Benefit Program Material

Los Alamos National Security, LLC

A Guide to Your Exclusive Provider Organization (EPO) Medical Program

Administered by:

Blue Cross and Blue Shield of New Mexico

NM81155 (01/12)

Customer Assistance

Customer Service and Claims: Medical/Surgical and Drug Plan Services — When you have questions or concerns, call the BCBSNM Customer Service department toll-free Monday through Friday from 6 A.M. – 8 P.M. Mountain Time or from 8 A.M. – 5 P.M. on Saturdays and most holidays; or you may visit the BCBSNM office in Albuquerque. (If you need assistance outside normal business hours, you may call the Customer Service telephone number and leave a message. A Customer Service Advocate will return your call by 5 P.M. the next business day.)

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

Mail all **medica/surgical inquiries** and/or **preauthorization** requests and submit all non-drug plan **claims*** to:

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

Submit **drug plan claims** to the pharmacy benefit manager at:

Prime Therapeutics
PO Box 14624
Lexington, KY 40512-4624

***Exceptions —** Claims for health care services received from providers that do not contract **directly** with BCBSNM should be sent to the Blue Cross Blue Shield Plan in the state where services were received or, if outside the United States, to the BlueCard Worldwide Service Center. See *Section 9* for details on submitting claims.

Preauthorizations: Medical/Surgical and Drug Plan Services — For preauthorizations related to medical/surgical or drug plan services, call a Health Services representative Monday through Friday from 8 A.M. – 5 P.M. Mountain Time. If you need assistance between 5 P.M. and 8 A.M. or on weekends or holidays, call Customer Service.

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

Preauthorizations and Customer Service: Mental Health and Chemical Dependency — For benefit inquiries or preauthorizations related to mental health or chemical dependency services, contact the BCBSNM Behavioral Health Unit (BHU). (Claims for behavioral health services are sent to the same address as are medical/surgical claims.)

Customer Service/Preauthorization Requests: 24 hours/day, 7 days/week: 1-877-878-LANL (5265)

Web Site — For provider network information, copies of BCBSNM Drug Lists, claim forms, and other information, or to e-mail your question to BCBSNM, visit the BCBSNM Web site at:
www.bcbsnm.com

To locate Preferred Providers throughout the United States and the world:

- Visit the BlueCard Doctor and Hospital Finder at **www.bcbs.com;** or
- Call BlueCard Access® at **1-800-810-BLUE (2583);** or
- When outside the United States, call the BlueCard Worldwide Service Center at **1-800-810-BLUE (2583)** or call collect: **1-804-573-1177.**

Welcome

This *EPO Medical Program Material* (or "benefit booklet") is a summary of the Exclusive Provider Option (EPO) Medical Program offered by Los Alamos National Security, LLC (LANS) to eligible employees and retirees of LANS or Los Alamos National Laboratory (LANL), and their eligible family members effective January 1, 2012. This Medical Program is "self-insured" by LANS. This means LANS is responsible for the design of the Medical Program and the setting of contributions. LANS sets the employee contribution rates to be adequate to pay for the claims all LANS Medical Program members incur. When claim costs exceed the contributions, the contribution rates have to go up. A small percentage of your contributions go toward the Medical Program administration costs (claims adjudication, customer service, provider networking, ID cards, booklet printing, etc.). The balance pays for the cost of your medical care.

In addition to this document, the *LANS Health & Welfare Benefit Plan for Employees* (or *for Retirees,* if applicable) *Summary Plan Description ("LANS SPD")* contains important information about your LANS Medical Program. If any conflict should arise between this benefit booklet and the procedures of the Claims Administrator (BCBSNM), or if any provision is not explained or only partially explained in this document, the relevant *LANS SPD* (described in *Section 1*) will govern in all cases.

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

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 Blue Shield Association is pleased to serve as Claims Administrator for the LANS self-funded EPO Medical Program. You will be accessing the worldwide Blue Cross Blue Shield Preferred Provider network as if you were insured by BCBSNM.

This is an Exclusive Provider Organization (EPO) Medical Program that generally provides benefits ONLY for services received from a BCBS-Preferred Provider. Although this Medical Program uses the same network of providers as the PPO Medical Program, this is NOT a "PPO" Medical Program. Under the EPO Medical Program, if you obtain nonemergency services from a Nonpreferred (non-PPO) provider, the services will usually NOT be covered. Exceptions to this requirement are listed in Section 3. It is YOUR responsibility to determine if a provider is in the national/worldwide BCBS-Preferred Provider network or not. See *Section 2* for details.

NOTE: The Medical Program for active employees is considered "grandfathered" and employees should read the disclosure notice of that status on page iv. The Medical Program for retirees is considered "ungrandfathered" as of January 1, 2011, resulting in minor benefit changes for preventive services and an additional appeal level for retirees regarding disputed claims and eligibility issues. See *Section 9* for more information about appeals.

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NOTICE FOR ACTIVE EMPLOYEE MEDICAL PROGRAM ONLY: Disclosure of Grandfathered Status

LANS believes this Medical Program for **active employees and their covered family members** is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on essential benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the employer or to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans.

Summary of Benefits: EPO Program

Active EE EPO Medical Program Cost-Sharing Features, Covered Services, and Limitations	Member's Share of Covered Charges Preferred Provider (In-Network) [1,2]
Calendar Year Deductible [1] (Family deductible is an aggregate of three times the Individual amount and may be met by three or more family members.)	$150 Individual/ $450 Family
Calendar Year Out-of-Pocket Limit [2] (Includes deductible, copayments, and percentage coinsurance amounts **except** residential treatment center and drug plan copayments. Family limit may be met by three or more family members.)	$2,000 Individual/ $6,000 Family
Lifetime Maximum Benefit Limit (per member)	Unlimited
Office Visit/Exam Charge Office Visits/Exams or Consultations (Other office services received during the visit, unless specified otherwise, are subject to deductible and/or coinsurance provisions as listed in the rest of the summary. Includes initial visit to OB/Gyn or midwife to confirm pregnancy; pre-natal and post-natal care is listed under "Hospital/Other Facility: Inpatient" as part of global delivery fee)	$20/visit *(deductible waived)* [4]
Family Planning: Office visit Sterilization/surgery (reversal not covered); other related services in office (IUD, diaphragm, Depo-Provera)	$20/visit *(deductible waived)* 10% after deductible
Allergy Injections (only) and Immunizations (only)	No Charge
Other Allergy Care (such as allergy testing)	10% after deductible
Lab, X-Ray, and Other Diagnostic Tests (nonroutine/nonpreventive)	10% after deductible [4]
Therapeutic Injections	10% after deductible [4]
Nutritional Counseling (**3 sessions/life** for certain conditions)	$20/visit *(deductible waived)*
Routine/Preventive Well-Baby Care (Through Age 2): Including routine checkups; immunizations; routine screenings; routine testing	No Copay (*deductible waived)*
Routine/Preventive Well-Child Care (Ages 3-18): Including routine physicals/exams, well-child care; immunizations, routine vision/hearing screenings	$20/visit *(deductible waived)*
Routine/Preventive Adult Care (Ages 19 and Older): Including routine adult physicals and gynecological exams, colonoscopies, immunizations	$20/visit *(deductible waived)*
Routine/Preventive Lab, X-Ray, Other Testing (Ages 3 and Up): Including routine Pap tests, mammograms, cholesterol tests, urinalysis, EKGs, etc.	No Charge
OTHER MEDICAL/SURGICAL SERVICES	
Acupuncture (limited to **20 visits**/year)	$20/visit *(deductible waived)*
Ambulance: Emergency Transport (Air/ground ambulance, as needed)	10% after deductible[3]
Ambulance: Nonemergency Transfer, Medically Necessary	10% after deductible[4]
Cancer/Congenital Heart Disease Care (Blue Distinction programs only, which include a lodging per diem benefit of **$50** per person, or $100/day for 2-3 persons. Travel and the above per diem allowances combined are limited to **$10,000** per lifetime for each program utilized. If program is not used, benefits are same as for any other service, based on place of treatment, provider, and type of service.)	10% after deductible[4,5]
Cardiac Rehabilitation, Outpatient/Office	$20/visit *(deductible waived)*[4]
Dental/Facial Accident[3], Oral Surgery, TMJ/CMJ Services (for limited, non-dental medical conditions; see a benefit booklet for details)	Usual benefit based on type/place of service[3,4,5]
Emergency Room Visit (*emergency* condition only)	$75/visit *(deductible waived)* [3]
Physician and Other Professional Provider Charges	10% after deductible [3]
Hearing-Related Services -Office exams and evaluations; cochlear implant surgery and auditory testing -Hearing aid services (maximum total benefit of **$2,200** during 36-month period, including fitting of hearing aid and ear molds)	10% after deductible 10% after deductible

IMPORTANT: Except under limited circumstances, nonemergency services must be received from a BCBS Preferred Provider in order to be covered. See the "NOTE" on page vii.

Active EE EPO Medical Program Covered Services and Limitations (continued)	Member's Share of Covered Charges Preferred Provider (In-Network) [1,2]
Home Health Care/Home I.V. Services (Private duty nursing **not** covered; care must be from a licensed home health care agency)	10% *(deductible waived for non-nursing services)* [4]
Hospice Services including bereavement counseling when such services are provided by a hospice (Respite care limited to **10 days** for each 6-month benefit period.)	10% *(deductible waived)* [4]
Hospital/Other Facility Services: Inpatient	
- ***Medical/Surgical Facility Acute Care, Observation, Medical Detox, Maternity-Related*** (including routine newborn nursery charges), *and* ***Extended Stay (Nonroutine) for Covered Newborn:*** Room and Board and Covered Ancillaries	10% after deductible[5]
- ***Birthing Center***	10% after deductible
- ***Skilled Nursing Facility*** and *Inpatient* ***Physical Rehabilitation*** (combined max. **100 days**/calendar year)	10% *(deductible waived)* [5]
- *Inpatient* ***Physician's Medical Visit*** *or* ***Consultation***; *Routine Inpatient* ***OB/Gyn Global Delivery Fee*** (includes pre-natal/post-natal care); *Inpatient Newborn Male* ***Circumcision***	No Charge
- *Inpatient* ***Surgeon, Anesthesiologist, Radiologist, Pathologist,*** *and* ***Assistant Surgeon*** (including maternity services that are **not** part of OB/Gyn global delivery fee and complications of pregnancy)	10% after deductible
Hospital/Other Facility: Outpatient/Ambulatory Surgery Center (Includes covered services, whether billed by facility or professional provider, including surgery , diagnostic tests, chemotherapy, dialysis, and radiation treatment.)	10% after deductible[4]
Lab, X-Ray, and Other Diagnostic Tests (nonpreventive) Including MRI, CT Scans, and PET Scans; Sleep Studies; EKGs, etc.	
- *Office or Freestanding/Independent Facility*	10% after deductible[4]
- *Outpatient Hospital*	10% after deductible[4]
Short-Term Rehabilitation, Outpatient/Office (Includes physical, occupational, and speech therapy services, each of which is limited to **20 visits**/ calendar year. Speech therapy is limited to specified medical conditions; see a benefit booklet for details.)	$20/visit *(deductible waived)* [4]
Spinal Manipulation/Osteopathic Manipulation (Max. **20 visits**/ calendar year)	$20/visit *(deductible waived)*
Supplies, Durable Medical Equipment, Prosthetics, Orthotics (Includes insulin pumps and pump supplies. Support hose limited to **6** pair/year. Mastectomy bras limited to **3**/year. For diabetic supplies such as needles, test strips, glucagon, etc., see drug plan provision.)	10% after deductible [4,6]
Surgery: Outpatient Hospital/Ambulatory Surgery Facility (including facility charges and related physician and other professional charges, such as surgeon, pathologist, radiologist, etc.)	10% after deductible [4]
Surgery: Office (including casts, splints, dressings, and diagnostic tests done in office on same day and billed by surgeon)	$20/visit *(deductible waived)* [4]
Therapy: Chemotherapy, Dialysis, and Radiation	
- *Office or Freestanding Clinic*	$20/visit *(deductible waived)* [4]
- *Outpatient Hospital*	10% after deductible[4]
Transplant Services: Limitations apply to donor charges and travel and lodging. Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network for the transplant provided.	Blue Distinction Center for Specialty Care: 10% after deductible[4,5]
Travel and Lodging: Benefits are available when these services are related to case-managed Cancer Services or Congenital Heart Disease if patient is receiving treatment from a Blue Distinction Center for Specialty Care or case-managed transplants (excluding cornea). Travel of more than 50 miles must be necessary in order to be eligible for coverage under this provision.	
Travel to and from health care facility plus per diem payments listed below	$10,000/lifetime after deductible [4]
Lodging **per diem** for patient and/or companion(s)	$50/individual or $100 for 2-3 persons after deductible[4]
Urgent Care Facility	$20/visit *(deductible waived)*
- Ancillary Services (lab tests, x-rays, supplies, etc.)	10% after deductible

Deductibles, copayments, and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than the provider's billed charges. Preferred Providers will not charge you the difference between the covered charge and the billed charge for covered services.

BEHAVIORAL HEALTH: Mental Health and Chemical Dependency	
Mental Health Services	
- *Office, Outpatient, Intensive Outpatient Programs (IOP)*	$20/visit *(deductible waived)* [4]
- *Inpatient and/or Partial Hospitalization*	10% after deductible[5]
-Related Inpatient Physician Claims	No Charge
Chemical Dependency Rehabilitation	
- *Office, Outpatient, Intensive Outpatient Programs (IOP)*	$20/visit *(deductible waived)* [4]
- *Outpatient Suboxone Treatment*	$20/visit *(deductible waived)* [4]
- *Inpatient and/or Partial Hospitalization*	10% after deductible [5]
-Related Inpatient Physician Claims	No Charge
- *Residential Treatment Center* (max. **130 days**/lifetime), including physician	$250 facility copay plus 20% after deductible [5,7]

DRUG PLAN: Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Specified Vaccines [8]			
Enteral nutritional products, compounded medications, special medical foods, and other drugs require preauthorization or benefits will be denied.	**Generic Drug**	**Brand-Name Drug [8]**	
		On Drug List	**Not on Drug List**
Retail Pharmacy/Specialty Pharmacy Programs (up to a 30-day supply or 180 units, whichever is less; benefits include flu, pneumococcal, and Zostavax vaccines for which no copayment is required)	$15	$30	$45
Mail-Order Program (up to a 60- or 90-day supply or 540 units, whichever is less)	$30	$60	$90
Nonprescription Enteral Nutritional Products and Special Medical Foods (up to a 30-day supply per 30-day period; requires preauthorization)	$45 retail/$90 mail-order		

FOOTNOTES:

1 All services – excluding items covered under the drug plan – are subject to deductible unless otherwise indicated in the *Summary of Benefits* (i.e., "deductible waived"). When applicable, the deductible must be met before benefit payments are made.

2 After a member (or family) reaches the out-of-pocket limit, the Medical Program pays 100 percent of that member's (or family's) covered charges for the rest of the calendar year (except for items covered under the drug plan and copayments for residential treatment).

3 Initial treatment by a Nonpreferred Provider of a medical emergency is paid. However, follow-up treatment from a Nonpreferred Provider and any other treatment from a Nonpreferred Provider that is not for an emergency is not covered unless listed as an exception in the "NOTE" at the bottom of the page.

4 Certain services are **not covered** if preauthorization is not obtained from BCBSNM (or the BCBSNM Behavioral Health Unit). A list of services requiring preauthorization and a description of when obtaining preauthorization is your responsibility is in Section 4. Some services may require a written request for preauthorization in order to be covered. Nonemergency ambulance services are covered **only** when it is medically necessary to transfer the patient from one facility to another. See Section 4 for details.

5 Preauthorization is required for inpatient admissions. You pay a **$300 penalty** for covered facility services if preauthorization is your responsibility and is not obtained. Some services, such as transplants and physical rehabilitation, require additional preauthorization. If you do not receive preauthorization for these individually identified procedures, benefits for any related admissions will be denied. (The $300 penalty will not apply in such cases.) See Section 4.

6 Rental benefits for medical equipment and other items will not exceed purchase price of a new unit.

7 Extended care facilities (such as nursing homes and residential treatment centers) are **excluded** from coverage. However, LANS has authorized the Claims Administrator to approve, when used as a cost-effective alternative to inpatient hospitalization, up to **130 days** of residential treatment center services for patients being treated for chemical dependency. This is a lifetime maximum that accrues from Medical Program to Medical Program and is the only exception that can be made to the extended care facility exclusion.

8 Prescription drugs and other items covered under the drug plan must be purchased at a pharmacy that participates in the Retail Pharmacy/Specialty Pharmacy or Mail-Order Programs. (BCBSNM has contracted with a separate program for administration of your outpatient drug plan benefits.) Some prescription drugs require preauthorization before coverage will be available. If you require a brand-name drug for which there is a generic equivalent, you will pay the difference in cost between the brand-name drug and the generic drug, plus the generic drug copayment.

NOTE: Nonpreferred Provider services may be covered in the following cases only: emergency care; transition of care (up to 90 days); pathologist, anesthesiologist, and radiologist services when member is receiving covered services at a preferred facility; and when a provider belongs to a type that is "unsolicited" (i.e., a type that is not offered a Preferred Provider contract). Also, if you must travel more than 30 miles to find a Preferred Provider for a covered service and a Nonpreferred Provider able to render the same covered service is closer, the Medical Program will cover the service of the Nonpreferred Provider, if eligible. If the providers are essentially equal in distance from your home or office (i.e., within 5 miles of each other), the exception does **not** apply and you must use a Preferred Provider in order to receive benefits. This "distance" exception also does **not** apply to services needed by members living or residing outside the United States. In any case, to receive Preferred Provider benefits for **nonemergency** services of a Nonpreferred Provider, you must first obtain **preauthorization** from BCBSNM (or the BCBSNM Behavioral Health Unit). **It is YOUR responsibility to determine if a provider is in the national/worldwide BCBS PPO network or not. See Section 2 for details.**

Summary of Benefits: EPO Program

Retiree EPO Medical Program Cost-Sharing Features, Covered Services, and Limitations	Member's Share of Covered Charges Preferred Provider (In-Network) [1,2]
Calendar Year Deductible [1] (Family deductible is an aggregate of three times the Individual amount and may be met by three or more family members.)	$150 Individual/ $450 Family
Calendar Year Out-of-Pocket Limit [2] (Includes deductible, copayments, and percentage coinsurance amounts **except** residential treatment center and drug plan copayments. Family limit may be met by three or more family members.)	$2,000 Individual/ $6,000 Family
Lifetime Maximum Benefit Limit (per member)	Unlimited
Office Visit/Exam Charge Office Visits/Exams or Consultations (Other office services received during the visit, unless specified otherwise, are subject to deductible and/or coinsurance provisions as listed in the rest of the summary. Includes initial visit to OB/Gyn or midwife to confirm pregnancy; pre-natal and post-natal care is listed under "Hospital/Other Facility: Inpatient" as part of global delivery fee)	$20/visit *(deductible waived)* [4]
Family Planning: Office visit Sterilization/surgery (reversal not covered); other related services in office (IUD, diaphragm, Depo-Provera)	$20/visit *(deductible waived)* 10% after deductible
Allergy Injections (only) and Immunizations (only)	No Charge
Other Allergy Care (such as allergy testing)	10% after deductible
Lab, X-Ray, and Other Diagnostic Tests (nonroutine/nonpreventive)	10% after deductible [4]
Therapeutic Injections	10% after deductible [4]
Nutritional Counseling (**3 sessions/life** for certain medical conditions)	$20/visit *(deductible waived)*
Routine/Preventive Well-Baby/Well-Child Care (Through Age 18): Including routine checkups; immunizations; routine screenings; routine testing, including routine vision/hearing screenings	No Charge
Routine/Preventive Adult Care (Ages 19 and Older): Including routine adult physicals and gynecological exams, colonoscopies, immunizations	No Charge
Routine/Preventive Lab, X-Ray, Other Testing (Ages 3 and Up): Including routine Pap tests, mammograms, cholesterol tests, urinalysis, EKGs, etc.	No Charge
OTHER MEDICAL/SURGICAL SERVICES	
Acupuncture (limited to **20 visits**/year)	$20/visit *(deductible waived)*
Ambulance: Emergency Transport (Air/ground ambulance, as needed)	10% after deductible[3]
Ambulance: Nonemergency Transfer, Medically Necessary	10% after deductible[4]
Cancer/Congenital Heart Disease Care (Blue Distinction programs only, which include a lodging per diem benefit of **$50** per person, or $100/day for 2-3 persons. Travel and the above per diem allowances combined are limited to **$10,000** per lifetime for each program utilized. If program is not used, benefits are same as for any other service, based on place of treatment, provider, and type of service.)	10% after deductible[4,5]
Cardiac Rehabilitation, Outpatient/Office	$20/visit *(deductible waived)*[4]
Dental/Facial Accident[3], Oral Surgery, TMJ/CMJ Services (for limited, non-dental medical conditions; see a benefit booklet for details)	Usual benefit based on type/place of service[3,4,5]
Emergency Room Visit (*emergency* condition only)	$75/visit *(deductible waived)* [3]
Physician and Other Professional Provider Charges	10% after deductible [3]
Hearing-Related Services -Office exams and evaluations; cochlear implant surgery and auditory testing -Hearing aid services (maximum total benefit of **$2,200** during 36-month period, including fitting of hearing aid and ear molds)	10% after deductible 10% after deductible

Deductibles, copayments, and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than the provider's billed charges. Preferred Providers will not charge you the difference between the covered charge and the billed charge for covered services.

Retiree EPO Medical Program Covered Services and Limitations (continued)	Member's Share of Covered Charges Preferred Provider (In-Network) [1,2]
Home Health Care/Home I.V. Services (Private duty nursing **not** covered; care must be from a licensed home health care agency)	10% *(deductible waived for non-nursing services)* [4]
Hospice Services including bereavement counseling when such services are provided by a hospice (Respite care limited to **10 days** for each 6-month benefit period.)	10% *(deductible waived)* [4]
Hospital/Other Facility Services: Inpatient	
- ***Medical/Surgical Facility Acute Care, Observation, Medical Detox, Maternity-Related*** (including routine newborn nursery charges), *and* ***Extended Stay (Nonroutine) for Covered Newborn:*** Room and Board and Covered Ancillaries	10% after deductible[5]
- ***Birthing Center***	10% after deductible
- ***Skilled Nursing Facility*** and *Inpatient* ***Physical Rehabilitation*** (combined max. **100 days**/calendar year)	10% *(deductible waived)* [5]
- *Inpatient* ***Physician's Medical Visit*** *or* ***Consultation***; *Routine Inpatient* ***OB/Gyn Global Delivery Fee*** (includes pre-natal/post-natal care); *Inpatient Newborn Male* ***Circumcision***	No Charge
- *Inpatient* ***Surgeon, Anesthesiologist, Radiologist, Pathologist,*** *and* ***Assistant Surgeon*** (including maternity services that are **not** part of OB/Gyn global delivery fee and complications of pregnancy)	10% after deductible
Hospital/Other Facility: Outpatient/Ambulatory Surgery Center (Includes covered services, whether billed by facility or professional provider, including surgery , diagnostic tests, chemotherapy, dialysis, and radiation treatment.)	10% after deductible[4]
Lab, X-Ray, and Other Diagnostic Tests (nonpreventive) Including MRI, CT Scans, and PET Scans; Sleep Studies; EKGs, etc.	
- *Office or Freestanding/Independent Facility*	10% after deductible[4]
- *Outpatient Hospital*	10% after deductible[4]
Short-Term Rehabilitation, Outpatient/Office (Includes physical, occupational, and speech therapy services, each of which is limited to **20 visits**/ calendar year. Speech therapy is limited to specified medical conditions; see a benefit booklet for details.)	$20/visit *(deductible waived)* [4]
Spinal Manipulation/Osteopathic Manipulation (Max. **20 visits**/ calendar year)	$20/visit *(deductible waived)*
Supplies, Durable Medical Equipment, Prosthetics, Orthotics (Includes insulin pumps and pump supplies. Support hose limited to **6** pair/year. Mastectomy bras limited to **3**/year. For diabetic supplies such as needles, test strips, glucagon, etc., see drug plan provision.)	10% after deductible [4,6]
Surgery: Outpatient Hospital/Ambulatory Surgery Facility (including facility charges and related physician and other professional charges, such as surgeon, pathologist, radiologist, etc.)	10% after deductible [4]
Surgery: Office (including casts, splints, dressings, and diagnostic tests done in office on same day and billed by surgeon)	$20/visit *(deductible waived)* [4]
Therapy: Chemotherapy, Dialysis, and Radiation	
- *Office or Freestanding Clinic*	$20/visit *(deductible waived)* [4]
- *Outpatient Hospital*	10% after deductible[4]
Transplant Services: Limitations apply to donor charges and travel and lodging. Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network for the transplant provided.	Blue Distinction Center for Specialty Care: 10% after deductible[4,5]
Travel and Lodging: Benefits are available when these services are related to case-managed Cancer Services or Congenital Heart Disease if patient is receiving treatment from a Blue Distinction Center for Specialty Care or case-managed transplants (excluding cornea). Travel of more than 50 miles must be necessary in order to be eligible for coverage under this provision.	
Travel to and from health care facility plus per diem payments listed below	$10,000/lifetime after deductible [4]
Lodging **per diem** for patient and/or companion(s)	$50/individual or $100 for 2-3 persons after deductible[4]
Urgent Care Facility	$20/visit *(deductible waived)*
- Ancillary Services (lab tests, x-rays, supplies, etc.)	10% after deductible

IMPORTANT: Except under limited circumstances, nonemergency services must be received from a BCBS Preferred Provider in order to be covered. See the "NOTE" on next page.

BEHAVIORAL HEALTH: Mental Health and Chemical Dependency	
Mental Health Services	
- *Office, Outpatient, Intensive Outpatient Programs (IOP)*	$20/visit *(deductible waived)* [4]
- *Inpatient and/or Partial Hospitalization*	10% after deductible[5]
-Related Inpatient Physician Claims	No Charge
Chemical Dependency Rehabilitation	
- *Office, Outpatient, Intensive Outpatient Programs (IOP)*	$20/visit *(deductible waived)* [4]
- *Outpatient Suboxone Treatment*	$20/visit *(deductible waived)* [4]
- *Inpatient and/or Partial Hospitalization*	10% after deductible [5]
-Related Inpatient Physician Claims	No Charge
- *Residential Treatment Center* (max. **130 days**/lifetime), including physician	$250 facility copay plus 20% after deductible [5,7]

DRUG PLAN: Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Specified Vaccines [8]			
Enteral nutritional products, compounded medications, special medical foods, and other drugs require preauthorization or benefits will be denied.	**Generic Drug**	**Brand-Name Drug [8]**	
		On Drug List	**Not on Drug List**
Retail Pharmacy/Specialty Pharmacy Programs (up to a 30-day supply or 180 units, whichever is less; benefits include flu, pneumococcal, and Zostavax vaccines for which no copayment is required)	$15	$30	$45
Mail-Order Program (up to a 60- or 90-day supply or 540 units, whichever is less)	$30	$60	$90
Nonprescription Enteral Nutritional Products and Special Medical Foods (up to a 30-day supply per 30-day period; requires preauthorization)	$45 retail/$90 mail-order		

FOOTNOTES:

1 All services – excluding items covered under the drug plan – are subject to deductible unless otherwise indicated in the *Summary of Benefits* (i.e., "deductible waived"). When applicable, the deductible must be met before benefit payments are made.

