



Provider Resource Guide

Introduction

UNM Health values your participation as a provider in its network. In an effort to make information about UNM Health more readily available, this document — the UNM Health Provider Resource Guide — is for your use.

This information is also posted on our UNM Health website: <http://unmhealth.org/>

- UNM Health is the medical coverage benefit designed for UNM and UNM Medical Group employees who receive their care at UNM.
- UNM Health members receive *care coordination* as part of their benefit, to assist with access to care within the UNM network of hospitals and physicians.
- UNM Health is focused on improving access to both primary care and specialty care at UNM, and will work with our members to expedite access within the system.
- To access Extended-Network providers (Blue Cross Blue Shield), members are **REQUIRED** to work with UNM Health provider teams to determine the medical necessity of accessing care outside UNM Health Tier 1 network, and obtain a Benefit Authorization.
- Prior Authorization is **NOT REQUIRED** to access specialty services within the UNM Health network.
- Prior Authorization is **NOT REQUIRED** to access urgent care or emergency room services.
- Out-of-state dependents, for example a college student, can see extended network out-of-state providers when notifying UNM Health.
- Blue Cross Blue Shield New Mexico is contracted to provide some services for UNM Health including claims administration.

Table of Contents

Contact Information	5
Schedule of Benefits	7
How the Plan Works	17
General Information/Medical Necessity	17
Provider Networks	17
Benefit Determination and Prior Authorization	19
Transitional Care	21
Health Management Programs	22
Covered Services	23
Accidental Injury/Urgent Care/Emergency Health and Trauma Services	23
Ambulance Services	24
Autism Spectrum Disorder	25
Clinical Trials	26
Clinical Preventive Services	27
Complementary Therapies (Limited: Acupuncture and Chiropractic)	28
Dental Services (Limited) Including TMJ/CMJ	29
Diabetes Services	30
Diagnostic Services	31
Durable Medical Equipment, Orthotic Appliances, Prosthetic Devices, Repair and Replacement, Surgical Dressing, Eyeglasses/Contact Lenses and Hearing Aids	32
Family Infant and Toddler (FIT) Program	34
Genetic Inborn Errors of Metabolism (IEM) Disorder	34
Home Healthcare Services/Home Intravenous Services and Supplies	35
Hospice Care	35
Hospital Admissions/Inpatient Services	36
Medical Evacuation Reimbursement	38
Mental Health, Alcoholism and Substance Abuse	38
Nutritional Support and Nutritional Supplements	39
Outpatient Medical Services	40
Provider/Practitioner Services	40
Covered Medications	41
Prescription Drugs (Express Scripts)	41
Radiological Services	41
Reconstructive Surgery	41

Therapy Services	42
Repatriation Reimbursement	43
Skilled-Nursing Facility Care	44
Smoking Cessation	44
Transplants	45
Women’s Health Care	45
Limitations and Exclusions	49
Limitations	49
Exclusions	50
Filing Claims	59
Claims Submission	59
Corrected Claims	59
Emergency Services or Out-of-Network Providers	59
Out-of-Network Services Claims	59
Prescription Drug Claims (Express Scripts)	60
How Payments are Made	60
Coordination of Benefits	60
Subrogation	62
Appeals and Grievances	62

Contact Information

Questions About	Contact
<p>ELIGIBILITY Initial enrollment, adding Dependents, qualifying change of status events, proof documentation, and eligibility rules</p>	<p>UNM Division of Human Resources Phone: 505-277-MyHR(6947) Website: http://hr.unm.edu</p>
<p>MEDICAL PLAN Plan coverage, benefit authorization, prior authorization, provider networks, billing, Explanations of Benefits, medical appeals and grievance procedures</p>	<p>UNM Health Customer Care: 505-925-2432 Or Toll free 1-844-866-2224 Website: http://unmhealth.org/</p>
<p>PRESCRIPTION DRUGS Pharmacy benefits, prior authorization of medications and pharmacy network</p>	<p>Express Scripts Customer Service: 1-800-232-6549 Web site: www.express-scripts.com</p>
<p>UNM HEALTH NETWORK Accessing services and care in the UNM Health Network</p>	<p>Customer Care: 505-925-2432 Or Toll free 1-844-866-2224 Website: http://unmmg.org/FindaDocUNMHealth Email: UNMHealthCustomerCare@unmmg.org</p>
<p>COBRA ADMINISTRATOR Continuation of coverage after participant and/or a Dependent are no longer eligible for coverage</p>	<p>Chard-Snyder Customer Service: 1-888-993-4646 Website: www.chard-snyder.com</p>

Schedule of Benefits

UNM Medical Plan Benefits and Coverage	UNM Health Network	Extended-Network (Benefit Determination Required) ⁽¹⁾	Out-Of-Network
ANNUAL PLAN YEAR DEDUCTIBLE (Deductible must be met for services subject to the deductible before benefits are paid)	Individual: \$600 Family: \$1,200		Individual: \$1,800 Family: \$3,600
ANNUAL PLAN YEAR OUT-OF-POCKET MAXIMUM (Includes: Medical Deductible, Coinsurance, AND Medical and Prescription Copayments)	Individual: \$3,000 Family: \$6,000		Individual: \$7,500 Family: \$15,000
ANNUAL AND MAXIMUM LIFETIME BENEFIT	Unlimited		
PRE-EXISTING CONDITION EXCLUSION	None		
PROVIDER/PRACTITIONER SERVICES Including:			
Non-specialist office visits (non-preventive)	\$25 ^(2,3) Co-pay per visit	\$30 ^(1,2,3) Co-pay per visit	40% ⁽⁵⁾ Coinsurance
Specialist office visits (non-preventive)	\$35 ^(2,3) Co-pay per visit	\$45 ^(1,2,3) Co-pay per visit	40% ⁽⁵⁾ Coinsurance
Outpatient surgery (In-Provider/Practitioner's office)	Included in office Co-pay	Included in office Co- pay	40% ⁽⁵⁾ Coinsurance
Allergy services • Testing and Extract • Injections Only (no office visit billed)	\$55 ^(2,3) Co-pay No Co-pay ⁽²⁾	\$55 ^(1,2,3) Co-pay No Co-pay ^(1,2)	40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance
Injections such as insulin, heparin and antibiotics	Included in office visit Co-pay	Included in office visit Co-pay	40% ⁽⁵⁾ Coinsurance
Infertility services – diagnosing only Non-specialist office visits	\$25 ^(2,3) Co-pay per visit	\$30 ^(1,2,3) Co-pay per visit	40% ⁽⁵⁾ Coinsurance
Specialist office visit	\$35 ^(2,3,6) Co-pay per visit	\$45 ^(1,2,3,6) Co-pay per visit	40% ^(5,6) Coinsurance

