box 660058
Dallas, TX 75266

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 UNM Team Health Customer Care or on the BCBSNM website at www.bcbsnm.com.

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 **Student** 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 **Student** under this Plan is the noncustodial parent, the custodial parent may receive the payment and the EOB.

If A Claim or Prior Authorization 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 **Emergency** services are received from a **Nonparticipating Provider**, payments are usually made to the **Student** (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 **Student** 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 **Student** 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 your **Group's** benefit plan or the **Claim Administrator** pays benefits for **Covered Charges** incurred by you or your **Eligible Family Members** and it is found that the payment was more than it should have been, or it was made in error ("Overpayment"), your **Group's** benefit plan or the **Claim Administrator** has the right to obtain a refund of the Overpayment amount from: (i) the person to, or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to **Participating Providers** or **Nonparticipating Providers**.

If no refund is received, your **Group's** benefit plan and/or **Blue Cross and Blue Shield of New Mexico** (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

- Any future benefit payment made to any person or entity under this **Benefit Booklet**, whether for the same or a different member; or
- Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield administered ASO benefit program and/or Blue Cross and Blue Shield administered insured benefit program or policy, if the future benefit payment owed is to a **Contracted Provider**; or
- Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured **Group** benefit plan or individual policy, if the future benefit payment owed is to a **Contracted Provider**; or
- Any future benefit payment, or other payment, made to any person or entity; or
- Any future payment owed to one or more **Contracted Providers**.

Further, the **Claim Administrator** has the right to reduce your benefit plan's payment to a **Contracted Provider** by the amount necessary to recover another Blue Cross and Blue Shield's plan or policy Overpayment to the same **Contracted Provider** and to remit the recovered amount to the other Blue Cross and Blue Shield plan or policy.

Student 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
 - Transition of care services when **Prior Authorization** has been obtained and are 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 having **Prior Authorization** , 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**.

Out-of-Area Services

Overview

Blue Cross and Blue Shield of New Mexico (BCBSNM), a division of Health Care Service Corporation, has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." These Inter-Plan Programs operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area BCBSNM serves, the **Claim** for those services may be processed through one of these Inter-Plan Programs. The Inter-Plan Programs are described generally below.

When you receive care outside the geographic area BCBSNM serves, you generally obtain care from healthcare **Providers** that have a contractual agreement ("**Participating 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 healthcare providers in the **Host Blue** geographic area that do not have a contractual agreement ("**Nonparticipating Providers**") with the Host Blue. BCBSNM explains how BCBSNM pays both kinds of providers below.

Inter-Plan Programs Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Programs, as described above, except for all dental care benefits, except when paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by BCBSNM to provide the specific service or services.

BlueCard® Program

Under the **BlueCard®** Program, when you access covered healthcare services within the geographic area served by a **Host Blue**, BCBSNM will remain responsible for doing what BCBSNM agreed to in the contract. However, the **Host Blue** is responsible for handling all interactions with its providers, including contracting with participating providers.

When you receive covered healthcare services outside BCBSNM's service area and the claim is processed through the **BlueCard®** Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed charges for your covered healthcare services; or
- The negotiated price that the **Host Blue** makes available to BCBSNM.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your provider. Sometimes, it is an estimated price that considers 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 considering the same types of transactions as with an estimated price.

Estimated pricing and average pricing also consider adjustments to correct for over or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price BCBSNM has used for your claim because they will not be applied after a claim has already been paid.

Negotiated Arrangements

With respect to one or more Host Blues, instead of using the **BlueCard**® Program, BCBSNM may process your claims for covered healthcare services through negotiated arrangements for national accounts.

The amount you pay for covered healthcare services will be calculated based on the lower of either billed charges for covered healthcare services or negotiated price (refer to the description of negotiated price under the **BlueCard**® Program section above) that the Host Blue makes available to BCBSNM.