2 After a member (or family) reaches the out-of-pocket limit, the Medical Program pays 100 percent of that member's (or family's) covered charges for the rest of the calendar year (except for items covered under the drug plan and copayments for residential treatment).

3 Initial treatment by a Nonpreferred Provider of a medical emergency is paid. However, follow-up treatment from a Nonpreferred Provider and any other treatment from a Nonpreferred Provider that is not for an emergency is not covered unless listed as an exception in the "NOTE" at the bottom of the page.

4 Certain services are **not covered** if preauthorization is not obtained from BCBSNM (or the BCBSNM Behavioral Health Unit). A list of services requiring preauthorization and a description of when obtaining preauthorization is your responsibility is in Section 4. Some services may require a written request for preauthorization in order to be covered. Nonemergency ambulance services are covered **only** when it is medically necessary to transfer the patient from one facility to another. See Section 4 for details.

5 Preauthorization is required for inpatient admissions. You pay a **$300 penalty** for covered facility services if preauthorization is your responsibility and is not obtained. Some services, such as transplants and physical rehabilitation, require additional preauthorization. If you do not receive preauthorization for these individually identified procedures, benefits for any related admissions will be denied. (The $300 penalty will not apply in such cases.) See Section 4.

6 Rental benefits for medical equipment and other items will not exceed purchase price of a new unit.

7 Extended care facilities (such as nursing homes and residential treatment centers) are **excluded** from coverage. However, LANS has authorized the Claims Administrator to approve, when used as a cost-effective alternative to inpatient hospitalization, up to **130 days** of residential treatment center services for patients being treated for chemical dependency. This is a lifetime maximum that accrues from Medical Program to Medical Program and is the only exception that can be made to the extended care facility exclusion.

8 Prescription drugs and other items covered under the drug plan must be purchased at a pharmacy that participates in the Retail Pharmacy/Specialty Pharmacy or Mail-Order Programs. (BCBSNM has contracted with a separate program for administration of your outpatient drug plan benefits.) Some prescription drugs require preauthorization before coverage will be available. If you require a brand-name drug for which there is a generic equivalent, you will pay the difference in cost between the brand-name drug and the generic drug, plus the generic drug copayment.

NOTE: Nonpreferred Provider services may be covered in the following cases only: emergency care; transition of care (up to 90 days); pathologist, anesthesiologist, and radiologist services when member is receiving covered services at a preferred facility; and when a provider belongs to a type that is "unsolicited" (i.e., a type that is not offered a Preferred Provider contract). Also, if you must travel more than 30 miles to find a Preferred Provider for a covered service and a Nonpreferred Provider able to render the same covered service is closer, the Medical Program will cover the service of the Nonpreferred Provider, if eligible. If the providers are essentially equal in distance from your home or office (i.e., within 5 miles of each other), the exception does **not** apply and you must use a Preferred Provider in order to receive benefits. This "distance" exception also does **not** apply to services needed by members living or residing outside the United States. In any case, to receive Preferred Provider benefits for **nonemergency** services of a Nonpreferred Provider, you must first obtain **preauthorization** from BCBSNM (or the BCBSNM Behavioral Health Unit). **It is YOUR responsibility to determine if a provider is in the national/worldwide BCBS PPO network or not. See Section 2 for details.**

1 How to Use This Booklet

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

- Always carry your current Medical Program ID card issued by BCBSNM. When you arrive at the provider's office or at the hospital, show the receptionist your Medical Program ID card. You may be required to pay copayments or other estimated amounts due at the time of the visit.
- **In an emergency, call 911 or go directly to the nearest hospital.**
- To find doctors and hospitals nearby, you may use the Internet, make a phone call, or request a hard copy of a directory from BCBSNM. See details in *Section 2*.
- Call BCBSNM (or the BCBSNM Behavioral Health Unit) for preauthorization, if necessary. The phone number is on your Medical Program ID card. See *Section 4* for details about the Blue Care Connection® preauthorization process.
- Please read this benefit booklet and familiarize yourself with the details of your Medical Program *before* you need services. Doing so could save you time and money.

Summary of Benefits

Throughout this booklet, you are asked to refer to the *Summary of Benefits*, beginning on page v (or, for retirees, on page viii), that shows member coinsurance, copayments, deductible and out-of-pocket amounts for the Medical Program, and coverage limitations. You will receive a new *Summary of Benefits* if changes are made to this EPO Medical Program. If the information for your Medical Program on the *Summary of Benefits* in this booklet does not match the information on the *Summary of Benefits* that you received before enrolling, the most recently revised document will prevail.

Other Benefit-Related Materials

In addition to this EPO Medical Program booklet you should have received (or have access to) the following documents:

Summary Plan Description (SPD) — You have on-line access to a *Summary Plan Description* (or *"SPD")* through the Los Alamos National Security Web site. The *LANS SPD* provides a summary of the principal features of the entire *LANS Health & Welfare Benefit Plan for Employees, ERISA Plan 501* or, if applicable, the *LANS Health & Welfare Benefit Plan for Retirees, ERISA Plan 502* (each called a "Plan"). The *LANS SPDs* provide summaries of all employee/retiree benefits such as, but not limited to, life insurance, short-term disability, survivor benefits, etc. This benefit booklet is only one component of the *LANS SPD* and is referenced in "Appendix B" of the *LANS SPD* as "Benefit Program Material" of the medical/surgical health plan. This document provides a summary only of your Medical Program benefits and exclusions, basic eligibility and enrollment requirements, cost-sharing features (such as deductible and copayments), and administrative provisions of the Claims Administrator (such as preauthorization

requirements, coordination of benefits rules, appeal procedures, etc.). The *LANS SPD* for your Benefit Program is available from the LANS Benefits Office at:

(877) 667-1806 or (505) 667-1806

BCBSNM ID Card — Your BCBSNM identification (ID) card shows that you are a member of a health care plan (or "Medical Program") administered by BCBSNM. The ID card provides the information needed when you require medical/surgical, mental health/chemical dependency services, prescription drugs, or any other items or services covered under the Medical Program. Carry your ID card with you. Have it handy when you are contacting a Customer Service Advocate, case manager, or care coordinator and when calling your doctor or hospital to arrange services. (If you are covered by Medicare, have both your Medicare ID card and your LANL Medical Program ID card available when you call.) When you arrive at a health care provider's office or at a treatment facility, show your ID card to the receptionist when you sign in. This card is part of your coverage. Do not let anyone who is not named in your coverage use your card to receive benefits. If you want additional cards or need to replace a lost card, contact a Customer Service Advocate or you may order a replacement and print a temporary ID card using the "Blue Access for Members" tool on the BCBSNM Web site.

Drug Plan Benefit Information — In addition to this document, you should have received a drug plan brochure and a mail-order claim form from the pharmacy benefit manager, Prime Therapeutics. These documents provide general, but important, information about your drug plan benefits and how to submit claims, if needed. (BCBSNM has contracted with Prime Therapeutics for administration of the Retail/Specialty Pharmacy and Mail Order Service outpatient drug plan benefits.) For information specific to your drug plan coverage, see *Section 6* of this booklet.

BlueCard Brochure — As a member of an EPO Medical Program administered by BCBSNM and using the worldwide Blue Cross Blue Shield (BCBS) Preferred Provider network, you take your health care 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 BCBS Plans, so you can receive Medical Program benefits – even when traveling or living outside New Mexico – by using health care providers that contract as Preferred Providers with their **local BCBS Plan** or with the **BCBS Association.** You should have received a brochure describing the BlueCard program in more detail. It's a valuable addition to your health care plan coverage.

Provider Network Directory — Because this is an EPO Medical Program that uses the BCBS **Preferred Provider** network, you must obtain most covered services from providers that are within the worldwide BCBS Preferred Provider network in order to receive benefits (exceptions are described in *Section 3).* Since it is **your responsibility** to determine if a provider is in the BCBS Preferred Provider network or not, BCBSNM has made every effort to assist you with finding a Preferred Provider – even while you are traveling. The entire provider network directory is available through the Internet or you can request a paper copy of the local BCBS Plan's Preferred Provider directory from a Customer Service Advocate; it will be mailed to you free of charge. There are also toll-free phone numbers to call if you are out of the country and need covered services.

Please see *Section 2* in this benefit booklet for instructions on locating a Preferred Provider inside or outside New Mexico, a Blue Distinction Center for Specialty Care (i.e., for transplants, cancer care, or congenital heart disease), a behavioral health (mental health or substance abuse) provider, or a participating pharmacy.

Using the Informational Graphics

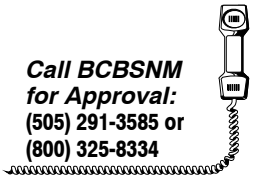
Graphic symbols are used throughout this benefit booklet to call your attention to certain information and requirements. Some commonly used symbols are:

Definitions

In order to make this booklet easier to read, defined terms are **not** capitalized. However, the definitions of important terms are provided to you directly under subsection headings throughout the booklet – at the point where you will most likely need that definition in order to more fully understand your Medical Program coverage. This symbol calls attention to definitions of important terms that are being provided outside the *Glossary*. All defined terms are also in the *Glossary,* so if you are unsure of the meaning of a term, please check the *Glossary* to see if the definition has been included.

Cross-References

Throughout this benefit booklet, cross-references direct you to read other sections of the booklet (such as the *Summary of Benefits*) when necessary. You will see this symbol next to such references in *Section 5*.



Preauthorization Required

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

Call Within 48 Hours
(505) 291-3585
(800) 325-8334

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 provider) must notify BCBSNM **within 48 hours** of admission (within **96 hours** for a C-section delivery), or as soon as reasonably possible. This symbol is a reminder to do so. Call BCBSNM's Health Services department, Monday through Friday, 8 A.M. to 5 P.M., Mountain Time.

Written Request Required — If a **written request** for preauthorization is required in order for a service to be covered, the provider should send the request, along with appropriate documentation, to:

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

Written requests may also be submitted over the BCBSNM Web site at www.bcbsnm.com. Please ask your health care provider to submit your request

early enough to ensure that there is time to process the request before the date you are planning to receive services.

Preauthorization of Behavioral Health Care

For all inpatient and outpatient services, you or your physician should call the Behavioral Health Unit for preauthorization **before** you schedule treatment. The Behavioral Health Unit will coordinate covered services with an in-network provider near you. If you do not call and receive authorization before receiving nonemergency services, benefits for services may be denied. Call 7 days a week, 24 hours a day. See *Section 4* for details.

Limitations and Exclusions

Each subsection in *Section 5* not only describes what is covered, but may list some limitations and exclusions that specifically relate to a particular type of service. *Section 7: General Limitations and Exclusions* lists limitations and exclusions that apply to *all* services. This symbol will be next to limitations or exclusions listed in *Section 5*.

BlueExtras℠

Certain local and national retailers, outlets, and businesses offer members an opportunity to save money on services that are not covered under the LANS Medical Program. These discount offers and other services are not part of the LANS Medical Program benefits described in this benefit booklet and the entities making the offers and the providers of the services may not be affiliated or associated with BCBSNM or your LANS Medical Program. However, from time to time, BCBSNM will be announcing such offers by sending manufacturer or retail discount coupons to member households, inserting information into *Member Newsletters*, or mailing descriptions of various programs being offered to BCBSNM members by businesses such as health clubs, pharmacies, vision care providers, hearing aid retailers, dentists, etc. These mailings may contain coupons or offers that enable you, at your discretion, to purchase the described product or enroll in a certain program at a discount or at no charge. The retailer, provider, or manufacturer may pay for and/or provide the content for this information. The discounts and services available to members may change at any time and LANS and BCBSNM do not guarantee that a particular discount or service will be available at a given time. For details of current discounts available, please contact a Customer Service Advocate by calling the phone number on the back of your ID card or by visiting BCBSNM offices in Albuquerque at 4373 Alexander Boulevard NE.

Dedicated Customer Service

If you have any questions about your coverage, call or e-mail BCBSNM's LANS Dedicated Customer Service department. Customer Service Advocates, dedicated to serving the members of LANS Medical Programs, are available Monday through Friday from 6 A.M.– 8 P.M. and 8 A.M.– 5 P.M. on Saturdays and most holidays. If you need assistance outside normal business hours, you may call the Customer Service telephone number and leave a message. A Customer Service

Advocate will return your call by 5 P.M. the next business day. Whether you call, write, or visit BCBSNM, Customer Service Advocates can help with the following:

- any questions about what is covered and what is not covered under the EPO Medical Program
- preauthorization requests
- checking on a claim's status
- ordering a replacement ID card, provider directory, benefit booklet, or forms

The inside front cover of this benefit booklet lists the most common telephone numbers and addresses that you will need. Also, for your convenience, the toll-free Customer Service number is printed at the bottom of every page in this booklet.

Web Site: www.bcbsnm.com
Street Address: 4373 Alexander Blvd. NE
Mailing Address: P.O. Box 27630
Albuquerque, NM 87125-7630

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.

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

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

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

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

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

Toll-free: 1-888-421-7781

On-Line Services: Blue Access for Members (BAM)

To help you track claims payments, make health care choices, and reduce health care costs, BCBSNM maintains a flexible array of online programs and tools for BCBSNM members ages 18 and older. BCBSNM's online "Blue Access for Members" (BAM) tool provides convenient and secure access to claims information and account management features and to various cost comparison tools. While online, you can also access a wide range of health and wellness programs and tools, including a health risk assessment and personalized health updates, and a program in which you can earn merchandise and gift cards for making healthy lifestyle choices and participating in various activities.

To access these online programs, go to www.bcbsnm.com, log into BAM, and create a user ID and password for instant and secure access. 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 members' needs change. We encourage you to enroll in BAM and check the online features available to you – and check back as frequently as you like. We are always looking for ways to add value to your Medical Program and we hope you will find the BCBSNM Web site helpful.

If you need help accessing the Blue Access for Members (BAM) site, call:

BAM Help Desk (toll-free): 888-706-0583
Help Desk Hours: Monday through Friday 7 A.M. – to 9 P.M. MST
Saturday 6 A.M. – 2:30 P.M. MST

Other LANS Program Assistance

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

	For Employees:	For Retirees:
Customer Service	Los Alamos National Laboratory (LANL) LANL Benefits Office PO Box 1663, Mail Stop P280 Los Alamos, NM 87544	Customer Care Center (866) 934-1200
Phone Number	(877) 667-1806 or (505) 667-1806	Customer Care Center (866) 934-1200
E-Mail Address	benefits@lanl.gov	www.ybr.com/benefits/lanl
Web Site	http://int.lanl.gov/worklife/benefits/	http://www.lanl.gov/worklife/benefits/retirees

2 Your Provider Network

Your Benefit Choices

This EPO Medical Program provides benefits under agreement with an exclusive network of **Preferred Providers** that contract with Blue Cross Blue Shield (BCBS) Plans throughout the United States. When you need nonemergency health care that is covered under the EPO Medical Program, **you must choose a provider from the national BCBS Preferred Provider Option (PPO) network in order to receive benefits.**

Preferred Provider Services
■ You pay an annual deductible and a percentage of covered charges* (coinsurance) after the deductible is met or, in some cases, a fixed-dollar amount (copayment) for a covered service. Services for which you pay only a fixed-dollar copayment are not subject to the deductible (see "Cost-Sharing Features" for details). All other services are subject to deductible and coinsurance. ■ Except as described under "Benefit Exceptions for Nonpreferred Providers" in *Section 3, benefits* are not available for services received from a Nonpreferred Provider. ■ You have an annual out-of-pocket limit (includes coinsurance/copayments only). ■ The Preferred Provider is responsible for filing claims for you directly to the local Blue Cross Blue Shield (BCBS) Plan. ■ The Preferred Provider will not bill you for amounts above the covered charge, which may be less than the billed charge. The "covered charge" is the amount that BCBSNM determines is a fair and reasonable allowance for a particular covered service. After your share of a covered charge (e.g., deductible, coinsurance, copayment, and/or penalty amount) has been calculated, BCBSNM pays the remaining amount of the covered charge, up to maximum benefit limits, if any. Preferred Providers that contract **directly** with BCBSNM are responsible for requesting all necessary preauthorizations and admission review for you. (Providers that contract with another BCBS Plan may call for preauthorization on your behalf, but you will be responsible for making sure that preauthorization is obtained when required. If you do not obtain preauthorization, benefits may be reduced or denied.)

Preferred vs. Nonpreferred Providers

Preferred Providers — Health care professionals and facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, another BCBS Plan, or the BCBS Association as Preferred ("PPO") Providers. These providers belong to the "Preferred Provider Network" and have agreed to accept the covered charge for a covered service plus the member's share (i.e., deductible, coinsurance, and/or copayment) as payment in full.

Nonpreferred Providers — A provider that does not have a **PPO** contract with BCBSNM, either directly or indirectly (for example, through another BCBS Plan). These providers may have "participating-only" provider or "HMO" provider agreements, but are **not** considered "preferred" and are **not** eligible for Preferred Provider coverage under your Medical Program – unless listed as an exception under "Benefit Exceptions for Nonpreferred Providers" in *Section 3* of this booklet. Except in limited situations, services of Nonpreferred Providers are **not** covered.

Preferred Providers — When you receive nonemergency medical care, services must be received from a provider that has contracted with BCBSNM and/or his/her local BCBS Plan as a Preferred Provider. The BCBS Preferred Provider network is one of the largest provider networks available. The contracts that BCBS has with providers allows you – and the entire Medical Program – to save money. This means that you can have a measurable and positive effect on the soaring costs of health care – not only by staying within the network whenever possible – but by using health care dollars wisely, following the rules of the Medical Program, and seeking medical care and medication only as needed and from appropriate sources.

A Preferred Provider will accept the BCBSNM covered charge – which is usually less than the billed charge – as payment in full. The BCBSNM covered charge is used to calculate your deductible, copayments, and/or coinsurance amounts. Those amounts, which are the amount due from you to the Preferred Provider, are subtracted from the covered charge in order to arrive at the benefit payment under the Medical Program. (See "Benefit Payment Examples" in *Section 3.)*

A Preferred Provider is required to write off the difference between the covered charge and the billed charge; a Nonpreferred Provider may bill you for the difference. Even if you are eligible to receive coverage for services of a Nonpreferred Provider during an emergency, for example, your share is less when calculated as a percentage of the covered charge rather than as a percentage of the billed charge. Therefore, it is almost always to your financial advantage to receive services from a Preferred Provider whenever possible.

In addition, a Preferred Provider will file claims for you and, if contracted with BCBSNM, will obtain any necessary preauthorizations for you. (A Preferred Provider outside New Mexico is not obligated to obtain preauthorizations that are required under this Medical Program; see *Section 4* for details as you may incur a penalty or be responsible for the entire billed amount if preauthorization is not obtained in such cases.)

Nonpreferred Providers — A provider may be offered more than one type of contract with a BCBS Plan. For example, there are "Participating Provider," "HMO," and "Preferred Provider" contracts. Some BCBS Plans may offer other types of contracts to providers in their state. A provider that does **not** have a **Preferred** Provider (or "PPO") contract – is a **Nonpreferred** Provider. The provider **must** have a **Preferred** Provider contract with the local BCBS Plan to be eligible for coverage (unless listed under "Benefit Exceptions for Nonpreferred Providers" in *Section 3.)*

A Nonpreferred Provider may charge you the difference between the covered charge and the billed charge, in addition to your deductible, coinsurance, and/or copayment. **This difference may be considerable.** Also, a Nonpreferred Provider is not obligated to obtain any necessary preauthorizations or to file your claims.

Since a physician's or other provider's contract may be separate from the facility's contract, choosing a facility with a Preferred Provider contract **does not guarantee** that each physician providing care to you during a hospitalization at that facility will also have a Preferred Provider contract unless he/she is directly employed by the facility. Therefore, when you receive treatment or schedule a surgery or admission, ask your attending physician if he/she is a BCBS Preferred Provider.

NOTE: If a Nonpreferred Provider waives copayments, coinsurance, or annual deductible for a particular health service, the Medical Program will not cover the service for which member copayments, coinsurance, or deductible was waived.

Provider Directories and Online Provider Finder®

When you need medical care, there are a variety of ways you can obtain lists of BCBS Preferred Providers in your area and participating pharmacies. Whichever method you choose, the directory gives each provider's specialty, the languages spoken in the office, the office hours, and other information such as whether the office is handicapped accessible. (To find this information on the Web site directory, click on the doctor's name once you have found one you want to know more about.) The Web site directory also gives you a map to the provider's office.

NOTE: Providers who are listed in a directory as having a "participating" contract or an "HMO" contract are **not** "preferred" providers (unless they are also listed as having a "preferred" provider contract). **You will not receive the "Preferred Provider" benefit when receiving services from "participating" or "HMO" network providers.** You must use providers in the **"preferred" provider network** in order to obtain benefits under this Medical Program for nonemergency care. **NOTE:** If you are in an emergency situation, call 911 if necessary or go directly to the nearest emergency room.

To verify a provider's current status or if you have any questions about how to use a Web-based or paper directory, contact a BCBSNM Customer Service Advocate or visit the BCBSNM Web site at www.bcbsnm.com.

Note: 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 status or if you have any questions about how to use the directory, contact a Customer Service Advocate. It is also a good idea to speak with a provider's office staff directly to verify whether or not they belong to the BCBS Preferred Provider network before making an appointment.

Web-Based BCBSNM Provider Finder — To find a Preferred Provider in New Mexico or along the borders of neighboring states, please visit the *Provider Finder* section of the BCBSNM Web site for a list of network providers:

www.bcbsnm.com

The Web site also has an Internet link to the behavioral health provider directory, to the national Blue Cross and Blue Shield Association Web site for services outside New Mexico, and to the Blue Distinction Centers for Specialty Care (see page 11). Web site directories also include maps and directions to provider locations.

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

Finding a Pharmacy — To find a participating pharmacy, visit the Prime Therapeutics Web site and click on *Find a Pharmacy:*

www.myrxhealth.com

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

Providers Outside New Mexico

Out-of-state providers that contract with their local Blue Cross and/or Blue Shield Plan and international providers that contract with the Blue Cross and Blue Shield Association as **Preferred Providers** are also eligible for benefits for covered services, including the fixed-dollar copayment amounts listed on the *Summary of Benefits*.

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

BCBSNM Web Site — If you have an Internet connection, you may check the BCBSNM Web site, click on "Provider Finder®" and then link to the line item entitled "Providers located outside New Mexico." You will then be linked to the Blue Cross Blue Shield Association's BlueCard Doctor and Hospital Finder:

www.bcbsnm.com

National Web Site — Visit the Blue Cross and Blue Shield Association Web site's national "BlueCard Doctor and Hospital Finder" and click on "Find a Doctor or Hospital." Then follow the instructions at:

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 a family member need care. When you call, a BlueCard representative will give you the name and telephone number of a local provider (you will be asked for the zip code in the area of your search) who will be able to call Customer Service for eligibility information and will submit a claim for the services provided to the local BCBS Plan. Call:

1-800-810-BLUE (2583)

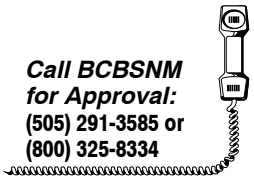
International Assistance — Call the BlueCard Worldwide Service Center at one of the phone numbers below, 24 hours a day, 7 days a week, for information on doctors, hospitals, and other health care professionals or to receive medical assistance services around the world. An assistance coordinator, in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

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

Blue Distinction Centers for Specialty Care®

Blue Distinction® is a designation awarded by Blue Cross and Blue Shield companies to medical facilities that have demonstrated expertise in delivering quality health care. The decision to include a facility on the Blue Distinction list is based on rigorous, evidence-based, objection selection criteria established in collaboration with expert physicians' and medical organizations' recommendations. The goal of the program is to help consumers find quality specialty care on a consistent basis, while enabling and encouraging healthcare professionals to improve overall quality and delivery of care nationwide. At the core of the Blue Distinction program are the *Blue Distinction Centers for Specialty Care,* facilities that are recognized for their distinguished clinical care and processes. Among other diseases, hundreds of Blue Distinction Centers are available to members nationwide for the treatment of the following conditions:

- congenital heart disease
- cancer (Please note that, although the heading for Blue Distinction Centers is for "Complex and Rare Cancers," these facilities treat other, more common or less complex cancer cases as well. In such cases, a BCBSNM case manager will help you find, if possible, a Blue Distinction Center that is able to treat your type of cancer although it may not be listed as complex or rare.)
- transplants



While you are not required to use Blue Distinction Centers when you need care for one of the conditions listed above, if you choose a Blue Distinction Center for **cancer** treatment or cardiac care for a **congenital heart defect**, or any Preferred Provider facility for a covered **transplant** (and services are **preauthorized** by your BCBSNM case manager), you may be eligible for travel and lodging benefits through the PPO Medical Program (for a full description of this additional coverage, see "Travel and Lodging" in *Section 5).*

You may view the entire list of Blue Distinction Centers and review the criteria used in selecting facilities for the designation at the Blue Cross and Blue Shield Association Web site:

www.bcbs.com/innovations/bluedistinction

If You Have Medicare

NOTE: This section applies to you only if you are primary under Medicare and Medical Program benefits are going to be coordinated with Medicare as a result. If you are not sure if Medicare is primary or secondary, please see "If You Have Medicare" in *Section 3* for a brief explanation or call the Social Security office for more information.

Medicare-Covered Services

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

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

See
also

See "Claims Payments and Appeals" for information about how to file claims when Medicare is primary.

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

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

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

Services Not Covered By Medicare

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

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

Member Privately Contracting With a Physician or Other Provider — When Medicare is your primary coverage (e.g., you are a retiree or a covered family member of a retiree or have completed the end-stage renal disease coordination period) or you have privately contracted with a provider as set forth in section

4507 of the Balanced Budget Act of 1997, BCBSNM will make the determination whether or not a service is covered by the Medical Program. If you privately contract with a provider, BCBSNM will estimate the amount that would have been paid by Medicare had you been able to submit a claim to Medicare first for primary payment.

