

 AcademicBlue<sup>SM</sup>



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## Introduction

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University of New Mexico (UNM) is pleased to offer AcademicBlue, its student health plan for students who are eligible to enroll in the UNM Student Health Plan (Plan). UNM contracts with Blue Cross and Blue Shield of New Mexico (BCBSNM) as its Third Party Administrator (TPA) for the administration of your health benefits. Academic HealthPlans, Inc. (AHP) is a separate company that provides program management and administrative services for the student health plans of Blue Cross and Blue Shield of New Mexico. This brochure explains your health care benefits, including which health care services are covered and how to use the benefits. This plan protects Insured students and their covered Dependents on or off campus for weekends, holidays, summer vacations, at home or while traveling, 24 hours per day, for the Contract year. This Plan meets the requirements of the Affordable Care Act. The actuarial value of this plan meets or exceeds a Platinum metal level of coverage. This plan will always pay benefits in accordance with any applicable Federal and New Mexico state insurance law(s). Please keep these three fundamental plan features in mind as you learn about this plan:

- **The Student Health Plan is a Preferred Provider Organization (PPO) plan.** You should seek treatment from the UNM Team 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 Team 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](http://unm.myahpcare.com).
- **Your Plan includes services provided by UNM Student Health & Counseling (SHAC), many provided at a low cost to you.**
- **Participating in the Plan does not mean all of your health care costs are paid in full by the Plan.** There are several areas for which you could be responsible for payment, including, but not limited to, a Deductible, a Copayment or Coinsurance (patient percentage of Covered Expenses), and medical costs for services excluded by the plan.
- **It is your responsibility to familiarize yourself with this plan.** Exclusions and limitations are applied to the coverage as a means of cost containment (please see the “Exclusions and Limitation” section for more details). To make this coverage work for you and to ensure services are medically necessary, it is helpful to be informed and proactive. Check the covered benefits in this brochure before your procedure whenever possible. Know the specifics and communicate them to your health care provider. Review the User Guide for a step-by-step overview of how to use your benefits.

### **We are here to help.**

Representatives from Academic HealthPlans and UNM Team Health are available to answer your questions. For enrollment and eligibility questions go to [unm.myahpcare.com](http://unm.myahpcare.com). For benefit and claims questions, call UNM Team Health at **(844) 866-2224**.

**Please Note:** We have capitalized certain terms that have specific, detailed meanings, which are important to help you understand your plan. Please review the meaning of the capitalized terms in the “Definitions” section .

AcademicBlue<sup>SM</sup> is offered by 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.

Academic HealthPlans, Inc. (AHP) is an independent company that provides program management and administrative services for the student health insurance plans of Blue Cross and Blue Shield of New Mexico.

## Privacy Notice

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We know that your privacy is important to you and we strive to protect the confidentiality of your personal health information. Under the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA), we are required to provide you with notice of our legal duties and privacy practices with respect to personal health information. You will receive a copy of the HIPAA Notice of Privacy Practices upon request. Please write to Academic HealthPlans, Inc., P.O. Box 1605, Colleyville, TX 76034-1605, or you may view and download a copy from the website at [unm.myahpcare.com](http://unm.myahpcare.com).

## Eligibility/How to Enroll

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It is your responsibility to enroll for coverage each year in order to maintain continuity of coverage, unless you are automatically enrolled. If you no longer meet the eligibility requirements, visit Academic HealthPlans at [unm.myahpcare.com](http://unm.myahpcare.com) prior to your termination date.

### *Eligibility Requirements*

The following types of students will be automatically enrolled in the Plan and the student health plan premium will be added to their tuition bill unless a waiver and proof of coverage under another plan is submitted and approved by the waiver deadline: (a) Medical Health Professional 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 credit hours in the summer and (b) Medical Doctorate and Pharm D Students. 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 of Graduate Studies at 277-2711 for additional eligibility information regarding assistantships) 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. Waiver procedures and deadline information are available at [unm.myahpcare.com](http://unm.myahpcare.com) and <https://hr.unm.edu/benefits/student-health-insurance>.

If your school offers dependent coverage, 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" section for more details.) "Dependent" means an Insured's lawful spouse including Domestic Partner; or an Insured's child, stepchild, child of a Covered Person's Domestic Partner, foster child, dependent grandchild or spouse's dependent grandchild; or a child who is adopted by the Insured or placed for adoption with the Insured, or for whom the Insured is a party in a suit for the adoption of the child; or a child whom the Insured 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 Insured 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 Company 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 Company may, from time to time, require proof of the continuation of such condition and dependence. After that, the Company 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 Insured's; therefore, it will expire concurrently with the Insured's plan.

A newborn child will be covered for the first 31 days following the child's birth, provided the covered student:

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

**RESCISSION OF COVERAGE IN THE EVENT OF FRAUD OR INTENTIONAL MISREPRESENTATIONS OF MATERIAL FACT**

If you knowingly make a false statement on your enrollment application or file a false claim, such application or claim may be rescinded retroactively to the date of the application or claim. Any premiums collected from you for coverage that is later revoked due to a fraudulent application may be refunded to you by the Plan. If a claim is paid by the Plan and it is later determined that the claim should not have been paid due to a fraudulent application or claim, you may be responsible for full reimbursement of the claim amount to the Plan.

If you're not eligible for the Student Health Plan and would like coverage, please visit [ahpcare.com](http://ahpcare.com).

If you're enrolled in Medicare due to age or disability, you are not eligible for the Student Health Plan.

## Qualifying Events

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Eligible students who have a change in status and lose coverage under another health care plan are eligible to enroll for coverage under the plan, provided, within 31 days of the qualifying event, such students send to Academic HealthPlans:

- A copy of the Certificate of Creditable Coverage, or a letter of ineligibility (lost coverage), from their previous health insurer

A change in status due to a qualifying event includes but is not limited to:

- Birth or adoption of a child
- Loss of a spouse, whether by death, divorce, annulment or legal separation
- If you are no longer covered on a family member's plan because you turned 26

The premium will be prorated as it would have been at the beginning of the semester. However, the effective date will be the later of the following: the date the student enrolls for coverage under the Plan and pays the required premium, or the day after the prior coverage ends. To apply for coverage that is needed because of a qualifying event, visit [unm.myahpcare.com](http://unm.myahpcare.com).

## Effective Dates and Termination

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The coverage under the Plan becomes effective at 12:00 a.m. Central time at the university's address on the later of the following dates:

- 1) The effective date of the Plan, **July 01, 2020**; or
- 2) The date after the premium is received by the Company or its authorized representative.

### *Effective and Termination Dates*

Term	From	Through
Fall (MD & Pharm D)	7/1/2020	12/31/2020
Spring/Summer (MD & Pharm D)	1/1/2021	6/30/2021

Term	From	Through
Fall	8/17/2020	1/17/2021
Spring/Summer	1/18/2021	8/22/2021
Summer	6/7/2021	8/22/2021

### *Waiver Deadlines*

Term	Date
Fall (MD & Pharma D Students)	8/17/2020
Spring/Summer (MD & Pharm D Students)	2/16/2021
Fall	9/14/2020
Spring	2/19/2021
Summer	6/28/2021

The coverage provided with respect to the Covered Person shall terminate at 11:59 p.m. Central time on the earliest of the following dates:

- 1) The last day of the period through which the premium is paid;
- 2) **August 22, 2021 and June 30, 2021 for MD and Pharm D**; or
- 3) The date the eligibility requirements are not met.

## Renewal Notice

It is the student's responsibility to enroll in or waive out of coverage each semester. Please refer to enrollment periods and effective dates for your campus listed above.

**PLEASE NOTE:** Renewal notices will not be mailed from one semester to the next. If you maintain your student status, you will be eligible to enroll in or waive the following semester.