Special Cases: Value-Based Programs

If you receive covered healthcare services under a value-based program inside a **Host Blue’s** service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a **Host Blue** passes these fees to BCBSNM through average pricing or fee schedule adjustments.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to fully insured accounts. If applicable, BCBSNM will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Nonparticipating Providers Outside BCBSNM’s Service Area

Member Liability Calculation

When covered healthcare services are provided outside of BCBSNM’s service area by nonparticipating providers, the amount(s) you pay for such services will be based on either the **Host Blue’s** nonparticipating healthcare provider local payment or the pricing arrangements required by applicable law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment BCBSNM will make for the covered healthcare services as set forth in this paragraph. Payments for out-of-network emergency services, certain services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance services will be governed by applicable federal and state law.

In certain situations, BCBSNM may use other payment methods, such as billed charges for covered healthcare services, the payment BCBSNM would make if the healthcare services had been obtained within BCBSNM’s service area, or a special negotiated payment to determine the amount BCBSNM will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment BCBSNM will make for the covered healthcare services as set forth in this paragraph.

Blue Cross Blue Shield Global® Core (Blue Cross Blue Shield Global SolutionsSM)

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, (hereinafter: “**BlueCard**® service area”), you may be able to take advantage of Blue Cross Blue Shield Global® Core when accessing covered healthcare services. Blue Cross Blue Shield Global® Core is unlike the **BlueCard**® Program available in the **BlueCard**® service area in certain ways. For instance, although Blue Cross Blue Shield Global® Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a **Host Blue**. As such, when you receive care from providers outside the **BlueCard**® service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the **BlueCard**® service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts/deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered healthcare services.

- **Outpatient Services**

Physicians, urgent care centers and other outpatient providers located outside the **BlueCard**® service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered healthcare services.

- **Submitting a Blue Cross Blue Shield Global® Core Claim**

When you pay for covered healthcare services outside the **BlueCard**® service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the provider’s itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSNM, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

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 **Prior Authorization** 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 **Prior Authorization** 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 UNM Customer Care. If you are not satisfied with the initial response, you can request internal review as described in the detailed *Inquiries/Complaints and Internal/External Appeals* notice included in the back of this 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 660058
Dallas, TX 75266

Telephone (toll-free): (800) 205-9926
See Website at 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 **Prior Authorization** 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 **Prior Authorization** 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 university 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 **Prior Authorization** 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 university 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 **Student** at the latest address on BCBSNM membership records or to the university.

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 UNM Student Health Plan.

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. **Summary of Benefits** can be obtained by contacting a UNM Team Health Customer Care Customer or by logging on to UNM.myahpcare.com.

Benefit Period

- Medical & Pharmacy Doctorate **Students**: July 1, 2026 – June 30, 2027
- Physician’s Assistants (New): August 10, 2026– July 15, 2027
- Physician’s Assistants (Returning): July 1, 2026 – July 15, 2027
- GA/Fellowship/Medical Health Professionals: August 10, 2026 – July 15, 2027
- Master of Science in Anesthesia July 27, 2026 – July 1, 2027
- Graduate Nursing (DNP, PhD, and Post-Graduate Certificate Program) August 10, 2026 – July 15, 2027

Benefit Program Application (BPA)— The application for coverage completed by the university (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 Doctor and **Hospital** Finder at bcbsnm.com

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

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 UNM Student Health Plan 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**.

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.).

Cytological Screening — A papanicolaou test or liquid-based cervical cytopathology, a human papillomavirus test, and a pelvic exam for symptomatic, as well as, asymptomatic female patients.

Deductible — The amount of **Covered Charges** that you must pay in a **Plan 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 Plan Year, you pay it only once each **Plan Year** and it applies to all **Covered Services** you receive during that **Plan Year**.

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

Dentist, Oral Surgeon — A Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.) who is licensed to practice prevention, diagnosis, and treatment of diseases, Accidental Injuries and malformation of the teeth, jaws, and mouth.