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

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

Quick Reference Guide

QUICK REFERENCE: FINDING A PREFERRED PROVIDER	
Finding a Provider	**Web Sites and Phone Numbers**
Providers in New Mexico	Call Customer Service (877-878-LANL) OR visit: **www.bcbsnm.com**; Click on "Find a Provider"
Pharmacy	www.myhealthrx.com; Click on "Find a Pharmacy"
Providers outside New Mexico	www.bcbs.com OR www.bluecares.com; Click on "Find a Doctor or Hospital"
International	Call BlueCard Access® at 1-800-810-BLUE (2583)
Blue Distinction Centers of Excellence	www.bcbs.com/innovations/bluedistinction

3 Member Cost-Sharing

This section describes each of the Medical Program's member cost-sharing features, such as fixed-dollar copayments, deductibles, payment of a percentage of the covered charge (called member "coinsurance"), out-of-pocket limits, and annual benefit limitations. 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.

Before seeking specialist care or high-cost services, **you need to be aware of preauthorization requirements,** which are described in *Section 4.* If you choose to see a physician for nonemergency care, whether preferred or nonpreferred, and find that you have received services needing preauthorization — and you did not get the preauthorization — benefits for the services may be denied. In such cases, **you may be responsible for the entire cost of the services** — even if you were not aware of the preauthorization requirements.

Calendar Year Deductible

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

See the Summary of Benefits for your deductible amount.

Individual Deductible — Regardless of whether you have "Individual," "Employee+Adult," "Employee+Child(ren)," or "Family" coverage, once the total **covered charges** paid by a member in a calendar year reach the "Individual" deductible amount indicated on the *Summary of Benefits,* this Medical Program begins to pay its portion of most of that member's covered charges for the rest of the calendar year. (For some services, you do not need to first meet a deductible; see the *Summary of Benefits.)*

Family Deductible — An entire family meets the calendar year deductible when the total deductible amounts for all family members combined reach the "Family" amount listed on the *Summary of Benefits.* **Note:** If a member's "Individual" deductible is met, no more charges incurred by that member may be used to satisfy the "Family" deductible. Therefore, if you have "Employee+Adult" coverage or cover yourself and only one child, each person must meet his/her own annual deductible each year, which will result in a total deductible payment that is not greater than two times the "Individual" deductible amount.

What is Not Subject to the Deductible — Services that are subject to **only** a fixed-dollar office copayment (e.g., office visit) and other services specified on your *Summary of Benefits* (such as preventive care and drug plan charges) are **not** subject to a deductible.

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

Timely Filing Reminder — Most benefits are payable only after BCBSNM's records show that an applicable deductible has been met. If you file your own claims for services from Nonpreferred Providers (see "Benefit Exceptions for Nonpreferred Providers," on the next page), you must file them within **12 months** of the date of service. (Providers that contract with BCBSNM will file claims for you and must submit them within a specified amount of time, usually within 180 days.) If a claim is returned for further information, resubmit it **within 45 days.** See "Filing Claims" in *Section 9* for details. **Note:** If there is a change in the Claims Administrator, the length of the timely filing period may also change.

Member Coinsurance and Copayments

Coinsurance — The **percentage** of covered charges that you must pay for a covered service after the deductible has been met.

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

See the Summary of Benefits for your coinsurance percentages and copayment amounts.

Coinsurance — For many covered services, you must pay a percentage of covered charges as "coinsurance." After your share has been calculated, this Medical Program pays the rest of the covered charge, up to maximum benefit limits, if any. **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; Nonpreferred Providers may.

Copayments — When you receive a charge for an office visit, consultation, or exam, you pay only a fixed-dollar amount – or copayment – for the covered **visit, exam, consultation, or surgical procedure.** (No deductible is required.) The copayment for an **office visit** is listed on your *Summary of Benefits.* Other services received during the office visit are subject to regular deductible and/or coinsurance requirements as listed on the *Summary of Benefits*. However, you will not pay more than one fixed-dollar copayment to the same doctor for services received during the same visit; for example, chemotherapy and an office visit charged on same day by one doctor. Also, medical supplies received during an office visit and diagnostic testing and supplies received during an office surgery (and billed by the surgeon on same day as the surgery) *are* included in the office visit copay.

Annual Out-of-Pocket Limits

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

Once the total **coinsurance, deductible,** and **copayment** amounts paid by a member in a calendar year reach the "Individual" limit indicated on the *Summary of Benefits,* this Medical Program pays 100 percent of most of that member's covered charges for the rest of the calendar year.

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

What is Not Included in the 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); noncovered expenses (including charges for services in excess of annual or lifetime day/visit limitations)
- drug plan copayments
- residential treatment center copayments

Benefit Exceptions for Nonpreferred Providers

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

There are some instances in which the services of a Nonpreferred Provider may be eligible for coverage. Regardless of medical necessity or non-medical issues, Nonpreferred Providers' services are NOT covered under this Medical Program, except in the situations listed below:

Emergency Care — If you visit a nonpreferred facility, the **emergency** room benefit is applied only to the initial treatment of an *emergency*. Nonpreferred Provider services for the initial emergency room treatment are covered in a true emergency. If you are hospitalized within 48 hours of an emergency, the entire hospitalization is considered part of the initial treatment (in such cases, the emergency room copayment is waived and inpatient hospital benefits apply). Follow-up care, which is no longer considered an emergency, will NOT be covered if received from a Nonpreferred Provider. (Office/urgent care facility services are **not** considered "emergencies" for purposes of this provision.) See "Emergency and Urgent Care" in *Section 5* for more information.

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) or the state may not allow Preferred Provider contracts to be offered by an insurer to a provider of any type. In either case, these provider types are referred to as **"unsolicited providers**" and

you will not be able to find a provider of that type in the local BCBS Plan's provider directory. The types of providers that are unsolicited varies from state to state; if you are not sure if a provider type is unsolicited, please call a Customer Service Advocate. If you receive covered services from an "unsolicited provider" outside New Mexico, you will receive coverage 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 or copayment. **Note:** Christian Science Practitioners and Sanatoriums are **not** considered "unsolicited" under this provision and you will receive benefits based solely on whether or not the provider in question has a Preferred Provider contract with the local BCBS Plan.

Network Availability in Your Area — If you must travel **more than 30 miles** to find a Preferred Provider for a covered service and a Nonpreferred Provider able to render the same covered service is closer, the Medical Program will cover the service of the Nonpreferred Provider, if eligible. If the providers are essentially equal in distance from your home or office (i.e., within **5 miles** of each other), the exception does **not** apply and you must use a Preferred Provider in order to receive benefits. This "distance" exception also does **not** apply to services needed by members living or residing outside the United States. In any case, to receive Preferred Provider benefits for nonemergency services of a Nonpreferred Provider under this "distance" exception, you must first obtain preauthorization from BCBSNM (or the BCBSNM Behavioral Health Unit). **NOTE: This exception due to distance is possible only under the EPO Medical Program.** This exception is **not** available under the PPO or CDHP Medical Programs since there are Nonpreferred Provider benefits available to members under those two Medical Programs.

Certain Professional Services While in a Preferred Hospital — Once you have obtained preauthorization for an inpatient admission to a **preferred hospital** or treatment facility, your preferred physician or hospital will make every effort to ensure that you receive ancillary services from other Preferred Providers. If you receive covered services from a **preferred** physician for outpatient surgery or inpatient medical/surgical care in a preferred hospital or treatment facility, services of a nonpreferred radiologist, anesthesiologist, or pathologist will be covered under the EPO Medical Program as if the provider was a Preferred Provider 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 or assistant surgeon provides your care or you are admitted to a nonpreferred hospital or other treatment facility, services will **not** be covered and you **will** be responsible for paying the entire bill for any services received from Nonpreferred Providers during the admission or procedure.

Transition of Care/Special Circumstances — 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 Preferred Provider network when you enroll, BCBSNM may authorize you to continue an ongoing course of treatment with the provider for a **transitional** period of time of not less than 90 days during which that provider's covered services will be eligible for benefits. (If necessary and ordered by the treating provider, BCBSNM 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 90 days. If you have entered the third trimester of pregnancy at the effective date of enrollment, the transitional period will include postpartum care directly related to the delivery. Call the BCBSNM Customer Service department for details.

PAYING NONPREFERRED PROVIDER CLAIMS		
Situation	**Member must call for notification?**	**Comments**
Emergency room care	No [1]	Call within 48 hours if you are admitted; services must qualify as an emergency or services may be denied
Unsolicited providers	No [1]	Call if service would normally require authorization
Professional services while in preferred facility	No [1]	Includes anesthesia, pathology, and radiology only; call for preauthorization if service would otherwise require it
Transition of care	Yes [2]	Up to 90 days; call for preauthorization

1 - Although you will receive benefits for these services when rendered by a Nonpreferred Provider, **you DO need to call for preauthorization if you are receiving a service that requires preauthorization** (such as home health care). See the list of services needing preauthorization in *Section 4*.
2 - In order for ANY "transition of care" services from Nonpreferred Providers to be covered, you must first obtain **preauthorization.**

Benefit Limits

Calendar year — January 1 through December 31 of the same year. The initial calendar year benefit period is from a member's effective date of coverage through December 31 of the same year, which may be less than 12 months.

There is no general lifetime maximum benefit. However, certain services have separate benefit limits per admission, per calendar year, etc. **See your *Summary of Benefits* for details.**

Generally, benefits are determined based upon the coverage in effect on the day a service is received, an item purchased, or a health care expense 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. Benefits for such services may be coordinated with any additional health care coverage that applies after your termination date under this Medical Program.

Changes to the Cost-Sharing Amounts

Coinsurance percentage amounts, deductibles, copayments, and out-of-pocket limits may change during a calendar year. If changes are made, the change applies only to services received after the change goes into effect. You will receive a revised *Summary of Benefits* and/or a new Medical Program ID card if changes are made to this Medical Program.

Benefit Payment Example

The example below demonstrates the difference between your liability for services from a Preferred Provider versus a Nonpreferred Provider (for example, during an emergency).

Nonpreferred Provider service eligible for Preferred Provider benefit level (e.g., emergency service) vs. Preferred Provider payment for same service: Medical Program pays facility in full after $75 copayment; professional charges subject to Preferred Provider deductible and 10 percent coinsurance:

	Preferred	**Nonpreferred**
Facility's billed charge for emergency service + ER physician's charge for emergency service	$10,000 $1,000	$10,000 $1,000
Covered charges (Nonpreferred Provider service must be allowed in full for emergency service; Preferred Provider must still accept the covered charge under the Medical Program)	$8,000 $500	$10,000 $1,000
BCBSNM payment to provider (100% of facility covered charge after $75 copay; 90% of professional covered charge)	$7,925 $450	$9,925 $900
Member copay/coinsurance (covered charge minus coinsurance for professional fees; both applied to the out-of-pocket limit)	$75 $50	$75 $100
Amount over the covered charges due from member	$0	$0
Total paid by Medical Program:	$8,375	$10, 825
Total amount due from member (copay + coinsurance, 10% based on covered charge, which is greater for Nonpreferred Provider professional fees in this case):	**$125**	**$175**

If You Have Medicare

NOTE: This section applies to you only if you are primary under Medicare and Medical Program benefits are going to be coordinated with Medicare as a result.

If you have Medicare as your **primary coverage,** the Medical Program usually pays benefits only after Medicare has paid its portion of your covered health care services. Medicare is called the "primary" coverage or carrier and pays its benefits first. The LANS Medical Program is "secondary" coverage.

You may not elect to change your LANS Medical Program to be primary coverage over Medicare and may not elect to bypass Medicare. If services are among those normally covered by Medicare, you or your doctor or hospital (your health care "provider") must submit a claim for those services first to Medicare. Medicare will calculate its benefits and will send you an *Explanation of Medicare Benefits* (EOMB) form. This form must be attached to any claim you send to BCBSNM. **NOTE:** For services received in New Mexico, a "crossover" claim should automatically be sent by the Medicare Part B carrier or Part A intermediary to BCBSNM for secondary benefit determination. If your claims are not being sent by Medicare to BCBSNM, please call a Customer Service Advocate to verify that the correct Medicare HIC number is on file for you. For details on how to submit claims when your claim is not automatically crossed-over from Medicare, see *Section 9*.

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

Active Employees and Their Covered Family Members — If you are an active employee or the covered family member of an active employee and are entitled to Medicare for any reason other than end-stage renal disease, this Medical Program pays benefits before Medicare and this section does not apply to you.

End Stage Renal Disease — If you become eligible for Medicare *solely* due to having ESRD (i.e., you are *not* also age 65 or older and/or you are *not* also eligible for Medicare due to a non-ESRD disability), this Medical Program pays benefits **before** Medicare **only** during the "ESRD coordination time period." The length of this time period may change if changes are made in Medicare Secondary Payer laws. You will be advised of the length of the ESRD coordination time period once you begin dialysis. This section does not apply to you if you are still within the initial ESRD coordination time period during which this Medical Program pays primary benefits.

If you complete the ESRD coordination time period or reach age 65 while eligible for Medicare as an ESRD patient, Medicare determines its benefits **before** this Medical Program pays its portion of covered charges. **This section of the booklet applies to such members who are primary under Medicare; your EPO Medical Program benefits will be coordinated with Medicare.** See the *LANS SPD* for enrollment rules.

Medicare-Eligible Retirees and Their Covered Family Members — If you are a Medicare-eligible retiree or the Medicare-eligible covered family member of a retiree receiving primary coverage from Medicare, Medicare determines its benefits

before this Medical Program pays its portion of covered charges. **This section of the booklet applies to such members who are primary under Medicare; your EPO Medical Program benefits will be coordinated with Medicare.** NOTE: If you are a retiree and eligible for Medicare, see the *LANS SPD* for enrollment rules.

How Benefits are Paid — All expenses are subject to the same annual Medical Program deductible, copayment, coinsurance, and out-of-pocket limits. This Medical Program's benefits are determined and the balance due after Medicare or the usual Medical Program benefit will be paid, whichever is less. **Note:** You must be enrolled in both Parts A and B of Medicare in order to retain coverage under this LANS Medical Program. If you privately contract with a provider, BCBSNM will calculate amounts that would have been paid by Medicare and deduct those amounts from the billed charge for a covered service in order to arrive at a benefit payment, subject to Medical Program deductible and coinsurance or Medical Program copayments.

Services that are not covered by Medicare may also be eligible for benefits under this Medical Program. See *Section 5* for a list of services that are covered by the Medical Program (services must be medically necessary and not listed as an exclusion in *Section 7).*

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

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

4 Health Care Management

Blue Care Connection®

To take the best care of you and make sure you are getting care in the best place and right time, BCBSNM has a number of programs in place. All together, these programs make up the Blue Care Connection program.

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.

If utilization review and quality management is done before a service is received, it is part of the "preauthorization" process. If it is done while a service is still being received, it is part of the "concurrent review" process. If it is done after a service is received, it is called "retrospective review."

Case Management — When BCBSNM helps you, your doctor, and other providers plan for major services, it is called "case management." When you have a need for many long-term services or services for more than one condition, BCBSNM has a "care coordination" program that is part of case management.

Disease Management — And any member that has certain conditions like diabetes or low back pain that they can help control on their own with, for example, nutrition and exercise, can participate in BCBSNM's "disease management" programs.

Before seeking specialist care or high-cost services, **you need to be aware of preauthorization requirements,** which are described in this *Section 4.* If you choose to see a physician for nonemergency care, whether preferred or nonpreferred, and find that you have received services needing preauthorization — and you did not get the authorization — benefits for the services may be denied. In such cases, **you may be responsible for the entire cost of the services** — even if you were not aware of the preauthorization requirements.

Preauthorizations

Preauthorization — A requirement that you or your provider must obtain approval from BCBSNM before you are admitted as an inpatient and before you receive certain types of services.

Although Preferred Providers contracting directly with BCBSNM will obtain necessary preauthorizations for you, there are certain instances in which **you** will be responsible for obtaining preauthorization. In such cases, if you do not ensure that the necessary authorizations are obtained, you may have to pay a preauthorization penalty or you may be responsible for paying the full billed charge to the provider. **Please read this section carefully so that you know when you are responsible for obtaining preauthorization** (see "Your Responsibility: Nonpreferred Providers or Providers Outside New Mexico," below).

These authorization requirements will provide you with assurance that you are being treated in the most efficient and appropriate health care setting and can help manage the rising costs of health care. Preauthorization determines only the medical necessity of a specific service and/or an admission and an allowable length of stay. Preauthorization does not guarantee your eligibility for coverage, that benefit payment will be made, or that you will receive the highest level of benefits. Eligibility and benefits are based on the date you receive the services. Services not listed as covered, excluded services, services received after your termination date under this Medical Program, and services that are not medically necessary will be denied.

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

- when recommending any nonemergency admission, readmission, or transfer
- when a covered newborn stays in the hospital longer than the mother
- before providing or recommending a service listed under "Other Preauthorizations," later in this section

The penalty a provider pays is based on BCBS Plan contractual agreements with the provider. You are not responsible for any penalties that apply when a provider who contracts **directly with BCBSNM** fails to obtain any needed preauthorization.

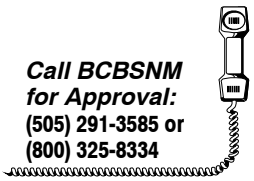
If You Live or Travel Outside New Mexico: Providers that contract with Blue Cross Blue Shield Plans other than BCBSNM are not familiar with the preauthorization requirements of BCBSNM and/or your particular Medical Program. Unless a provider contracts **directly** with **BCBSNM** as a Preferred Provider, the provider is **not** responsible for being aware of BCBSNM's preauthorization requirements. You may have to pay a penalty if preauthorization is not obtained in these cases. See below.

YOUR RESPONSIBILITY: Nonpreferred Providers or Providers Outside New Mexico — If any provider outside New Mexico (except those listed as BCBSNM network providers in your BCBSNM provider directory) or any Nonpreferred Provider recommends an admission or a service that requires preauthorization,

the provider is **not** obligated to obtain the preauthorization for you. In such cases, it is **your** responsibility to ensure that preauthorization is obtained. (For example, if you live in a state that does not offer Preferred Provider contracts, services from Nonpreferred Providers in that state will be considered for coverage and you will be responsible for obtaining necessary authorizations from BCBSNM. See details under "Benefit Exceptions for Nonpreferred Providers" in *Section 3.)* In any case, if authorization is not obtained **before** services listed in this section are received from a provider outside New Mexico or from any Nonpreferred Provider, **you may pay a $300 penalty, your benefits for covered services may be reduced or, for some services, you may be entirely responsible for the charges.** The provider may call on your behalf, but it is **your responsibility** to ensure that BCBSNM (or the BCBSNM Behavioral Health Unit, when applicable) is called:

BCBSNM: Monday through Friday, 8 A.M. to 5 P.M., Mountain Time
(505) 291-3585 or toll-free, at (800) 325-8334

For mental health and chemical dependency:
1-888-898-0070



If You Call for Preauthorization — While you may call BCBSNM for preauthorization (before you incur costs that may not be covered), you may be told in most cases that your doctor or hospital must call BCBSNM to obtain the preauthorization for you. If this is the case, please call your doctor and discuss your preauthorization request with them. **Your provider is not obligated to request preauthorization on your behalf if he/she does not agree that services you are requesting are appropriate or medically necessary.**

How the Preauthorization Procedure Works — When you or your provider call, BCBSNM's Health Services staff 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 staff will evaluate the information and notify the attending physician and the facility (usually at the time of the call) if benefits for the proposed hospitalization or other service are approved. If the admission or other service is not authorized, you may appeal the decision as explained in *Section 9*.

Notification of Approval/Denial — When you or your treating health care professional requests a preauthorization for a health care service, the Claims Administrator – BCBSNM – initially determines whether the service is or is not medically necessary. This standard review is completed within 15 working days (an expedited review is completed within 72 hours). If BCBSNM's initial review results in the denial, reduction, or termination of the requested health care service, BCBSNM will notify you of the "adverse determination" and of your right to request an internal review by BCBSNM. If requested services are not authorized, 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 9* for more information about appealing a decision to deny or terminate a preauthorization request.

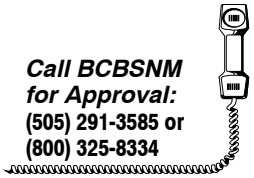
When You Have Other Coverage — When this Medical Program pays secondary benefits (i.e., you have another health care plan that pays its benefits before

LANS, excluding Medicare), you must still follow these preauthorization procedures – in addition to following the required authorization or referral procedures of your primary coverage. You must always file claims to your primary insurance first, even if the other carrier will not cover the service (BCBSNM needs to have a denial notice from the other carrier before processing the claim under this Medical Program.) There are exceptions for persons who are primary under Medicare (such as retirees), which are listed below.

When Medicare is Primary — If you have primary benefits through Medicare (i.e., retirees and certain members with end-stage renal disease), preauthorization for services **covered by Medicare** is **not** required. However, you must have **preauthorization** for the following services:

- services from provider types that are not covered by Medicare, excluding doctors of oriental medicine (e.g., licensed marriage and family therapists)
- services normally needing preauthorization (listed in this section) if such services will **not** be covered by Medicare (e.g., dental-related services, services from facilities that do not participate with Medicare, or any service received from a provider who "privately contracts" with you*)
- admissions and other services normally needing preauthorization when received outside the United States territorial limits

***Reminder:** If you privately contract with a provider as set forth in section 4507 of the Balanced Budget Act of 1997, BCBSNM will estimate the amount that would have been paid by Medicare had you been able to submit a claim to Medicare first for primary payment.



Inpatient Admission Review

Preauthorization is required for most admissions **before** you are admitted to the hospital or skilled nursing, physical rehabilitation, or other treatment facility. If you do not obtain authorization within the time limits indicated in the table below, benefits will be **reduced or denied** as explained on the next page:

Type of inpatient admission, readmission, or transfer	When to obtain inpatient admission authorization:
Nonemergency	**Before the patient is admitted.**
Emergency, nonmaternity	**Within 48 hours of the admission.** If the patient's condition makes it impossible to call within 48 hours, call as soon as possible.
Maternity-related (including eligible newborns for whom the mother will not be covered)	**Before the mother's maternity due date,** soon after pregnancy is confirmed. However, you should always call within 48 hours of the admission for routine deliveries (96 hours for C-sections). If the mother's condition makes it impossible to call within 48 (or 96) hours, call as soon as possible.
Extended stay, newborn (an eligible newborn stays in the hospital longer than the mother)	**Before the newborn's mother is discharged.**

Penalty for Not Obtaining Inpatient Admission Preauthorization — If you or your provider does not call, or if you call and do not receive preauthorization for

an inpatient admission including for behavioral health services, but you choose to be hospitalized anyway, no benefits may be paid or partial payment may be made, as indicated 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 are **denied.***
The admission was for an item listed under **"Other Preauthorizations,"** on the next page (e.g., home health care).	Benefits for the facility and all related services are **denied.***
The admission was for any other covered service but hospitalization was **not medically necessary.**	Benefits are **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 non-emergency services are **reduced by $300.***

* Note: The inpatient admission preauthorization penalty of $300 and charges for noncovered and denied services are **not** applied to any deductible or out-of-pocket limit.

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

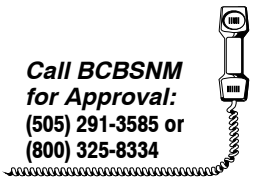
Mental Health/Chemical Dependency Services

Whether you are required to call for preauthorization of inpatient services or choose to call for preauthorization of outpatient services, please call the BCBSNM Behavioral Health Unit at the phone number listed on the back of your ID card for preauthorization. You or your health care provider should call the Behavioral Health Unit **before** you schedule treatment. **NOTE:** Your provider may be asked to submit clinical information in order to obtain preauthorization for the services you are planning to receive. Services may be authorized or may be denied based on the clinical information received. *(Clinical information* is information based on actual observation and treatment of a particular patient.)

If you or your provider do not call for preauthorization of nonemergency **inpatient** services, benefits for covered, medically necessary inpatient facility care may be reduced **by $300.** If inpatient services received without preauthorization are determined to be not medically necessary or not eligible for coverage under your Medical Program for any other reason, the admission and all related services will be denied. In such cases, **you may be responsible for all charges.**

Although preauthorization is not required for outpatient services, you may want to call before you seek services so that the Behavioral Health Unit staff can assist you with finding a provider appropriate for your needs and can help coordinate your care if needed. Also, if preauthorization is **not** obtained before you receive outpatient services, your claims may still be denied as being **not medically necessary.** In such cases, **you may be responsible for all charges.** Therefore,

you may want to make sure that you (or your provider) have obtained preauthorization for outpatient services *before* you start treatment.



Other Preauthorizations

In addition to preauthorization for all inpatient services, preauthorization is required for certain other services. Most preauthorizations may be requested over the telephone. If a *written* request is needed and you call, a Health Services representative will give you instructions for filing a written request for preauthorization. If preauthorization is not obtained for the following services, **benefits will be denied** for all related services:

- **air ambulance** services (unless during a medical emergency)
- **cardiac** or **pulmonary rehabilitation**
- **chemotherapy** (high-dose)
- **dental-related** services or **oral surgery** in a hospital or other facility (the procedure may not be covered even if benefits for the hospitalization are preauthorized as medically necessary; see *Section 5)*; treatment of **accidental injuries to teeth** (except initial treatment); and treatment of **orthognathism**
- **dialysis in the home**
- **durable medical equipment, medical/diabetic supplies**, and **prosthetic** devices costing **$500** (or more) or requiring **long-term rental; insulin pumps; orthopedic appliances, orthotics,** and **surgically implanted prosthetics,** regardless of total cost
- **enteral nutritional products, special medical foods,** and certain **drugs** purchased through the drug plan; prescription **refills** before the supply should have been exhausted (See *Section 6.)*
- **fetal echocardiograms and other in-utero services for a fetus**
- **home health care** and **home I.V.** services
- **hospice care**
- **infertility-related services** (Only limited services are covered.)
- certain **injections** (see "Physician Visits/Medical Care" in *Section 5* for details.)
- **PET scans; cardiac CT scans; genetic testing or counseling; infertility testing**
- **private room charges**
- **speech therapy for children under age three**
- certain **surgical procedures,** whether inpatient or outpatient, including:
  - **bariatric (obesity) surgery**
  - **breast reduction**
  - **breast surgery** following a mastectomy (Note: This is the only cosmetic procedure covered under this Medical Program.)
  - **cochlear implants**
  - **reconstructive surgical procedures**
  - **transplants,** including pretransplant evaluations
- **transition of care** from Nonpreferred Providers
- **travel and lodging** when available through the Cancer Treatment, Congenital Heart Disease, or Transplant Services case management and care coordination programs
- **weight management** programs for obesity such as dietary control, advice, or exercise

Some services requiring preauthorization will not be authorized for payment (for example, because they are experimental, do not meet medical policy criteria, or are not medically necessary). It is strongly recommended that you request preauthorization for high-cost services in order to reduce the likelihood of benefits being denied *after* charges are incurred.