**Coverage period notice:** Coverage Periods are established by the University and subject to change from one Plan year to the next. In the event that a coverage period overlaps another coverage period, the prior coverage period will terminate as of the effective date of the new coverage period. In no case will an eligible member be covered under two coverage periods within the same group.

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## Coordination of Benefits

Under a Coordination of Benefits (COB) provision, the plan that pays first is called the primary plan. The secondary plan typically makes up the difference between the primary plan's benefit and the Covered Expenses. When one plan does not have a COB provision, that plan is always considered the primary plan, and always pays first. You may still be responsible for applicable Deductible amounts, Copayments and Coinsurance.

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## Additional Covered Expenses

The Plan will always pay benefits in accordance with any applicable federal and state insurance law(s).

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## UNM Student Health & Counseling (SHAC)

**Eligibility and Cost:** Students currently enrolled at UNM are eligible for medical care at UNM SHAC. This service is funded in part by student activity fees. Fees are charged for: primary care and specialist visits, physical therapy, pharmacy, Counseling Services and for certain procedures (e.g., x-rays, lab tests, injections). The UNM Student Health Plan may help pay for these charges.

**Hours and Location:** Monday through Thursday 8:00 a.m. - 5:30 p.m.; Friday 9:00 a.m. - 5:00 p.m. (Closed on all official University holidays and campus closures due to weather/unseen circumstances.) Location: Main campus north of Johnson Center. Hours are subject to change; check SHAC website for updates— [shac.unm.edu](http://shac.unm.edu).

**SHAC TTY Phone:** (277-7926) SHAC website: [shac.unm.edu](http://shac.unm.edu).

**Appointments:** (277-3136): Appointments with a Doctor or practitioner are available weekdays.

**General Medical Services:** (277-3136): UNM SHAC is a primary care facility offering comprehensive primary care including scheduled and same day Doctor appointments. Students with long-term healthcare problems are urged to make an appointment to discuss their health problems.

**Women's Health Care:** (277-3136): A comprehensive service addresses women's health needs: birth control, pregnancy counseling, sexually transmitted disease testing, routine pap smears, and annual exams.

**Counseling Services:** (277-3136): Counseling Services provide services that help students function successfully in their academic lives. Those services include assessment; emergency and crisis intervention; short-term counseling for individuals; and medication evaluation and monitoring. Sessions are confidential. Students in need of extended care are referred to professionals in the community.

**Allergy and Immunization:** (277-3136): UNM SHAC offers a full-service, year-round allergy and immunization clinic, as well as travel consultation.

**Specialty Clinics:** (277-3136): Appointments for specialty clinics may be obtained by a referral from a UNM SHAC practitioner. These clinics are held on a regular basis and are conducted by qualified specialists in the areas of Acupuncture, Physical Therapy, Psychiatry, Massage Therapy and Sports Medicine.

**Lab and X-Ray:** (277-3136): Routine laboratory tests and X-rays are performed at UNM SHAC at a reduced rate.

**Pharmacy:** (277-6306): Location: Second floor (Room 206). Prescriptions and over-the-counter drugs are available. Prescriptions from any healthcare provider can be filled. Current I.D. cards are always required.

**Health Education:** (277-1074): Nutrition Clinic and Health Weight Plan are offered at low-cost rates.

## Schedule of Benefits

**In addition to SHAC, the provider networks for this plan are the UNM Team Health and BCBSNM PPO Networks.** After the Deductible is satisfied, benefits will be paid based on the selected provider. Benefits will be paid at 20% of the Allowable Amount of services rendered by Network Providers in the UNM Team Health and BCBSNM PPO Network, unless otherwise specified in the Plan. Services obtained from Out-of-Network Providers (any provider outside the UNM Team Health Network or BCBSNM PPO Network) will not be paid EXCEPT for ambulance and emergency services. Benefits will be paid up to the maximum for each service, as specified below, regardless of the provider selected.

**AT PHARMACIES CONTRACTING WITH THE PRIME THERAPEUTICS NETWORK:** You must go to a pharmacy contracting with the Prime Therapeutics Network in order to access this program. Present your insurance ID card to the pharmacy to identify yourself as a participant in this Plan. Eligibility status will be online at the pharmacy. You can locate a participating pharmacy by calling **(800) 423-1973** or online at **bcbsnm.com**.

Maximum Benefit	Unlimited		
	UNM SHAC Network	UNM Team	BCBSNM PPO Network
<b>Deductible (Per Covered Person, Per Benefit Period)</b>	<b>\$0 Student  N/A Family</b>	<b>\$250 Student  \$500 Family</b>	
<b>Out-Of-Pocket Maximum (Per Covered Person, Per Benefit Period)</b>	<b>\$6,350 Student  \$12,700 Family</b>		

The relationship between Blue Cross and Blue Shield of New Mexico (BCBSNM) and contracting pharmacies is that of independent contractors, contracted through a related company, Prime Therapeutics, LLC. Prime Therapeutics also administers the pharmacy benefit program. BCBSNM, as well as several other independent Blue Cross plans, has an ownership interest in Prime Therapeutics.

**OUT-OF-POCKET MAXIMUM** means the maximum liability that may be incurred by a Covered Person in a benefit period for covered services, under the terms of a coverage plan. Once the Out-of-Pocket Maximum has been satisfied, Covered Expenses will be payable at **100%** for the remainder of the Plan year, up to any maximum that may apply. Coinsurance applies to the Out-of-Pocket Maximum.

The Network Out-of-Pocket Maximum may be reached by:

- The network Deductible
- Charges for outpatient prescription drugs
- The hospital emergency room Copayment
- The Copayment for Doctor office visits
- The Copayment for specialist’s office visits
- The payments for which a Covered Person is responsible after benefits have been provided (except for the cost difference between the hospital's rate for a private room and a semi-private room, or any expenses incurred for Covered Expenses rendered by an Out-of-Network Provider other than Emergency Care and Inpatient treatment during the period of time when a Covered Person’s condition is serious)

***Deductible applies only to UNM Team Health Network and BCBSNM PPO Network unless otherwise noted. The benefits on this chart represent what the member will pay:***

Inpatient	UNM SHAC Network	UNM Team Health Network	BCBSNM PPO Network
<b>Hospital Expenses:</b> Include the daily semi-private room rate; intensive care; general nursing care provided by the hospital; and hospital miscellaneous expenses such as the cost of the operating room, laboratory tests, X-ray examinations, pre-admission testing, anesthesia, drugs (excluding take-home drugs) or medicines, physical therapy, therapeutic services and supplies.	Not Available	20% of Allowable Amount	20% of Allowable Amount
<b>Surgical Expenses, Anesthetist and Assistant Surgeon:</b> When multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for full Allowable Amount for that procedure.	Not Available	20% of Allowable Amount	20% of Allowable Amount
<b>Doctor’s Visits</b>	Not Available	20% of Allowable Amount	20% of Allowable Amount
<b>Routine Well-Baby Care</b>	Not Available	20% of Allowable Amount	20% of Allowable Amount
<b>Mental Illness/Chemical Dependency</b>	Not Available	Paid as any other covered Sickness	Paid as any other covered Sickness