Dependent — A **Student's** lawful spouse including domestic partner; or an **Student's Child**, stepchild, **Child** of a covered person's domestic partner, foster **Child**, a grandchild for whom the **Student** or **Student's** spouse has legal guardianship; or a **Child** who is adopted by the **Student** or placed for adoption with the **Student**, or for whom the **Student** is a party in a suit for the adoption of the **Child**; or a **Child** whom the **Student** is required to insure under a medical support order issued or enforceable by the courts. Any such **Child** must be under age 26.

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

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

Doctor of Oriental Medicine — A person who is a **Doctor of Oriental Medicine** (D.O.M.) licensed by the appropriate governmental agency to practice **Acupuncture** and Oriental Medicine.

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

Drug Abuse Treatment Facility — An appropriately licensed **Provider** primarily engaged in detoxification and rehabilitation treatment for **Chemical Dependency**.

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

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

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

Eligible Family Members — See “**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.

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 or university covering employees of such employer for the benefit of persons other than the employer or university; 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.

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.

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 **Student** that identifies the cardholder as a Plan **Member**.

Infusion Suite — An alternative to **Hospital** and clinic-based infusion settings where specialty medications can be infused.

Initial Enrollment Eligibility Date — A **Member's** Effective Date of Coverage imposed on the **Member** by the employer or university, 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.

Intensive Outpatient Program (IOP) — Distinct levels or phases of treatment that are provided by a certified/licensed **Chemical Dependency** or behavioral 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 separately issued **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 **Student** 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 Level Exceptions” 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 behavioral 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 **Plan 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 **Plan Year**, not to exceed any benefit limits.

Outpatient Services — Medical/**Surgical Services** received in the outpatient department of a **Hospital**, observation room, **Emergency** room, **Ambulatory Surgical Facility**, freestanding **Dialysis Facility**, or other covered outpatient treatment **Facility**.

Outpatient Surgery — Any **Surgical Services** that is performed in an **Ambulatory Surgical Facility** or the outpatient department of a **Hospital**, but not including a procedure performed in an office or clinic. Outpatient Surgery includes any procedure that requires the use of an **Ambulatory Surgical Facility** or an outpatient **Hospital** operating or recovery room.

Participating Pharmacy — See the definition of “**Provider**.”

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

Pharmacy-Related Definitions — The definitions below are specifically related to **Pharmacy** services.

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

Coinsurance — A percentage amount paid by you for each covered specialty **Pharmacy Prescription** order filled through a designated **Specialty Pharmacy Provider**.

Copayment — The maximum fixed-dollar amount you pay for each covered **Prescription** order filled or refilled or a covered supply purchased through a retail **Pharmacy** or **Specialty Pharmacy Provider**.

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

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

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

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

Generic Drug — A drug that has the same active ingredient as a **Brand-Name Drug** and is allowed to be produced after the **Brand-Name Drug’s** patent has expired. In determining the brand or generic

classification for covered drugs, BCBSNM uses the generic/brand status assigned by a nationally recognized **Provider** of drug product database information.

Maintenance Medications — Prescription Drugs that are taken regularly to treat a chronic health condition such as high cholesterol, high blood pressure, or asthma. A list of **Maintenance Medications** is available on the BCBSNM website at www.bcbsnm.com. You may also contact a Customer Service Advocate for a copy.

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

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

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

Pharmacy — A state and federally licensed establishment where the **Practice of Pharmacy** occurs, that is physically separate and apart from any **Provider's** office, and where drugs and **Devices** are **Dispensed** under **Prescription** orders to the general public by a pharmacist licensed to **Dispense** such drugs and **Devices** under the law of the state in which he/she practices.

Practice of Pharmacy — The evaluation and implementation of a lawful order of a licensed practitioner: the dispensing of **Prescriptions**; the participation in drug and **Device** selection or drug administration that has been ordered by a licensed practitioner; drug regimen reviews and drug or drug-related research; the administering or prescribing of dangerous drug therapy; the provision of **Patient Counseling** and **Pharmaceutical Care**; the responsibility for compounding and labeling of drugs and **Devices**; the proper and safe storage of drugs and **Devices**; and the maintenance of proper records.