The complete list of services requiring preauthorization is subject to review and change by BCBSNM. Preferred Providers in New Mexico have a list of all procedures and services, including surgeries and injectable drugs, that require preauthorization. If you or your doctor need a copy of this list, call a BCBSNM Customer Service Advocate.

If You Are Not Satisfied

If you have a question or complaint about any preauthorization request, call Customer Service. Many problems can be handled quickly by calling or writing BCBSNM Customer Service. If you are not satisfied with the response, you can file a reconsideration request to BCBSNM. See "Reconsideration Requests (Appeals)" in *Section 9*.

Disease Management

If you're living with a long-term health condition, you may have a hard time managing your health on a day-to-day basis. Help is available with disease management programs offered by BCBSNM. These programs, which you do not have to participate in if you don't want to, are for members with diabetes, heart conditions, asthma, low back pain, migraine headaches, and lung disease. BCBSNM will try to identify members who could use these programs, but you can also enroll yourself. If you are enrolled, you will be called by a Blue Care Advisor, a nurse that will identify your needs and work with you and your doctors.

Case Management

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

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

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

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

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

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

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

You can call BCBSNM Care Coordinators at:

1-800-325-8334 (select the "Los Alamos National Lab" option)

Advance Benefit Information

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 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 or any other coverage that applies on the date of service.

Health Care Fraud Information

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

- Be wary of offers to waive copayments, deductibles, or coinsurance. These costs are passed on to you eventually.

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

If you suspect fraud, contact the BCBSNM Fraud Hotline at:

1-888-841-7998

5 Covered Services

This section describes the services and supplies covered by your EPO Medical Program, subject to the limitations and exclusions listed throughout this booklet. All payments are based on covered charges as determined by BCBSNM. Reminder: You must receive care from **Preferred Providers** in order to receive benefits for most nonemergency care.

Medically Necessary Services

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 in the *Glossary* 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.)

Before seeking specialist care or high-cost services, **you need to be aware of preauthorization requirements,** which are described in *Section 4.* If you choose to see a physician for nonemergency care, whether preferred or nonpreferred, and find that you have received services needing preauthorization — and you did not get the preauthorization — benefits for the services may be denied. In such cases, **you may be responsible for the entire cost of the services** — even if you were not aware of the preauthorization requirements.

If Medicare is Primary — When Medicare is primary (for example, you are a retiree and eligible for Medicare due to age, you are under age 65 and have exhausted the end-stage renal disease coordination time period under Medicare, or you are eligible for Medicare due to end-stage renal disease and turn age 65), if Medicare allows a service as medically necessary, the Medical Program will also consider it medically necessary. When Medicare determines that a service was not medically necessary, BCBSNM may (at your request) make its own determination regarding the service's medical necessity. However, for non-Medicare-covered services, BCBSNM determines whether a service or supply is medically necessary and, therefore, whether the expense is covered under this Medical Program.

Acupuncture/Spinal Manipulation

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

This Medical Program covers acupuncture and osteopathic or spinal manipulation (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 osteopathic and spinal manipulation are limited as specified on 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 limits.

See Section 7: General Limitations and Exclusions

Ambulance Services

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.

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

Air Ambulance — This Medical Program covers air ambulance only when terrain, distance, or your physical condition requires the use of air ambulance services, or for high-risk maternity and newborn transport to tertiary care facilities. 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.

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

Exclusions — This Medical Program does **not** cover:

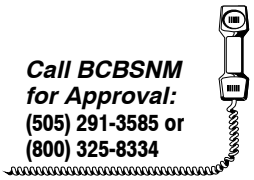
- commercial transport, private aviation, or air taxi services
- services not specifically listed as covered, such as private automobile, public transportation, or wheelchair ambulance
- services ordered only because other transportation was not available or for your convenience

See Section 7: General Limitations and Exclusions

Cancer Treatment, Chemotherapy, and Radiation Therapy

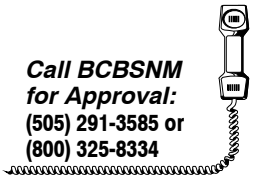
When billed by a facility during a covered admission, covered therapy is paid in the same manner as the other covered services billed by the facility (see "Hospital/Other Facility Services").

This Medical Program covers the treatment of malignant disease and other medical conditions by standard chemotherapy and/or by radiation therapy.



Cancer Clinical Trials — If you are a participant in an approved "cancer clinical trial" (see *Glossary)*, you may receive coverage for certain routine patient care costs incurred in the trial. The trial must be conducted as part of a scientific study of a new therapy or intervention and be designed to study the 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 clinical trial.

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 provider of the drug. See *Section 6* for information about these prescription drug benefits.



Blue Distinction Centers for Specialty Care — While you are not required to use a Blue Distinction Center for treatment of cancer, if you choose a Blue Distinction Center and services are **preauthorized** by your BCBSNM case manager, you may be eligible for travel and lodging benefits described under "Travel and Lodging," later in this *Section 5,* which applies to this cancer treatment coverage for up to five days before a covered treatment and for one year following the date of the initial cancer treatment. Facilities selected as Blue Distinction Centers feature:

- multi-disciplinary team input, including sub-specialty trained teams for complex and rare cancers and demonstrated depth of expertise across cancer disciplines in medicine, surgery, radiation oncology, pathology and radiology
- ongoing quality management and improvement programs for cancer care
- ongoing commitment to using clinical data registries and providing access to appropriate clinical research for complex and rare cancers
- sufficient volume of experience in treating rare and complex cancers such as:
  - acute leukemia (inpatient/nonsurgical)
  - bladder cancer
  - bone cancer
  - brain cancer — primary
  - esophageal, gastric, liver, pancreatic, and rectal cancers
  - head and neck cancers
  - ocular melanoma
  - soft tissue sarcomas
  - thyroid cancer — medullary or anaplastic

Note: Although facilities in the Blue Distinction network may be designated by their subspecialties for rare and complex cancers, each facility provides comprehensive cancer care services. Because there are so many types of cancer, they cannot all be listed on the Blue Distinction Web site. Therefore, consult with your physician and/or with a BCBSNM Cancer Care Coordinator to determine which facility is best for you. You may view the entire list of Blue Distinction Centers and review the criteria used in selecting facilities for the designation at the Blue Cross and Blue Shield Association Web site:

www.bcbs.com/innovations/bluedistinction

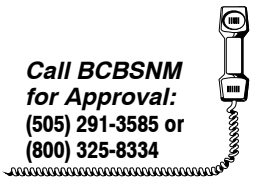
You may be referred by your physician to this specialty cancer care, or you may self-refer by contacting the BCBSNM Health Services department toll-free at 1-800-325-8334 (select the "Los Alamos National Lab" option from the menu). When prompted, select the "Cancer Care Coordinator" option. The Cancer Care

Coordinator will help you find a cancer treatment resource using the Blue Distinction Centers, facilitate an introduction to the case manager at the facility, and continue to follow your progress and care throughout the course of treatment.

See Section 7: General Limitations and Exclusions

Cardiac Care & Pulmonary Rehabilitation

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



Cardiac and Pulmonary Rehabilitation — This Medical Program covers outpatient cardiac rehabilitation programs initiated within six months of a cardiac incident and outpatient pulmonary rehabilitation services. **Preauthorization is required.**

Congenital Heart Disease — Services covered under the congenital heart disease care program include any service listed as covered in this benefit booklet (such as office visits, diagnostic testing, etc.), but specifically target the following services for members with congenital heart disease:

- congenital heart disease surgical interventions
- interventional cardiac catheterizations
- fetal echocardiograms
- in-utero services and other preauthorized fetal interventions

While you are not required to use a Blue Distinction Center for treatment of congenital heart disease, if you choose a Blue Distinction Center and services are **preauthorized** by your BCBSNM case manager, you may be eligible for travel and lodging benefits described under "Travel and Lodging," later in this *Section 5,* which applies to this congenital heart disease coverage for up to five days before a covered treatment and for one year following the date of the initial cardiac treatment.

You may view the entire list of Blue Distinction Centers and review the criteria used in selecting facilities for the designation at the Blue Cross and Blue Shield Association Web site:

www.bcbs.com/innovations/bluedistinction

You may be referred by a physician to this congenital heart disease care program, or you may contact the BCBSNM Health Services department toll-free at 1-800-325-8334 (select the "Los Alamos National Lab" option from the menu) if you have questions about this program. When prompted, select the "Congenital Heart Disease Care Coordinator" option. The Care Coordinator will help you find a congenital heart disease treatment resource using the Blue Distinction Centers, facilitate an introduction to the case manager at the facility, and continue to follow your progress and care throughout the course of treatment.

See Section 7: General Limitations and Exclusions

Dental-Related, TMJ, Oral Surgery

Accidental injury — A condition that is not the result of illness but is caused solely by external, traumatic, and unforeseen means. Accidental injury does not include disease or infection. Dental injury caused by chewing, biting, or malocclusion is **not** considered an accidental injury.

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

Sound natural tooth — A tooth that is whole, without impairment or decay, has no fillings on more than two surfaces, is without periodontal or other conditions, has had no root canal therapy, is not a dental implant, functions normally in chewing and speech, and is not in need of treatment for any reason other than the 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.")

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

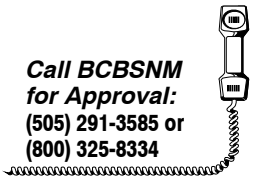
Dental and Facial Accidents — Benefits for covered services for the treatment of accidental injuries to the jaw, mouth, face, or sound natural teeth are generally subject to the same limitations, exclusions, and member cost-sharing provisions that would apply to similar services when not dental-related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

To be covered, *initial* treatment for the injury must be sought **within 72 hours** of the accident. Any services required after the initial treatment must be received **within 12 months** of the date of accident in order to be covered. In addition, dental services for final treatment to repair the damage to a sound, natural tooth must be started within three months of the accident.

Dental-Related Services — This Medical Programs covers **preauthorized** dental-related services such as x-rays, supplies, procedures, and appliances ONLY if required for transplant preparation, initiation of immunosuppressive treatment, or direct treatment of acute traumatic injury, cancer, or cleft palate. Such services should, however, be submitted under your dental plan first, if any.

This Medical Program covers inpatient or outpatient hospital expenses for dental services that are not themselves covered under this Medical Program **only** if the patient meets one or more of the following criteria:

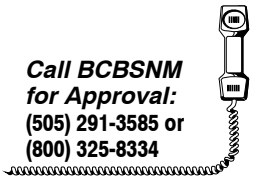
- the person is under age six and the treating provider asserts that general anesthesia is necessary to protect the health of the patient
- the treating provider affirms that the person is developmentally disabled
- the treating provider affirms that the person has a non-dental, hazardous physical condition (e.g., heart disease or hemophilia) that makes general anesthesia and/or hospitalization medically necessary.



All hospital services for dental-related procedures must be **preauthorized** by BCBSNM. **Note:** Unless listed as a covered dental/facial accident, oral surgery, or TMJ/CMJ procedure in this section, the dentist's services for the dental procedure itself will not be covered.

Oral Surgery — Covered services include surgeon's charges for the following procedures only:

- medically necessary orthognathic surgery when **preauthorized** by BCBSNM
- external or intraoral cutting and draining of cellulitis (cells affected by a bacterial infection); this does **not** include treatment of dental-related abscesses
- incision of accessory sinuses, salivary glands, or ducts
- lingual frenectomy
- removal or biopsy of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of mouth when pathological examination is required



TMJ/CMJ Services — This Medical Program covers only the following diagnostic and surgical treatments of temporomandibular joint (TMJ) or craniomandibular joint (CMJ) disorders or accidental injuries when **preauthorized** by BCBSNM::

- arthrocentesis proven for the treatment of:
  - documented, symptomatic degenerative joint disease osteoarthritis, or
  - documented, intracapsular soft tissue abnormalities, such as disc displacement or adhesions
- arthroplasty proven for the treatment of:
  - documented, symptomatic osteophytes affecting the TMJ
  - documented, symptomatic intracapsular soft tissue abnormality (such as disc displacement or adhesions)

Covered services may include orthodontic appliances and treatment, crowns, bridges, or dentures **only if** services are required because of an accidental injury to sound natural teeth involving the temporomandibular or craniomandibular joint.

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

- services that have not been **preauthorized** by BCBSNM (except initial emergency treatment of accidental injuries)
- surgeon's or dentist's charges for a noncovered dental-related service, even if hospitalization and/or general anesthesia is covered
- hospitalization or general anesthesia for the patient's or provider's convenience
- any service related to a dental procedure that is not medically necessary or that is excluded under this Medical Program for reasons other than being dental-related, even if hospitalization and/or general anesthesia is medically necessary for the procedure being received (e.g., cosmetic procedures, experimental procedures, services received after coverage termination, services related to pre-existing conditions, work-related injuries, etc.)
- nonstandard services (diagnostic, therapeutic, or surgical)
- removal of tori, exostoses, or impacted teeth
- dental services that may be related to, or required as the result of, a medical condition or procedure (e.g., chemotherapy or radiation therapy) **except** that dental x-rays, supplies, and appliances may be covered if required for transplant preparation, initiation of immunosuppressives, or direct treatment of

acute traumatic injury, cancer, or cleft palate (such services should be submitted under your dental plan first, if any)
- procedures involving orthodontic care, the teeth, dental implants, periodontal disease or condition, or preparing the mouth for dentures
- services to correct damage to a tooth as a result of normal activities of daily living or extraordinary use of the teeth
- treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a congenital anomaly
- 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"
- artificial devices and/or bone grafts for denture wear

See Section 7: General Limitations and Exclusions

Diabetic Services

For insulin and over-the-counter diabetic supplies, see Section 6.

For durable medical equipment, see "Supplies, Medical Equipment, and Prosthetics."

For educational services and diabetes management services, see "Physician Visits/Medical Care."

Diabetes is not excluded and 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, see the above topics. **Note:** The Medical Program will also cover items not specifically listed as covered when new and improved equipment, appliances, and prescription drugs for the treatment and management of diabetes are approved by the United States Food and Drug Administration.

See Section 7: General Limitations and Exclusions

Dialysis

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

This Medical Program covers the following services when received from a dialysis provider or, when **preauthorized** by BCBSNM, when received in your home:
- renal dialysis (hemodialysis)
- continual ambulatory peritoneal dialysis (CAPD)
- apheresis and plasmapheresis
- the cost of equipment rentals and supplies for home dialysis

Emergency and Urgent Care

Emergency condition — A medical or behavioral condition that has symptoms so severe (including severe pain) that any reasonable person who has average knowledge of health and medicine might expect that, if they do not get care right away, his/her health might seriously suffer (or in the case of a pregnant woman, the health of the unborn child). An emergency might also be a case where the patient believes he/she might ruin a bodily function, lose an organ, or lose a body part if they don't get medical attention right away.

Urgent care — 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.

For accidental injury to the mouth, jaw, teeth, or TMJ, see "Dental-Related, TMJ, Oral Surgery."

Also see other subheadings when applicable (such as "Hospital/Other Facility Services").

Emergency Care

Acute medical emergency care is available 24 hours per day, 7 days a week. If services are received in an emergency room or other trauma center, **the condition must meet the definition of an "emergency" in order to be covered. To decide if you have an emergency, you should ask yourself:**

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

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

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

What to Do — If you are very sick or injured and have a real emergency like one of the illnesses on the list above, then:

- If cardiopulmonary resuscitation (CPR) is necessary or if there is an immediate threat to life or limb, **call 911.**
- If you do not call 911, **go to the nearest medical facility or trauma center.**

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

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

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

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

If you call your doctor and his/her office staff instruct you to go to an emergency room and you believe that your condition is not a true emergency, call the free BCBSNM 24/7 Nurseline. **Do NOT go to an emergency room if you do not believe you have an emergency.** Nonemergency services will not be covered – even if your doctor's office staff instructed you to go to an emergency room.

Emergency Room and Ambulance Services — If you have an emergency, you do **not** need to call BCBSNM before going to the emergency room or calling 911 for emergency ambulance services. If **emergency** room treatment is administered by either a Preferred or Nonpreferred Provider, benefits for the **initial** treatment, including emergency ambulance services, will be paid if required for an emergency condition. If you are hospitalized within 48 hours of an emergency, the entire, related inpatient hospitalization (as long as you remained covered under this EPO Medical Program) is considered part of the initial treatment. **NOTE:** If you know that your illness is not serious or life-threatening and you go to the emergency room or call an ambulance anyway, you will be responsible for the entire cost of all nonemergency services.

Call Within 48 Hours
(505) 291-3585
(800) 325-8334

Inpatient Admission Notification Required — If you are admitted as an inpatient from an emergency room or within 48 hours of the related emergency room visit, you (or a family member or your doctor) should notify BCBSNM **within 48 hours** of the admission (or as soon as reasonably possible) with hospital admission information in order to ensure that benefits will be paid correctly. See *Section 4*.

If you are directly admitted as an inpatient, the emergency room copayment is waived and hospital inpatient benefits apply to covered facility services. **Note:**

Services received in an emergency room that do not meet the definition of an "emergency" may be reviewed for appropriateness and may be denied.

Follow-Up Care — After a visit to the emergency room, you may need follow-up care. The health care you receive will either keep your health stable or improve or resolve your health problem. This is called post-stabilization care. This Medical Program covers post-stabilization care in a hospital or other facility. For other follow-up care, such as medicine refills or having a cast removed, go to your doctor's office. Covered services for follow-up care from a Preferred Provider are covered. Covered services for the same care from a Nonpreferred Provider, including services received after you are discharged from the hospital or emergency room, are **not covered** under this Medical Program since they are no longer emergency services.

Urgent Care

Urgent care is needed for sudden illnesses or injuries that are not life-threatening. You can wait a day or more to receive care without putting your life or a body part in danger. If you need urgent care, you have the choice of taking any of the following steps to receive care:

- Call your doctor's office and tell them you need to see a doctor as soon as possible, but that there is no emergency. If your doctor tells you to go to the emergency room because he or she cannot see you right away and you do not believe you have an emergency, please call the free BCBSNM 24/7 Nurseline for advice.
- Ask your doctor to recommend another provider if he/she is unable to see you within 24 hours.
- Visit the nearest urgent care center in the Preferred Provider network.
- If you are outside New Mexico and need urgent care, call a Customer Service Advocate for help or go to a local urgent care center.

When you visit a preferred urgent care facility, you pay a fixed-dollar amount, or copayment, for the covered visit and deductible and coinsurance for remaining ancillary services (such as lab work and medical supplies). When you visit a nonpreferred urgent care facility, services will **not** be covered unless such services meet one of the criteria listed in *Section 3* as being eligible for a "benefit exception" for Nonpreferred Providers. **Note:** Paying for services of a nonpreferred urgent care facility is most likely less costly for the member than paying for an unnecessary visit to a preferred emergency room – which may also be denied if you are not having a true emergency.

See Section 7: General Limitations and Exclusions

Hearing-Related Services

For routine hearing screening, see "Routine/Preventive Services."

This Medical Programs pays for the following hearing-related services (in addition to the routine hearing screening payable for children under "Routine/Preventive Services," later in this *Section 5):*

- digital and analog hearing devices, including fitting and dispensing fees for hearing aids, and ear molds
- charges by a licensed or certified audiologist for physician-prescribed hearing evaluations to determine the location of a disease within the auditory system; for validation or organicity tests to confirm an organic hearing problem
- diagnosis of severe to profound bilateral sensorineural hearing loss and severely difficult speech discrimination

This Medical Program does not cover routine hearing *screening* except as specified for children through age 18 under "Routine/Preventive Services." A "screening" is used to detect the need for additional hearing tests and is usually received when there is no symptom of hearing loss. A screening does *not* include a hearing test to determine the amount and kind of correction needed for a known hearing loss. Testing performed for known hearing loss *is* covered under this "Hearing-Related Services" provision.

Hearing Aids — This Medical Program covers the cost of hearing aids, hearing tests and exams related to hearing aids, the fitting and dispensing fees for hearing aids, and ear molds up to a maximum benefit payment of **$2,200 every 36 months.** This benefit maximum applies whether one or both ears require a hearing aid. The 36-month benefit period begins on the date the first covered hearing aid-related service is received and payable under this provision and ends 36 months later. The next benefit period for the hearing aid benefit begins 36 months after the first hearing aid-related service (e.g., fitting cost, ear mold, etc.) OR on the date of the next hearing aid-related service, whichever length of time is greater.

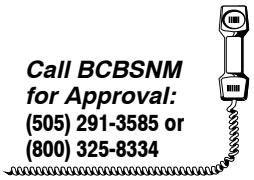
Cochlear Implants — This Medical Program covers cochlear implantation of a hearing device (such as an electromagnetic bone conductor) to facilitate communication for the profoundly hearing impaired, including training to use the device. The cochlear implant is covered when the diagnosis is severe to profound bilateral sensorineural hearing loss, resulting in severely difficult speech discrimination or post-lingual sensorineural deafness in an adult. Benefits are subject to usual deductible, coinsurance, and copayment provisions for office services, such as for training to use the device, and surgery. Benefits for these additional services are **not** applied to the maximum benefit available for hearing aids.

See Section 7: General Limitations and Exclusions

Home Health Care/Home I.V. Services

For oxygen, ostomy supplies, and medical equipment, see "Supplies, Equipment, and Prosthetics."

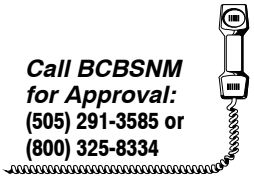
Conditions and Limitations of Coverage — If you are homebound (unable to receive medical care on an outpatient basis), home health care and home I.V. services are covered. Services must be provided under the direction of a physician and nursing management must be through a home health care agency approved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



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

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

- skilled nursing care provided on an intermittent basis by a registered nurse or licensed practical nurse
- physical, occupational, or respiratory therapy provided by licensed or certified physical, occupational, or respiratory therapists
- speech therapy provided by an American Speech and Hearing Association certified therapist



- intravenous medications and other prescription drugs ordinarily not available through a retail pharmacy if **preauthorization** is received from BCBSNM
- parenteral and enteral nutritional products that can only be legally dispensed by the written prescription of a physician and are labeled as such on the packages (If *not* provided by the home health care agency or if products do not require a prescription, see *Section 6.)*
- medical supplies
- skilled services by a qualified aide to do such things as change dressings and check blood pressure, pulse, and temperature

Exclusions — This Medical Program does **not** cover:

- care provided primarily for your or your family's convenience
- homemaking services or care that consists mostly of bathing, feeding, exercising, preparing meals for, moving, giving medications to, or acting as a sitter for the patient (See the "Custodial Care" exclusion in *Section 7*.)
- services provided by a nurse who ordinarily resides in your home or is a member of your immediate family
- nonprescription enteral nutritional products (See *Section 6* for details about possible benefits for these products.)

See Section 7: General Limitations and Exclusions

Hospice Care

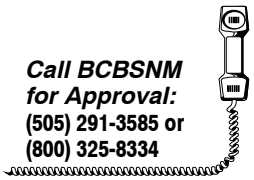
Hospice benefit period — The period of time during which hospice benefits are available. It begins on the date the attending physician certifies that the member is terminally ill and ends six months after the period began (or upon the member's death, if sooner). The benefit period must begin while the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

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.).

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

Conditions and Limitations of Coverage — This Medical Program covers inpatient and home hospice services for a terminally ill member received during a hospice benefit period when provided by a hospice program approved by BCBSNM. Hospice care benefits are limited as specified on the *Summary of Benefits*.

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. No more than two hospice benefit periods will be authorized. **Note:** An extension of the hospice benefit period does **not** increase the total amount of benefits payable under this provision for respite care and bereavement counseling.



Preauthorization Required — Before you receive hospice care, you, your attending physician, or the hospice agency must request **preauthorization** from BCBSNM. This Medical Program does **not** cover hospice services without preauthorization.

Covered Services — This Medical Program covers the following services, subject to the limitations and conditions above, 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 *Section 6*.)
- 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

In addition to the hospice services listed above, you have coverage for:

- two respite care periods for up to a maximum of **ten days each** during the six-month hospice benefit period (*Respite care* provides a brief break from total care-giving by the family.)
- bereavement counseling provided by an M.S.W. or M.A. for immediate family members if ordered and received under the hospice program during a hospice benefit period or within three months of the death of the member covered under this Medical Program (A maximum of **three counseling sessions** will be covered.)

Exclusions — This Medical Program does **not** cover:

- food, housing, or delivered meals
- medical transportation
- homemaker and housekeeping services; comfort items

- private duty nursing
- pastoral or spiritual counseling
- bereavement counseling not billed as part of overall hospice service
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this Medical Program

The following services are **not** hospice care benefits but may be covered elsewhere under this Medical Program: acute inpatient hospital care for curative services, durable medical equipment, physician visits unrelated to hospice care, and ambulance services.

See Section 7: General Limitations and Exclusions

Hospital/Other Facility Services

If applicable, see:
"Dental-Related, TMJ, Oral Surgery"
"Emergency and Urgent Care"
"Hospice Care"
"Maternity/Reproductive Services and Newborn Care"
"Psychotherapy (Mental Health, Alcoholism, Drug Abuse)"

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

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

Blood Services

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

Inpatient Services

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. Benefits for such services may be coordinated with any additional health care coverage that applies after your termination date under this Medical Program.)

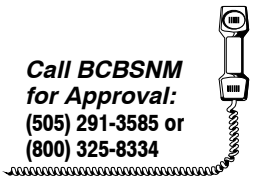
Medical detoxification — Treatment in an acute care facility for withdrawal from the physiological effects of alcoholism or drug abuse.

Preauthorization Required — If hospitalization is recommended by a Nonpreferred Provider, **you are responsible** for obtaining preauthorization for the services. If you do not follow the preauthorization procedures, benefits will be **reduced or denied** as explained under "Preauthorizations" in *Section 4*.

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

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

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



While you are not required to use Blue Distinction Centers when you need care for one of the conditions listed above, if you choose a Blue Distinction Center for **cancer** treatment, cardiac care for a **congenital heart defect**, or a **transplant** (and services are **preauthorized** by your BCBSNM case manager), you may be eligible for covered travel and lodging benefits through the EPO Medical Program (for a full description of this additional coverage, see "Travel and Lodging" later in this *Section 5).*

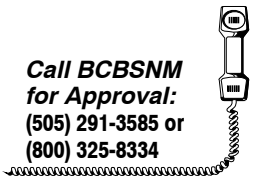
Christian Science Sanatorium — A Christian Science Sanatorium will be considered a "hospital" if it is accredited by the Commission of Accreditation of Christian Science Nursing Organizations/Facilities, Inc. and the member is admitted for the active care of an illness or injury. **This Medical Program does not cover** "spiritual refreshment" – and all other exclusions and provisions of this benefit booklet that apply to medical care apply equally to Christian Science services. **Note:** Christian Science Practitioners and Sanatoriums are not considered "unsolicited" (see *Section 2)* and you will receive benefits based solely on whether or not the provider in question has a Preferred Provider contract with the local BCBS Plan.