Outpatient	UNM SHAC Network	UNM Team Health Network	BCBSNM PPO Network
<p><b>Surgical Expenses, Anesthetist and Assistant Surgeon:</b> When multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for full Allowable Amount for that procedure. <i>*For Covered Students only, surgery to remove non-malignant warts, moles and lesions will be covered at UNM SHAC.</i></p>	Not Available	20% of Allowable Amount	20% of Allowable Amount
<p><b>Day Surgery Miscellaneous:</b> Related to scheduled surgery performed in a hospital, including the cost of the operating room, laboratory tests, X-ray examinations, professional fees, anesthesia, drugs or medicines and supplies.</p>	Not Available	20% of Allowable Amount	20% of Allowable Amount
<p><b>Doctor Office Visit: 0%</b> of Allowable Amount after copay</p> <p><b>Doctor Copayment Amount:</b> For office visit/consultation when services rendered by a Family Practitioner, OB/GYN, Pediatrician, Behavioral Health Practitioner, or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed physicians.</p> <p><b>Specialist Copayment Amount:</b> For office visit/consultation when services rendered by a Specialty Care Provider refer to Medical/Surgical Expenses section for more information.</p>	<p>\$5 Copayment per visit (Deductible Waived)</p> <p>\$10 Copayment per visit (Deductible waived)</p>	<p>\$15 Copayment per visit (Deductible waived)</p> <p>\$25 Copayment per visit (Deductible waived)</p>	<p>\$25 Copayment per visit (Deductible waived)</p> <p>\$35 Copayment per visit (Deductible waived)</p>
<p><b>Physical Medicine Services:</b> Physical therapy or chiropractic care – office services. Physical medicine services include, but are not limited to, physical, occupational and manipulative therapy.</p>	20% of Allowable Amount	50% of Allowable Amount	50% of Allowable Amount
<p><b>Benefit Period Visit Maximum</b> Chiropractic services only</p>	Benefits for chiropractic services will be limited to 30 visits per Benefit Period.		
<p><b>Massage Therapy:</b></p>	\$5 Copayment per visit Limited to 2 per semester and 6 per Benefit Period	Not Available	Not Available
<p><b>Radiation Therapy and Chemotherapy:</b> Including dialysis and respiratory therapy.</p>	Not Available	20% of Allowable Amount	20% of Allowable Amount
<p><b>Emergency Care and Accidental Injury</b></p>			
<p><b>Facility Services:</b> (Copayment is waived if the Insured is admitted; Inpatient hospital expenses will apply).</p>	Not Available	20% of Allowable Amount	
<p><b>Physician Services</b></p>	Not Available	20% of Allowable Amount	

Outpatient	UNM SHAC Network	UNM Team Health	BCBSNM PPO Network
<b>Non-Emergency Care</b>			
<b>Facility Services:</b> (Copayment is waived if the Insured is admitted; Inpatient hospital expenses will apply).	Not Available	<b>20%</b> of Allowable Amount	<b>20%</b> of Allowable Amount
<b>Physician Services</b>	Not Available	<b>20%</b> of Allowable Amount	<b>20%</b> of Allowable Amount
<b>Urgent Care Services</b>	Not Available	<b>20%</b> of Allowable Amount after <b>\$15</b> Copayment for Urgent Care Visit	<b>20%</b> of Allowable Amount after <b>\$25</b> Copayment for Urgent Care Visit
<b>Diagnostic X-rays and Laboratory Procedures</b> (MRI's, PET scans, and CT scans are included and require preauthorization).	<b>20%</b> of Allowable Amount	<b>20%</b> of Allowable Amount	<b>20%</b> of Allowable Amount
<b>Tests and Procedures:</b> Diagnostic services and medical procedures performed by a Doctor, other than Doctor's visits.	<b>20%</b> of Allowable Amount	<b>20%</b> of Allowable Amount	<b>20%</b> of Allowable Amount
<b>Allergy Injections and Testing</b> (Copay may apply if billed in the office)	<b>20%</b> of Allowable Amount	<b>20%</b> of Allowable Amount	<b>20%</b> of Allowable Amount
<b>Mental Illness/Chemical Dependency</b>	<b>20%</b> of Allowable Amount	Paid as any other covered Sickness	Paid as any other covered Sickness
Extended Care Expenses	UNM SHAC Network	UNM Team Health	BCBSNM PPO Network
<b>Extended Care Expenses:</b> All services must be pre-authorized.	Not Available	<b>20%</b> of Allowable Amount	<b>20%</b> of Allowable Amount
Home Health Care	Not Available	Limited to 100 visit maximum each Benefit Period	
Skilled Nursing	Not Available	Limited to 60 days maximum each Benefit Period	
Hospice Care	Not Available	No Benefit Period Visit Maximum	
Private Duty Nursing	Not Available	Not Available	
Other	UNM SHAC Network	UNM Team Health Network	BCBSNM PPO Network
<b>Ground and Air Ambulance Services</b>	Not Available	<b>20%</b> of Allowable Amount	<b>20%</b> of Allowable Amount
<b>Durable Medical Equipment:</b> When prescribed by a Doctor and a written prescription accompanies the claim when submitted.	Not Available	<b>20%</b> of Allowable Amount	<b>20%</b> of Allowable Amount
<b>Maternity/Complications of Pregnancy</b>	Not Available	<b>20%</b> of Allowable Amount	<b>20%</b> of Allowable Amount
<b>Speech and Hearing Services:</b> Services to restore loss of hearing/speech, or correct an impaired speech or hearing function.  Hearing Aids	Not Available	<b>20%</b> of Allowable Amount	<b>20%</b> of Allowable Amount
<b>Acupuncture Services:</b> 0% of Allowable Amount after copay. Limited to 1 visit per day.	<b>\$5</b> Copayment per visit (Deductible Waived)	<b>\$15-\$25</b> Copayment per visit (Deductible Waived)	<b>\$25-\$35</b> Copayment per visit (Deductible Waived)

Other	UNM SHAC Network	UNM Team Health Network	BCBSNM PPO Network
<b>Dental:</b> Made necessary by Injury to sound, natural teeth only.	Not Available	<b>20%</b> of Allowable Amount	<b>20%</b> of Allowable Amount
<b>Pediatric Vision, up to age 19:</b> See benefit flier for details.	Not Available	<b>0%</b> of Allowable Amount	<b>0%</b> of Allowable Amount
<b>Pediatric Routine Dental Care, up to age 21:</b> See benefit flier for details.	Not Available	<b>20%</b> of Allowable Amount	<b>20%</b> of Allowable Amount
<b>Pediatric Basic and Major Dental, up to age 21:</b> See benefit flier for details.	Not Available	<b>50%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Pediatric Medically Necessary Orthodontia, up to age 21:</b> See benefit flier for details.	Not Available	<b>50%</b> of Allowable Amount	<b>50%</b> of Allowable Amount
<b>Organ and Tissue Transplant Services:</b> The transplant must meet the criteria established by BCBSNM for assessing and performing organ or tissue transplants as set forth in BCBSNM's written medical policies.	Not Available	<b>20%</b> of Allowable Amount	<b>20%</b> of Allowable Amount
<b>Preventative Care Services:</b> Includes but are not limited to: <ul style="list-style-type: none"> <li>a. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");</li> <li>b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC");</li> <li>c. Evidenced-informed preventative care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, child(ren), and adolescents; and</li> <li>d. With respect to women, such additional preventative care and screenings, not described in item "a" above, as provided for in comprehensive guidelines supported by the HRSA.</li> </ul> Preventative care services as mandated by state and federal law are covered. Please refer to the Plan or call UNM Team Health for more information at <b>(844) 866-2224</b> .	<b>0%</b> of Allowable Amount (Deductible waived)	<b>0%</b> of Allowable Amount (Deductible waived)	<b>0%</b> of Allowable Amount (Deductible waived)

Pharmacy Benefits	UNM SHAC Network	UNM Team Health Network	BCBSNM PPO Network
<p><b>Retail Pharmacy:</b> (Deductible waived) Benefits include diabetic supplies. Copayment amounts are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available at three (3) times the Copayment. Copayment amounts will apply to Out-of-Pocket maximum.</p> <p><b>Prescription Drugs at SHAC:</b> (Deductible waived)</p>		<p><i>At pharmacies contracting with Prime Therapeutics Network: 0% of Allowable Amount after the below copayment:</i></p>	<p><i>At pharmacies contracting with Prime Therapeutics Network: 0% of Allowable Amount after the below copayment:</i></p>
<b>Generic Drug</b>	<b>\$10</b> Copayment	<b>\$20</b> Copayment	<b>\$20</b> Copayment
<b>Preferred Brand-name Drug</b>	<b>\$20</b> Copayment*	<b>\$40</b> Copayment*	<b>\$40</b> Copayment*
<b>Non-preferred Brand-name Drug</b>	<b>\$30</b> Copayment*	<b>\$60</b> Copayment*	<b>\$60</b> Copayment*
<b>Specialty Drug</b>	<b>\$100</b> Copayment	<b>\$100</b> Copayment	<b>\$100</b> Copayment

\*Copayment plus the cost difference between the Brand Name Drug or supplies per prescription for which there is Generic Drug or supply available.