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

Prescription Drugs, Medicines and Devices — Those that are taken at the direction and under the supervision of a **Provider**, that require a **Prescription** before being **Dispensed**, and are labeled as such on their packages. All **Prescription Drugs, Medicines and Devices** must be approved by the FDA, and must not be **Experimental, Investigational, or Unproven**. (See "**Experimental, Investigational, or Unproven Service**" in Section 6: General Limitations and Exclusions.)

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

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

Physician — See definition of "**Provider**," below.

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

Plan Year

- Medical & Pharmacy Doctorate **Students**: July 1, 2026 – June 30, 2027
- Physician’s Assistants (New): August 10, 2026 – July 15, 2027
- Physician’s Assistants (Returning): July 1, 2026– July 15, 2027
- GA/Fellowship/Medical Health Professionals: August 10, 2026 – July 15, 2027
- Master of Science in Anesthesia July 27, 2026 – July 1, 2027
- Graduate Nursing (DNP, PhD, and Post-Graduate Certificate Program) August 10, 2026 – July 15, 2027

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**.”

Prior Authorization — An advance confirmation to determine **Medical Necessity**, as may be required where permitted by law, for certain services to be eligible for benefits.

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

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

Health Care Facility: An institution providing health care services, including a **Hospital** or other licensed inpatient center, an Ambulatory Surgical or treatment Center, a **Skilled Nursing Facility**, a **Home Health Care Agency**, a diagnostic laboratory or imaging center, and a rehabilitation or other therapeutic health setting.

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

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**.

Participating Pharmacy: A retail supplier that has contracted with BCBSNM or its authorized representatives to **Dispense Prescription Drugs** and medicines, insulin, diabetic supplies, and nutritional products to **Members** covered under the drug plan portion of this Plan and that has contractually accepted the terms and conditions as set forth by BCBSNM and/or its authorized representatives. Some Participating Pharmacies are contracted with BCBSNM to provide specialty drugs to **Members**; these pharmacies are called **“Specialty Pharmacy Providers”** and some drugs must be **Dispensed** by these specially contracted **Pharmacy Providers** in order to be covered.

A **Network Provider** agrees to provide health care services to **Members** with an expectation of receiving payment (other than **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 service for patients with mental illness and/or **Chemical Dependency** disorders.

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

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. Breast cancer screening also covers additional imaging and pathology evaluation, if indicated to complete the initial screening for malignancies. (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 unm.myahpcare.com/benefits with the Adult Preventive Services Member Flyer and the Child Preventive Services Member Flyer.

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 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 **Student** or **Eligible Family Member** did not enroll in the Plan when initially eligible, there are certain instances (or “qualifying events”) during which the **Student** 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 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 healthy diet intended to decrease the risk of disease, such as reduced-fat foods, low sodium foods, or weight loss products.

Specialty Pharmacy Provider — See definition of “**Participating Pharmacy**.”

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

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

Student — 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 **Copayment** and/or **Coinsurance** requirements, **Deductible**, **Out-of-Pocket Limit**, and annual or lifetime benefits, and provides an overview of **Covered Services**. It is referred to as the **Summary of Benefits** throughout this **Benefit Booklet** and can be obtained by contacting a UNM Team Health Customer Care Customer or by logging on to UNM.myahpcare.com.

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

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

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

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

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

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

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

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

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

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

General Inquiries and Complaints

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

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

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

Initial Internal Review of Claims/Prior Authorization Requests

When you or your treating health care professional requests a **Prior Authorization** or files a **Claim** for a health care service, BCBSNM first determines whether the requested service is covered under your Plan. If the requested service is not covered, BCBSNM will not review for **Medical Necessity**, but will send you notice that there is no coverage for the requested service.