Also see "Physician Visits/Medical Care" for office services of a Christian Science Practitioner.

Medical Detoxification — This Medical Program covers medically necessary hospital services related to medical detoxification from the effects of alcoholism or drug abuse (usually limited to three days in an acute care hospital). See "Psychotherapy (Mental Health, Alcoholism, Drug Abuse)" for information about benefits for alcoholism and drug abuse rehabilitation.

Physical Rehabilitation and Skilled Nursing Facility — This Medical Program covers inpatient rehabilitation and skilled nursing facility services that are medically necessary to restore and improve lost function following accidental injury or illness. The patient must require an intensity of care or a combination of skilled nursing, rehabilitation, and facility services that are less than those of a general acute care hospital, but greater than those available in the home setting. The patient is expected to improve to a predictable level of recovery.

Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis. Accordingly, this Medical Program does not cover these services if they are required only intermittently (such as physical therapy three times a week).



To be covered, all admissions must receive authorization from BCBSNM **before** admission or benefits for covered services may be **reduced by $300.** Hospitalization for rehabilitation must begin within one year after the onset of the condition and while you are covered under this Medical Program. Inpatient treatment must be medically necessary and not for personal convenience.

Therapy required due to reinjury or aggravation of an injury is also covered but must receive a separate preauthorization from BCBSNM, even if therapy was authorized for the original injury.

Covered expenses include the daily semiprivate room expenses and other medically necessary services provided by the facility. This benefit is limited as specified on the *Summary of Benefits* and is subject to continued stay review for medical necessity.

Exclusions — This Medical Program does **not** cover:

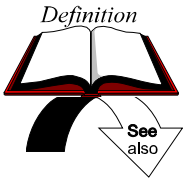
- private room expenses, unless your medical condition requires isolation for protection from exposure to bacteria or diseases (e.g., severe burns or conditions that require isolation according to public health laws) and BCBSNM has given preauthorization for such medically necessary charges
- maintenance therapy or care provided after you have reached your rehabilitative potential (Even if you have not reached your rehabilitative potential, this Medical Program does **not** cover services that are in excess of maximum benefit limitations. See the "Long-Term or Maintenance Therapy" exclusion in *Section 7.)*
- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay
- extended care facility admissions, such as nursing homes, or admissions to similar institutions
- admissions related to noncovered services or procedures (See "Dental-Related, TMJ, Oral Surgery" for an exception.)
- admissions for rehabilitative treatment, such as oxygen therapy
- private duty nursing

Outpatient or Observation Services

Coverage for outpatient or observation room services depends on the type of service received (e.g., "Lab, X-Ray, Other Diagnostic Services") or on special circumstances (e.g., "Emergency and Urgent Care"). If you are directly admitted as an inpatient, the observation room copayment is waived and hospital inpatient benefits apply to covered facility services.

See Section 7: General Limitations and Exclusions

Lab, X-Ray, Other Diagnostic Services



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

For services received during a covered inpatient admission, see "Hospital/Other Facility Services."

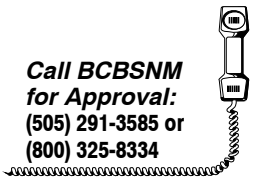
For allergy testing benefits, see "Physician Visits/Medical Care."

If applicable, also see these topics:
"Dental-Related, TMJ, Oral Surgery"
"Routine/Preventive Services"
"Emergency and Urgent Care"
"Transplant Services"

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

This Medical Program covers diagnostic services, including preadmission testing, that are related to an illness or injury. Covered services include:

- psychological testing (You should request **preauthorization** from the BCBSNM Behavioral Health Unit in order to ensure services will be covered.)
- x-ray and radiology services, ultrasound, and imaging studies
- laboratory and pathology tests
- EKG, EEG, and other electronic diagnostic medical procedures
- audiometric (hearing) and vision tests required for the diagnosis and/or treatment of an accidental injury or an illness
- sleep disorder studies
- bone density studies



- prenatal genetic testing and, when **preauthorized** by BCBSNM, home uterine monitoring (Tests such as amniocentesis or ultrasound to determine the sex of an unborn child are not covered; see "Maternity/Reproductive Services and Newborn Care.")
- PET (Positron Emission Tomography) scans and cardiac CT scans, with **preauthorization** from BCBSNM
- infertility-related testing (See "Maternity/Reproductive Services and Newborn Care")
- fetal echocardiograms and other in-utero testing, with **preauthorization** from BCBSNM (Also see "Cardiac Care and Pulmonary Rehabilitation" for details about the Blue Distinction program for congenital heart disease.)

Note: Whether a service requires preauthorization or not, it may not be approved for payment (for example, due to being experimental/investigational or not medically necessary). All services, including those for which preauthorization is required, must meet the standards of medical necessity criteria established by BCBSNM and will not be covered if excluded for any reason under this Medical Program. Also, some diagnostic procedures are billed as surgical procedures (such as colonoscopies or laparoscopies) and will be paid the same as any other **surgical** procedures – not the same as non-invasive diagnostic lab, and x-ray, and electronic procedures.

See Section 7: General Limitations and Exclusions

Maternity/Reproductive Services and Newborn Care

See other subheadings in this section for services received during a covered pregnancy, such as "Hospital/ Other Facility Services."

For oral contraceptive coverage or contraceptive devices purchased from a pharmacy, see Section 6.

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

Family Planning — LANS offers the following family planning services and related services to all of its members:

- family planning counseling and health education
- follow-up care for trouble you may have from using a birth control method that a family planning provider gave you
- birth control pills (covered under the drug plan provision)
- pregnancy testing and counseling
- FDA-approved devices and other procedures such as:
  - injection of Depo-Provera for birth control purposes
  - diaphragm, including fitting
  - IUDs or cervical caps, including fitting, insertion, and removal
  - surgical sterilization procedures such as vasectomies and tubal ligations (benefits based on place of treatment, such as outpatient hospital vs. office)

NOTE: Abortion is not a "family planning" service. Such services are subject to the cost-sharing provisions of surgical procedures.

Infertility-Related Services — This Medical Program covers the following infertility-related treatments (note that the following procedures only *secondarily* also treat infertility):

- surgical treatments such as opening an obstructed fallopian tube, epididymis, or vas 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. Infertility *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 Medical Program will cover lab tests to monitor hormone levels following the hormone replacement treatment listed as covered above. However, daily ultrasounds to monitor ova maturation are **not** covered since the testing is being used to monitor a noncovered infertility treatment.

Exclusions — In addition to services not listed as covered, above, this Medical Program does **not** cover:

- contraceptive devices that do not require a prescription, including over-the-counter contraceptive products such as condoms and spermicide

- 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) or 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

A covered daughter also has coverage for pregnancy-related or maternity services. However, if the parent of the newborn is a covered child of the subscriber (i.e., the newborn is the subscriber's grandchild)and the newborn is not eligible under any provision described in the *LANS SPD,* benefits are **not** available for the newborn except as specified under "Covered Services," below.

Call Within 48 Hours
(505) 291-3585
(800) 325-8334

If you are pregnant, you or your doctor should call BCBSNM before your maternity due date, soon after your pregnancy is confirmed. The care of a pregnant mother is important and the mother's health can affect the health of her newborn. When you call, BCBSNM will have you enroll in its special program for pregnant members, *Special Beginnings* (see below).

If you are pregnant on the date you enroll in the BCBSNM-administered EPO Medical Program and you are already seeing a provider, please call Customer Service so that BCBSNM can approve your visits to the provider if she or he is outside the Preferred Provider network. If you are in your first or second trimester, in most cases you will be allowed to continue your care with that doctor for at least 30 days. If you are six or more months pregnant, you can continue seeing your doctor for the rest of your pregnancy.

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

1-888-421-7781

Call Within 48 Hours
(505) 291-3585
(800) 325-8334

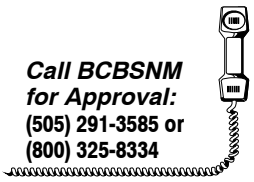
Admission Notification — If you are receiving services out-of-network, you are responsible for making sure that BCBSNM is notified **within 48 hours** of admission for a routine delivery or **within 96 hours** for a C-section delivery (or as soon as possible). If not notified within this time period and your admission extends beyond 48 hours or 96 hours (as applicable), benefits for covered facility services will be reduced by **$300.** See *Section 4*.

Covered Services — Covered services include:

- hospital or other facility charges for semiprivate room and ancillary services, including the use of labor, delivery, and recovery rooms (This Medical Program

covers all medically necessary hospitalization for the covered mother and her newborn child, including at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a C-section delivery. **Note:** Newborns who are not eligible for coverage under this Medical Program will not be covered beyond the 48 or 96 hours required under federal law.)

- routine or complicated delivery in your home, licensed birthing center, or hospital, including prenatal and postnatal medical care of an obstetrician, certified nurse-midwife, or licensed midwife (Expenses for prenatal and postnatal care are included in the total covered charge for the actual delivery or completion of pregnancy. The office visit during which a pregnancy is confirmed is subject to the same copayment amount that applies to any other office visit. Home birth is not covered unless the provider has a Preferred Provider contract with his/her local BCBS Plan – or is "unsolicited" as described in *Section 3* – and is credentialed to provide the service.)



- pregnancy-related diagnostic tests, including **preauthorized** home uterine monitoring, and genetic testing or counseling (Genetic testing services must be sought due to a family history of a sex-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 sex 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 procedure and administered by a physician, a licensed doctor of oriental medicine, or other practitioner as required by law
- services of a physician who actively assists the operating surgeon in performing a covered procedure when the procedure requires an assistant
- spontaneous, therapeutic, or elective termination of pregnancy prior to full term (payable as a surgical procedure)

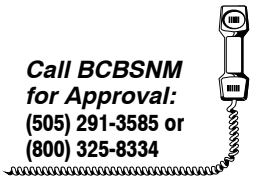
Newborn Care

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 standby care at a C-section procedure; and services related to circumcision of a male newborn.

See your LANS SPD for details about enrolling your newborn.

You must contact your Benefits Office to enroll your newborn within 31 days of his/her birth. Note: If the parent of the newborn is a covered child of the subscriber (i.e., the newborn is the subscriber's grandchild) and the newborn is not eligible under any provision described in the *LANS SPD,* services for the newborn are **not** covered except as specified under "Pregnancy-Related/ Maternity Services: Covered Services," above. See the *LANS SPD* for details about enrolling your newborn and newborn coverage.

If both the baby's and the mother's charges are eligible for coverage under this Medical Program, no additional deductible for the newborn is required for the initial routine hospital nursery services (i.e, if the covered newborn is discharged on the same day as the mother).



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

See Section 7: General Limitations and Exclusions

Physician Visits/Medical Care

If needed, see other more specific topics – arranged alphabetically throughout this section – that relate to your situation (such as a specific type of service like "Acupuncture/Spinal Manipulation" or a specific diagnosis such as "Hearing-Related Services" or a certain place of treatment or provider such as "Home Health Care."

This section describes benefits for nonsurgical, nonroutine medical visits to a health care provider for evaluating your condition and planning a course of treatment.

This Medical Program covers medically necessary care provided by a physician or other professional provider for an illness or injury. **Your choice of provider can make a difference in the amount you pay.** See *Section 2*.

Office Visits and Consultations

In addition to coverage for diagnosis, evaluation, and treatment of illness or injury in a health care provider's office, the following office services are covered:

Member cost-sharing amounts for services received in a physician's office are based on the type of service received while in the office. See your Summary of Benefits for details.

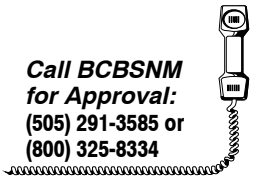
Allergy Care — This Medical Program covers direct skin (percutaneous and intradermal) and patch allergy tests, radioallergosorbent testing (RAST), covered charges for allergy serum, and appropriate FDA-approved allergy injections administered in a provider's office or in a facility.

Christian Science Practitioners — A Christian Science Practitioner will be considered a "physician" under this Medical Program if such practitioner is approved and listed in the current issue of *The Christian Science Journal,* the official organ of The First Church of Christ, Scientist; and is providing active treatment for a diagnosed illness or injury according to the healing practices of Christian Science. **This Medical Program does not cover** "spiritual refreshment" – and all other exclusions and provisions of this benefit booklet that apply to medical care apply equally to Christian Science services. **Note:** Christian Science Practitioners and Sanatoriums are **not** considered "unsolicited" (see *Section 3)* and you will receive benefits based solely on whether or not the provider in question has a Preferred Provider contract with the local BCBS Plan.

Also see "Hospital/Other Facility Services" for Christian Science Sanatorium admissions.

Diabetes Self-Management Education — This Medical Program covers medically necessary services to treat and evaluate diabetes (such as regularly covered office visits of a physician, lab tests to monitor blood glucose levels, and medical equipment described under "Supplies, Equipment, and Prosthetics").

See Section 6 for benefits for insulin and oral agents to control blood glucose levels, needles, syringes, and test strips; see "Supplies, Equipment, and Prosthetics" for other covered supplies and equipment required due to diabetes.



Injections and Injectable Drugs — This Medical Program covers most FDA-approved therapeutic injections administered in a provider's office. However, if you are receiving injections from a Nonpreferred Provider, you should familiarize yourself with the list of drugs and injections that are commonly excluded. These drugs are listed on the BCBSNM *Specialty Pharmacy Drugs* list. In addition to drugs on the *Specialty Pharmacy Drug* list (which can be found on the BCBSNM Web site), injectable drugs such as Synvisc and Rituxan may also be excluded.

If you are concerned that an injection may not be covered under BCBSNM medical policy, you may also get information about drugs at the BCBSNM Web site. Once you have logged onto the Web site at www.bcbsnm.com, select the tab for **Members** at the top of the page. On the **Welcome Page,** select "Prescription Drugs" from the right hand column. Then select the **"Drug List Limitations, Exclusions, and Prior Authorization Criteria"** topic under the **BCBSNM Drug List** heading. The document will provide you with information about injectable drugs and BCBSNM medical policy.

When you request preauthorization for an injection being administered in a doctor's office, you may be directed to purchase a self-injectable medication through the drug plan (see *Section 6)* or you may be advised that the injection is not covered. Proposed new uses for injectable drugs previously approved by the FDA will be evaluated on a medication-by-medication basis. Call a BCBSNM Health Services representative if you have any questions about this policy.

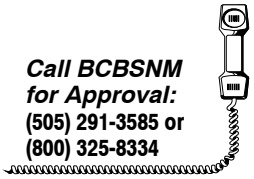
Mental Health Evaluation Services — This Medical Program covers medication checks and intake evaluations for mental health, alcoholism, and drug abuse. You should request **preauthorization** from the BCBSNM Behavioral Health Unit to ensure services will be covered. See "Psychotherapy (Mental Health, Alcoholism, Drug Abuse)" for psychotherapy and other therapeutic service benefits.

Nutritional Counseling — This Medical Program covers services provided by a registered dietician in an individual session for members with medical conditions that require a special diet. Such medical conditions include:

- diabetes mellitus
- coronary artery disease
- congestive heart failure
- severe obstructive airway disease
- gout
- renal failure
- phenylketonuria
- hyperlipidemias

Benefits for nutritional counseling are limited to three individual sessions during a member's lifetime for each covered medical condition.

Enteral feeding is covered when it is the sole source of nutrition or when a certain nutritional formula treats a specific inborn error of metabolism; however, these products must be purchased through the drug plan. See Section 6 for details.



Weight Management Programs — This Medical Program covers weight-loss or other weight-management programs, dietary control, or medical obesity treatment if dietary advice and exercise are provided by a physician, nutritionist, or dietitian licensed by the appropriate agency and the service is **preauthorized** by BCBSNM. The member must have a body mass index of 40 or more (BMI is calculated as the patient's weight in kilograms divided by the patient's height in meters squared). See "Surgery and Related Services" for information about surgery for weight loss purposes.

This Medical Program does **not** cover nonmedical services such as Weight Watchers, Jenny Craig Personal Weight Management, gym, fitness club, or spa programs.

Inpatient Medical Visits

With the exception of dental-related services (see "Dental-Related, TMJ, Oral Surgery"), this Medical Program covers the following services when received on a covered inpatient hospital day:

- visits for a condition requiring **only** medical care, unless related to hospice care (See "Hospice Care.")
- consultations (including second and third surgical 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 (care of a child immediately following his/her birth that includes pediatrician standby care at a C-section) for a newborn added to coverage within the time limits specified in your *LANS SPD* (See "Maternity/Reproductive Services and Newborn Care" for details and for non-routine, extended stay benefits.)

See Section 7: General Limitations and Exclusions

Prescription Drugs and Other Items

For outpatient prescription drugs, insulin, diabetic supplies, and other items covered under the drug plan portion of the Medical Program, see *Section 6*.

See Section 7: General Limitations and Exclusions

Psychotherapy (Mental Health, Alcoholism, Drug Abuse)

Alcoholism or drug abuse — Conditions defined by patterns of usage that continue despite occupational, marital, or physical problems that are related to compulsive use of alcohol or drugs. Alcoholism and drug abuse may also be defined by

significant risk of severe withdrawal symptoms if the use of alcohol or drugs is discontinued. Drug abuse does not include nicotine addiction or alcohol use.

Inpatient services — Care provided while you are confined as an inpatient in a hospital or treatment center for at least 24 hours. Inpatient care includes partial hospitalization (a nonresidential program that includes from 3 to 12 hours of continuous psychiatric care in a treatment facility).

Mental illness, 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 spectrum disorders, drug or alcohol abuse, or learning disabilities.

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 (LISW); licensed professional clinical mental health counselors (LPCC); masters-level registered nurse certified in psychiatric counseling (RNCS); licensed marriage and family therapist (LMFT). For substance abuse services, a provider also includes a licensed alcohol and drug abuse counselor (LADAC).

Residential treatment center — An institution that specializes in the treatment of mental illness, alcohol or drug abuse, or other related illness, provides residential treatment programs and is licensed in accordance with the laws of the appropriate legally authorized agency.

Substance abuse — Includes alcoholism and drug abuse conditions. Sometimes referred to as "chemical dependency."

For nontherapeutic services (e.g., intake evaluations, medication checks), see "Physician Visits/Medical Care."

For psychological testing, see "Lab, X-Ray, Other Diagnostic Services."

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

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

Covered Services/Providers — Covered services include solution-focused evaluative and therapeutic mental health services (including individual and group psychotherapy) received in a psychiatric hospital or an alcoholism treatment program that complies with alcohol and drug abuse program standards developed by the state of New Mexico, and services rendered by psychiatrists, licensed psychologists, and other providers (as defined above). See your BCBSNM provider directory for a list of contracting providers or check the BCBSNM Web site at:

www.bcbsnm.com

Preauthorization Requirements — All inpatient mental health and chemical dependency services must be preauthorized by the Behavioral Health Unit at the

phone number listed on the back of your ID card. You or your physician should call the Behavioral Health Unit **before** you schedule treatment. If you do not call before receiving nonemergency services from any provider outside New Mexico (or from any Nonpreferred Provider), whether inpatient *or* outpatient, **benefits for covered services may be reduced or denied** as explained in the *Health Care Management* section, earlier. In such cases, you may be responsible for all charges, so – in order to make sure that services will be eligible for coverage under your Medical Program – please obtain preauthorization for any inpatient or outpatient services you plan to receive.

If you are admitted for a medical condition and later transferred to another unit in the same or different facility for drug abuse rehabilitation (or vice versa), **both admissions must receive preauthorization.**

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

Residential Treatment Center — Care must be preauthorized by the BCBSNM Behavioral Health Unit. Failure to obtain **preauthorization** for services in a residential treatment center services will result in a denial of coverage. Benefits are limited as specified on the *Summary of Benefits*.

Exclusions — This Medical Program does **not** cover:

- inpatient care that has not been **preauthorized**
- psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education
- residential treatment for other than chemical dependency
- services performed or billed by a school, or halfway house, group home, day treatment, or their staff members, or foster care
- long-term therapy or therapy for the treatment of chronic mental health or incurable conditions for which treatment produces minimal or temporary change or relief – except that medication management for chronic conditions is covered (Chronic conditions are conditions such as, but not limited to, autism, Down's Syndrome, and developmental delays.)
- maintenance therapy or care provided after you have reached your rehabilitative potential
- biofeedback, hypnotherapy, or behavior modification services
- custodial care (See the "Custodial Care" exclusion in *Section 7*.)
- 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 illness or other disturbances
- non-national standard or experimental therapies

- the cost of any damages to a treatment facility
- residential treatment in excess of the lifetime maximum benefits specified on the *Summary of Benefits*

See Section 7: General Limitations and Exclusions

Routine/Preventive Services

For diabetic self-management services, see "Physician Visits/Medical Care."

For non-routine hearing related services, see "Hearing-Related Services."

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

- routine physical, breast, and pelvic examinations
- routine adult and pediatric immunizations, including human papilloma vaccine (HPV) for members aged 9 through 26
- an annual routine gynecological examination and low-dose mammogram screenings, Pap tests, papilloma virus screening, and prostate screenings (PSA)
- periodic blood hemoglobin, blood pressure, and blood glucose level 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; periodic colorectal screening, and periodic glaucoma eye tests
- well-child care
- vision and hearing screenings in order to detect the need for additional vision or hearing testing in children through age 18 when received as part of a routine physical exam (A screening does *not* include an eye exam, refraction, or other test to determine the amount and kind of correction needed.)
- health education and counseling services of a physician, including an annual consultation with your physician to discuss lifestyle behaviors that promote health and well-being

Exclusions — This Medical Program does **not** cover:

- employment physicals, insurance examinations, or examinations at the request of a third party (the requesting party may be responsible for payment); premarital examinations; sports or camp physicals; any other nonpreventive physical examination
- immunizations or medications required for international travel
- hepatitis B immunizations when required due to possible exposure during the member's work
- routine hearing or eye examinations; eye refractions; hearing or visual screening for members over age 18 (For benefits for hearing aids, cochlear implants, and routine hearing tests and exams, see "Hearing-Related Services.")

See Section 7: General Limitations and Exclusions

Short-Term Rehabilitation, Outpatient (Physical, Occupational, Speech Therapy)

Short-term rehabilitation — A term used to describe inpatient and outpatient occupational, physical, and speech therapy techniques that are medically necessary to restore and improve lost bodily functions following illness or injury. Short-term rehabilitation does not include substance abuse rehabilitation.

See "Acupuncture/Spinal Manipulation" if applicable.

For inpatient rehabilitation and skilled nursing facility services, see "Hospital/Other Facility Services."

Conditions of Coverage — To be eligible for benefits, therapies must meet the following conditions:

- There is a documented condition or delay in recovery that can be expected to measurably improve with therapy within two months of beginning active therapy.
- Improvement would not normally be expected to occur without intervention.

Covered Services — Subject to the conditions, limitations, and exclusions of this provision, this Medical Program covers the following services when provided for the medically necessary treatment of accidental injury or illness:

- occupational therapy performed by a licensed occupational therapist
- physical therapy performed by a physician or licensed physical therapist
- speech therapy, including audio diagnostic testing, performed by an accredited speech therapist for the treatment of communication impairment or swallowing disorders caused by disease, trauma, congenital anomaly, or a previous treatment or therapy or when required following the placement of a cochlear implant

Speech Therapy for Children — This Medical Program covers **preauthorized** services provided by a licensed speech therapist for treatment given to a child under age three whose speech is impaired due to one of the following conditions:

- infantile autism
- developmental delay or cerebral palsy
- hearing impairment
- major congenital anomalies that affect speech such as, but not limit to cleft lip and cleft palate

Benefit Limitations — Benefits are limited as indicated on the *Summary of Benefits*. Additional benefits for rehabilitation may be considered for coverage if BCBSNM determines the visits are necessary and expected to result in significant physical improvement. Such continued treatment must be prescribed by a physician.

Exclusions — This Medical Program does **not** cover:

- maintenance therapy or care provided after you have reached your rehabilitative potential or to prevent a medical problem from occurring or reoccurring (Even if you have not reached your rehabilitative potential, this Medical Program does **not** cover services that exceed maximum benefit limits, except as specified under "Benefit Limitations" above. Also see the "Long-Term or Maintenance Therapy" exclusion in *Section 7.)*

- long-term therapy or therapy for the treatment of chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief, even if you have not yet used or exhausted maximum benefits (Chronic conditions are conditions such as, but not limited to, cerebral palsy, childhood autism, muscular dystrophy, Down's syndrome, and developmental delay. Speech therapy may be covered for children under age three who have these chronic conditions, but such therapy must be **preauthorized** by BCBSNM.)
- diagnostic, therapeutic, rehabilitative, or health maintenance 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

See Section 7: General Limitations and Exclusions

Supplies, Equipment, and Prosthetics

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

For diabetic supplies such as needles, syringes, and test strips, see Section 6.

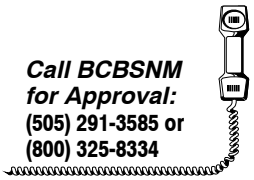
For hearing aids and related services, see "Hearing-Related Services."

For supplies or equipment used during an inpatient or outpatient stay, see "Hospital/Other Facility Services." (Supplies or equipment that are dispensed by a facility for use outside of the facility are subject to the provisions of this "Supplies, Equipment, and Prosthetics" section.)

To be covered, items must be medically necessary and ordered by a health care provider. If you have a question about items not listed in this section, please call the BCBSNM Health Services department.

Preauthorization from BCBSNM is required for:
- items requiring rental
- orthopedic appliances and orthotics, regardless of total cost
- any item costing $500 or more in total charges *(Total charges* means either the total purchase price of the item or total rental charges for the estimated period of use. Rental charges considered for benefit payment will not exceed the purchase price of a new unit.)

Diabetic Equipment — Under this provision of the Medical Program, the following supplies and equipment are covered for diabetic members and individuals with elevated blood glucose levels due to pregnancy:
- insulin pump supplies (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, including implantable pumps
- blood glucose monitors, including those for the legally blind
- medically necessary podiatric appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or

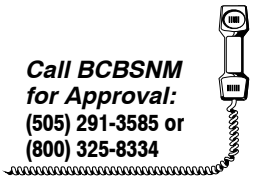


depth-inlay shoes, functional orthotics that have been **preauthorized** by BCBSNM, custom molded inserts, replacement inserts, preventive devices, and shoe modifications

- replacement of items only when required because of wear (and the item cannot be repaired) or because of a change in your condition

Reminder: Preauthorization is required for items costing $500 or more or requiring rental. For additional diabetic supply coverage (e.g., insulin needles and syringes, autolet, test strips, glucagon emergency kits), see *Section 6*.