The relationship between Blue Cross and Blue Shield of New Mexico (BCBSNM) and Contracting Pharmacies is that of Independent Contractors, contracted through a related company, Prime Therapeutics, LLC. Prime Therapeutics also administers the pharmacy benefit program. BCBSNM, as well as several other independent Blue Cross Plans, has an ownership interest in Prime Therapeutics.

## Pre-Authorization Notification

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BCBSNM should be notified of all hospital confinements prior to admission.

- 1) **Pre-authorization Notification of Medical Non-emergency Hospitalizations:** The patient, Doctor or hospital should telephone **(844) 866-2224** from 8 a.m. to 5 p.m. Mountain Time at least one (1) business day prior to the planned admission.
- 2) **Pre-authorization Notification of Medical Emergency Hospitalizations:** The patient, patient's representative, Doctor or hospital should telephone **(844) 866-2224** from 8 a.m. to 5 p.m. Mountain Time within two (2) working days of the admission or as soon as reasonably possible to provide the notification of any admission due to medical emergency.
- 3) **Pre-authorization Notification of Mental Illness/Chemical Dependency Hospitalizations:** The patient, Doctor or hospital should telephone **(888) 898-0070** from 8 a.m. to 5 p.m. Mountain Time at least one (1) business day prior to the planned admission.

**IMPORTANT:** Failure to follow the notification procedures will not affect benefits otherwise payable under the Plan; in addition, pre-authorization notification is not a guarantee that benefits will be paid. Please refer to your policy for additional details.

## Schedule of Pediatric Dental Benefits for Members Under Age 21

Your dental Benefits are highlighted below. To fully understand all the terms, conditions, limitations and exclusions which apply to your Benefits, please read your entire Policy.

The Deductibles, Coinsurance, Benefit Period Maximums and/or Out-of-Pocket Limits below are subject to change as permitted by applicable law.

COVERED SERVICES	BENEFIT PAYABLE Services Obtained From:	
	Participating Dentist	Out-of-Network Dentist*
<b>Diagnostic Evaluations</b> (Deductible waived)	80% of Allowable Charge	60% of Allowable Charge
<b>Preventive Services</b> (Deductible waived)	80% of Allowable Charge	60% of Allowable Charge
<b>Diagnostic Radiographs</b> (Deductible waived)	80% of Allowable Charge	60% of Allowable Charge
<b>Miscellaneous Preventive Services</b>	80% of Allowable Charge	60% of Allowable Charge
<b>Basic Restorative Services</b>	50% of Allowable Charge	30% of Allowable Charge
<b>Non-Surgical Extractions</b>	50% of Allowable Charge	30% of Allowable Charge
<b>Non-Surgical Periodontal Services</b>	50% of Allowable Charge	30% of Allowable Charge
<b>Adjunctive General Services</b>	50% of Allowable Charge	30% of Allowable Charge
<b>Endodontic Services</b>	50% of Allowable Charge	30% of Allowable Charge
<b>Oral Surgery Services</b>	50% of Allowable Charge	30% of Allowable Charge
<b>Surgical Periodontal Services</b>	50% of Allowable Charge	30% of Allowable Charge
<b>Major Restorative Services</b>	50% of Allowable Charge	30% of Allowable Charge
<b>Prosthodontic Services</b>	50% of Allowable Charge	30% of Allowable Charge
<b>Miscellaneous Restorative and Prosthodontic Services</b>	50% of Allowable Charge	30% of Allowable Charge

COVERED SERVICES	BENEFIT PAYABLE Services Obtained From:	
	Participating Dentist	Out-of-Network Dentist*
<b>Medically Necessary Orthodontia</b> (Deductible waived)		
Pediatric Orthodontic Services: Coverage limited to children under age 21 with an orthodontic condition meeting Medical Necessity criteria established by the Plan (e.g., severe, dysfunctional malocclusion)	50% of Allowable Charge	30% of Allowable Charge
Optional Orthodontic Services: Coverage for orthodontic conditions not meeting Medical Necessity criteria established by the Plan	Not Covered	
<b>Deductible</b>		
Individual	\$75	
Family Deductible	\$225	
<b>Benefit Period Maximum</b> - Excluding any Orthodontic Services (In/Out-of-Network accumulate together)	Unlimited	
<b>Out-of-Pocket Maximum per Benefit Period</b>		
1 Child	\$350	No Limit
2+ Children	\$700	No Limit
* For Out-of-Network Provider services, the Allowable Charge is the Provider's usual charge, not to exceed the amount that the Plan would reimburse a Participating Provider for the same services. The Member may be responsible for the full amount by which the actual charges of an Out-of-Network Provider exceed the Allowable Charge.		

## Covered Dental Services

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The Benefits of this section are subject to all the terms and conditions of your Policy. Benefits are available only for services and supplies that are determined by the Plan to be "Medically Necessary", unless otherwise specified. All Covered Services listed in this section are subject to the **Exclusions and Limitations** section of this Policy, which lists services, supplies, situations or related expenses that are not covered.

It is important for you to refer to your Schedule of Benefits to find out what a Subscriber's Deductible, Coinsurance and Benefit Period Maximum will be for a Covered Service. If you do not have a Schedule of Benefits, please call a Customer Service Representative at 1-877-723-5697.

A Subscriber's Dental Benefits include coverage for the following Covered Services as long as these services are rendered to a Subscriber by a Dentist or a Physician. When the term "Dentist" is used in this Policy, it will mean Dentist or Physician.

## **DIAGNOSTICEVALUATIONS**

Diagnostic evaluations aid the Dentist in determining the nature or cause of a dental disease and include:

- Periodic oral evaluations for established patients.
- Problem-focused oral evaluations, whether limited, detailed or extensive.
- Comprehensive oral evaluations for new or established patients.
- Comprehensive periodontal evaluations for new or established patients.
- Oral evaluations of children, including counseling with primary caregiver.

Benefits for periodic and comprehensive oral evaluations are limited to a combined maximum of two every 12 months. In addition, Benefits for problem-focused oral evaluations and comprehensive periodontal evaluations are limited to a combined maximum of two every 12 months.

Benefits will not be provided for comprehensive periodontal evaluations or problem-focused evaluations if Covered Services are rendered on the same date as any other oral evaluation and by the same Dentist.

## **PREVENTIVE SERVICES**

Preventive services are performed to prevent dental disease. Covered Services include:

- Prophylaxis – Professional cleaning, scaling and polishing of the teeth. Benefits are limited to two cleanings every 12 months. Additional Benefits will not be provided for prophylaxis based on degree of difficulty.
- Topical Fluoride Application – Benefits for Fluoride Application are limited to two applications every 12 months.