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

Prior Authorization - A decision by BCBSNM that a health care service has been reviewed and, based upon the information available, meets BCBSNM's requirements for coverage and **Medical Necessity**.

Timing of Required Notices and Extensions

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

- **Urgent Care clinical Claim** - Any pre-service **Claim** that requires **Prior Authorization**, as described in the **Benefit Booklet**, for a benefit determination for medical care or treatment for which the application of regular notification time periods could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of the **Physician** with knowledge of your medical

condition, would subject you to severe pain that cannot adequately be managed without the care or treatment.

- **Post-service Claim** - A notification in a form acceptable to the **Claim Administrator** that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the **Provider**, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the **Claim** charge, and any other information which the **Claim Administrator** may request in connection with services rendered to you.
- **Pre-service Claim** - A request for **Prior Authorization**, which is any non-urgent request for a benefit or for a benefit determination for which the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. A voluntary request for advance determination of benefits is not a pre-service request for purposes of this provision.

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

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

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

*This period may be extended one time by the Claims Administrator for up to 15 days, provided that the Claims Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the

Plan and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

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

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

Concurrent Care

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

Manner and Content of Claim/Prior Authorization Denial Notices

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

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

- Subject to privacy laws and other restrictions, if any, the identification of the **Claim**, the date of service, health care **Provider**, **Claim** amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- The specific reason(s) for determination;
- A reference to the specific health plan provision(s) on which the denial is based, or the contractual, administrative or protocol for the determination;
- The specific internal rule, guideline, protocol, or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request;

- An explanation of the scientific or clinical judgment relied on in the determination, if the denial was based on **Medical Necessity**, experimental treatment, or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- A description of additional information that may be needed to perfect the request or **Claim** and an explanation of why such material is needed;
- A description of BCBSNM's internal review/appeals and external review procedures and time limits (and how to initiate a review/appeal or external review) including a statement of your right, if any, to pursue any state and, if applicable, federal legal remedies, including your right to pursue arbitration following a final denial on internal review/appeal;
- In certain situations, a statement in non-English language(s) that written notice of **Claim** denials and certain other benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the **Claim Administrator**;
- The right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the **Claim** for benefits;
- In the case of a denial of an **Urgent Care** clinical **Claim**, a description of the expedited internal review procedure applicable to such **Claims** (an **Urgent Care Claim** decision may be provided orally, so long as written notice is furnished to you within three days of oral notification);
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

IMPORTANT: For *Adverse Benefit Determinations* that are related to any **Claim** or **Prior Authorization** denial, reduction, termination, or failure to provide or make payment that is based on a **determination of eligibility** to participate in the Plan, including contributions for coverage, you must contact **The University of New Mexico**.

Internal Appeal Procedures

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

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

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

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

Expedited Clinical Appeals

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

Upon receipt of an expedited pre-service or concurrent clinical appeal, the **Claims Administrator** will notify the party filing the appeal, as soon as possible, but no more than **24 hours** after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within **24 hours** of request. The **Claims Administrator** shall render a determination on the appeal within **24 hours** after it receives the requested information, but no later than **72 hours** after the appeal has been received by the **Claims Administrator**.

How to Appeal an Adverse Benefit Determination

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

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

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

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

BCBSNM Appeals Unit

P.O. Box 660058

Dallas, TX 75266

Telephone (toll-free): (800) 205-9926

- In support of your **Claim** review, you have the option of presenting evidence and testimony to the **Claim Administrator**. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within **180**

days after you receive notice of an *Adverse Benefit Determination* or at any time during the **Claim** review process.