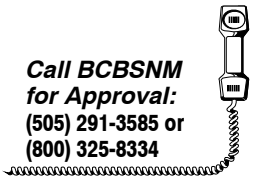
Durable Medical Equipment and Appliances — This Medical Program covers the rental of (or at the option of BCBSNM, the purchase of) durable medical equipment (including repairs to such purchased items), when prescribed by a covered health care provider and required for therapeutic use **(preauthorization is required for items costing $500 or more or requiring rental).** Covered equipment includes items such as:



- orthopedic appliances **(preauthorization** is required, regardless of total cost)
- oxygen and oxygen equipment, wheelchairs, hospital beds, crutches, and other 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, other intraocular surgery, or ocular injury, 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
- replacement of items only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- delivery pumps for tube feedings, including tubing and connectors

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

- gastrostomy tubes
- hollister supplies
- tracheostomy kits, masks
- lamb's wool or sheepskin pads
- ace bandages, elastic supports
- slings
- mastectomy brassieres when required due to a mastectomy (Benefits are limited to **three** bras per calendar year.)
- support hose when prescribed by a physician for the medically necessary treatment of varicose veins (Benefits are limited to **six** pair of hose per calendar year.)
- ostomy supplies
- other supplies determined by BCBSNM to be medically necessary and covered under the Medical Program



Orthotics, Prosthetics, and Implantable Devices — This Medical Program covers the following items:

- orthotics (rigid or semi-rigid supportive devices) or orthopedic appliances (pre-fabricated) that support or eliminate motion of a weak or diseased body part, when **preauthorized** by BCBSNM
- shoe orthotics for diabetes (See "Diabetic Equipment and Supplies" for details.)
- mechanical equipment for the treatment of chronic or acute respiratory failure or conditions
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces
- surgically implanted prosthetics or devices, including penile implants required as a result of illness or injury
- implantable mechanical devices such as cardiac defibrillators, epidural pain pumps, and neurostimulators
- intraocular lenses; artificial eyes
- cochlear implants (See "Hearing-Related Services" for additional information about benefits available for cochlear implantation.)
- externally attached prostheses to replace a limb or other body part lost after accidental injury or surgical removal; their fitting, adjustment, and repairs
- replacement of items 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

When alternative prosthetic/orthotic devices are available, the allowance for a prosthesis/orthotic will be based upon the least costly item.

Exclusions — This Medical Program does **not** cover, regardless of therapeutic value, items such as, but not limited to:

- air conditioners, biofeedback equipment, humidifiers, purifiers, self-help devices, or whirlpools
- items that are primarily nonmedical in nature such as Jacuzzi units, hot tubs, exercise equipment, heating pads, bed pans, disposable bed pads, or hot water bottles
- nonstandard or deluxe equipment, such as motor-driven wheelchairs, chair-lifts, or beds when standard equipment is available and adequate
- external prosthetics that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing or devices used specifically as safety items or to affect performance in sports-related activities
- repairs to items that you do not own
- comfort items such as bedboards, beds or mattresses of any kind, bathtub lifts, overbed tables, or telephone arms
- stethoscopes and manual blood pressure cuffs
- repair costs that exceed the rental price of another unit for the estimated period of need, or repair or rental costs that exceed the purchase price of a new unit
- tubing, nasal cannulas, connectors, and masks, except when used with a covered piece of durable medical equipment
- dental appliances (See "Dental-Related, TMJ, Oral Surgery" for exceptions.)
- functional foot orthotics, except for members with diabetes when **preauthorized** by BCBSNM

- accommodative foot orthotics (deal with structural abnormalities of the foot, accommodate such abnormalities, and provide comfort, but do not alter function)
- orthopedic or corrective shoes, arch supports, shoe appliances, and custom fitted braces or splints, except for members with diabetes and when **preauthorized** by BCBSNM
- replacement of a breast implant if the existing breast implant was performed as a cosmetic procedure (replacement of a breast implant is considered reconstructive if the initial breast implant followed mastectomy)
- 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
- voice synthesizers or other communication devices
- wigs, toupees, or hairpieces regardless of reason for hair loss
- eyeglasses or contact lenses and 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 (See *Section 6* for information about benefits for insulin needles and syringes and other diabetic supplies not listed as covered in this section.)
- items that can be purchased over-the-counter, including but not limited to dressings for bed sores or burns, gauze, and bandages
- contraceptive devices that do not require a prescription, including over-the-counter contraceptive products such as condoms and spermicide
- items not listed as covered

See Section 7: General Limitations and Exclusions

Surgery and Related Services

Surgical services — Any of a variety of technical procedures for treatment or diagnosis of anatomical disease or 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.

For accidental injuries to the jaws, mouth, or teeth, oral surgery, or treatment of TMJ or CMJ disorders or injuries, see "Dental-Related, TMJ, Oral Surgery."

For cochlear implants, see "Hearing-Related Services."

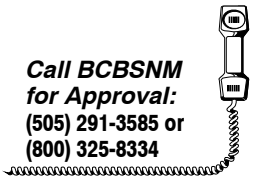
For transplants (other than for cornea, which is covered under this "Surgery and Related Services" provision), see "Transplant Services."

If applicable, also see these topics:

"Hospital/Other Facility Services"

"Maternity/Reproductive Services and Newborn Care" for deliveries, C-sections, surgical sterilization and limited infertility-related treatments

"Transplant Services"



You are responsible for obtaining preauthorization when necessary when services are provided by a Preferred Provider outside New Mexico or by any Nonpreferred Provider when eligible for coverage as a "benefit exception" in Section 3.

Surgeon's Services

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

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

This Medical Program also covers cosmetic breast surgery when **preauthorized** by BCBSNM following a mastectomy for breast cancer. Covered services are limited to:

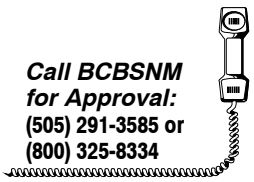
- cosmetic surgery of the breast/nipple on which the mastectomy was performed, including tattooing procedures; and
- the initial surgery of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications following the mastectomy, including treatment of lymphedema.

This Medical Program does **not** cover subsequent procedures to correct unsatisfactory cosmetic results attained during the initial breast/nipple surgery or tattooing, or breast surgery that has not received preauthorization from BCBSNM.

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

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

You or your physician must obtain **preauthorization, requested in writing,** from BCBSNM **before** the reconstructive service is provided. If the procedure (including any reconstructive service listed under "Dental-Related, TMJ, Oral Surgery") has not received preauthorization, **the surgery and all related charges will be denied.** Cosmetic procedures and procedures that are not medically necessary, including all services related to such procedures, will also be **denied.**



Obesity Surgery — This Medical Program covers **preauthorized** surgical services for the treatment or control of morbid obesity as defined below and if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the morbid obesity. (*Morbid obesity* is defined as having a Body Mass Index (BMI) of 40 or greater without co-morbidities, or a

BMI of 35-39 with co-morbidities. BMI is calculated as the patient's weight in kilograms divided by the patient's height in meters squared.) See "Physician Visits/Medical Care" for information about weight-loss programs that may be preauthorized by BCBSNM.

Exclusions — This Medical Program does **not** cover:

- medical and surgical services to alter appearances or physical changes that are the result of any services performed for the treatment or control of obesity or morbid obesity
- weight loss programs or treatments, whether or not they are prescribed or recommended by a physician or are under medical supervision (such services may be eligible, if preauthorized, under "Physician Visits: Weight Management Programs")
- 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," on the previous page)
- 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 or severe systemic disease, routine foot care (trimming, cutting, or debriding of corns, calluses, toenails), or treatment of bunions (except surgical treatment such as capsular or bone surgery)
- sex change operations or complications arising from transsexual surgery
- subsequent surgical procedures needed because you did not comply with prescribed medical treatment or because of a complication from a previous noncovered procedure (such as a noncovered organ transplant, sex change operation, or previous cosmetic surgery)
- any reconstructive procedure, fetal intervention, in-utero procedure, weight-loss surgery, or cosmetic breast surgery that has not received preauthorization from BCBSNM (Also see list of other surgical procedures requiring preauthorization in *Section 4.)*
- the insertion of artificial organs or devices (Exceptions: cardiac pacemakers, implantable cardiac defibrillators, implantable insulin pumps, implantable epidural pain pumps, neurostimulators, intraocular lenses, Teflon/Dacron surgical grafts and meshes, cochlear implants, and penile prosthetics)
- standby services unless the procedure is identified by BCBSNM as requiring the services of an assistant surgeon and the standby physician actually assists

Anesthesia Services

This Medical Program covers necessary anesthesia services, including acupuncture used as an anesthetic, when administered during a covered surgical procedure by a physician, certified registered nurse anesthetist (CRNA), a licensed doctor of oriental medicine (for acupuncture), or other practitioner as required by law. (See "Acupuncture/Spinal Manipulation" for information about acupuncture benefits.)

Exclusions — This Medical Program does **not** cover local anesthesia as a separate service. (Coverage for surgical procedures includes an allowance for local anesthesia because it is considered a routine part of the surgical procedure.)

Assistant Surgeon Services

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

Exclusions — This Medical Program does **not** cover: services of an assistant only because the hospital or other facility requires such services; services performed by a resident, intern, or other salaried employee or person paid by the hospital; or services of more than one assistant surgeon unless the procedure is identified by BCBSNM as requiring the services of more than one assistant surgeon.

See Section 7: General Limitations and Exclusions

Transplant Services

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. Covered transplants include pre-screening for solid human organ transplants, islet cell infusion and autologous or allogeneic bone marrow transplants, including peripheral stem cell, as determined to be medically necessary.

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.

See "Surgery and Related Services" for covered cardiac surgeries, such as valve replacements and pacemaker insertions and for cornea transplants, which are covered as any other surgical procedure.

Also see other subheadings in this section, such as "Hospital/Other Facility Services."

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

If you are approved as a transplant recipient candidate, you must ensure that **preauthorization** for the actual transplant is also received. None of the benefits described here are available unless you have this preauthorization.

Blue Distinction Centers for Transplants — While you can select any in-network facility for your transplant, the Blue Distinction Centers for Transplants® program can help you find the transplant program that meets your needs. Blue Distinction Centers for Transplants have demonstrated their commitment to quality care, resulting in better overall outcomes for transplant patients. Each facility meets stringent clinical criteria, established in collaboration with expert physicians' and medical organizations' recommendations, including the Center for

International Blood and Marrow Transplant Research (CIBMTR), the Scientific Registry of Transplant Recipients (SRTR) and the Foundation for the Accreditation of Cellular Therapy (FACT), and is subject to periodic reevaluation as criteria continue to evolve.

Blue Distinction Centers for Transplants provide a range of services for transplants, including:

- heart or heart-lung
- lung (deceased and living donor)
- liver (deceased and living donor), liver/small bowel, small bowel
- kidney or simultaneous pancreas-kidney (SPK)
- pancreas (PAK/PTA)
- bone marrow/peripheral stem cell (autologous and allogeneic, meaning either from yourself or from a compatible donor), with or without high-dose chemotherapy (Not all bone marrow transplants are covered.)

Organ or tissue transplants or multiple organ transplants other than those listed above are **not** covered.

You may view the entire list of Blue Distinction Centers and review the criteria used in selecting facilities for the designation at the Blue Cross and Blue Shield Association Web site:

www.bcbs.com/innovations/bluedistinction

You may be referred by your physician to a Blue Distinction transplant facility, or you may self-refer by contacting the BCBSNM Health Services department toll-free at 1-800-325-8334 (select the "Los Alamos National Lab" option from the menu). When prompted, select the "Transplant Care Coordinator" option. The Transplant Care Coordinator will help you find a transplant resource using the Blue Distinction Centers, facilitate an introduction to the case manager at the facility, and continue to follow your progress and care throughout the course of treatment.

Organ Procurement or Donor Expenses — If a transplant is covered, this Medical Program also covers the surgical removal, storage, and transportation of an organ acquired from a cadaver. If there is a living donor that requires surgery to make an organ available for a covered transplant, this Medical Program covers expenses incurred by the donor for travel to and from the transplant facility (if required and authorized by the case manager), surgery, organ storage expenses, and inpatient follow-up care only.

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

Travel and Lodging Expenses — If your transplant is preauthorized and eligible for benefits, you will be entitled to the travel and lodging benefit described later in this *Section 5,* which applies to this coverage for up to **5 days** before a covered transplant and for **one year** following the date of the actual transplant or retransplant.

Exclusions — This Medical Program does **not** cover:

- any transplant or organ-combination transplant not listed as covered
- implantation of artificial organs or devices (mechanical heart); nonhuman organ transplants (See "Surgery and Related Services" for benefits related to surgical implantation of mechanical devices such as insulin pumps and neuro-stimulators.)
- care for complications of noncovered transplants or follow-up care related to such transplants
- services related to a transplant that did not receive preauthorization from BCBSNM
- services related to a transplant performed in a facility not contracted directly or indirectly with BCBSNM to provide the required transplant
- expenses incurred by a member of this Medical Program for the donation of an organ to another person (Such expenses should be covered under the recipient's medical plan coverage.)
- drugs that are self-administered or for use while at home (See *Section 6* for drug plan benefits.)
- donor expenses after the donor has been discharged from the transplant facility
- food/meal expenses

See Section 7: General Limitations and Exclusions

Travel and Lodging Expenses

See "Cancer Treatment, Chemotherapy, and Radiation Therapy," "Cardiac Care and Pulmonary Rehabilitation," and/or "Transplant Services" for a description of standard Medical Program benefits for these services.

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

- cancer care at a Blue Distinction Center for Specialty Care
- congenital heart disease treatment at a Blue Distinction Center for Specialty Care
- covered transplant at an in-network (Preferred Provider) facility (excluding cornea transplants, which are covered as any other surgical procedure)

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

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

the purposes of an evaluation, to undergo the procedure or other treatment, and/or receive necessary post-discharge follow-up.

The following travel expenses are covered when supported by receipts (or, in the case of mileage reimbursement, a reasonable estimate of distance traveled using a standard map or Internet-available programs that provide users with destination maps and mileage estimates):

- automobile mileage, reimbursed at the standard IRS **medical purpose** rate (visit www.irs.gov to determine current IRS rates)
- taxi fares
- economy/coach airfare (anything other than economy or coach is NOT covered)
- parking and/or tolls
- trains, boat, or bus fares

Limitations and Exclusions

This Medical Program does **not** cover automobile rental or gasoline expenses. Also, if you need to travel by air or ground ambulance to a facility, those services may be covered under the standard Medical Program benefit. Such ambulance expenses are not covered under this "Travel and Lodging Expenses" provision. See "Ambulance Services," earlier in this section for more information.

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

Limitations and Exclusions

Lifetime Maximum Travel and Lodging Benefit — Travel expenses and standard per diem allowances for the patient and companion(s) are limited to a combined total lifetime maximum benefit of **$10,000** per member for each of three following treatment/program types (regardless of how many admissions or treatments the patient receives for each program type):

- cancer care at a Blue Distinction Center for Specialty Care
- congenital heart disease at a Blue Distinction Center for Specialty Care
- transplants at an in-network (Preferred Provider) facility

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

Limitations and Exclusions

Exclusions — This Medical Program does **not** cover travel expenses and per diem allowances are **not** paid if:

- you receive cancer care or treatment of congenital heart disease at a facility other than a Blue Distinction Center

- you *choose* to travel to receive care for which travel is not considered medically necessary by the case manager
- the travel occurs more than five days before or more than one year following the actual transplant or the start of cancer care or treatment of congenital heart disease

This Medical Program also does **not** cover:

- automobile rental charges or gasoline expenses
- 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 provide such services in return for payment)
- food or lodging expenses, except for those **lodging** expenses that are eligible for a per diem allowance

See Section 7: General Limitations and Exclusions

6 Drug Plan Benefits and Exclusions

Prescription Drugs and Other Items

IMPORTANT NOTE FOR MEDICARE-ELIGIBLE MEMBERS: Medicare-eligible members will continue to receive this drug coverage under this Medical Program as long as the member does **not** purchase Medicare Part D drug coverage. This drug coverage **is** considered "creditable coverage" should you lose this Medical Program coverage and later choose to enroll in Medicare Part D according to the time limits specified by CMS. However, if you choose to purchase Medicare Part D while covered under this Medical program, benefits will be coordinated with Medicare Part D as the primary coverage.

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

Drug List — A list of prescription drugs preferred for use by BCBSNM for pharmacy benefits administered by Prime Therapeutics. You pay the lower "Tier-One" and "Tier-Two" copayments for drugs listed in the BCBSNM Drug List. You pay the higher "Tier-Three" copayment for drugs not listed. The list is subject to periodic review and change by BCBSNM. A copy of the BCBSNM Drug List is available on the BCBSNM Web site at www.bcbsnm.com. Select "Quick Help" and then "Prescription Drugs." You may also contact a Customer Service Advocate for a copy of the Drug List. BCBSNM-contracted providers may contact their Network representative for a copy.

Enteral nutritional product — 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 — The chemical equivalent of a brand-name prescription drug. According to United States Food and Drug Administration (FDA) regulations, brand-name and generic drugs must meet the same standards for safety, purity, strength, and quality. A generic drug is usually available from multiple sources and is not protected by a patent.

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.

Maintenance medications — Prescription drugs taken regularly to treat a chronic health condition, such as high blood pressure or diabetes.

Participating pharmacy — A retail supplier that has contracted with BCBSNM or its authorized representative to dispense covered prescription drugs and medicines, insulin, diabetic supplies, and nutritional products to Medical Program members, and that has contractually accepted the terms and conditions as set forth by BCBSNM and/or its authorized representative. Some pharmacies are contracted with BCBSNM to provide specialty pharmacy drugs to Medical Program 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.

Prescription drugs and medicines — 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 drugs and medicines must be approved by the FDA, and must not be experimental, investigational, or unproven. (See the "Experimental, Investigational, or Unproven Services" exclusion in *Section 7*.)

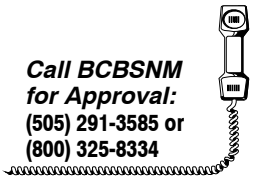
Special medical foods — Nutritional substances in any form that are consumed or administered internally under the supervision of a physician, specifically processed or formulated to be distinct in one or more nutrients present in natural food; intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements established by medical evaluation; and essential to optimize growth, health, and metabolic homeostasis.

Specialty pharmacy drugs — Specialty pharmacy drugs: a) are high cost, b) are used in limited patient populations or indications, c) are typically self-injected, d) have limited availability, require special dispensing or delivery, and/or patient support is required and, therefore, are difficult to obtain via traditional pharmacy channels, and/or e) require complex reimbursement procedures. Also, a considerable portion of the use and costs are frequently generated through office-based medical claims.

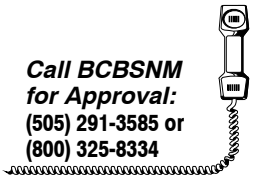
Covered Medications and Other Items

This Medical Program covers the following drugs, supplies, and other products through this drug plan provision only when dispensed by a **participating pharmacy** under the Prime Therapeutics **Retail Pharmacy/Specialty Pharmacy Programs** (unless required as the result of an emergency, as defined) or ordered through the Prime Therapeutics **Mail Order Service** (also called "Prime Mail"):

- prescription drugs and medicines (includes prescription contraceptive medications and commercially available products that include at least one covered prescription ingredient and are modified or "compounded" *only* for dosing and/or route of administration requirements), insulin, glucagon, and prescription contraceptive devices purchased from a participating pharmacy, unless listed as an exclusion **(Note:** Prescription contraceptive devices fitted or inserted by, and purchased directly from, a physician are payable under the "Family Planning" benefit of the Medical Program.)



- specialty pharmacy drugs such as, but not limited to, self-administered injectable drugs such as growth hormone, Copaxone, and Avonex (Most injectable drugs require **preauthorization** from BCBSNM. Some self-administered drugs, whether injectable or not, are identified as specialty pharmacy drugs and must be acquired through a participating specialty pharmacy provider in order to be covered.)
- insulin needles, syringes, and diabetic supplies (e.g., glucagon emergency kits, autolet, lancets, lancet devices, blood glucose and visual reading urine and ketone test strips) (There is a separate copayment for each item purchased.)



- nonprescription enteral nutritional products and special medical foods only when either: 1) delivered by a medically necessary enteral access tube that has been surgically placed (e.g., gastrostomy, jejunostomy) or 2) meeting the definition of special medical foods used to treat and to compensate for the metabolic abnormality of members with genetic inborn errors of metabolism in order to

maintain their adequate nutritional status (These products must have **preauthorization** from BCBSNM in order to be covered.)

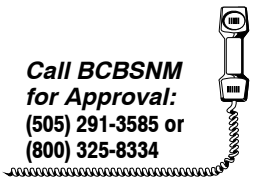
Other Preauthorizations — Certain prescription drugs, injectable medications, and specialty pharmacy drugs may require preauthorization from BCBSNM. A list of drugs requiring preauthorization is available on the BCBSNM Web site at www.bcbsnm.com. Your physician can request the necessary preauthorization.

Retail/Specialty Pharmacy Programs

All items covered under this provision of your EPO Medical Program must be purchased from a participating retail pharmacy. **Some drugs must be purchased from a participating specialty pharmacy provider in order to be covered.** (Refer to your provider directory for a list of participating pharmacies and specialty pharmacy providers. If you do not have a directory, call Customer Service for a list or visit the BCBSNM Web site.)

You must present your Medical Program ID card to the pharmacist at the time of purchase to receive this benefit. **Note:** You do not receive a separate prescription drug ID card; use your BCBSNM ID card to receive all medical/surgical and prescription drug services covered under this Medical Program. You can use your ID card to purchase covered items only for yourself and covered family members. When coverage for you or a family member ends under this Medical Program, the ID card may not be used to purchase drugs or other items for the terminated member(s).

If you do not have your ID card with you or if you purchase your prescription or other covered item from a nonparticipating provider in an **emergency,** you must pay for the purchase in full and then submit a claim directly to Prime Therapeutics as explained on the next page.



If you are leaving the country or need an extended supply of medication, call BCBSNM Customer Service at least two weeks before you intend to leave. (Extended supplies or "vacation overrides" are not available through the Mail Order Service and may be approved by BCBSNM through the Retail Pharmacy Program only. In some cases, you may be asked to provide proof of continued enrollment eligibility under the Retail Pharmacy Program.) Do not call Prime Therapeutics for vacation override requests. Such requests must be directed to BCBSNM and BCBSNM will advise Prime Therapeutics if your request has been approved. **Vacation override requests are limited to a 90-day supply.**

Finding a Retail Pharmacy

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

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

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

Drug Plan Claims

If you purchase a prescription 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, you must pay for the prescription in full and then submit a claim to BCBSNM's designated pharmacy benefit manager, Prime Therapeutics. **(Do not send these claims to BCBSNM.)** The bills or receipts must be issued by the pharmacy and must include pharmacy name and address, drug name, prescription number, and amount charged. If not included in your enrollment materials, you can obtain the necessary claim forms from a Customer Service Advocate or on the BCBSNM Web site (www.bcbsnm.com). Send Retail Pharmacy claims to:

Prime Therapeutics
PO Box 14624
Lexington, KY 40512-4624

Mail Order Service

Except for supply limitations and specialty pharmacy or enteral nutritional products, all items that are covered under the Mail Order Service are the same items that are covered under the Retail Pharmacy Program and are subject to the same limitations and exclusions. Items covered through a specialty pharmacy provider may not be covered through the Mail Order Service. To use the Mail Order Service, follow the instructions outlined in the materials provided to you in your enrollment packet. (If you do not have this information, call a BCBSNM Customer Service Advocate.)

Note: Prescription drugs and other items may **not** be mailed outside the United States. Extended supplies or vacation overrides required when you are outside the country may be approved through the Retail Pharmacy Program only.

Send 60-day to 90-day Mail Order Service prescriptions to the following address (prescriptions written for less than a 60-day supply are not accepted):

Prime Mail
PO Box 27836
Albuquerque, NM 87125-7836

Member Copayments

For covered prescription drugs (including specialty pharmacy 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 on the next page). Copayments are **not** included in the out-of-pocket limit, and are not 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 next page). The copayments are listed on the *Summary of Benefits*.

Brand-Name vs. Generic Drug Costs

If you request the brand-name drug when there is an FDA-approved generic equivalent available, **you must pay the difference in cost between the brand-name and its generic equivalent,** plus the generic drug copayment.

No Coordination of Benefits

If you have other drug plan coverage that is primary over this Medical Program (excluding Medicare Part D), this Medical Program will **not** coordinate benefits with the other drug plan coverage. **You are responsible for paying the full amounts due under your primary drug plan coverage.** If you choose to purchase Medicare Part D, Medicare Part D is your primary drug plan and this Medical Program will coordinate its benefits with Medicare Part D.

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:

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

* 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 days' supply the package represents.** For example, if two inhalers are purchased under the Retail Pharmacy Program, two copayments will apply. Under Mail-Order, you can receive up to three times the number of packages obtainable from a retail pharmacy for only twice the copayment amount required under the Retail Pharmacy Program.

Drug Plan Exclusions

In addition to items excluded in general (see *Section 7)*, this Medical Program does **not** cover:

- nonprescription and over-the-counter drugs (unless specifically listed as covered) including herbal or homeopathic preparations, or prescription drugs that have over-the-counter equivalents

- non-commercially available compounded medications, regardless of whether or not one or more ingredients in the compound requires a prescription (Non-commercially available compounds are those made by mixing or reconstituting ingredients in a manner or ratio that is inconsistent with United States Food and Drug Administration-approved indications provided by the ingredients' manufacturers.)
- drugs (or other items covered only under this drug plan provision of the Medical Program) when purchased from a nonparticipating pharmacy, nonparticipating specialty pharmacy provider, or any other provider that does not participate under the drug plan unless eligible for benefits in an emergency situation
- refills before the normal period of use has expired, in excess of the number specified by the physician, or requested more than one year following the physician's original order date (Prescriptions cannot be refilled until at least 75 percent of the previously dispensed supply will have been exhausted according to the physician's instructions. Call BCBSNM for instructions on obtaining a greater supply if you are leaving home for more than a 30-day period of time.)
- replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced
- infertility medications
- drugs or other items intended for smoking or tobacco use cessation
- drugs or other items intended for treatment of sexual or erectile dysfunction
- therapeutic devices or appliances, including support garments and other non-medicinal 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 by a temporary naso-enteric tube (e.g., nasogastric, nasoduodenal, or nasojejunal tube), unless the patient meets criteria for genetic inborn errors of metabolism and the product is **preauthorized** by BCBSNM
- shipping, handling, or delivery charges incurred outside Prime Mail Service
- prescription drugs and/or immunizations that are required only for international travel or work and that are unrelated to a medical condition
- appetite suppressants or diet aids; weight reduction drugs; food or diet supplements and medication prescribed for body building or similar purposes
- infant formula, donor breast milk, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins and oral minerals except when listed as covered due to being the sole source of nutrition or for treating a specific inborn error of metabolism

Brand-Name Exclusion — Some equivalent drugs are manufactured under multiple brand-names. In such cases, BCBSNM may limit benefits to only one of the brand equivalents available. Your pharmacist will advise you if a particular brand-name drug is excluded. If you do not accept the brand that is covered under this Medical Program, the brand-name drug purchased will not be covered under any benefit level.