### **Special Provisions Regarding Preventive Services**

Cleanings include associated scaling and polishing procedures.

Combination of prophylaxes and periodontal maintenance treatments (see “Non-Surgical Periodontal Services”) are limited to two every 12 months.

## **DIAGNOSTICRADIOGRAPHS**

Diagnostic radiographs are x-rays taken to diagnose a dental disease, including their interpretations, and include:

- Full-mouth (intraoral complete series) and panoramic films - Benefits are limited to a combined maximum of one every 36 months.
- Bitewing films - Benefits are limited to four horizontal films or eight vertical films two every 12 months. However, Benefits are not available for bitewing films taken on the same date as full-mouth films.
- Periapical films, as Medically Necessary for diagnosis

Benefits will not be provided for any radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction.

## **MISCELLANEOUS PREVENTIVE SERVICES**

Miscellaneous preventive services are other services performed to prevent dental disease and include:

- Sealants – Benefits for sealants are limited on first and second permanent molars, one per 60 months.
- Space Maintainers

Benefits are not available for nutritional or oral hygiene counseling, except as provided under the pediatric dental benefits for members to the age of 21.

### **BASIC RESTORATIVE SERVICES**

Basic restorative services are restorations necessary to repair basic dental decay, including tooth preparation, all adhesives, bases, liners and polishing. Covered Services include:

- Amalgam restorations
- Resin-based composite restorations

### **NON-SURGICAL EXTRACTIONS**

Non-surgical extractions are non-surgical removal of tooth and tooth structures and include:

- Removal of retained coronal remnants – deciduous tooth.
- Removal of erupted tooth or exposed root.

### **NON-SURGICAL PERIODONTAL SERVICES**

Non-surgical periodontal service is the non-surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

- Periodontal scaling and root planing – Benefits are limited to one per quadrant every 24 months.
- Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to once every 12 months.
- Periodontal maintenance procedures – Benefits are limited to two every 12 months in combination with routine oral prophylaxis and must be performed following active periodontal treatment.

Benefits will not be provided for chemical treatments, localized delivery of chemotherapeutic agents without history of active periodontal therapy, or when performed on the same date (or in close proximity) as active periodontal therapy.

### **ADJUNCTIVE GENERAL SERVICES**

Adjunctive General Services include:

- Palliative treatment (emergency) of dental pain, and when not performed in conjunction with a definitive treatment.
- Deep sedation/general anesthesia and intravenous/non-intravenous conscious sedation - By report only and when determined to be Medically Necessary for documented Subscribers with a disability or for a justifiable medical or dental condition. A person's apprehension does not constitute Medical Necessity.

Nitrous oxide analgesia is provided for Subscribers under age 21.

### **ENDODONTIC SERVICES**

Endodontics is the treatment of dental disease of the tooth pulp and includes:

- Therapeutic pulpotomy and pulpal debridement, when performed as a final endodontic procedure.
- Root canal therapy, including treatment plan, clinical procedures, working and post-operative radiographs and follow-up care.
- Apexification/recalcification procedures and apicoectomy/periradicular services including surgery, retrograde filling, root amputation and hemisection.

Pulpal debridement is considered part of endodontic therapy when performed by the same Provider and not associated with a definitive emergency visit.

Benefits will not be provided for the following “*Endodontic Services*”:

- Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist.
- Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of preformed dowel and post or post removal.
- Endodontic therapy if a Subscriber discontinues endodontic treatment.

### **ORAL SURGERY SERVICES**

Oral surgery means the procedures for surgical extractions and other dental surgery under local anesthetics and includes:

- Surgical tooth extractions.
- Alveoloplasty and vestibuloplasty.
- Excision of benign odontogenic tumor/cysts.
- Excision of bone tissue.
- Incision and drainage of an intraoral abscess.
- Other Medically Necessary surgical and repair procedures not specifically excluded in this Policy.

Intraoral soft tissue incision and drainage is only covered when it is provided as the definitive treatment of an abscess. Routine follow-up care is considered part of the procedure.

Benefits will not be provided for the following Oral Surgery procedures:

- Surgical services related to a congenital malformation.
- Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bones; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of the temporomandibular joints.

### **SURGICAL PERIODONTAL SERVICES**

Surgical periodontal service is the surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

- Gingivectomy or gingivoplasty and gingival flap procedures (including root planing) – Benefits are limited to one per quadrant every 24 months.
- Clinical crown lengthening.
- Osseous surgery, including flap entry and closure – Benefits are limited to one per quadrant every 24 months. In addition, osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service, by the same Dentist, and in the same area of the mouth, will be processed as crown lengthening in the absence of periodontal disease.
- Osseous grafts – Benefits are limited to one per site every 24 months.
- Soft tissue grafts/allografts (including donor site) – Benefits are limited to one per site every 24 months.

- Distal or proximal wedge procedure.
- Anatomical crown exposures – Benefits are limited to one per quadrant every 24 months.

Surgical periodontal services performed in conjunction with the placement of crowns, inlays, onlays, crown buildups, posts and cores or basic restorations are considered part of the restoration.

Benefits will not be provided for guided tissue regeneration, or for biologic materials to aid in tissue regeneration.

### **MAJOR RESTORATIVE SERVICES**

Restorative services restore tooth structures lost as a result of dental decay or fracture and include:

- Single crown restorations.
- Gold foil and inlay/onlay restorations.
- Labial veneer restorations.

Benefits will be provided for the replacement of a lost or defective crown. However, Benefits will not be provided for the restoration of occlusion or incisal edges due to bruxism or harmful habits.

Benefits for major restorations are limited to one per tooth every 60 months whether placement was provided under this Policy or under any prior dental coverage, even if the original crown was stainless steel. Crowns placed over implants will be covered.

### **PROSTHODONTIC SERVICES**

Prosthodontics involves procedures Medically Necessary for providing artificial replacements for missing natural teeth and includes:

- Complete and removable partial dentures - Benefits will be provided for the initial installation of removable complete, immediate or partial dentures, including any adjustments, relines or rebases during the six-month period following installation. Benefits for replacements are limited to once in any 60-month period, whether placement was provided under this Policy or under any prior dental coverage. Benefits will not be provided for replacement of complete or partial dentures due to theft, misplacement or loss.
- Denture reline/rebase procedures - Benefits will be limited to one procedure every 36 months.
- Fixed bridgework - Benefits will be provided for the initial installation of a bridgework, including inlays/onlays and crowns. Benefits will be limited to once every 60 months whether placement was under this Policy or under any prior dental coverage.

Prosthetics placed over implants will be covered.

Tissue conditioning is part of a denture or a reline/rebase, when performed on the same day as the delivery.

Benefits will not be provided for the following Prosthodontic Services:

- Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.

### **MISCELLANEOUS RESTORATIVE AND PROSTHODONTIC SERVICES**

Other restorative and prosthodontic services include:

- Prefabricated crowns – Benefits for stainless steel and resin-based crowns are limited to one per tooth every 60 months. These crowns are not intended to be used as temporary crowns.

- Recementation of inlays/onlays, crowns, bridges, and post and core – Benefits will be limited to two recementations every 12 months. However, any recementation provided within six months of an initial placement by the same Dentist is considered part of the initial placement.
- Post and core, pin retention, and crown and bridge repair services.
- Pulp cap – direct and indirect.
- Adjustments – Benefits will be limited to three times per appliance every 12 months.
- Repairs of inlays, onlays, veneers, crowns, fixed or removable dentures, including replacement or addition of missing or broken teeth or clasp (unless additions are completed on the same date as replacement partials/dentures) are limited to a lifetime maximum of once per tooth or clasp.