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

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

BCBSNM Appeals Unit
P.O. Box 660058
Dallas, TX 75266
Telephone (toll-free): (800) 205-9926
FAX: (505) 816-3837

Timeframe for Completion of Internal Appeal

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

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

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

Manner and Content of Notification of Internal Appeal Decision

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

- Subject to privacy laws and other restrictions, if any, the identification of the **Claim**, the date of service, health care **Provider**, **Claim** amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

- The specific reason(s) for the determination;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the **Claim** for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
- A description of the standard that was used in denying the **Claim** and a discussion of the decision;
- A description of BCBSNM's external review procedures and time limits including your right to pursue, if applicable, federal legal remedies including your right to pursue arbitration following a final **Adverse Determination** on external appeal;
- In certain situations, a statement in non-English language(s) that written notice of **Claim** denials and certain other benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the **Claim Administrator**;
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

If the **Claims Administrator's** or your university's decision is to continue to deny or partially deny your **Claim** or **Prior Authorization** request or you do not receive a timely decision, you may be able to request an external review of your **Claim** or **Prior Authorization** request by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the next section.

Independent External Review

For non-eligibility issues, you or your authorized representative may make a request for a standard external review or expedited external review of an *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* by an independent review organization (IRO). External review is available for an *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* that involves medical judgment (including, but not limited to, those based on requirements, for **Medical Necessity**, appropriateness, health care setting, level of care or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational), as determined by the external reviewer. Rescissions are also eligible for external review.

Request for external review. Within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from BCBSNM, you or your authorized representative must file your request for standard external review.

Preliminary review. Within five business days following the date of receipt of the external review request, BCBSNM must complete a preliminary review of the request to determine whether:

- You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
- The *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);

- You have exhausted BCBSNM's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the "Exhaustion" section below for additional information about the exhaustion of the internal appeal process; and
- You or your authorized representative has provided all the information and forms required to process an external review.

You will be notified within one business day after BCBSNM completes the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four-month appeal period (or **48 hours** following receipt of the notice), whichever is later, to perfect the appeal request. If your **Claim** is not eligible for external review, BCBSNM will outline the reasons it is ineligible in the notice.

Referral to Independent Review Organization. When an eligible request for external review is completed within the time period allowed, BCBSNM or your university will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, BCBSNM will take action against bias and to ensure independence. Accordingly, BCBSNM must contract with at least three IROs for assignments under the plan and rotate **Claims** assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

- Utilization of legal experts where appropriate to make coverage determinations under the plan.
- Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
- Within five business days after the date of assignment of the IRO, BCBSNM must provide to the assigned IRO the documents and any information considered in making the *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination*. Failure by BCBSNM to timely provide the documents and information must not delay the conduct of the external review. If BCBSNM fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination*. Within one business day after making the decision, the IRO must notify BCBSNM and you or your authorized representative.
- Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to BCBSNM. Upon receipt of any such information, BCBSNM may reconsider its *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* that is the subject of the external review. Reconsideration by BCBSNM must not delay the external review. The external review may be terminated as a result of the reconsideration only if BCBSNM decides, upon completion of its reconsideration, to reverse its *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* and provide coverage or payment. Within one business day after making such a decision, BCBSNM must provide written notice of its decision to you and the

assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from BCBSNM.

- Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the **Claim** de novo and not be bound by any decisions or conclusions reached during BCBSNM's internal **Claims** and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
 - — Your medical records;
 - — The attending health care professional's recommendation;
 - — Reports from appropriate health care professionals and other documents submitted by BCBSNM, you, or your treating **Provider**;
 - — The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
 - — Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
 - — Any applicable clinical review criteria developed and used by BCBSNM, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
 - — The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider appropriate.
- Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to BCBSNM and you or your authorized representative.
- The notice of final external review decision will contain:
 - — A general description of the reason for the request for external review, including information sufficient to identify the **Claim**;
 - — The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - — References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 - — A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - — A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either BCBSNM and you or your authorized representative;
 - — A statement that judicial review may be available to you or your authorized representative; and
 - — Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
- After a final external review decision, the IRO must maintain records of all **Claims** and notices associated with the external review process for six years. An IRO must make such records available for examination by

the **Claim Administrator**, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

Reversal of Plan's Decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, BCBSNM immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the **Claim**.