UNM Medical Plan Benefits and Coverage	UNM Health Network	Extended-Network (Benefit Determination Required) ⁽¹⁾	Out-Of-Network
HOSPITAL SERVICES – Inpatient Coverage includes: <ul style="list-style-type: none"> • Room and board • Newborn delivery and other hospital obstetrical services • In-hospital Provider/Practitioner visits, Surgeons, Anesthesiologist and other Inpatient services • Detoxification • Administration of blood/blood components 	10% ^(3,4,6,7) Coinsurance	30% ^(1,3,4,6,7) Coinsurance	40% ^(5,6,7) Coinsurance
MEDICAL SERVICES – Outpatient			
Surgeries ⁽¹⁾⁽⁷⁾ <ul style="list-style-type: none"> • Hospital/ASC Facility Fees • Professional Fees 	10% ^(3,4,6) Coinsurance 10% ^(3,4,6) Coinsurance	30% ^(1,2,3) Coinsurance 30% ^(1,3,4,6) Coinsurance	40% ^(5,6) Coinsurance 40% ^(5,6) Coinsurance
X-ray, laboratory, and diagnostic tests <ul style="list-style-type: none"> • Preventive • Non-preventive 	No Co-pay ⁽²⁾ No Co-pay ⁽²⁾	No Co-pay ^(1,2) No Co-pay ^(1,2)	Not Covered 40% ⁽⁵⁾ Coinsurance
Endoscopy	10% ^(3,4,6) Coinsurance	30% ^(1,3,4,6) Coinsurance	40% ^(5,6) Coinsurance
Colonoscopy (Non-preventive)	No Co-pay ⁽²⁾	No Co-pay ^(1,2)	40% ⁽⁵⁾ Coinsurance
Radiation therapy (Non-Surgical) <ul style="list-style-type: none"> • In Provider/Practitioner's office • Outpatient facility 	Office visit Co-pay ^(2,3,6) 10% ^(3,4,6) Coinsurance	Office visit Co-pay ^(1,2,3,6) 30% ^(1,3,4) Coinsurance	40% ^(5,6) Coinsurance 40% ^(5,6) Coinsurance
Chemotherapy <ul style="list-style-type: none"> • In Provider/Practitioner's office • Outpatient facility 	Office visit Co-pay ^(2,3,6) 10% ^(3,4,6) Coinsurance	Office visit Co-pay ^(1,2,3,6) 30% ^(1,3,4,6) Coinsurance	40% ^(5,6) Coinsurance 40% ⁽⁵⁾ Coinsurance
Computed Axial Tomography (CAT) Scans	10% ^(3,4,6) Coinsurance	30% ^(1,3,4,6) Coinsurance	40% ^(5,6) Coinsurance
Positron Emission Tomography (PET) Scans	10% ^(3,4,6) Coinsurance	30% ^(1,3,4,6) Coinsurance	40% ^(5,6) Coinsurance
Magnetic Resonance Imaging (MRI)	10% ^(3,4,6) Coinsurance	30% ^(1,3,4,6) Coinsurance	40% ^(5,6) Coinsurance
Nuclear Medicine	10% ^(3,4,6) Coinsurance	30% ^(1,3,4,6) Coinsurance	40% ^(5,6) Coinsurance
Sleep studies	10% ^(3,4,6) Coinsurance	30% ^(1,3,4,6) Coinsurance	40% ^(5,6) Coinsurance
Administration of blood/blood components	10% ^(3,4,6) Coinsurance	30% ^(1,3,4,6) Coinsurance	40% ^(5,6) Coinsurance
RECONSTRUCTIVE SURGERY	Usual copayment or coinsurance based on place of treatment and type of service ^(1,2,3,4,5,6,7,9)		

UNM Medical Plan Benefits and Coverage	UNM Health Network	Extended-Network (Benefit Determination Required) ⁽¹⁾	Out-Of-Network
EMERGENCY ROOM CARE Including trauma services	\$150 ^(2,3) Co-pay per visit	\$150 ^(2,3) Co-pay per visit	\$150 ^(2,3) Co-pay per visit
URGENT CARE	\$75 ^(2,3) Co-pay per visit	\$75 ^(2,3) Co-pay per visit	40% ⁽⁵⁾ Coinsurance
AMBULANCE SERVICES Includes: • Emergency or high risk Ground and Air ambulance • Inter-facility transfer services Ground and Air ambulance	Applies to In-Network Benefit	30% ^(3,4) Coinsurance No Co-pay ⁽²⁾	Applies to In-Network Benefit
CLINICAL PREVENTIVE SERVICES Includes: • Well child care including vision and hearing screening • Preventive physical exam • Adult and child immunizations • Office based health education • Family Planning Services • Colonoscopy	No Co-pay ^(2,8)	No Co-pay ^(1,2,8)	Not Covered
WOMEN'S HEALTH CARE			
Preventive Care Services • Well-woman visits to include adult and female-specific screenings • Mammograms • Cytological Screening (Pap tests) including screening for papillomavirus • Screening for gestational diabetes • Counseling for HIV and sexually transmitted diseases • Screening and counseling for interpersonal and domestic violence • FDA Approved Surgical sterilization procedures for women's sterilization • Contraceptive implant insertion/re-insertion fee • Contraception counseling • Breast feeding support, supplies and counseling ⁽⁸⁾	No Co-pay ^(2,8)	No Co-pay ^(1,2,8)	40% ⁽⁵⁾ Coinsurance
Non-preventive Non-specialist	\$25 ^(2,3) Co-pay per visit	\$30 ^(1,2,3) Co-pay per visit	40% ⁽⁵⁾ Coinsurance
Specialist (includes Perinatologist)	\$35 ^(2,3) Co-pay per visit	\$45 ^(1,2,3) Co-pay per visit	40% ⁽⁵⁾ Coinsurance
Obstetrical/Maternity/Prenatal and Postnatal care (excludes delivery)	\$25 ^(2,3) Co-pay for first visit. (Plan pays 100% thereafter)	\$30 ^(1,2,3) Co-pay for first visit. (Plan pays 100% thereafter)	40% ⁽⁵⁾ Coinsurance

UNM Medical Plan Benefits and Coverage	UNM Health Network	Extended-Network <i>(Benefit Determination Required)</i> ⁽¹⁾	Out-Of-Network
DIABETES SERVICES Office visit and Diabetes Education			
Non-specialist	\$25 ^(2,3) Co-pay per visit	\$30 ^(1,2,3) Co-pay per visit	40% ⁽⁵⁾ Coinsurance
Specialist	\$35 ^(2,3) Co-pay per visit	\$45 ^(1,2,3) Co-pay per visit	40% ⁽⁵⁾ Coinsurance
Diabetes supplies (If purchased through a Durable Medical Equipment Provider). Other Diabetic Supplies are covered under the Express Scripts Prescription Drug Benefit.	10% ^(3,4,6) Coinsurance	30% ^(1,3,4,6) Coinsurance	40% ⁽⁵⁾ Coinsurance
PRESCRIPTION DRUGS ^(2,3)	Administered by Express Scripts. Call Express Scripts at 1-800-232-6549.		
MENTAL HEALTH SERVICES • Outpatient • Inpatient/Partial Hospitalization	\$35 ^(2,3) Co-pay per visit 10% ^(3,4,6) Coinsurance	\$45 ^(1,2,3) Co-pay per visit 30% ^(1,3,4,6) Coinsurance	40% ⁽⁵⁾ Coinsurance 40% ⁽⁵⁾ Coinsurance
ALCOHOL AND SUBSTANCE ABUSE SERVICES			
Rehabilitation • Outpatient ⁽¹⁾ • Inpatient/Partial Hospitalization	\$35 ^(2,3) Co-pay per visit 10% ^(3,4,6) Coinsurance	\$45 ^(1,2,3) Co-pay per visit 30% ^(1,3,4,6) Coinsurance	40% ⁽⁵⁾ Coinsurance 40% ^(5,6) Coinsurance
Detoxification • Outpatient • Inpatient/Partial Hospitalization	\$35 ^(2,3) Co-pay per visit 10% ^(3,4,6) Coinsurance	\$45 ^(1,2,3) Co-pay per visit 30% ^(1,3,4,6) Coinsurance	40% ^(5,6) Coinsurance 40% ^(5,6) Coinsurance
REHABILITATION AND THERAPY SERVICES			
Cardiac rehabilitation (36 visits per Annual Plan Year)	\$35 ^(2,3,6) Co-pay per visit	\$45 ^(1,2,3,6) Co-pay per visit	40% ^(5,6) Coinsurance
Dialysis/Plasmapheresis/Photopheresis	10% ^(3,4,6) Coinsurance	30% ^(1,3,4,6) Coinsurance	40% ^(5,6) Coinsurance
Pulmonary rehabilitation (up to 24 visits per Annual Plan Year)	\$35 ^(2,3,6) Co-pay per visit	\$45 ^(1,2,3,6) Co-pay per visit	40% ^(5,6) Coinsurance
Short-term rehabilitation (up to 70 visits combined per Annual Plan Year) • Physical therapy • Occupational therapy • Speech and Hearing therapy	\$35 ^(2,3) Co-pay per visit	\$45 ^(1,2,3) Co-pay per visit	40% ⁽⁵⁾ Coinsurance