The frequency limitation specified in the Policy for prefabricated crowns does not apply to Subscribers under age 21.

### **ORTHODONTIC SERVICES**

Orthodontic procedures and treatment include examination records, tooth guidance and repositioning (straightening) of the teeth for Subscribers covered for orthodontics as shown on your ***Schedule of Benefits***.

#### **Covered Services include:**

- Diagnostic orthodontic records and radiographs **limited to a lifetime maximum of once per Subscriber.**
- Limited, interceptive and comprehensive orthodontic treatment.
- Orthodontic retention, **limited to a lifetime maximum of one appliance per Subscriber.**

#### **Special Provisions Regarding Orthodontic Services:**

- Orthodontic services are paid over the Course of Treatment, up to the maximum Benefit Period orthodontic Benefit. Benefits cease when the Subscriber is no longer covered, whether or not the entire Benefit has been paid out.
- Orthodontic treatment is started on the date the bands or appliances are inserted.
- Payment for diagnostic services performed in conjunction with orthodontics is applied to the orthodontic Benefit and subject to the Benefit Period Maximum for orthodontic services.
- If orthodontic treatment is terminated for any reason before completion, Benefits will cease on the date of termination.
- If the Subscriber's coverage is terminated prior to the completion of the orthodontic treatment plan, the Subscriber is responsible for the remaining balance of treatment costs.
- Recementation of an orthodontic appliance by the same Provider who placed the appliance and/or who is responsible for the ongoing care of the Subscriber is not covered.
- Benefits are not available for replacement or repair of an orthodontic appliance.
- For services in progress on the Effective Date, Benefits will be reduced based on other benefits paid prior to this coverage beginning.

## Dental Exclusions and Limitations

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These general **Exclusions and Limitations** apply to all services described in this dental Policy. Dental coverage is limited to services provided by a Dentist, a dental auxiliary, or other Provider licensed to perform services covered under this dental Policy.

### IMPORTANT INFORMATION ABOUT YOUR DENTAL BENEFITS

- **Dental Procedures Which Are Not Medically Necessary**

**Please note that in order to provide Subscribers with dental care Benefits at a reasonable cost, this Policy provides Benefits only for those Covered Services for eligible dental treatment that are determined by the Plan to be Medically Necessary.**

No Benefits will be provided for procedures which are not Medically Necessary. Medically Necessary generally means that a specific procedure provided to a Subscriber is required for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to a Subscriber, as determined by the Plan.

The fact that a Physician or Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Medically Necessary.

- **Care By More Than One Dentist**

If a Subscriber changes Dentists in the middle of a particular Course of Treatment, Benefits will be provided as if the Subscriber had stayed with the same Dentist until the Subscriber's treatment was completed. There will be no duplication of Benefits.

- **Alternate Benefits**

In all cases in which there is more than one Course of Treatment possible, the Benefit will be based upon the most efficient Course of Treatment, as determined by the Plan.

If a Subscriber and a Subscriber's Dentist or Physician decide on personalized restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for dental services rather than standard procedures, the Benefits provided will be limited to the Benefit for the standard procedures for dental services, as determined by the Plan.

- **Non-Compliance with Prescribed Care**

Any additional treatment and resulting liability which is caused by the lack of a Subscriber's cooperation with the Dentist or from non-compliance with prescribed dental care will be the responsibility of the Subscriber.

### EXCLUSIONS — WHAT IS NOT COVERED

No Benefits will be provided under this Policy for:

- Services or supplies not specifically listed as a Covered Service, or when they are related to a non-covered service.
- Amounts which are in excess of the Allowable Charge, as determined by the Plan.
- Dental services for treatment of congenital or developmental malformation, or services performed for cosmetic purposes, including but not limited to bleaching teeth and grafts to improve aesthetics.

- Dental services or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders, unless specifically mentioned in this Policy or if resulting from accidental injury. Dental services or appliances to increase vertical dimension, unless specifically mentioned in this Policy.
  - Dental services which are performed due to an accidental injury. Injury caused by chewing or biting an object or substance placed in a Subscriber's mouth is not considered an accidental injury.
  - Services and supplies for any illness or injury suffered after the Subscriber's Effective Date as a result of war or any act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.
  - Services or supplies that do not meet accepted standards of dental practice.
  - Experimental, Investigational and/or Unproven services and supplies and all related services and supplies.
  - Hospital and ancillary charges.
  - Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants.
  - Services or supplies for which Subscribers are not required to make payment or would have no legal obligation to pay if Subscribers did not have this or similar coverage.
  - Services or supplies for which "discounts" or waiver of Deductible or Coinsurance amounts are offered.
  - Services rendered by a Dentist related to a Subscriber by blood or marriage.
  - Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.
  - Any illness or injury occurring in the course of employment if whole or partial compensation or benefits are or might have been available under the laws of any governmental unit; any policy of worker's compensation insurance; or according to any recognized legal remedy arising from an employer-employee relationship. This applies whether or not Subscribers claim the benefits or compensation or recover the losses from a third party.
- Subscribers agree to:
- pursue their rights under the workers' compensation laws;
  - take no action prejudicing the rights and interests of the Plan; and
  - cooperate and furnish information and assistance the Plan requires to help enforce its rights.
- If Subscribers receive any money in settlement of their employer's liability, regardless of whether the settlement includes a provision for payment of their medical bills, they agree to:
- hold the money in trust for the benefit of the Plan to the extent that the Plan has paid any Benefits or would be obligated to pay any Benefits; and
  - repay the Plan any money recovered from the employer or insurance carrier.
- Any services or supplies to the extent payment has been made under Medicare or would have been made if a Subscriber had applied for Medicare and claimed Medicare benefits, or to the extent governmental units provide benefits (some state or federal laws may affect how we apply this exclusion).
  - Charges for nutritional, tobacco or oral hygiene counseling for adults.
  - Charges for local, state or territorial taxes on dental services or procedures.
  - Charges for the administration of infection control procedures as required by local, state or federal mandates.
  - Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.

- Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or x-rays.
- Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, preparations or medicament carriers.
- Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.
- Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.
- Any services, treatments or supplies included as Covered Services under other hospital, medical and/or surgical coverage.
- Case presentations or detailed and extensive treatment planning when billed for separately.
- Charges for occlusion analysis or occlusal adjustments.

The Plan may, without waiving these exclusions, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the exclusions listed above. If it is later determined that the care and services are excluded from the Subscriber's coverage, the Plan will be entitled to recover the amount it has allowed for Benefits under this Policy. The Subscriber must provide the Plan with all documents it needs to enforce its rights under this provision.

## Definitions

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**Allowable Amount** means the maximum amount determined by Us to be eligible for consideration of payment for a particular service, supply or procedure.

**For hospitals, Doctors and other providers contracting with UNM Team Health and BCBSNM in New Mexico or any other Blue Cross and Blue Shield Plan** – The Allowable Amount is based on the terms of the Network Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRGs), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.

**For hospitals, Doctors and other providers not contracting with UNM Team Health and BCBSNM in New Mexico or any other Blue Cross and Blue Shield Plan outside of New Mexico (non-contracting Allowable Amount)** – The Allowable Amount will be the lesser of:

- i. The provider's billed charges, or;
- ii. The BCBSNM non-contracting Allowable Amount. Except as otherwise provided in this section, the non-contracting Allowable Amount is developed from base Medicare participating reimbursements adjusted by a predetermined factor established by BCBSNM. Such factor shall be not less than **75 percent** and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

Notwithstanding the preceding sentence, the non-contracting Allowable Amount for home health care is developed from base Medicare national per-visit amounts for low utilization payment adjustment, or LUPA, episodes by home health discipline type adjusted for duration and adjusted by a predetermined factor established by Us. Such factor shall be not less than **75 percent** and shall be updated on a periodic basis. When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on the claim, the Allowable Amount for non-contracting providers will represent an average contract rate in aggregate for network providers adjusted by a predetermined factor established by Us. Such factor shall be not less than **75 percent** and shall be updated not less than every two years.