Expedited External Review

Request for expedited external review. BCBSNM must allow you or your authorized representative to make a request for an expedited external review with BCBSNM at the time you receive:

- An *Adverse Benefit Determination* if the *Adverse Benefit Determination* involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A *Final Internal Adverse Benefit Determination*, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the *Final Internal Adverse Benefit Determination* concerns an **Admission**, availability of care, continued stay, or health care item or service for which you received **Emergency** services, but have not been discharged from a **Facility**.

Preliminary review. Immediately upon receipt of the request for expedited external review, BCBSNM must determine whether the request meets the reviewability requirements set forth in the "Standard External Review" section above. BCBSNM must immediately send you a notice of its eligibility determination that meets the requirements set forth in the "Standard External Review" section above.

Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, BCBSNM will assign an IRO pursuant to the requirements set forth in the "Standard External Review" section above. BCBSNM must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the **Claim** de novo and is not bound by any decisions or conclusions reached during BCBSNM's internal **Claims** and appeals process.

Notice of final external review decision. BCBSNM's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the "Standard External Review" section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to BCBSNM and you or your authorized representative.

Exhaustion

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if BCBSNM waives the internal review process or has failed to comply with the internal **Claims** and appeals process. If you have been deemed to have exhausted the internal review process due to BCBSNM's failure to comply with the internal **Claims** and appeals process, you may also have the right to pursue arbitration and any available remedies under federal or under state law.

External review may not be requested for an Adverse Benefit Determination involving a **Claim** for benefits for a health care service that you have already received until the internal review process has been exhausted.

Other External Actions

If you are still not satisfied after having completed BCBSNM's or, for eligibility and **Student** contribution issues, your university's complaint, appeal, grievance, or reconsideration procedure, you may have the option of taking one of the following steps. No legal action at law or in equity may be taken or arbitration demand made earlier than 60 days after the **Claims Administrator** has received the **Claim** for benefits or **Prior Authorization** request, or later than three years after the date that the **Claim** for benefits should have been filed with the **Claims Administrator**.

Arbitration for Non- ERISA Plans — The "Arbitration for Non- ERISA Plans" provision applies to all **Governmental Plans, Church Plans**, and plans maintained outside the United States primarily for the benefit of persons substantially all of whom are non-resident aliens. If a dispute about coverage, benefits, or handling of **Claims** or appeals continues after you have followed and exhausted the appeals and grievance process set forth above, including having completed the external review process, the issue or **Claim** may be submitted to arbitration. The rules for arbitration shall be the "Commercial Arbitration Rules" developed by the American Arbitration Association. You may obtain a copy of these rules from a Customer Service Advocate. The rules are also available from the American Arbitration Association's Web site (www.adr.org).

Retaliatory Action

BCBSNM and your university shall not take any retaliatory action against you for making a complaint, filing an appeal, or requesting external review under this health plan.

NOTE: BCBSNM provides administrative **Claims** payment services only and does not assume any financial risk or obligation with respect to **Claims**, except as may be specified in the **Administrative Services Agreement**.

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 UNM Student Health Plan and **Blue Cross and Blue Shield of New Mexico** (BCBSNM) includes the following documents:

- this **Benefit Booklet** and any amendments, riders, or endorsements;
- the **Members' Identification Cards**; and
- the **Summary of Benefits and Coverage**

In addition, your university (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 UNM Student Health Plan.

The above documents constitute the entire legal agreement between BCBSNM and UNM Student Health Plan. 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.

UNM Student Health Plan reserves the right to amend, modify, or discontinue coverage provided for **Students** and their **Dependents**. This **Benefit Booklet** is not an implied contract and does not guarantee benefits or employment.

BCBSNM provides administrative **Claims** payment services only and does not assume any financial risk or obligation with respect to **Claims**, except as may be specified in the **Administrative Services Agreement**.



**BlueCross BlueShield
of New Mexico**



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