UNM Medical Plan Benefits and Coverage	UNM Health Network	Extended-Network (Benefit Determination Required) ⁽¹⁾	Out-Of-Network
AUTISM/APPLIED BEHAVIORAL ANALYSIS	Usual copayment or coinsurance based on place of treatment and type of service ^(1,2,3,4,5,6,7,9) (Autism related short-term rehabilitation services are subject to the combined 70 visit limitation listed above in the Short-term rehabilitation section)		
TRANSPLANTS	10% ^(3,4,6) Coinsurance	30% ^(1,3,4,6) Coinsurance	Not Covered
COMPLEMENTARY THERAPIES (Limited)			
Acupuncture treatment (20 visits per Annual Plan Year)	\$35 ^(2,3) Co-pay per visit	\$45 ^(1,2,3) Co-pay per visit	40% ⁽⁵⁾ Coinsurance
Chiropractic services (20 visits per Annual Plan Year)	\$35 ^(2,3) Co-pay per visit	\$45 ^(1,2,3) Co-pay per visit	40% ⁽⁵⁾ Coinsurance
SKILLED NURSING FACILITY⁽¹⁾ (Up to 60 days per Annual Plan Year)	10% ^(3,4,6) Coinsurance	30% ^(1,3,4,6) Coinsurance	40% ^(5,6) Coinsurance
HOME HEALTH CARE SERVICES/ HOME INTRAVENOUS SERVICE⁽¹⁾ Services provided by an RN, LPN and other specified specialist to include, but not limited to home IV services (up to 100 days per Annual Plan Year)	10% ^(3,4,6) Coinsurance	30% ^(1,3,4,6) Coinsurance	40% ^(5,6) Coinsurance
HOSPICE CARE	10% ^(3,4,6) Coinsurance	30% ^(1,3,4,6) Coinsurance	40% ^(5,6) Coinsurance
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND APPLIANCES Hearing Aids (for school-aged children under age 18 or 21 years of age if still attending high school). Up to \$2,200 every 36 months "per hearing-impaired ear"	10% ^(3,4,6) Coinsurance	30% ^(1,3,4,6) Coinsurance	40% ⁽⁵⁾ Coinsurance
EYEGASSES AND CONTACT LENSES Limited to the following: • Eyeglasses and contact lenses within 12 months following cataract surgery or for the correction of Keratoconus • Refraction eye exam associated with post-cataract surgery or Keratoconus correction	10% ^(3,4,6) Coinsurance 10% ^(3,4,6) Coinsurance	30% ^(1,3,4,6) Coinsurance 30% ^(1,3,4,6) Coinsurance	Not Covered Not Covered
DENTAL SERVICES (LIMITED)/ CMJ/TMJ	10% ^(3,4,6) Coinsurance	30% ^(1,3,4,6) Coinsurance	40% ⁽⁵⁾ Coinsurance

UNM Medical Plan Benefits and Coverage	UNM Health Network	Extended-Network <i>(Benefit Determination Required)</i> ⁽¹⁾	Out-Of-Network
FAMILY, INFANT AND TODDLER PROGRAM Family, Infant and Toddler Program (FIT): Medically Necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel as defined in NMAC Title 7, Chapter 30, Part 8 Health Family & Children Health Care Services.	No Co-pay ^(2,6)	No Co-pay ^(1,2,6)	Not Covered
	\$3,500 per Participant per Plan Year Maximum annual benefit Not applicable to any lifetime maximums or annual limits		

⁽¹⁾Benefit Determination is required prior to receiving services from an Extended Network Provider. Please work with your Primary Care Provider to obtain a Benefit Determination. Claims submitted without a Benefit Determination are subject to the Out-of-Network benefit level.

⁽²⁾Not Subject to the Deductible.

⁽³⁾Included in the UNM Health Network/Extended Network Out-of-Pocket Maximum.

⁽⁴⁾Subject to the UNM Health Network/Extended Network Deductible.

⁽⁵⁾Subject to the Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum.

⁽⁶⁾Prior authorization for medical necessity is required before receiving services. Please work with your Primary Care Provider to obtain prior authorization. Claims submitted without prior authorization are deemed an ineligible benefit.

⁽⁷⁾Each Inpatient or Outpatient facility visit will generate at least two claims; a facility claim and a professional claim, both will apply deductible and coinsurance.

⁽⁸⁾The Patient Protection and Affordable Care Act requires the UNM Medical to cover specific Preventive Care Services, including Women's Preventive Care Services, at no cost to participants when the services are provided by a UNM Health Network or In-Network Participating Provider. Though these specific services are covered at no charge, the provider may charge a co-payment or other applicable fees for other services provided during the office visit. Additionally, some covered Family Planning services, for example male vasectomies, continue to require some participant cost sharing. If you have questions regarding the Preventive Care Services that are covered under your plan, including Family Planning services, or your cost for these services, please refer to your PBB or contact the Customer Care Center.

⁽⁹⁾Patients are responsible for co-payments related to place of services, ancillary services, and additional procedures performed at the same time. Prior authorization rules still apply.

Exclusions for UNM Medical Plan

Any exclusion listed would not be applicable, if covered under, the FIT Program in accordance with that which is defined in NMAC Title 7, Chapter 30, Part 8 Health Family & Children Health Care Services.

Refer to your Participant Benefit Booklet for details.

- Any service, treatment, procedure, facility, equipment, drugs, drug usage, device or supply determined to be **not Medically Necessary** or accepted medical practice. This includes any service, which is not generally recognized by the medical community as conforming to accepted medical practice, or any service for which the required approval of a government agency has not been granted at the time the service is provided.
- **Alternative/complementary therapies** except as specified in the Covered Services Section under “Complementary Therapies” of the *Participant Benefit Booklet*.
- **Artificial aids** including speech synthesis devices (except items identified as being covered in the Covered Services Section under “Durable Medical Equipment” in the *Participant Benefit Booklet*.)
- **Athletic trainers**
- **Autopsies and/or transportation costs** for deceased Participants, excepts as outlined in the Covered Section under “Repatriation Reimbursement.”
- **Baby food** (including baby formula or breast milk) or other regular grocery products that can be blenderized for oral or tube feedings.

BEHAVIORAL HEALTH SERVICES:

- **Halfway houses**
- **Residential Treatment Centers**
- **Co-dependency treatment**
- **Counseling** – sex, pastoral/spiritual, and bereavement counseling
- **Psychological testing** when not Medically Necessary
- **Special education**, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary problems. This applies whether or not associated with manifest mental illness or other disturbances except as Covered under the Family, Infant and Toddler Program. Refer to the *Participant Benefit Booklet* for more information.

BENEFITS AND SERVICES NOT SPECIFIED AS COVERED

- **Biofeedback**
- **Cancer Clinical Trials** must be provided for in the State of New Mexico **in accordance with the provisions set forth in the *Participant Benefit Booklet***. Refer to your *Participant Benefit Booklet* for details.
- **Care for conditions which state or local law requires** be treated in a public or correctional facility.
- **Care for military service connected disabilities** to which the Participant is legally entitled and for which facilities are reasonably available to the Participant.
- **Charges that are determined to be unreasonable by PHP and charges in excess of Reasonable and Customary Charges.**
- **Circumcisions** performed other than during the newborn’s Hospital stay, unless Medically Necessary.
- **Clothing or other protective devices** including prescribed photo protective clothing, windshield tinting, lighting fixtures and/or shields, and other terms or devices whether by prescription or not.
- **Common disposable medical supplies** that can be purchased over the counter such as, but not limited to, bandages, band aids, gauze (such as 4 by 4’s), and ace bandages, except when provided in a Hospital or Physician’s office or by and home health professional.
- **Convenience items** as listed in the Exclusions Section under “Convenience items of the *Participant Benefit Booklet*.”
- **Corrective eyeglasses** or sunglasses, frames, lens prescriptions, contact lenses or fitting thereof, except as identified in the Covered Services Section under “Durable Medical Equipment” of the *Participant Benefit Booklet*.
- **Cosmetic Surgery, treatments, devices, orthotics, and medications**, including treatment of hair loss as listed in the *Participant Benefit Booklet*.
- **Costs for extended warranties** and premiums for other insurance coverage.

- **Court ordered evaluation or treatment** or treatment that is a condition of parole or probation or in lieu of sentencing, such as Alcohol or Substance Abuse programs and/or psychiatric evaluation or therapy.