See Section 7: General Limitations and Exclusions

7 General Limitations and Exclusions

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

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

Also see Section 5 and Section 6 for specific benefit limits and exclusions.

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

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

Before Effective Date or After Termination Date of Coverage — This Medical Program does not cover any service received, item purchased, or health care expense incurred before your effective date or after your termination date of coverage, even if: 1) preauthorization for such service, item, or drug was received from BCBSNM, or 2) the service, item, or drug was needed because of an event that occurred while you were covered. If you are an inpatient when coverage begins, benefits for the admission will be available only for those covered services received on and after your effective date of coverage. Also see "Benefit Limits" in *Section 3*.

Benefits may be available for covered services received after your termination date during a hospital admission that began *before* coverage ended. Coverage for the admission and related inpatient services may continue until the earlier of the date: 1) benefits for the admission are exhausted, or 2) when there is an interruption of the inpatient stay (such as discharge or a leave of absence from the facility, regardless of the date of discharge). Benefits for such services may be coordinated with any additional health care coverage that applies after your termination date under this Medical Program.

Biofeedback — This Medical Program does not cover biofeedback or services related to biofeedback.

See additional exclusions related to specific types of covered services in *Sections 5 and 6.*

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

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

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

Convalescent Care or Rest Cures — This Medical Program does not cover convalescent care or rest cures.

Cosmetic Services — Cosmetic surgery is beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic. **This Medical Program does not cover** cosmetic surgery, services, or procedures for psychiatric or psychological reasons, or to change family characteristics or conditions caused by aging. **This Medical Program does not cover** services related to or required as a result of a cosmetic service, procedure, or surgery, or subsequent procedures to correct unsatisfactory cosmetic results attained during an initial surgery; liposuction; treatment of benign gynecomastia; or treatment of excessive sweating (or hyperhidrosis).

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: Cosmetic breast/nipple surgery required due to a mastectomy that occurred less than **12 months** before the planned cosmetic procedure may be covered. However, **preauthorization, requested in writing,** must be obtained from BCBSNM for such services. Also, preauthorized reconstructive surgery, which may have a coincidental cosmetic effect, may be covered when required as the result of accidental injury, illness, or congenital defect. See *Section 4* for details about preauthorization.

Custodial Care — This Medical Program does not cover custodial care, or care in a place that is primarily your residence when you do not require skilled nursing. **This Medical Program does not cover** services to assist in activities

See additional exclusions related to specific types of covered services in *Sections 5 and 6.*

of daily living (such as sitter's or homemaker's services), or services not requiring the continuous attention of skilled medical or paramedical personnel, regardless of where they are furnished or by whom they were recommended.

Dental-Related/TMJ Services and Oral Surgery — This Medical Program does not cover dental-related services except as indicated in *Section 5*. **This Medical Program does not cover** treatment of congenitally missing, malpositioned, or supernumerary teeth – even if part of a congenital anomaly. In addition to services excluded by the other general limitations and exclusions listed throughout this *Section 7,* see "Dental-Related/TMJ Services and Oral Surgery" in *Section 5* for additional exclusions.

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

Duplicate (Double) Coverage — This Medical Program does not cover amounts already paid by other valid coverage or that would have been paid by Medicare as the primary carrier if you were entitled to Medicare, had applied for Medicare, and had claimed Medicare benefits. See *Section 8* for more information. Also, if your prior coverage has an extension of benefits provision, **this Medical Program will not cover** charges incurred after your effective date under this Medical Program that are covered under the prior plan's extension of benefits provision.

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

Experimental, Investigational, or Unproven Services — This Medical Program does not cover any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical practice,* as defined on the next page, or those considered experimental, investigational, or unproven. 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 or investigational, 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, 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, its efficacy, 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, or its efficacy as compared with the standard means of treatment or diagnosis.

See additional exclusions related to specific types of covered services in *Sections 5 and 6.*

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

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

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

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

Food or Lodging Expenses — This Medical Program does not cover food or lodging expenses, except for those lodging expenses that are eligible for a per diem allowance under the "Transplant Services" and "Travel and Lodging" provisions in *Section 5* and not excluded by any other provision in this *Section 7*.

Foot Care — This Medical Program does not cover:

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

Genetic Testing or Counseling — This Medical Program does not cover tests such as amniocentesis or ultrasound to determine the sex of an unborn child.

Hair Loss Treatments — This Medical Program does not cover wigs, artificial hairpieces, hair transplants or implants, or medication used to promote hair growth or control hair loss, even if there is a medical reason for hair loss.

See additional exclusions related to specific types of covered services in *Sections 5 and 6.*

Home Health/I.V. Services and Hospice — In addition to services excluded by the other general limitations and exclusions listed throughout this *Section 7,* see "Home Health/I.V. Services" and "Hospice Care" in *Section 5* for additional exclusions.

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

Infertility Services/Artificial Conception — This Medical Program does not cover services related to, but not limited to, procedures such as: surrogate parenting; 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) or Zygote Intrafallopian Transfer (ZIFT), embryo transfer, drugs for induced ovulation, or other artificial methods of conception. **This Medical Program does not cover** the cost of donor sperm, costs associated with the collection, preparation, or storage of sperm for artificial insemination, or donor fees; costs for ova or embryonic donations or monthly fees for the maintenance/storage of sperm, ova, or embryos.

This Medical Program does not cover infertility testing, treatments, or related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization. **This Medical Program does not cover** reversal of a prior sterilization procedure. (Certain treatments of medical conditions that sometimes result in restored fertility may be covered; see "Maternity/Reproductive Services and Newborn Care" in *Section 5*.)

Late Claims Filing — This Medical Program does not cover services of a Nonpreferred Provider if the claim for such services is received by BCBSNM more than **12 months** after the date of service. (Providers that contract with BCBSNM will file claims for you and must submit them within a specified amount of time, usually within 180 days.) If a claim is returned for further information, resubmit it **within 45 days. Note:** If there is a change in the Claims Administrator, the length of the timely filing period may also change. See "Filing Claims" in *Section 9* for details.

Learning Deficiencies/Behavioral Problems — This Medical Program does not cover special education, counseling, therapy, diagnostic testing, treatment, or any other service for learning deficiencies or chronic behavioral problems, whether or not associated with a manifest mental disorder, retardation, or other disturbance.

Limited Services/Covered Charges — This Medical Program does not cover amounts in excess of covered charges or services that exceed any maximum benefit limits listed in this benefit booklet, or any amendments, riders, addenda, or endorsements.

Local Anesthesia — This Medical Program does not cover local anesthesia as a separate service. (Coverage for surgical, maternity, diagnostic, and other procedures includes an allowance for local anesthesia because it is considered a routine part of the procedure.)

See additional exclusions related to specific types of covered services in *Sections 5 and 6.*

Long-Term or Maintenance Therapy — This Medical Program does not cover long-term therapy whether for physical or for mental conditions, even if medically necessary and even if any applicable benefit maximum has not yet been reached, except that medication management for chronic conditions is covered. Therapies are considered long-term if measurable improvement is not possible within two months of beginning active therapy. Long-term therapy includes treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Treatment of chronic conditions is not covered. (Chronic conditions include, but are not limited to, childhood autism, muscular dystrophy, Down's syndrome, and cerebral palsy.)

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

Medical Policy Determinations — Any technologies, procedures, or services for which medical policies have been developed by BCBSNM are either limited or excluded as defined in the medical policy (see "Medical policy" in the *Glossary).*

Medically Unnecessary Services — This Medical Program does not cover services that are not medically necessary as defined in *Section 5* unless such services are specifically listed as covered (e.g., see "Routine/Preventive Services" in *Section 5*). BCBSNM 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.)

No Legal Payment Obligation — This Medical Program does not cover services for which you have no legal obligation to pay or that are free, including:

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

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

Noncovered Providers of Service — This Medical Program does not cover services prescribed or administered by a:

See additional exclusions related to specific types of covered services in *Sections 5 and 6.*

- member of your immediate family, whether relationship is due to birth, marriage, law (e.g., spouse), adoption, domestic partnership; a brother, sister, parent, or child; or a person normally living in your same residence
- provider sanctioned under a federal program for reason of fraud, abuse, or medical competency
- 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
  - private sanitarium
  - extended care facility or similar institution
  - dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group

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

- adoption or surrogate expenses
- educational programs such as behavior modification and arthritis classes (Some diabetic services and other educational programs may be covered; see "Routine/Preventive Services" and "Physician Visits/Medical Care" in *Section 5*.)
- autopsies
- personal convenience items such as, but not limited to, air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers, humidifiers, breast pumps, or exercise equipment, or personal services such as haircuts, shampoos, guest meals, and television rentals
- vocational or training services and supplies
- mailing, shipping, handling, or delivery
- missed appointments; "get-acquainted" visits without physical assessment or medical care; telephone consultations; provision of medical information to perform preauthorizations; filling out of claim forms; copies of medical records; interest expenses
- modifications to home, vehicle, or workplace to accommodate medical conditions; voice synthesizers; other communication devices
- membership at spas, health clubs, or other such facilities
- personal comfort services, including homemaker and housekeeping services, except in association with respite care covered during a hospice admission
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; phone calls; day care expenses)
- physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, medications, or treatments when required solely for purposes of career, education, sports, camp, travel, employment, insurance, marriage, or adoption; related to a judicial or administrative proceeding or order; conducted for purposes of medical research; or required to obtain or maintain a license of any type

See additional exclusions related to specific types of covered services in *Sections 5 and 6.*

- hepatitis B immunizations when required due to possible exposure during the member's work
- medical or surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea; appliances to treat snoring
- the cost of any damages to a treatment facility that are caused by the member

Nonpreferred Provider Services — This Medical Program does not cover services of a Nonpreferred Provider unless listed under "Benefit Exceptions for Nonpreferred Providers" in *Section 3* of this benefit booklet.

Nutritional Supplements and Nonprescription Drugs — This Medical Program does not cover herbal or homeopathic preparations, prescription drugs that have over-the-counter equivalents, vitamins, megavitamin or nutrition-based therapy, dietary/nutritional supplements, special foods, formulas, mother's milk, or diets, or any nonprescription drugs. (Insulin and certain nutritional products may be covered, but must be purchased through the drug plan. See *Section 6* for information about these benefits and how to obtain them.)

Preauthorization Not Obtained When Required — This Medical Program does not cover certain services if you do not obtain preauthorization from BCBSNM before those services are received. See *Section 4*.

Private Duty Nursing Services — This Medical Program does not cover private duty nursing services.

Private Room Expenses — This Medical Program does not cover private room expenses, unless your medical condition requires isolation for protection from exposure to bacteria or diseases (e.g., severe burns and conditions that require isolation according to public health laws). Private room charges must be **preauthorized** by BCBSNM to be covered.

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

Sexual Dysfunction Treatment — This Medical Program does not cover services related to the treatment of sexual dysfunction.

Therapy or Counseling Services — This Medical Program does not cover therapies and counseling programs other than the therapies listed as covered in this booklet. In addition to treatments excluded by the other general limitations and exclusions listed throughout this *Section 7,* **this Medical Program does not cover** services such as, but not limited to:

- recreational, sleep, crystal, primal scream, sex, or Z therapies
- self-help, stress management, smoking/tobacco use cessation, or codependency programs
- transactional analysis, encounter groups, and transcendental meditation (TM); moxibustion; sensitivity or assertiveness training

See additional exclusions related to specific types of covered services in *Sections 5 and 6.*

- vision therapy; orthoptics
- pastoral, spiritual, or religious counseling (This Medical Program also excludes such services even when rendered by a Christian Science Practitioner.)
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this Medical Program
- any therapeutic exercise equipment for home use (e.g., treadmill, weights)

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

Transplant Services — See "Transplant Services" in *Section 5* 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 7,* **this Medical Program does not cover** any other transplants (or organ-combination transplants) or services related to any other transplants.

Travel or Transportation — This Medical Program does not cover travel, taxicab or bus fare, parking, vehicle rental, or similar expenses (even if travel is necessary to receive covered services and/or is ordered by a physician), unless such services are eligible for coverage and not excluded under "Transplant Services," "Cardiac Care and Pulmonary Rehabilitation," "Cancer Treatment, Chemotherapy, and Radiation Therapy," or "Ambulance Services" in *Section 5*. If you are eligible to receive travel reimbursement for a covered service, **this Medical Program does not cover** automobile rental or gasoline expenses.

Veteran's Administration Facility — This Medical Program does not cover services or supplies furnished by a Veterans Administration facility for a service-connected disability or while a member is in active military service.

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

War-Related Conditions — This Medical Program does not cover any service required as the result of any act of war or related to an illness or accidental injury sustained during combat or active military service.

Weight Management — This Medical Program does not cover weight-loss or other weight-management programs, dietary control, or medical obesity treatment unless dietary advice and exercise are provided by a physician, nutritionist, or dietitian licensed by the appropriate agency and services are **preauthorized**

See additional exclusions related to specific types of covered services in *Sections 5 and 6.*

by BCBSNM. Medical and surgical treatment of morbid obesity and covered weight management services are covered only when **preauthorized** by BCBSNM and only when the member has a body mass index (BMI = weight in kilograms divided by height in meters squared) of 40 or more. (Weight loss medications, when **preauthorized** by BCBSNM, are covered only when medically necessary and for a BMI of 40 or more.)

Work-Related Conditions — This Medical Program does not cover services resulting from work-related illness or injury, or charges resulting from occupational accidents or sickness covered under:

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

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

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

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

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.)

See additional exclusions related to specific types of covered services in *Sections 5 and 6.*

8 COB and Reimbursement

Coordination of Benefits (COB)

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.

For a work-related injury or condition, see the "Work-Related Conditions" exclusion in Section 7.

This Medical Program contains a coordination of benefits (COB) provision that prevents duplication of payments. When you are enrolled in any other valid coverage, the combined benefit payments from all coverages cannot exceed 100 percent of BCBSNM's covered charges.

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

NOTE: If you have other prescription drug coverage that is primary over this Medical Program (excluding Medicare Part D), this Medical Program will not coordinate benefits with the other coverage. You are responsible for paying the amounts due under primary coverage for prescription drugs. If you choose to purchase Medicare Part D, Medicare Part D is your primary drug plan and this Medical Program will coordinate its benefits with Medicare Part D.

The following rules determine which coverage pays first:

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

Medicare — If the other valid coverage is Medicare and Medicare is primary according to federal regulation, Medicare pays first. You may not elect to change this Medical Program to be primary coverage over Medicare and may not elect to bypass Medicare. If services are among those normally covered by Medicare, you or your doctor or hospital (your health care "provider") must submit a claim for those services first to Medicare as explained in *Section 9*. Medicare will calculate its benefits and will send you an *Explanation of Medicare Benefits* (EOMB) form. This form must be attached to any claim you send to BCBSNM (however, most providers will file claims for you or a "crossover" claim should automatically be sent by the Medicare Part B carrier or Part A intermediary to BCBSNM for secondary benefit determination).

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

Subscriber/Family Member — If the member who received care is covered as an employee, retiree, or other policyholder (i.e., as the subscriber) under one coverage and as a spouse, child, or other covered family member under another, the coverage that designates the member as the employee, retiree, or other policyholder (i.e., as the subscriber) pays first. This rule includes coverage that designates a covered child under this health plan as the employee/subscriber under another health plan. **Exception:** If a person is covered under two health plans and one is primary over Medicare and the other is secondary to Medicare, the plan that is secondary to Medicare pays last. The plan that is primary over Medicare always pays first when a person is enrolled in Medicare, then Medicare pays, and then the plan that is secondary to Medicare. (For example, if a retiree with retiree coverage is also covered under his/her spouse's policy, the retiree's own coverage would normally pay first since the spouse's plan covers the retiree as a family member, and not as a subscriber. But if the spouse's policy is primary over Medicare because the spouse is still actively employed, the spouse's coverage would pay first for the retiree, then Medicare, and then the retiree's own coverage last.)

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

If you have other valid group 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.

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

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

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

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

Responsibility for Timely Notice

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

Facility of Payment

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

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 Provision

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

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

BCBSNM and LANS are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits LANS provided for that sickness or injury.

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

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

9 Claims Payments and Appeals

Filing Claims

You must submit claims **within 12 months** after the date services or supplies were received. **A claim submitted more than 12 months after the service was received will not be accepted under any circumstance. Note:** If there is a change in the Claims Administrator, the length of the timely filing period may also change.

If a claim is returned for further information, resubmit it **within 45 days.**

Important Note About Filing Claims and Appeals — This section addresses the procedures for filing claims and appeals. The instructions in no way imply that filing a claim or an appeal will result in benefit payment and do not exempt you from adhering to all of the provisions described in this benefit booklet. All claims submitted will be processed by BCBSNM according to the patient's eligibility and benefits in effect at the time services are received. Whether inside or outside New Mexico and/or the United States, you must meet all preauthorization requirements or benefits may be reduced or denied as explained in *Section 4*. Covered services are the same services listed as covered in *Sections 5* and *6* and all services are subject to the limitations and exclusions listed throughout this booklet.

If You Have Other Coverage

When you have any other coverage (including a LANS dental or vision plan) that is "primary" over this Medical Program, you need to file your claim to the other coverage first. 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," on the next page. If you are primary under Medicare, also see "If You Have Medicare," later in this section and also in *Section 3*.

If the other 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 Nonpreferred 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" contract and another "participating" provider contract. Some providers have only the participating provider contract and are not considered preferred. 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) also have specific timely filing limits in their contracts with BCBS, usually 180 days. The contract language lets providers know that they may not bill the employer or any member if they do not meet that filing limit for a service and the claim for that service is denied.

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 coverage's payment explanation, to a *Member Claim Form.* (Forms can be printed from the BCBSNM Web site or requested from a Customer Service Advocate.) Complete the claim form using the instructions on the form. (See special claims filing instructions for out-of-country claims under "Where to Send Claim Forms," below.)

Itemized Bills — Claims for covered services must be itemized on the provider's billing forms or letterhead stationery and must show:

- member's identification number
- member's and subscriber's name and address
- member's date of birth and relationship to the subscriber
- name, address, 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)

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 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.

Where to Send Claim Forms

If your provider does not file a claim for you, you (not the provider) are responsible for filing the claim. *Member Claim Forms* are available from a BCBSNM Customer Service Advocate or a copy can be printed off the BCBSNM Web site. **Remember:** Preferred Providers will file claims for you; these procedures are used only when you must file your own claim. See "Participating and Preferred Providers," on the previous page, for more information.

Services in United States, Canada, Jamaica, U.S Virgin Islands, and Puerto Rico — When covered services are received from nonparticipating providers, mail the forms and itemized bills to the local Blue Cross Blue Shield Plan in the state where services were received. If a provider will not file a claim for you, ask for an itemized bill and complete it the same way that you would for services received from any other nonparticipating provider. In New Mexico, send claims to:

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

Drug Plan Claims — If you purchase a prescription 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, you must pay for the prescription in full and then submit a claim to Prime Therapeutics, BCBSNM's designated pharmacy benefit manager. **(Do not send these claims to BCBSNM.)** The bills or receipts must be issued by the pharmacy and must include pharmacy name and address, drug name, prescription number, and amount charged. If not included in your enrollment materials, you can obtain the necessary claim forms from a Customer Service Advocate or on the BCBSNM Web site (www.bcbsnm.com).

Send Retail Pharmacy claims to:
Prime Therapeutics
PO Box 14624
Lexington, KY 40512-4624

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

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

www.bcbs.com/coverage/bluecard/bluecard-worldwide.html

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

Since the claim cannot be returned, please be sure to keep photocopies of all bills and supporting documentation for your personal records. The member should submit an *International Claim Form,* attach itemized bills, and mail to BlueCard Worldwide at the address below. BlueCard Worldwide will then translate the

information, if necessary, and convert the charges to United States dollars. They also will contact BCBSNM for benefit information in order to process the claim. Once the claim is finalized, and *Explanation of Benefits* will be mailed to the subscriber and payment, if applicable, will be made to the subscriber via wire transfer or check. Mail international claims to:

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

If You Have Medicare

NOTE: This section applies to you only if you are primary under Medicare and Medical Program benefits are going to be coordinated with Medicare as a result. If you are not sure if Medicare is primary or secondary, please see "If You Have Medicare" in *Section 3* for a brief explanation or call the Social Security office for more information.

Filing Claims If Medicare is Primary

If you have Medicare and Medicare is primary over this Medical Program (i.e., you are retired, a covered family member of a retiree, or a member that has exhausted the end-stage renal disease coordination time period under Medicare), when you receive health care, be sure to present both your Medicare ID card and your LANS Medical Program ID card issued by BCBSNM. Always present your Medicare ID card to your health care providers so that they will bill Medicare first. After Medicare has paid its portion **for services received in New Mexico,** a claim should automatically be sent by the Medicare Part B carrier or Part A intermediary to BCBSNM for secondary benefit determination. (If your claims are not being sent by Medicare to BCBSNM, please call a Customer Service Advocate to verify that the correct Medicare HIC number is on file for you. Also, in order to ensure that claims are filed properly, the provider must have information from the ID cards issued to you by **both** Medicare and BCBSNM.)

If you must file a claim for services that were covered by Medicare (for example, because services were received outside New Mexico and the claim does not automatically "cross-over" once Medicare has paid its portion), you will have to file a copy of the EOMB that you receive from Medicare and all other required claim information with the local BCBS Plan. On the EOMB you receive from Medicare, **print your Plan ID number (found on your Medical Program ID card issued by BCBSNM) – including the three alphabetic characters that precede the nine-digit number – and your correct mailing address and zip code.** Make a copy of the EOMB for your records.

Mail claims, EOMBs, and other needed information to the local BCBS Plan in the state where you receive services. Your provider should be familiar with this process, and in most cases, will file on your behalf. If you receive services in New Mexico and need to file a claim to BCBSNM, send the claim to:

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

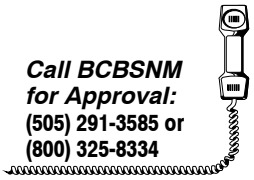
Medicare-Covered Facility Services — All Medicare-participating providers of Part A services, including skilled nursing facilities and hospice agencies, will submit claims directly to Medicare. To file claims, the facility must have the information from the identification cards issued to you by **both** Medicare and BCBSNM.

After Medicare Part A has paid its portion of covered charges for services received in New Mexico, it is **not** necessary for you to file a claim for most facility services with BCBSNM. These claims are automatically submitted, by the Medicare Part A intermediary, to BCBSNM. An *Explanation of Benefits* will be sent to you by BCBSNM after Plan benefits have been determined. If you must file your own claim after Medicare pays its portion (for example, because services were received outside New Mexico), you must file the claim for services received from the hospital, along with Medicare's *Explanation of Medicare Benefits* form (EOMB), to **the local BCBS Plan.** (See instructions earlier in this section.)

Medicare-Covered Non-Facility Services — A claim for physician and other professional provider services must be filed **first** with Medicare Part B Medical Insurance. (All Medicare providers must file claims for you to Medicare.)

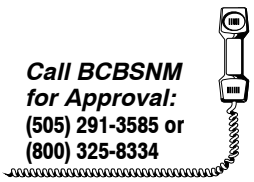
If you have given your LANS Medical Program ID card to your provider, the Medicare Part B carrier will send an electronic copy of the claim to BCBSNM **if services are received in New Mexico.** If Medicare does not have your LANS Medical Program ID number, you must file a copy of the EOMB and all other required claim information with BCBSNM after Medicare has sent an EOMB to you. Even though providers may file claims on your behalf, it is **your** responsibility to make sure that the claim is filed to BCBSNM. If you must file your own claim after Medicare pays its portion (for example, because services were received outside New Mexico), you must file the claim for services received from the hospital, along with Medicare's *Explanation of Medicare Benefits* form (EOMB), to **the local BCBS Plan.** (See instructions earlier in this section.)

Services Not Covered by Medicare — You may have to file your claim yourself. If your provider does not file a claim for you, you must submit a separate claim form for each family member. Submit all claims as the services are received. If a service is normally covered by Medicare, you must submit a copy of the EOMB (showing Medicare's denial reason) with the claim form that you send to BCBSNM.



When An EOMB is Not Required: An EOMB indicating Medicare denied the service is required on all claims except claims for:

- services received outside the Medicare territorial limits
- services from providers with whom you have privately contracted (BCBSNM will estimate what Medicare would have paid had you not privately contracted with the provider and had you submitted the claim to Medicare for payment.)
- services received from licensed professional clinical mental health counselors (LPCC) and licensed marriage and family therapists (LMFT). (However, you will need **preauthorization** from **BCBSNM** in order to receive benefits for covered mental health and chemical dependency services received from LPCC and LMFT providers.)



NOTE: If the services you intend to receive would be covered by Medicare if you were to obtain the service from a Medicare-eligible provider, you or your provider must call BCBSNM for **preauthorization** before receiving services from such a provider. This will verify that the services being planned will be or will not be covered under the Medical Program and if the services require additional

preauthorization from BCBSNM. If a Medicare provider is in your area and able to provide the services you need, you may be required to receive the service from a Medicare-eligible provider in order to receive benefits under the LANS Medical Program.

Services Outside Medicare Territorial Limits — When services are received outside the Medicare territorial limits, you must pay for the services or supplies. **Keep copies of your receipts.** File claims as you would for any other service not covered by Medicare. (Medicare defines *Medicare territorial limits* as the United States, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.)

If you receive covered services while outside the United States, call the BlueCard Worldwide Service Center, collect, at (804) 673-1177 for assistance with claims filing. Or visit the Blue Cross and Blue Shield Association Web site to locate nearby participating physicians and hospitals.

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

Claims Payment Provisions

After a claim has been processed, the subscriber will receive an *Explanation of Benefits* (EOB). The EOB indicates what charges were covered and what charges, if any, were not.

Qualified Medical Child Support Order — If a *Qualified Medical Child Support Order* (QMCSO) or a properly completed *National Medical Support Notice* (NMSN) is in effect and conforms to ERISA requirements, the QMCSO or NMSN provisions will be followed. For details, see the applicable *LANS Health and Welfare Benefit Plan for Employees/Retirees Summary Plan Description.*

Preferred Providers — Payments for covered services usually are sent directly to providers that contract with their local BCBS Plan. The EOB you receive explains the payment.