We will utilize the same claim processing rules and/or edits that We utilize in processing Network Provider claims for processing claims submitted by non-contracted providers, which may also alter the Allowable Amount for a particular service. In the event we do not have any claim edits or rules, We may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Amount will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by Us within ninety (90) days after the effective date that such change is implemented by the Centers for Medicare and Medicaid Services, or its successor.

**For multiple surgeries** - The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus a determined percentage of the Allowable Amount for each of the other covered procedures performed.

**For prescription drugs as applied to Network Provider and Out-of-Network Provider pharmacies** - The Allowable Amount for pharmacies that are Network Providers will be based on the provisions of the contract between BCBSNM and the pharmacy in effect on the date of service. The Allowable Amount for pharmacies that are not Network Providers will be based on the Average Wholesale Price.

**Benefit Period** means the period of time starting with the effective date of this plan through the termination date as shown on the face page of the plan. The Benefit Period is as determined by UNM.

**Clinical Trials Benefits** means 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 cancer or other life-threatening disease or condition and is recognized under state and/or federal law. 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. If benefits for services provided in the trial are denied, you may contact the Superintendent of Insurance for an expedited appeal.

**Coinsurance** means a percentage of an eligible expense that the Covered Person is required to pay toward a Covered Expense.

**Company** means Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (also referred to herein as "BCBSNM").

**Copayment** means a fixed dollar amount that the Covered Person must pay before benefits are payable under the Plan.

**Covered Expenses** means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies not excluded or limited by the Plan. Coverage under the Plan must remain continuously in force from the date

of the accident or Sickness until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply that gave rise to the expense or the charge was rendered or obtained.

**Covered Person** means any eligible student or an eligible dependent who applies for coverage, and for whom the required premium is paid to the Company.

**Deductible** means the dollar amount of Covered Expenses that must be incurred as an out-of-pocket expense by each Covered Person on a plan term basis before benefits are payable under the Plan.

**Dependent** means an Insured's lawful spouse including Domestic Partner; or an Insured's child, stepchild, child of a Covered Person's Domestic Partner, foster child, dependent grandchild or spouse's dependent grandchild; or a child who is adopted by the Insured or placed for adoption with the Insured, or for whom the Insured is a party in a suit for the adoption of the child; or a child whom the Insured is required to insure under a medical support order issued or enforceable by the courts. Any such child must be under age 26.

**Doctor** means a Doctor licensed to practice medicine. It also means any other practitioner of the healing arts who is licensed or certified by the state in which his or her services are rendered and acting within the scope of that license or certificate. It will not include a Covered Person or a member of the Covered Person's immediate family or household.

**Domestic Partner** means a person with whom a student has entered into a Domestic Partnership.

**Domestic Partnership** means a long-term committed relationship of indefinite duration with a person that meets the following criteria: (i) a student and his/her Domestic Partner have lived together for at least six (6) months; (ii) neither a student nor his/her Domestic Partner is married to anyone else or has another domestic partner; (iii) a student's Domestic Partner is at least 18 years of age and mentally competent to consent to a contract; (iv) a student's Domestic Partner resides with him/her and intends to do so indefinitely; (v) a student and his/her Domestic Partner have an exclusive mutual commitment similar to marriage; and (vi) a student and his/her Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

**Emergency Care** means health care services provided in a hospital emergency facility (emergency room) or comparable facility to evaluate and stabilize medical conditions of recent onset and severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, Sickness, or Injury is of such a nature that failure to get immediate care could result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment of bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

**Emergency Services** means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and, within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize the patient.

**Injury** means accidental bodily harm sustained by a Covered Person that results directly and independently from all other causes from a covered accident. The Injury must be caused solely through external, violent and accidental means. All injuries sustained by one person in any one accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

**Inpatient** means that a Covered Person is a registered bed patient and is treated as such in a health care facility.

**Insured** means a person in a Class of Eligible Persons who enrolls for coverage and for whom the required premium is paid, making coverage in effect for that person. An Insured is not a dependent covered under the Plan.

**Interscholastic Activities** means playing, participating and/or traveling to or from an interscholastic, intercollegiate, club sports, professional, or semi-professional sport, contest or competition, including practice or conditioning for such activity.

**Medically Necessary** means those services or supplies covered under the plan that are:

- Essential to, consistent with, and provided for in the diagnosis or in the direct care and treatment of the condition, Sickness, disease, Injury, or bodily malfunction; and
- Provided in accordance with, and are consistent with, generally accepted standards of medical practice in the United States; and
- Not primarily for the convenience of the Insured, his physician, behavioral health practitioner, the hospital, or other provider; and
- The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Insured. When applied to hospitalization, this further means that the Insured requires acute care as a bed patient due to the nature of the services provided or the Insured's condition, and the Insured cannot receive safe or adequate care as an outpatient.

The medical staff of BCBSNM shall determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities; the guidelines and practices of Medicare, Medicaid, or other government-financed programs; and peer-reviewed literature. Although a physician, behavioral health practitioner or professional other provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

**Network Provider** means a hospital, Doctor or other provider who has entered into an agreement with UNM Team Health or BCBSNM (and, in some instances, with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care provider.

**Out-of-Network Provider** means a hospital, Doctor or other provider who has not entered into an agreement with UNM Team Health or BCBSNM (or other participating Blue Cross and/or Blue Shield Plan) as a managed care provider.

**Outpatient** means that a Covered Person is receiving treatment while not an Inpatient. Services considered Outpatient include, but are not limited to, services in an emergency room regardless of whether a Covered Person is subsequently registered as an Inpatient in a health care facility.

**Out-of-Pocket Maximum** means the maximum liability that may be incurred by a Covered Person in a Benefit Period before benefits are payable at 100 percent of the Allowable Amount.

**Pre-authorization** means the process that determines in advance the Medical Necessity or experimental, investigational and/or unproven nature of certain care and services under this Plan.

**Qualifying Intercollegiate Sport** means a sport: a.) which has been accorded varsity status by the Institution as an NCAA sport; and (b.) which is administered by such Institution's department of intercollegiate athletics; and (c.) for which the eligibility of the participating student athlete is reviewed and certified in accordance with NCAA legislation, rules, or regulations; and (d.) which entitles qualified participants to receive the Institution's official awards.

**Rescission** means a cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if:

- the cancellation or discontinuance of coverage has only a prospective effect; or
- the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

**Sickness** means an illness, disease or condition causing a Covered Person to incur medical expenses while covered under the Plan. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

**We, Our, Us** means Blue Cross and Blue Shield of New Mexico or its authorized agent.

## Exclusions and Limitations

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Except as specified in this Plan, coverage is not provided for loss or charges incurred by or resulting from:

1. as a result of dental treatment, except as provided elsewhere in the Plan. This exclusion does not apply to Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.
2. for services normally provided without charge by the Policyholder's Health Center or by health care providers employed/retained by the Policyholder. The eligibility fee assessed by the Policyholder's Health Center is not a covered item.
3. for eye examinations, eyeglasses, contact lenses, or prescription for such (except as specifically provided in the Plan) or treatment for visual defects and problems. "Visual defects" means any physical defect of the eye which does or can impair normal vision apart from the disease process. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
4. 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 a fare-paying passenger in an aircraft operated by a commercial scheduled airline.
5. for physical, behavioral or mental health conditions, Injury, Sickness or disease resulting from war or act of war, declared or undeclared.
6. as a result of an physical, behavioral or mental health conditions, Injury, Sickness or disease for which benefits are paid under any Workers' Compensation or Occupational Disease Law.
7. as a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces of any country, the Company will refund any unearned pro rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days.

8. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
9. for cosmetic surgery except that "cosmetic surgery" shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part and reconstructive surgery because of a congenital disease or anomaly which has resulted in a functional defect. It also shall not include breast reconstructive surgery after a mastectomy.
10. for 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.
11. 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.
12. as a result of committing or attempting to commit an assault or felony or participation in a riot or civil commotion.
13. for Elective Treatment or elective surgery, except as specifically provided in the Plan.
14. after the date plan terminates for a Covered Person except as may be specifically provided in the Extension of Benefits provision.
15. for any services rendered by a Covered Person's Immediate Family Member.
16. for a treatment, service or supply which is not Medically Necessary or covered as a Preventive Service.
17. for surgery and/or treatment of: except as specifically provided in the Plan; biofeedback-type services; breast implants or breast reduction; deviated nasal septum, including submucous resection and/or other surgical correction thereof; family planning, except as specifically provided; hair growth or removal; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; vasectomy; and erectile dysfunction. This exclusion does not apply to Essential Health Benefit mandated by the Patient Protection and Affordable Care Act.
18. for routine physical examinations, health examinations or preschool physical examinations, except as specifically provided for in the Plan. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
19. 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.
20. for treatment in the Hospital emergency room which is not due to an Emergency Medical Condition.
21. for treatment, services, drugs, device, procedures or supplies that are Experimental or Investigational unless specifically provided under Clinical Trials Benefit.
22. for treatment, services or supplies that are not deemed to be an Eligible Expense.
23. for weight management, weight reduction, or treatment for obesity including bariatric surgery and any condition resulting therefrom, including surgery for the removal of excess skin or fat.

## Academic Emergency Services\*

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To ensure immediate access to assistance if you experience a crisis while traveling over 100 miles from home, or outside your home country, Academic HealthPlans has included Academic Emergency Services (AES) benefits in your student health plan coverage. AES offers a wide range of services and benefits to provide everything you need to prepare for your international experience, as well as get the help or information you need in a crisis, no matter how large or small. For more details, visit [unm.myahpcare.com](http://unm.myahpcare.com).

### BlueCard®

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Like all Blue Cross and Blue Shield Licensees, We participate in a program called “BlueCard.” Whenever the Covered Person accesses health care services outside Our service area, the claims for those services may be processed through BlueCard and presented to Us for payment in conformity with network access rules of the BlueCard Policies then in effect (“Policies”). Under BlueCard, when Covered Persons incur Covered Expenses within the geographic area served by an onsite Blue Cross and/or Blue Shield Licensee (“Host Blue”), We will remain responsible to the Covered Person for fulfilling the Plan's contract obligations. The Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its participating Providers and handling all interactions with its participating Providers.

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 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 Blue Cross Blue Shield Global Core 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.

For additional information regarding the BlueCard® Program or Blue Cross and Blue Shield Global Core, refer to your policy located at [unm.myahpcare.com](http://unm.myahpcare.com).

\*Academic Emergency Services (AES) is a global emergency services product. These services are provided by a separate and independent company from AES or Academic HealthPlans. Academic EmergencyServices and AD&D coverage are underwritten by 4 Ever Life International Limited and administered by Worldwide Insurance Services, LLC, separate and independent companies from Academic HealthPlans.

## Summary of Benefits and Coverage

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The Affordable Care Act requires all health insurers to provide consumers with a Summary of Benefits and Coverage (SBC). The SBC is a description of the benefits and health coverage offered by a particular health plan. The SBC is intended to provide clear, consistent descriptions that may make it easier for people to understand their health plan coverage.

The items in the SBC just represent an overview of coverage; they are not an exhaustive list of what is covered or excluded. The full terms of coverage are located in your plan. To obtain an SBC for your Plan, visit [unm.myahpcare.com](http://unm.myahpcare.com).

## BCBSNM Online Resources

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**BCBSNM** members have online access to claims status, Explanations of Benefits, ID cards, Network Providers, correspondence and coverage information by logging in to **Blue Access for Members<sup>SM</sup>** (BAM). Visit **BCBSNM.com** and click on the “Log in” tab. Follow the simple, onscreen directions to establish an online account in minutes.

**BAM** has been enhanced to include BAM Mobile, a self-service tool that provides a quick and easy way to view any email notifications We may have sent. In Message Center, notifications are securely sent directly to the Insured student’s email address. If the Insured student prefers to receive paper copies, he or she may opt out of electronic delivery by going into “My Email Preferences” and making the change there.

Please visit [unm.myahpcare.com](http://unm.myahpcare.com) for additional premium and benefit information.

## Claims Procedure

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In the event of Injury or Sickness, the student should:

1. Report to the Student Health Center for treatment, or, when not in school, to his/her Doctor or hospital. Insureds should go to a Network Doctor or hospital for treatment, if possible.

**IN AN EMERGENCY, REPORT DIRECTLY TO THE NEAREST EMERGENCY ROOM FOR TREATMENT.**

2. Mail to the address below all prescription drug receipts (for providers outside of those contracting with Prime Therapeutics), medical and hospital bills, along with patient’s name and Insured student’s name, address, Social Security Number, BCBSNM member ID number, and name of the University under which the student is Insured.
3. File claims within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

**The Plan is administered by:**

Blue Cross Blue Shield of New Mexico

UNM Team Health Customer Service: **(844) 866-2224**

**Administrative Services by:**

Academic HealthPlans, Inc.

P. O. Box 1605

Colleyville, TX 76034-1605

For more information visit

**[unm.myahpcare.com](http://unm.myahpcare.com)**

## Important Information

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### **Breast Reconstructive Surgery after Mastectomy**

Your Plan as required by the federal Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services. If a Covered Person is eligible for mastectomy benefits under this Plan and she elects breast reconstruction in connection with such mastectomy, she also is covered for the following:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Mastectomy related coverage for breast reconstructive surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the Plan definition of “Medically Necessary”. Benefits will be payable on the same basis as any other Sickness or Injury under the Plan, including the application of appropriate Deductibles and Coinsurance amounts.

### **Inpatient Stay Following Birth of a Child**

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

- a. 48 hours following an uncomplicated vaginal delivery; and
- b. 96 hours following an uncomplicated delivery by Cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to:

- a. Give birth in a hospital or other health care facility; or
- b. Remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 hour or 96 hours has expired, the Plan will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breastfeeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriately licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office for a health care facility.

**Mental Health Parity** - Benefits for Covered Expenses incurred for the treatment of Mental Health Care will be the same as for treatment of any other sickness. Subject to the Preauthorization guidelines set forth in this Plan.

### **Preventive Services**

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

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

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

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

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



**Health care coverage is important for everyone.**

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator  
300 E. Randolph St.  
35th Floor  
Chicago, Illinois 60601

Phone:  
TTY/TDD:  
Fax:  
Email:

855-664-7270 (voicemail)  
855-661-6965  
855-661-6960  
CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building 1019  
Washington, DC 20201

Phone: 800-368-1019  
TTY/TDD: 800-537-7697

Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>



If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعد أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમ મદદ કરી રહ્યા હોય અથવા કોઈ બાજુ વ્યાકરણ અસુબા અમ કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાની હક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसको सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर काल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago la'da biká anánilwo'ígíí, na'idílkidgo, ts'idá bee ná ahóótí'i' t'áá níik'e níká a'doolwoł dóó bina'idílkidígíí bee níł h odoonih. Ata'dahalne'ígíí bich'i' hodíílnih kwe' é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiegokolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulongan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.