- **Custodial or domiciliary or Respite care**

DENTAL SERVICES:

- **Dental care** and dental ex-rays except as provided in the *Participant Benefit Booklet*
- **Dental implants**
- **Malocclusion treatment**, if part of routine dental care and orthodontics
- **Orthodontic appliances, endodontics, dental prosthetics, crowns, bridges, and dentures**
- **Orthodontic appliances** and orthodontic treatment (braces), crowns, bridges and dentures used for the treatment of Craniomandibular and Temporomandibular Joint disorders, unless the disorder is trauma related

DURABLE MEDICAL EQUIPMENT:

- **Duplicate Durable Medical Equipment items** (i.e., for home and office)
- **Foot orthotics**, functional and/or customized except as described in the *Participant Benefit Booklet*.
- **Upgraded or deluxe Durable Medical Equipment**
- **Additional wheelchairs**, if the Participant has a functional wheelchair, regardless of the original purchaser of the wheelchair.
- **Repair or replacement of Durable Medical Equipment**, Orthotic Appliances and Prosthetic Devices due to loss, neglect, misuse, abuse, to improve appearance or convenience.
- **Repair and replacement** of items under the manufacturer or supplier's warranty.
- **Elastic support hose**
- **Elective abortions** after the 24th week of pregnancy
- **Elective Home Birth** and any prenatal or postpartum services connected with an elective home birth.
- **Emergency facility** used for non-emergent services
- **Exercise equipment and videos**, personal trainers, club membership and weight reduction programs.

- **Experimental or Investigational**, as determined by PHP, drugs, medicines, treatments, or procedures as listed in the Exclusions Section under "Experimental or Investigational" of the *Participant Benefit Booklet*.

- **Extracorporeal shock wave therapy** involving the musculoskeletal system.

- **Foot care (routine)**, except as provided in the *Participant Benefit Booklet*.

- **Genetic Inborn Errors of Metabolism** as listed in the *Participant Benefit Booklet*.

- **"Get acquainted"** visits without physical assessment or diagnostic or therapeutic intervention provided.

- **Gloves**, unless part of a wound treatment kit.

- **Hair loss** (or baldness) treatments, medications, supplies and devices including wigs, and special brushes.

- **Hearing aids** and the evaluation for the fitting of hearing aids except for school-aged children under 18 years old (or under 21 years of age if still attending high school).

- **Home sleep studies**

HOSPICE BENEFITS ARE NOT AVAILABLE FOR THE FOLLOWING SERVICES

- **Food, housing, and delivered meals;** or
- Volunteer services; or
- **Comfort items** such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those Covered under Durable Medical Equipment benefits); or
- **Homemaker and housekeeping services;** or
- **Private duty nursing;** or
- **Pastoral and spiritual counseling;** or
- **Bereavement counseling**

- **Hypnotherapy**

- **Infant formula**

INFERTILITY/ARTIFICIAL CONCEPTION:

- **Artificial insemination**
- **Donor sperm**
- **In-vitro, GIFT and ZIFT fertilization**
- **Lay midwife** – Services of a lay midwife or an unlicensed midwife. (Services of a certified lay midwife in an inpatient facility are covered)

- **Massage Therapy**
 - **Medical and Hospital services of a donor** when the recipient of an organ transplant is not a Participant or when the transplant procedure is not covered.
 - **Nutritional supplements** unless for prenatal care as prescribed by the attending Physician or as sole source of nutrition.
 - **Organ transplants (Non-human)**, except for porcine (pig) heart valve.
 - **Orthopedic or corrective shoes**, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints except for patients with diabetes or other significant neuropathies.
 - **Personal or comfort items, services or treatments**
 - **Photopheresis** for all conditions other than mycosis fungoides.
 - **Physical examinations**, vaccinations, drugs and immunizations for the primary intent of medical research or non-Medically Necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, flight, travel, passports or functional capacity examinations related to employment.
 - **Private-duty nursing**
 - **Reversals of voluntary sterilization**
 - **Rolfing**
 - **Routine foot care, except** as listed in the *Participant Benefit Booklet*.
 - **Services for which the Participant or Dependent is eligible under any governmental program** (except Medicaid) or services for which, in the absence of any health service plan or insurance plan, no charge would be made to the Participant or Dependent.
 - **Services**, other than Emergent or urgent in nature, received **outside of the United States**.
 - **Services requiring Benefit Certification** when Benefit Certification was not obtained.
 - **Sex transformation surgery and drugs** relating to sex transformations.
 - **Sexual dysfunction treatment**, including medication, counseling, and clinics except for penile prosthesis as provided in the *Participant Benefit Booklet*.
 - **Storage of banking** of sperm, ova (human eggs), embryos, zygotes, or other human tissue.
 - **“Telephone visits”** by a Provider/Practitioner or “environmental intervention” or “consultation” by telephone for which a charge is made to the patient.
 - **Transportation costs** for deceased Participants except as outlined in the Covered Services Section under “Repatriation Reimbursement” of the *Participant Benefit Booklet*.
 - **Travel and lodging expenses**, except as provided in the *Participant Benefit Booklet*.
- VISION SERVICES:**
- **Eye movement therapy**
 - **Eye refractive procedures** including radial keratotomy, laser procedures and other techniques
 - **Routine vision care and Eye Refractions** for determining prescriptions for corrective lenses, except as listed as Covered in the *Participant Benefit Booklet*.
 - **Visual training**
 - **Vocational Rehabilitation services and Long-Term Rehabilitation services.**
 - Medical and surgical services for **weight management** except as listed as Covered in the *Participant Benefit Booklet*.
 - Treatment and medications for the purpose of **weight reduction** or control
 - **Work-related accidents** or injuries or occupational illness or disease if the Participant is required to be covered under workers’ compensation insurance, whether or not such coverage actually exists.
 - **Please refer to the *Participant Benefit Booklet* for a more complete description of exclusions and limitations.**
 - This Schedule of Benefits and services is subject to the provisions of the contract and cannot modify or affect the *Participant Benefit Booklet* in any way; nor shall you accrue rights because of any statement in or omission from this Schedule.

How The Plan Works

General Information

MEDICAL NECESSITY

This benefit Plan helps pay for healthcare expenses that are medically necessary and specifically listed in the *Covered Services* section of the UNM Health Participant Benefit Booklet.

- “Medical Necessity” or “Medically Necessary,” means appropriate or necessary services as determined by a Provider/Practitioner, in consultation with UNM Health. These necessary services are provided to a Participant for any covered condition requiring medical care, according to generally accepted principles of good medical practice guidelines developed by the federal government, national or professional medical societies, boards, and associations, or any applicable clinical protocols. These services are also determined according to guidelines developed by UNM Health, consistent with such federal, national and professional practice guidelines for the diagnosis or direct care and treatment of an illness, injury, or medical condition. These necessary services are **not** services provided only as a convenience.

The fact that a Provider/Practitioner has prescribed, ordered, recommended or approved a healthcare service or supply does not make it medically necessary, even if it is not specifically listed as an exclusion.

- “Covered Services” means only those healthcare expenses that are expressly listed and described by this Plan.

UNM Health, the third party administrator (TPA) acting on UNM’s behalf, determines whether a healthcare service or supply is a Covered Service. The fact that a Provider/Practitioner has prescribed, ordered, recommended, or approved a healthcare service or supply does not guarantee that it is a specifically covered service, even if it is not listed as an exclusion.

Covered Services are subject to the following:

- The **Limitations, Exclusions**, and other provisions of the Participant Benefit Booklet.
- **Payment by the Participant** of the Co-payment, Deductible, or Coinsurance amount, if any, directly to the Provider/Practitioner of healthcare services at the time services are rendered.

Provider Networks

UNM Health is a medical benefit plan and coordinated care model in which a primary care team coordinates care and facilitates referral processes within the UNM Health Network for specialty care, and facilitates any required Benefit Determinations and prior authorizations for services external to UNM Health System. Refer to the UNM Health’s online Provider Directory for a list of UNM Health Network providers. The UNM Health Provider Directory is available at <http://unmhealth.org/>, using the “Provider Finder” link. Providers can also contact the UNM Health Customer Care Center.

As a Provider of the UNM Medical Plan, we ask that you carefully follow all procedures and conditions for obtaining in-network care for participants, as is medically appropriate. Certain procedures, described in this Provider Resource, require prior authorization. **In-Network Providers (UNM Health Network) must obtain this prior authorization before providing these services to participants. Participants are responsible** for ensuring that Extended-network or Out-of-Network Providers have obtained a Benefit Determination and Prior Authorization when required.

3-Network Points of Service (POS): Three Networks of Benefits

UNM HEALTH NETWORK

- UNM Health System providers and facilities include UNM Hospitals and associated clinics, ABQ Health Partners, Sandoval Regional Medical Center, UNM Medical Group clinics, and First Choice Community Health clinics. There are additional healthcare providers in-network, as well as home care, laboratories, and DME providers. **Please refer to : <http://unmhealth.org/> for a full list of Network providers.** Participants pay lower co-payments and coinsurance amounts when they access the UNM Health Network.