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

If You Have Medicare — The drug coverage provided under this Medical Program is creditable toward Medicare Part D drug coverage; therefore, persons covered under this Medical Program need not purchase Medicare Part D. However, if you are retired and eligible for Medicare, the EPO Medical Program provides benefits secondary to Medicare. In order to receive benefits under the Medical Program, you must be **enrolled** in both Parts A and B of Medicare. If you are a retiree or covered family member of a retiree, see the *LANS SPD* for important information about how your decision to enroll or not into Medicare will affect your

benefits and/or eligibility under this Medical Program. Also see *Section 3* for more information about how benefits are paid when Medicare is primary to this Medical Program.

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

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

Covered Charge — Provider payments are based upon provider agreements and covered charges as determined by BCBSNM. You are responsible for paying copayments, deductibles, coinsurance, any penalty amounts, and noncovered expenses. For covered services received in foreign countries, BCBSNM uses the exchange rate in effect on the date of service in order to determine billed charges.

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

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

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

- services for which a Medicare Allowable cannot be determined based on the information submitted on the claim (in such cases, the covered charge is 50 percent of the billed charge)
- home health claims (the covered charge is 50 percent of the billed charge)
- services administered and priced by any subcontractor of BCBSNM or by the Blue Cross Blue Shield Association
- claims paid by Medicare as primary coverage and submitted to this Medical Program for secondary payment
- New Mexico ground ambulance claims (for which the state's Public Regulatory Commission sets fares)

NOTE: Nonemergency services are generally **not covered** under EPO plans when received out-of-network from noncontracted providers. The pricing methods

above apply **only** when the claim for out-of-network services has been authorized for payment and does not satisfy any of the conditions below:

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
- covered claims priced by another BCBS Plan through BlueCard using local pricing methods
- services from noncontracted providers that satisfy at least one of the three conditions below and, as a result, are eligible for coverage under this EPO Medical Program:
  - covered services from noncontracted providers within the United States that are classified as "unsolicited" as explained in your benefit booklet and as determined by the member's Host Plan while outside the service area of BCBSNM
  - **preauthorized** transition of care services received from noncontracted providers
  - covered services received from a noncontracted anesthesiologist, pathologist, or radiologist while you are a patient at a **contracted** facility receiving covered services or procedures that have been preauthorized, if needed
- preauthorized services from noncontracted providers when eligible for benefits due to network availability issues as explained in *Section 3*

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

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

BlueCard Program — BCBSNM hereby informs you that other Blue Cross and Blue Shield Plans outside of New Mexico ("Host Blue") may have contracts with certain providers in their service areas. Under BlueCard, when you receive covered health care services outside of New Mexico from a Host Blue contracting provider that does not have a contract with BCBSNM, the amount you pay for covered services is calculated on the lower of:

- the billed charges for your covered services, or
- the negotiated price that the Host Blue passes on to BCBSNM.

Often, this "negotiated price" is a **simple discount** that reflects the actual price the Host Blue pays. Sometimes, it is an **estimated price** that takes into account special arrangements the Host Blue has with an individual provider or a group of providers. Such arrangements may include settlements, withholds, non-claims transactions, and/or other types of variable payments. The "negotiated price" may also be an **average price** based on a discount that results in expected average savings (after taking into account the same special arrangements used to obtain an estimated price). Average prices tend to vary more from actual prices than estimated prices.

Negotiated prices may be adjusted from time to time to correct for over- or under-estimation of past prices. However, the amount used by BCBSNM to calculate your share of the billed amount is considered a final price.

Laws in a small number of states may require the Host Blue to 1) use another method for, or 2) add a surcharge to, your liability calculation. If any state laws mandate other liability calculation methods, including a surcharge, BCBSNM would calculate your liability for any covered services according to the applicable state law in effect when you received care. Surcharges are not your responsibility.

Drug Plan Copayments — When the copayment for an item covered under the drug plan is greater than the covered charge for the supply being purchased from a participating pharmacy, you pay the **lesser** of: 1) your copayment, or 2) the pharmacy's retail price. For claims submitted to the drug plan administrator for reimbursement, you are paid the **lesser** of: 1) the sum of the drug ingredient cost, the dispensing fee that would be payable to a participating pharmacy, and any sales tax minus the applicable copayment, or 2) the pharmacy's retail price minus the applicable copayment.

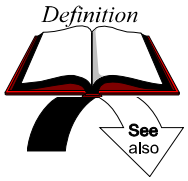
If you are a new member and need to fill a prescription at a participating pharmacy but have not yet received your ID card (and are unable to print a temporary ID card from the BCBSNM Web site), you must pay for the prescription in full and then submit a claim to Prime Therapeutics as instructed earlier in this section under "Filing Claims." **(Do not send these claims to BCBSNM.)** In these cases where you have been unable to establish your eligibility to the pharmacy at the time of purchase, the Medical Program will reimburse you the fulled billed amount less your copayment. This reimbursement policy will end after 45 days of enrollment or upon receipt of your ID card, whichever comes first.

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 judgement obtained by you when the facility has not been paid its total billed charges from all other sources.

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

If a Claim or Preauthorization Request 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 "Reconsideration Requests (Appeals)" below).

Reconsideration Requests (Appeals)



Claim — As used in this document, the term "claim" refers only to post-service bills for services already received and sent to BCBSNM (or its designee) for benefit determination.

For appeals related to eligibility, enrollment, and termination, contact LANS.

If you have an inquiry or a concern about a claim payment or denial or about a preauthorization request, call your Customer Service Advocate for assistance. Many complaints or problems can be handled informally by calling or writing BCBSNM Customer Service. If you make an oral complaint, a BCBSNM Customer Service Advocate will assist you.

Initial Informal Review of BCBSNM Decision/Complaint — If your request for claim payment or preauthorization has been denied in whole or in part, you may ask BCBSNM to informally review its benefit or preauthorization determination. Within **180 days** after you receive notice of a claim payment or denial on a claim or a preauthorization request, call or write to BCBSNM Customer Service and explain your reasons for disagreeing with the determination. You may also ask to see relevant documents and may submit written issues, comments, and additional medical information. Requests for review received more than 180 days following notification will not be considered unless you can satisfy BCBSNM that matters beyond your control prevented an earlier request for review.

Formal Reconsideration/Appeal Requests — A decision by BCBSNM to deny, in whole or in part, your request for preauthorization for services or claims for services you have already received is an "adverse determination." If you want to dispute an adverse determination made by BCBSNM related to coverage, reimbursement, or any other non-eligibility matter related to your Medical Program, you *may* (but are not required to) first seek clarification by calling or writing BCBSNM Customer Service as explained under "Initial Informal Review of BCBSNM Decision/Complaint," above. If you remain dissatisfied after discussing your concerns with BCBSNM Customer Service, you can appeal the adverse determination by requesting a reconsideration as described below.

Reconsiderations regarding claims payments or denials, preauthorization request decisions, or provider network issues are administered by BCBSNM. LANS administers appeals regarding eligibility and enrollment issues. (See "LANS Administrative Errors and Eligibility Escalation Appeals Process" later in this section.) You must participate in BCBSNM's formal reconsideration procedures (or, if applicable, in the appeals process for eligibility and enrollment issues administered by LANS) before seeking any remedies available to you under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

Your appeal may be in writing or verbal (you can request an appeal by calling and speaking to a Customer Advocate). Your appeal must be received within **180 days** from the date BCBSNM first notified you of the adverse determination or **your right to appeal is waived.** BCBSNM will provide you with one appeal level. With the exception of expedited appeals regarding preauthorization decisions, your request for appeal will be acknowledged in writing by BCBSNM within five days of receipt of your 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.** You, your legal guardian, agent, or your authorized representative may appeal on your behalf and represent you in the appeal process. You should include the following items with your appeal request:

- a copy of the *Explanation of Benefits* (EOB) and/or denial letter; *and*
- copies of related medical records from your provider; *and*
- any additional information from your provider in support of your appeal.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal and you will have access to all documents that are relevant to your claim or preauthorization request. Your appeal will be handled by a person who is different from – and not subordinate to – the person who made the initial decision. No deference will be given to the original decision.

Upon your request and free of charge, BCBSNM will provide you with copies of all documents, records, and other information relevant to your appeal as defined by ERISA.

If your appeal involves a medical judgment question, BCBSNM will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved and who is not subordinate to the person who made the initial adverse determination.

BCBSNM will acknowledge receipt of the request for reconsideration within five days of receipt and will thoroughly investigate the request.

If you appeal a BCBSNM determination *before* you actually receive the service **(standard pre-service appeal),** BCBSNM will notify you of the appeal decision within **30 days** of receipt of your appeal. A **15-day delay** may be needed to obtain medical records and other documents for review in the reconsideration.

Expedited Appeals: BCBSNM will notify you of its decision on confirmed **expedited appeals** no later than **72 hours** after receipt of your request. You should only request an expedited appeal if the absence of an expedited review would seriously jeopardize your life, health, or ability to gain maximum functioning; or subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. An expedited appeal request will be reviewed by a physician to evaluate whether it meets criteria for an expedited appeal. You will be notified of this initial decision by telephone and in writing. Expedited appeals should be submitted by calling or faxing your request to the Appeals Unit.

If you appeal a BCBSNM determination *after* you have received the services and BCBSNM has denied the claims **(post-service appeal),** BCBSNM will notify you of the appeal decision within **60 days** of receipt of your appeal. A **15-day delay** may be needed to obtain medical records and other documents for review in the reconsideration.

If your claim on appeal is denied in whole or in part, you will receive a written notification of the denial as required by ERISA.

BCBSNM Contacts — For appeals regarding medical/surgical preauthorizations and any post-service claims payment/denial decisions for any type of service, contact:

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

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

LANS Administrative Errors and Eligibility Escalation Appeals Process

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

External Appeal

Since this Medical Program is governed by the Employee Retirement Income Security Act of 1974 (ERISA), if you are still not satisfied after having completed the appeal process administered by BCBSNM and described above, or if applicable, the eligibility and enrollment appeal process administered by LANS and described in the *LANS SPD*, you may have a right to bring a civil action under ERISA Section 502(a).You may not take legal action to recover benefits under this Medical Program until 60 days after BCBSNM has received the claim or pre-authorization request in question. Also, you may not take any legal action after three years from the date that the claim in question must be filed with BCBSNM.

RETIREES ONLY: External Review Board

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

Request for Medicare Reconsideration

When Medicare Part A or B denies part or all of a claim, you can obtain from a local Social Security Office information on how to request reconsideration or re-

view of denied Medicare claims and a description of your right to appeal Medicare claims decisions. If Medicare makes an additional payment after reconsideration, file the new *Explanation of Medicare Benefits* (EOMB) form to BCBSNM for additional reimbursement under this Medical Program.

Retaliatory Action

BCBSNM and LANS shall not take any retaliatory action against you for filing an appeal under this Medical Program.

Summary of Appeals and Claims Procedures

Summary of Contact Information for Customer Service, Preauthorization, Claim Submission, and Appeal (or Reconsideration) Processes for Medical/Surgical Services, Behavioral Health Services, or Eligibility Issues:		
Process:	**Type of Service:**	**Send to:**
Request **preauthorization** or **benefit inquiry**	Medical/surgical	BCBSNM
	Mental health or chemical dependency	Behavioral Health Unit
Submit **claim** (post-service)	Medical/surgical	BCBSNM or local BCBS Plan
	Mental health or chemical dependency	BCBSNM or local BCBS Plan
Request **appeal** or reconsideration of an **eligibility** issue	Eligibility decisions, including terminations of coverage	LANS (see SPD)
Request **appeal** or reconsideration of **preauthorization** or **claim** decision	Medical/surgical	BCBSNM Appeals Unit
	Mental health or chemical dependency	BCBSNM Appeals Unit
External appeal of decision made by BCBSNM or LANS	Active employees and their covered family members	Civil action under ERISA Section 502(a)
	Retirees and their covered family members	External Review Board hearing OR civil action under ERISA Section 502(a)

Catastrophic Events

In case of fire, flood, war, civil disturbance, court order, strike, or other cause beyond BCBSNM's commercially reasonable control, BCBSNM may be unable to process claims or provide preauthorization for services on a timely basis. If due to circumstances not within the commercially reasonable 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.

10 When Group Coverage Ends

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

Conversion to Individual Coverage

Involuntarily terminated members may change to individual (direct-pay) conversion coverage if this LANS group health care plan is still in effect and coverage is lost due to one of the following circumstances:

- termination of employment
- a member no longer meets the eligibility requirements of LANS
- the period of continuation coverage expires (or you choose to convert before continuation expires)
- a family member loses coverage for one of the following reasons:
  - divorce or legal separation from the subscriber
  - disqualification of the member under the definition of an eligible spouse or eligible child (excluding domestic partnership dissolution)
  - death of the subscriber

The subscriber and any eligible family members *who were covered* at the time that group (or continuation) coverage was lost are eligible to apply for conversion coverage without a health statement. BCBSNM must receive your application for conversion coverage **within 31 days** after you lose eligibility under the group (or continuation) plan. **You must pay conversion coverage premiums from the date of such termination.**

Conversion coverage is **not** available in the following situations:

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

Medicare-Eligible Members — If you are entitled to Medicare, your conversion coverage option is limited to a Medicare Supplemental Plan administered by BCBSNM. Depending upon your age and if you request a different plan than the policy offered to you, a health statement may be required and a pre-existing conditions limitation may apply. (The options for members under age 65 are limited.) Call a Customer Service Advocate for the enrollment options available to you. The benefits and premiums for conversion coverage will be those available to terminated health care plan members on your coverage termination date. You will receive a new benefit booklet if you change to conversion coverage. (Some benefits of this Medical Program are not available under conversion coverage.) Contact a Customer Service Advocate for details.

11 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.

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.

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.

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

Independent Contractors

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

Member Rights and Responsibilities

As a member of a medical plan administered by BCBSNM, you have:

- a right to receive information about BCBSNM, its services, its network practitioners and providers and members' rights and responsibilities;
- a right to be treated with respect and recognition of your dignity and right to privacy;

- a right to a candid discussion with your treating provider of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage;
- a right to voice complaints or request appeals about BCBSNM decisions or the health care coverage it administers;
- a right to make recommendations regarding BCBSNM's member rights and responsibilities policies;
- a responsibility to supply information (to the extent possible) that BCBSNM and its network practitioners and providers need in order to provide care;
- a responsibility to follow plans and instructions for care that you have agreed on with your treating provider or practitioners; and
- a 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 LANS will periodically forward information to BCBSNM to administer the benefits of this Medical Program. You can inspect all records concerning your membership in this Medical Program during normal business hours given reasonable advance notice.

Research Fees

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

Sending Notices

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

12 Glossary

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 body for the prevention, cure, or correction of any disease, illness, injury, or pain.

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

Admission — The period of time between the dates 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. Benefits for such services may be coordinated with any additional health care coverage that applies after your termination date under this Medical Program.) Also see the exclusion for services received "Before Effective Date or After Termination Date of Coverage" in *Section 7* and "Benefit Limits" in *Section 3*.

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

Alcoholism treatment facility, alcoholism treatment program — An appropriately licensed provider of detoxification and rehabilitation treatment for alcoholism.

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

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

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis; *and*
- provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility; *and*

- does not provide inpatient accommodations; *and*
- is not a facility used primarily as an office or clinic for the private practice of a physician or other provider.

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

Benefit booklet — This document or evidence of coverage, which explains the benefits, limitations, exclusions, terms, and conditions of this health coverage.

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

Blue Cross and Blue Shield of New Mexico (BCBSNM) — The Claim Administrator of this EPO Medical Program, as selected by LANS. BCBSNM is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Cancer clinical trial — A course of treatment provided to a patient for the prevention of reoccurrence, early detection, or treatment or palliation 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 efficacious 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 from 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.

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

Chiropractic care — 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.

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 — The percentage of a covered charge that is your responsibility to pay. 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 applicable) has been met. See *Section 3* for details.

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 Medical Program's payment (provided in accordance with the provisions of the contract) plus the member's share (coinsurance, deductibles, copayments, etc.) as payment in full for covered services. Also see "Network provider (in-network provider)," later in this section.

Copayment — The fixed-dollar amount of a covered charge that you pay for many Preferred Provider services and visits, outpatient surgery, urgent care facility, and other specified services. See the *Summary of Benefits*. See *Section 3* for details.

Cosmetic — See the "Cosmetic Services" exclusion in *Section 7*.

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 Medical Program. For Medicare-covered services, the covered charge is Medicare's approved amount for assigned claims, or Medicare's limiting charge (or 115 percent of the Medicare-approved amount) for nonassigned claims. See "Claims Payment Provisions" in *Section 9*.

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 providers' claims payments for some covered services of noncontracted providers under this Medical Program. 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 Medical Program, and has paid for a service, the covered charge under this Medical Program 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 Medical Program 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 Medical Program. **Note:** Not all Medicare-covered services from nonparticipating providers are restricted by a Medicare limiting charge.

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

Covered services — Services or supplies that are listed in this benefit booklet, including any endorsements, addenda, or riders, for which benefits are provided.

Creditable coverage — Health care coverage through an employment-based group health 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.

Deductible — The amount of covered charges that you must pay each calendar year before this Medical Program begins to pay most of its share of covered charges you incur during the rest of the same calendar year. If the deductible amount remains the same during the calendar year, you pay it only once each calendar year, and it applies to all covered services you receive during that calendar year. See *Section 3* for details.

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

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

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

Diagnostic tests — 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 (DOM) 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 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.

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 begins.

Eligible family member — The subscriber's legal spouse, the subscriber's eligible child, or the subscriber's eligible domestic partner as defined in the *LANS SPD*.

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.)

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

Experimental, investigational, or unproven — See the "Experimental, Investigational, or Unproven Services" exclusion in *Section 7*.

Facility — A hospital (see "Hospital," on the next page) or other institution (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.

Good cause — Failure of the subscriber to pay the premiums or other applicable charges for coverage; a material failure to abide by the rules, policies, or procedures of this Medical Program; or fraud or material misrepresentation affecting coverage.

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

Group health plan — An employee welfare benefit plan as defined in Section 3(1) of the 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 dependents/covered family members (as defined under the terms of the Plan).

Health care professional — A physician or other health care practitioner, including a pharmacist, who is licensed, certified, or otherwise authorized by the state to provided health care services consistent with state law.

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

- brings skilled nursing 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,* 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 individuals 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 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.)

A hospital is not, other than incidentally, a skilled nursing facility, nursing home, custodial care home, health resort, spa, or sanatorium; is not a place for rest, the aging, or the treatment of mental illness, alcoholism, drug abuse, or pulmonary tuberculosis; ordinarily does not provide hospice or rehabilitation care; and is not a residential treatment facility. **Note:** A Christian Science Sanatorium will be considered a "hospital" if it is accredited by the Commission of Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

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

Inpatient services — Care provided while you are confined as an inpatient in a hospital or treatment center for at least 24 hours. Inpatient care includes partial hospitalization (a nonresidential program that includes from 3–12 hours of continuous psychiatric care in a treatment facility).

Involuntary loss of coverage — 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 cause.

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.

Massage therapy services — Manipulation of tissues with the hand or an instrument for therapeutic purposes.

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 Cesarean section. See "Maternity/Reproductive Services and Newborn Care" in *Section 5* 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 alcoholism or drug abuse. (Detoxification usually takes about three days in an acute care facility.)

Medical Program — The component of the LANS Health & Welfare Benefit Plan for Employees, ERISA Plan 501 or the LANS Health & Welfare Benefit Plan for Retirees, ERISA Plan 502 that provides coverage and/or reimbursement, as explained in this *EPO Medical Program Benefit Program Material,* for specified medical, surgical, mental health, chemical dependency, and prescription drug expenses. The Medical Program is a component of the overall "Plan."

Medical 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 web site 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 injury.

Medically necessary, medical necessity — 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 the Medical Program, and is determined by BCBSNM's medical director to meet all of the following conditions:

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

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.

Medicare-approved amount — The Medicare fee schedule amount upon which Medicare bases its payments. This amount may be less than the actual amount charged by the provider.

Medicare limiting charge — As determined by Medicare, the limit on the amount that a nonparticipating provider can actually charge a Medicare beneficiary. **Note:** Not all Medicare-covered services from nonparticipating providers are restricted by a Medicare limiting charge.

Medicare-participating provider — A health care provider or practitioner that accepts Medicare's approved amount as payment in full by accepting Medicare assignment. These providers have been approved by the Department of Health and Human Services of the United States for receiving Medicare payments.

Member — The enrollee (the subscriber or any eligible family member) who is enrolled for coverage and entitled to receive benefits under this Medical Program in accordance with the terms of the Administrative Services Agreement. Throughout this booklet, the terms "you" and "your" refer to each member.

Mental illness, 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 or illness does not include developmental disabilities, 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 (i.e., PPO, EPO, 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 Medical Program.

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

Nonpreferred Provider — A provider that does not have a **PPO** contract with BCBSNM, either directly or indirectly (for example, through another BCBS Plan). These providers may have "participating-only" provider or "HMO" provider agreements, but are **not** considered "preferred" and are **not** eligible for Preferred Provider coverage under your Medical Program – unless listed as an exception under "Benefit Exceptions for Nonpreferred Providers" in *Section 3* of this booklet. See "Provider," on the next page, and also see *Section 2* for details.

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.

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

Participating provider — Any provider that, for the service being provided, contracts with BCBSNM, a BCBSNM contractor or subcontractor, another Blue Cross Blue Shield (BCBS) Plan, or the national BCBS transplant network as a "participating" provider. A participating-only provider is **not** part of the PPO network and covered services receive from a participating-only provider are **not** eligible for benefits under the EPO Medical Program. See "Provider," below.

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 — A practitioner of the healing arts (doctor of medicine or osteopathy only) who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided. Also, a Christian Science Practitioner will be considered a "physician" under this Medical Program if such practitioner is approved and listed in the current issue of *The Christian Science Journal,* the official organ of The First Church of Christ, Scientist; and is providing treatment for a diagnosed illness or injury according to the healing practices of Christian Science.

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

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

Preauthorization — A requirement that you or your provider must obtain approval from BCBSNM before you are admitted as an inpatient and before you receive certain types of services. See *Section 4* for details.

Preferred Provider — See "Provider," below.

Pregnancy-related services — See "Maternity," earlier in this section.

Prosthesis 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 professional provider 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.
- **Practitioner, practitioner of the healing arts:** A physician or other health care practitioner, including (for example) a pharmacist, chiropractor, dentist or oral surgeon, optometrist, or registered nurse in expanded practice, or a podiatrist who is licensed, certified, or otherwise authorized by the state to provide health care services consistent with state law.
- **Preferred Provider:** Health care professionals and facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, the BCBS Association, or another BCBS Plan as "preferred" ("PPO") providers. These providers belong to the "Preferred Provider Network." An "HMO" or a "participating-only" provider is NOT a Preferred Provider under this Medical Program.
- **Transplant providers:** These providers have contracted with BCBSNM through the Blue Cross and Blue Shield Association to provide transplant services covered under this Medical Program. They belong to the "National Blue Distinction Transplant Network."
- **Participating pharmacies:** Retail suppliers that have contracted with BCBSNM or its authorized representative (i.e., Prime Therapeutics) to dispense prescription drugs and medicines, insulin, diabetic supplies, special medical foods, and enteral nutritional products covered under the drug plan portion of the Medical Program and that have contractually accepted the terms and conditions as set forth by BCBSNM and/or its authorized representative. They belong to the Retail Pharmacy Network.

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

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

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

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

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

Registered 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 — An institution that specializes in the treatment of mental illness, alcohol or drug abuse, or other related illness, provides residential treatment programs and is licensed in accordance with the laws of the appropriate legally authorized agency.

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

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

Routine newborn care — Care of a child immediately following his/her birth that includes: routine hospital nursery services, including alpha-fetoprotein IV screening; routine medical care in the hospital after delivery; pediatrician standby care at a C-section procedure; and services related to circumcision of a male newborn.

Routine patient care cost — For purposes of the cancer clinical trial benefit described under "Cancer Treatment, Chemotherapy, and Radiation Therapy" in *Section 5,* 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 provider of the drug (such drugs would be paid under the drug plan provision if eligible for coverage). **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 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.

Short-term rehabilitation — Occupational, physical, and speech therapy techniques that are medically necessary to restore and improve lost bodily functions following illness or injury. (This does not include alcoholism 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 drug abuse, mental disease, or tuberculosis, or for intermediate, custodial, or educational care.

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.

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

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

Subscriber — The individual whose employment is the basis for enrollment eligibility, or in the case of a direct-pay contract, the person in whose name the contract is issued. The term "subscriber" may also encompass other persons in a nonemployee relationship with the employer, group, or business if specified in the Administrative Services Agreement (e.g., retirees, COBRA members).

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

Summary of Benefits — The schedule beginning on page v (or, for retirees, on page viii) that defines your copayment and coinsurance requirements, deductible, out-of-pocket limit, and annual or lifetime benefit limits, and provides an overview of covered services.

Surgical services — Any of a variety of technical procedures for treatment or diagnosis of anatomical disease or 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.

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).

Notes

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 Los Alamos National Security (LANS) and Blue Cross and Blue Shield of New Mexico (BCBSNM) includes the following documents:

- this benefit booklet (or *Medical Benefit Program Material)* and any amendments, riders, or endorsements to it;
- the *LANS Health & Welfare Benefit Plan for Employees, ERISA Plan 501* or the *LANS Health & Welfare Benefit Plan for Retirees, ERISA Plan 502, Summary Plan Description (LANS SPD)* – whichever applies to you – and any *Summary of Material Modifications* to the *LANS SPD;*
- the enrollment/change form(s) for the subscriber and his/her dependents; and
- the members' identification cards.

In addition, LANS has important documents that are part of the legal agreement:

- the *Group Master Application* from LANS; and
- the *Administrative Services Agreement* between BCBSNM and LANS.

The above documents constitute the entire legal agreement between BCBSNM and LANS for these EPO Medical Program benefits. No agent or employee of BCBSNM has authority to change this *Medical Benefit Program Material* or waive any of its provisions. Receipt of this *Medical Benefit Program Material* (or "benefit booklet") and/or your participation in a Plan and any Benefit Programs offered under the Plan is not an implied contract and does not guarantee your employment or any rights or benefits under a Plan or Medical Benefit Program. Each Plan and the Benefit Programs offered to you are governed by federal law (known as ERISA), which provides rights and protections to Plan participants and beneficiaries.

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.* **Note:** LANS reserves the right to amend, modify, or discontinue each Plan or any Benefit Program under a Plan at any time. If that happens, LANS will notify you of those changes.

BlueCross BlueShield of New Mexico

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