EXTENDED-NETWORK

- Extended-Network providers include, facilities, and pharmacies that are contracted with Blue Cross Blue Shield of New Mexico.
- Access to Extended-Network providers and facilities within New Mexico requires a Benefit Determination from UNM Health.
 - **If care or services are available within the Tier 1 network , and timely, a referral to Tier 2 providers will not be approved for Extended-Network benefit.**
- Failure to obtain a Benefit Determination before accessing the Extended-Network providers and facilities will result in services being covered at the Out-of-Network level of benefit.

PROVIDERS OUTSIDE NEW MEXICO

- Services provided by Extended-Network Providers outside of New Mexico will be administered at the Extended-Network benefit level and subject to Deductibles, Coinsurance, and Co-payments listed in the *Schedule of Benefits*, provided the following conditions are met:
 - Participants receive a Benefit Determination from UNM Health. If a Benefit Determination is not obtained, services will be subject to the Out-of-Network level of benefit listed on the *Schedule of Benefits*.
 - Participants work with the provider to ensure prior authorization requirements are met. If a prior authorization is required and not obtained, services will not be covered and participants will be responsible for the entire cost of the services received.
- **If participants travel outside of New Mexico and require urgent or emergency care, they may utilize Extended-Network providers WITHOUT the requirement of a Benefit Determination.**
- **Dependents who reside outside of New Mexico (either temporarily or permanently) may utilize Extended-Network providers without meeting the requirements of a Benefit Determination when they notify UNM Health BEFORE receiving services.**

OUT-OF-NETWORK

Note: Participants are responsible for obtaining any required Prior Authorizations BEFORE to receiving services from Out-of-Network Providers, Practitioners, and/or facilities.

- Services received from providers and/or facilities that are not in the UNM Health Network or not contracted with UNM Health.
- Payments by the Plan for *Covered Services* will be limited to Reasonable and Customary Charges.
- Participants will be responsible for any balance due above the Reasonable and Customary Charges, in addition to any applicable Deductibles or Coinsurance. Reasonable and Customary Charges are defined in the *Glossary of Terms* section of this PBB.
- If an Extended-Network Provider/Practitioner recommends or refers a participant to an Out-of-Network Provider/Practitioner, services from that Out-of-Network Provider/Practitioner are subject to the Out-of-Network benefits as shown in the *Schedule of Benefits*.
- Out-of-Network Providers/Practitioners may require participants to pay them directly at the time of service. Participants will then have to file their claim for reimbursement with the Blue Cross Blue Shield of New Mexico Claims Office.
- Some services are not covered when received from Out-of-Network Providers/Practitioners. Please refer to the *Schedule of Benefits (above)*, and elsewhere in these pages, throughout this Provider Resource for a complete listing of *Covered Services*.
- Covered services will not be eligible at the In-Network level of benefits if the participant chooses to use a Provider/Practitioner outside of New Mexico for the express purpose of receiving medical treatment, without a Benefit Determination.

Benefit Determination And Prior Authorization

Benefit Determination is the process whereby UNM Health reviews and approves, in advance, the provision of certain *Covered Services* to Participants before those services are rendered. If a required Benefit Certification is not obtained for services/providers in the Tier 2 Extended Network, the benefit will pay at the Out-of-Network (Tier 3) benefit level.

Prior Authorization means that the TPA approves the services as **medically necessary**, per standard criteria, BEFORE the services are performed. If a required prior authorization is not obtained for Out-of-Network (Tier 3) services/providers, the Participant may be responsible for the resulting charges. Services rendered beyond the scope of the prior authorization may not be covered.

WHAT IS REQUIRED?

Certain services and supplies are covered only with prior authorization. Prior authorization means the TPA or the TPA's delegated vendor approves as medically necessary, the provision of certain *Covered Services* to Participants BEFORE those services are rendered. **If services requiring prior authorization are received from Out-of-Network Providers/Practitioners and prior authorization was not obtained, the participant will be responsible for the resulting charges.** Services rendered beyond the scope of **prior authorization** are **not covered**.

WHO IS RESPONSIBLE?

Prior authorization of services or supplies rendered by UNM Health Network is the responsibility of the UNM Health Network. Participants will not be liable for charges resulting from the failure of the UNM Health Network Provider/Practitioner to obtain such required prior authorization. All prior authorizations are provided by a Medical Director or the Medical Director's designee at the TPA.

Blue Cross and Blue Shield of New Mexico: Participants are responsible for ensuring Benefit Determination and prior authorization requirements are met prior to receiving services from an Extended Network provider. BCBSNM providers should request a Benefit Determination when participants request services.

When accessing Out-of-Network benefits, participants are responsible for ensuring any necessary prior authorizations have been obtained prior to receiving the Out-of-Network services. **If prior authorizations are not obtained when required, the services will not be covered by the Plan.**

OBTAINING PRIOR AUTHORIZATION

For prior authorization, complete the Prior Authorization Request Form located on our website, <http://UNMHealth.org>, Provider Resources link. Prior authorization may also be requested by calling the prior authorization phone number listed on the back of the member's ID card or UNM Health Customer Care at 505-925-2432.

If you are faxing or mailing in a request, please submit the completed form along with your supporting documentation. The medical management staff will:

- Evaluate the request using MCG (formerly Milliman) criteria and medical policy as indicated.
- Assign a reference number.

You will receive a response within five business days of receiving the request (within 72 hours for urgent care requests).

Note: Prior authorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if prior authorization is approved for treatment of a particular service, that authorization applies only to the medical necessity of treatment. **All services are subject to benefit limitations and exclusions.**

WHAT SERVICES AND SUPPLIES REQUIRE PRIOR AUTHORIZATION?

The prior authorization process and requirements are regularly reviewed and updated based on various factors, including medical trends, Provider/Practitioner participation, state and federal regulations, and the UNM Health's own policies and procedures related to the Plan. A detailed list of services requiring prior authorization, including codes, is posted on our website under the Provider Resources link, <http://unmhealth.org>. If a participant receives the following services from either an Extended-Network or an Out-of-Network Provider, *the participant is responsible for ensuring the Provider/Practitioner requests prior authorization from the TPA*, or the participant may be required to request prior authorization:

- Autism Spectrum Disorder
- Clinical Trials (Investigational/Experimental) as specified in the *Covered Services* section
- CT scans
- Custom ankle-foot orthosis for Participants ages 9 and older, restricted to diabetes services
- Durable Medical Equipment (certain service/equipment may require Preauthorization; contact your TPA for a complete list.) Durable Medical Equipment includes, but not limited to:
 - Bone growth stimulators
 - Communication devices
 - CPAP/BiPAP
 - High frequency chest compression
 - Hydraulic lift
 - Insulin pump
 - Lift chair
 - Mattress and mattress overlay, active (Dynamic)
 - Microchip limb (Robotic Limb)

- Seat cushions, alternating pressure support
- Any requests for Durable Medical Equipment that exceed the industry definition of “standard” in excess of \$1,000. Examples, not limited to: custom wheelchairs and electric/motorized scooters or wheelchairs
- Foot Orthotics, as specified in the *Covered Services* section under Durable Medical Equipment
- Genetic Testing and Counseling
- Genetic Inborn Errors of Metabolism treatment
- Home health services/home health intravenous drugs
- Hospice Care
- Hospital admissions, Inpatient/non-emergency
- Injectable drugs
- Medical detoxification
- Mental Health services (Inpatient)
- MRIs and MRAs
- Nuclear Medicine
- Organ transplants
- PET (Positron Emission Tomography) scans
- Prosthetics
- Reconstructive and potentially cosmetic procedures
- Skilled-nursing facility care
- Substance Abuse services, Inpatient
- Uterine monitoring, home.

If a request for prior authorization is made and not approved, you and the participant will be notified of the adverse determination by telephone (or as required by the medical exigencies of the case), within 24 hours after making the determination. You and the participant will also be notified of the adverse determination by written or electronic communication sent within one working day of a telephone notice.

Please see the “*Filing Claims*” section under “*Appeal and Grievance Procedures*” for information regarding the request for review of any adverse determination.

Transitional Care

Certain Covered Expenses may be paid at the applicable Participating Provider benefit level if the Participant is currently under a treatment plan by a Physician or other health care provider or facility that was a member of this Plan’s previous Network, but who is not a member of this Plan’s current Network. In order to ensure continuity of care for certain medical conditions already under treatment, the Participating Provider benefit level may continue for 180 days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

1. Cancer, if under active treatment with chemotherapy and/or radiation therapy.
2. Organ transplant patients, if under active treatment (such as seeing a Physician on a regular basis, being on a transplant waiting list, being ready at any time for transplant).
3. If the Participant is inpatient in the Hospital on the effective date.
4. Post-acute Injury or Surgery within the past three months.
5. Pregnancy in the second or third trimester and up to eight weeks postpartum.

6. Behavioral health – any previous treatment.
7. HIV/AIDS – any previous treatment.

The participant or dependents must call the TPA prior to the effective date, or within four weeks after the effective date, to see if they are eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, minor illnesses and elective surgical procedures will not be covered by transitional level benefits.

Health Management Programs

UNM Health works with participants and their doctors to help enhance quality of life by providing support for staying healthy, living with illness, and getting better. If you would like more information for your patients, please contact UNM Health's Customer Care Center at 505-925-2432.

WELLNESS

Nuvita Live Younger wellness program is a 12-week program with live coaches and a personal fitness monitor. It will be offered to a limited number of members on a first-come, first-serve basis. Program registration will be in July 2016.

24/7 NURSE ADVICE

Telephone advice from a New Mexico registered nurse is available 24 hours a day, 365 days a year at NurseAdvice New Mexico, toll-free at 1-877-725-2552. For hearing-impaired/TTY assistance, call 1-800-659-8331. NurseAdvice New Mexico also answers our UNM Health customer care phone line during non-business hours to provide UNM Health members with information regarding their health benefits.

CONDITION MANAGEMENT

Asthma, Coronary Artery Disease, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and Diabetes programs offer education, coaching and help in monitoring these conditions. Registered nurses or other health care professionals help your patient set goals, adopt healthier habits, and learn to better manage their medical conditions.

CASE MANAGEMENT

Registered nurse case managers and care coordinators help members understand their benefits, assist in coordinating care, and help members cope when experiencing a serious illness or injury.

SPECIAL BEGINNINGS®

Participating in this maternity program from early pregnancy through six weeks after delivery will help members manage and understand their pregnancy using educational materials and support, pregnancy risk factor identification, ongoing communication and monitoring, and access to an online resource center.

TOBACCO CESSATION AND WEIGHT MANAGEMENT PROGRAMS

These programs are available for members who would like personal coaching and support to help quit smoking or lose weight.

Covered Services

Accidental Injury, Urgent Care, Emergency Health, And Trauma Services

URGENT CARE

Urgent Care means Medically Necessary medical or Surgical procedures, treatments, or health care services received in an Urgent Care facility or other Provider/Practitioner's office for a condition that is not life threatening, but requires prompt medical attention to prevent a serious deterioration in a Participant's health.

The Plan will reimburse for all services rendered that satisfy this definition, unless otherwise limited or excluded in this PBB.

EMERGENCY HEALTH SERVICES

This Plan covers acute Emergency Health Services Emergency Health Services 24/7 hours per day, 7 days per week, when those services are needed immediately to prevent jeopardy to a Participant's health.

Benefits for the initial treatment are paid at the In-Network benefit level, regardless of whether Emergency Health Services are administered by an Extended-Network or Out-of-Network Provider/Practitioner.

If a participant is hospitalized within 48 hours of Emergency Health Services, the entire hospitalization will be considered part of the initial treatment. The Emergency Room Co-pay is waived and the participant is responsible for the appropriate admission Coinsurance. Once discharged, follow-up care received through an Out-of-Network Provider/Practitioner will be paid at the Out-of-Network benefit level.

If, as a result of Emergency Health Services, the participant is admitted to an Out-of-Network Hospital, services will be provided at the UNM Health-Network benefit level until the participant is medically stable and a safe transfer can be arranged to a Hospital participating in the TPA's network, where the participant will continue to receive benefits at the UNM Health-Network benefit level. If the participant's condition is stabilized and he or she chooses to remain at the Out-of-Network Hospital, services will then be paid at the Out-of-Network benefit level.

The TPA will provide reimbursement when the participant, acting in good faith, obtains Emergency Health Services for what reasonably appears to the participant, acting as a reasonable layperson, to be an acute condition that requires immediate medical attention, even if the condition is subsequently determined to be non-emergent.

In determining whether the participant acted as a "reasonable layperson" as described above, the TPA will consider the following factors:

- A reasonable person's belief that the circumstances required immediate medical care that could not wait until the next working day or the next available appointment.
- The time of day the care was provided.
- The presenting symptoms.
- Any circumstance that prevented the participant from using established procedures for obtaining Emergency Health Services

Prior authorization is not required for Emergency Health Services.

For Emergency Health Services, the participant may seek Emergency Health Services from the nearest appropriate facility where Emergency Health Services can be rendered. These services will be covered as In-Network Services. Non-emergent follow-up care received from an Out-of-Network Provider/Practitioner is covered as Out-of-Network service(s).

All Emergency Health Services, Urgent Care, and Trauma Care services are subject to the limitations listed in the *Limitations* section of this document and the *Exclusions* listed in the Exclusions section of this PBB.

OBSERVATION SERVICES

Observation Services are defined as Outpatient services furnished by a Hospital and Provider/Practitioner on the Hospital's premises. These services may include the use of a bed and periodic monitoring by a Hospital's nursing staff, which are reasonable and necessary to evaluate the participant's condition, determine the need for possible admission to the Hospital, or where rapid improvement of the participant's condition is anticipated or occurs. When a Hospital places the participant under Outpatient observation, it is on the Providers/Practitioners written order. To transition from Observation Services to an Inpatient admission, the participant must meet the Level of Care criteria used by the TPA. The length of time spent in the Hospital is not the sole factor determining Outpatient Observation Services versus Inpatient Hospital stays.

Ambulance Services

The following types of Ambulance Services are covered: Emergency Ambulance Services, High-Risk Ambulance Services and Inter-Facility Transfer Services.

Emergency Ambulance Services are defined as ground or air Ambulance Services used if a participant requires Emergency Health Services, under circumstances that would lead a reasonable layperson acting in good faith to believe that transportation in any other vehicle would endanger the patient's health. Emergency Ambulance Services are covered only under the following circumstances:

- Within the TPA's service area, to the nearest Participating Hospital where emergency medical treatment can be rendered, or to an Out-of-Network Hospital if a Participating Hospital is not reasonably accessible. Such services must be provided by a licensed Ambulance Service in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.
- Outside the TPA's service area, to the nearest appropriate facility where emergency medical treatment can be rendered. Such services must be provided by a licensed ambulance service, in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.
- UNM Health will not pay more for air ambulance transportation than it would have paid for transportation over the same distance by ground transportation services, unless the participant's condition renders the utilization of such ground transportation services medically inappropriate.
- Ambulance Service (ground or air) to the coroner's office or to a mortuary is not covered, unless the ambulance had been dispatched prior to the pronouncement of death by an individual authorized under state law to make such pronouncements.
- In determining whether the participant "acted in good faith" as a "reasonable layperson" when obtaining emergency Ambulance Services, the TPA will take the following factors into consideration:
 - Whether the participant required Emergency Health Services, as defined above.
 - The presenting symptoms.
 - Whether the participant, as a layperson who possesses average knowledge of health and medicine, would have believed that transportation in any other vehicle would have endangered their health.
 - Whether the participant was advised to seek an ambulance by their Provider/Practitioner or by the TPA.
 - Any such advice will result in reimbursement for all Medically Necessary services rendered, unless otherwise limited or excluded under this Plan.

High-Risk Ambulance Services are defined as Ambulance Services that are:

- Non-emergency.
- Medically Necessary for transporting a high-risk patient.
- Prescribed by the Provider/Practitioner

Coverage for High-Risk Ambulance Services is **limited to**:

- Air Ambulance Service when Medically Necessary. (*The plan will not pay more for air ambulance transportation than it would have paid for transportation over the same distance by ground transportation services, unless the participant's condition renders the utilization of such ground transportation services medically inappropriate.*)
- Maternity/Neonatal Ambulance Services, including ground or air-ambulance transportation to the nearest Tertiary Care facility. (For the medically high-risk pregnant woman with an impending delivery of a potentially viable infant or when necessary to protect the life of a newborn.)
- Ground or air Ambulance Services to any Level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols.

Inter-Facility Transfer Services are defined as ground or air Ambulance transportation between any of the following: Hospitals, Skilled-Nursing Facilities or diagnostic facilities. Inter-facility Transfer Services are covered only if they are:

- Medically Necessary.
- Prescribed by the Participant's Provider/Practitioner
- Provided by a licensed Ambulance Service in a vehicle which is equipped and staffed with life-sustaining equipment and personnel.

Autism Spectrum Disorders

For a Participant **19 years old or younger** (or, if enrolled in high school, 22 years old or younger), this Plan covers the habilitative and rehabilitative treatment of Autism Spectrum Disorder through Speech Therapy, Occupational Therapy, Physical Therapy, and Applied Behavioral Analysis (ABA). Providers must be credentialed to provide such therapy.

Treatment must be prescribed by the Participant's treating Physician in accordance with a treatment plan. The treatment plan must receive prior authorization by the TPA to determine that the services are to be performed in accordance with such a treatment plan. If services are received but were not approved as part of the treatment plan, benefits for services will be denied.

Services not Certified by the TPA must be performed in accordance with a treatment plan and must be Medically Necessary or benefits for such services will be denied. **Note:** Habilitative treatment is defined as treatment programs that are necessary to: (1.) develop, (2.) maintain, and (3.) restore to the maximum extent practicable the functioning of an individual. **All three conditions must be met in order to be considered habilitative.**

Services are subject to usual Member cost-sharing features such as the Deductible, Co-payments, and Out-of-Pocket Maximum, based on place of treatment, type of service and whether prior authorization was obtained from the TPA. All services are subject to the *General Limitations and Exclusions section* except where explicitly mentioned as being an exception. This benefit is subject to the other general provisions of the Plan, including, but not limited to: coordination of benefits, Participating Provider agreements, restrictions on *Covered Services* (including review of Medical Necessity), case management, and other managed care provisions.

Autism related short-term rehabilitation services are subject to the combined 70-visit limitation listed in the Short-term Rehabilitation section.

Regardless of the type of therapy received, Claims for services related to Autism Spectrum Disorder should be mailed the TPA.

AUTISM EXCLUSIONS

This Plan does **not** cover:

- Experimental, long-term, or maintenance treatments not covered under state law.
- Services that are not Medically Necessary
- Any services received under the federal Individuals with Disabilities Education Improvement Act of 2004.

- Related state laws that place responsibility on state and local school boards for providing specialized education and related services to children 3-22 years old who have Autism Spectrum Disorder.
- Respite services or care.
- Services in accordance with a treatment plan that have not been Preauthorized by the TPA
- Sensory Integration Therapy (SIT) or Auditory Integration Therapy (AIT).
- Music therapy, vision therapy, or touch or massage therapy.
- Floor time.
- Facilitated communication.
- Elimination diets, nutritional supplements, intravenous immune globulin infusion; secretin infusions.
- Chelation therapy.
- Hippotherapy, animal therapy, or art therapy.

Clinical Trials

Qualified Clinical Trial Expenses are, except as excluded below, healthcare items and services for the treatment of cancer or any other life threatening condition for a qualifying individual enrolled in a qualified Clinical Trial that are otherwise consistent with the terms of the Plan and would be covered if the Participant did not participate in the qualified Clinical Trial.

For purposes of this section, a “life threatening condition” means any condition or disease from which the likelihood of death is probable unless the course of the disease or condition is interrupted. A “qualifying individual” means any Participant who is eligible to participate in a qualified Clinical Trial according to the trial protocol for treatment of cancer or any other life threatening condition that makes his or her participation in the program appropriate, as determined based on either:

- A conclusion of a referring health care professional.
- Medical and scientific information provided by the Participant.

Notwithstanding the above, qualified Clinical Trial expenses do not include any of the following:

- (a) Costs associated with managing the research associated with the qualified Clinical Trial.
- (b) Costs that would not be covered for Non-Experimental and/or Investigational treatments.
- (c) Any item or service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Clinical Trial means a Phase I, Phase II, Phase III or Phase IV Clinical Trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening condition and is described in (1), (2) or (3) below:

1. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - (a) The National Institutes of Health.
 - (b) The Centers for Disease Control and Prevention.
 - (c) The Agency for Health Care Research and Quality.
 - (d) The Centers for Medicare & Medicaid Services.
 - (e) A cooperative group or center of one of the entities described in (a) – (d) above.
 - (f) A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for Center Support Grants, or
 - (g) The Department of Veteran Affairs; the Department of Defense or the Department of Energy, if...

- i. The study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, **and...**
 - ii. Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
 3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Clinical Preventive Services

Clinical Preventive Services are covered only when provided by a UNM Health Network Provider/Practitioner or Extended-Network Providers (BCBSNM) when authorized by the TPA. Coverage is provided for the following Clinical Preventive Services at an age and frequency determined by the health care UNM Health Network or Extended-Network Provider/Practitioner:

Preventive Physical Examinations including:

- Health appraisal exams, laboratory and radiological tests, and early detection procedures for the purpose of a routine physical exam or as required for participation in sport, school, or camp activities.
- Periodic tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level, or alternatively, a fractionated cholesterol level, including a low-density lipoprotein (LDL) level and a high-density lipoprotein (HDL) level.
- Periodic stool examination for the presence of blood for all persons 40 years of age or older.
- **Note:** Physical examinations, vaccinations, drugs, and immunizations for the primary intent of medical research or Non-Medically Necessary purpose(s) including, but not limited to: licensing, certification, employment, insurance, flight, travel, passports or functional capacity examinations related to employment are not covered.

Well-Child Care in accordance with the recommendations of the American Academy of Pediatrics.

Vision and Hearing Screening to determine the need for vision and hearing correction. This does not include routine eye exams or Eye Refractions performed by eye care specialists. One Eye Refraction per Annual Plan Year is covered for children under age 17, when, Medically Necessary to aid in the diagnosis of certain eye diseases. **Hearing Aids and the evaluation for the fitting of Hearing Aids are Not Covered, except for school-aged children under 18 years old (or under 21 years of age if still attending high school).**

Adult and Child Immunizations (shots or vaccines), in accordance with the recommendations of the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, or the U.S. Preventive Services Task Force. **Immunizations for the purpose of foreign travel are not covered.**

Colorectal Cancer Screening, in accordance with the evidence-based recommendations established by the United States Preventive Task Force for determining the presence of pre-cancerous or cancerous conditions and other health problems including:

- Fecal occult blood testing (FOBT).
- Periodic left-sided colon examination of 35 to 60 centimeters (Flexible Sigmoidoscopy).
- Colonoscopy.
- Double-contrast barium enema.

Periodic Glaucoma Eye Test

Health Education materials and consultation from Providers/Practitioners to discuss lifestyle behaviors that promote health and well-being including, but not limited to, the consequences of Tobacco use and/or smoking control, nutrition and diet recommendations, and exercise plans. For Participants under 19 years of age, this includes (as deemed appropriate by the Participant's Provider/Practitioner, or as requested by the parents or legal guardian) education information on Alcohol and Substance Abuse, sexually transmitted diseases, and contraception. For Participants 19 years of age or older, health education also includes information related to lower back protection, immunization practices, breast self-examination, testicular self-examination, use of seat belts in motor vehicles and other preventive health care practices.

Smoking Cessation. For information regarding Smoking Cessation programs, refer to the "Smoking Cessation Programs" of this section.

Mammography Coverage for low-dose screening mammograms, to determine the presence of breast cancer. Coverage includes, but is not limited to, one baseline mammogram for women ages 35-39, one mammogram every two years for women ages 40-49 and one mammogram each year for women age 50 and over.

Cytologic (Pap Smear Screening) Screening and Human Papillomavirus (HPV) Screening, to determine the presence of precancerous or cancerous conditions and other health problems. Coverage includes, but is not limited to, women who are 18 years of age or older, and for women who are at risk of cancer or other health conditions that can be identified through Cytologic screening.

HPV Vaccine Coverage for the Human Papillomavirus, as approved by the Food and Drug Administration, for females 9-14 years of age, used for the prevention of Human Papillomavirus infection and cervical pre-cancers. In addition, the HPV vaccine is covered for other populations *in accordance with guidelines established by The Advisory Committee on Immunization Practices (ACIP).*

Women's Preventive Care including, but not limited to:

- Well-Woman Visits.
- Gestational Diabetes Screening.
- HPV DNA Testing.
- STI Counseling.
- HIV Screening and Counseling.
- Contraception and Contraceptive Counseling.
- FDA approved women's Surgical sterilization procedures.
- Contraception implant insertion/reinsertion.
- Breastfeeding Support, Supplies and Counseling.
- Interpersonal and Domestic Violence Screening and Counseling.

Complementary Therapies

The only alternative/complementary therapies that are covered are those that are identified in the Participant Benefit Booklet, and summarized here.

Acupuncture Services are available, subject to the following limitations:

- Acupuncture is specifically limited to treatment by means of inserting needles into the body to reduce pain, induce anesthesia, or for Smoking Cessation treatment. It may also be used for other diagnoses as determined appropriate by the Provider/Practitioner.
- It is recommended that Acupuncture be part of a coordinated plan of care approved by the Provider/Practitioner.
- Acupuncture services are limited to an Annual Plan Year Maximum. Refer to your *Schedule of Benefits* for this maximum. Maintenance treatment is not covered.

CHIROPRACTIC SERVICES (LIMITED)

Chiropractic Services are available for specific medical conditions and are not available for maintenance therapy such as routine “adjustments.” Chiropractic Services are subject to the following limitations:

- **The Provider/Practitioner determines** in advance what chiropractic treatment can be expected to result in Significant Improvement in the participant’s condition.
- Chiropractic **treatment is specifically limited** to treatment by means of manual manipulation, i.e., by use of hands, and other methods of treatment approved by the TPA including, but not limited to, ultrasound therapy.
- Subluxation **must be documented** by chiropractic examination and documented in the chiropractic record. Radiologic (x-ray) demonstration of Subluxation is not a requirement of the TPA for Chiropractic Services.
- **Chiropractic x-rays are only covered** when performed by a chiropractor for the following clinical situations (unless clinically relevant x-rays already exist):
 - Acute trauma with a suspected fracture, such as motor vehicle accidents or slip-and-fall accidents.
 - Clinical evidence of significant osteoporosis, recent fracture of the spine, wrist or hip, loss of height over one-half inch, or spine curvature consistent with osteoporotic fractures.
 - Abnormal neurologic or orthopedic findings suggesting spinal nerve impingement.

Treatment of conditions, other than headaches, which do not have acute Subluxation demonstrable on exam, are not covered. This includes chronic Subluxation of rheumatoid arthritis, allergy, muscular dystrophy, multiple sclerosis, pneumonia, chronic lung disease, and other diseases/conditions as determined by your TPA as not meeting this definition.

No other diagnostic or therapeutic service furnished by a chiropractor or under his or her order is covered except as specified in this PBB.

Treatment provided beyond the point at which the participant is no longer making Significant Improvement will not be covered.

Chiropractic services are limited to an Annual Plan Year Maximum. Refer to the *Schedule of Benefits* for this maximum.

Dental Services Including Temporo/Craniomandibular Joint Disorders (TMJ/CMJ)

Dental services will be provided in connection with the following conditions when deemed, Medically Necessary except in an emergency as described in the *Covered Services* section.

- **Accidental Injury to sound natural teeth, jawbones or surrounding tissue.** Accidental Injury treatment is limited to initial services received within 72 hours of the date of the accident. Additionally, follow-up care must begin within three months of the date of the accident and be completed within one year of the date of the accident unless treatment must be delayed due to medical necessity as determined by the TPA. **Dental injury caused by chewing, biting, or Malocclusion is not considered an Accidental Injury.**
- The correction of non-dental physiological conditions such as, but not limited to, cleft palate repair that has resulted in a severe functional impairment.
- The treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

- The Surgical and Non-Surgical treatment of temporo/craniomandibular joint disorders (TMJ/CMJ) such as arthroscopy, physical therapy, or the use of Orthodontic Devices (TMJ splints) are subject to the same conditions, limitations, and prior authorization procedures as are applicable to treatment of any other joint in the body. Orthodontic appliances and treatment (braces), crowns, bridges and dentures used for the treatment of **temporo/craniomandibular joint disorders are specifically excluded, unless the disorder is trauma-related. Services related to Malocclusion treatment, if part of routine dental care and orthodontics, are not covered.**
- **Hospitalization, Day Surgery, Outpatient Services and/or anesthesia for non-covered dental services are covered if** provided in a Hospital or ambulatory Surgical center for dental Surgery, when approved by the TPA. Plan benefits for these Outpatient services are for...
 - For Participants who exhibit physical, intellectual, or medically compromising conditions for which dental treatment under local anesthesia (with or without additional adjunctive techniques and modalities) cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results.
 - Participants for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy.
 - Covered children or adolescents who are extremely uncooperative, fearful, anxious, or uncommunicative with dental needs. These dental needs are of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity.
 - Participants with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.
 - Other procedures for which hospitalization or general anesthesia in a Hospital or ambulatory Surgical center is Medically Necessary.

EXCLUSIONS RELATING TO DENTAL SERVICES:

- **Dental care and** dental x-rays, except as provided in the *Covered Services* section, Hospitalization, Day Surgery, Outpatient Services and/or anesthesia for non-covered dental services **are covered if provided in a Hospital or ambulatory Surgical center for dental Surgery when approved by your TPA.**
- **Dental implants are not covered under this plan and are specifically excluded.**

Diabetes Services

The Plan provides Coverage for individuals with insulin dependent (Type I) diabetes, non-insulin dependent (Type II) diabetes, and elevated blood glucose levels induced by pregnancy (gestational diabetes). The TPA will provide coverage for equipment and appliances. Express Scripts will cover Prescription Drug(s), insulin, or supplies that meet Food and Drug Administration (FDA) approval, and are the medically accepted standards for diabetes treatment, supplies and education.

DIABETES EDUCATION

The following benefits are available from an approved Diabetes Educational Provider/Practitioner:

- **Diabetes self-management training, limited to:**
 - a. Medically Necessary visits upon the diagnosis of diabetes.
 - b. Visits following a Provider/Practitioner diagnosis that represents a significant change in condition or symptoms requiring changes in the patient's self-management.
 - c. Visits when re-education or refresher training is prescribed by a health care Provider/Practitioner with prescribing authority.
- Medical nutrition therapy related to diabetes management.

Approved Diabetes Educational Providers/Practitioners must be Certified, registered or licensed health care professionals with recent education in diabetes management.

DIABETES SUPPLIES AND SERVICES

When prescribed by the Provider/Practitioner the following equipment, supplies, appliances and services are covered for diabetes:

- Prescriptive diabetic oral agents for controlling blood sugar levels. (Provided by **Express Scripts**, call **1-800-232-6549** or visit **www.express-scripts.com**.)
 - Medically Necessary podiatric appliances for prevention of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment. (Only when Certified by the TPA.)
- Insulin pumps, when Medically Necessary and prescribed by an endocrinologist.

For additional diabetic supply coverage (e.g., insulin needles and syringes, autolets, test strips, glucagon emergency kits), call **Express Scripts at 1-800-232-6549** or visit **www.express-scripts.com**.

Diagnostic Services

Diagnostic Services are tests performed to determine if the participant has a medical problem.

Coverage is provided for Diagnostic Services, when Medically Necessary and subject to the **limitations in the Limitations section, the exclusions in the Exclusions section and the “prior authorization” requirements in the How the Plan Works section** of this PBB. All Diagnostic Services must be provided under **the direction of the Provider/Practitioner**. Examples of covered procedures include, but are not limited to, the following:

- Cardiac procedures such as EKG, EEG, echocardiograms and MUGA scans.
- Clinical laboratory tests.
- CT scans (requires prior authorization).
- Endoscopy procedures (requires prior authorization).
- Gastrointestinal lab procedures.
- Magnetic Resonance Imaging (MRI) tests (requires prior authorization).
- Pulmonary function tests.
- Radiology/x-ray services.
- Ultrasound procedures.
- Sleep disorder studies (requires prior authorization).
- Bone density studies (requires prior authorization).

Unless otherwise noted, **prior authorization** is not required for the Diagnostic Services listed above.

Durable Medical Equipment, Orthotic Appliances, Prosthetic Devices, Repair And Replacement, Surgical Dressing, Eyeglasses/ Contact Lenses And Hearing Aids

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment (DME) is equipment that is Medically Necessary for treatment of an illness, Accidental Injury, or to prevent the patient's further deterioration. This equipment is designed for repeat use, and includes items such as oxygen equipment, wheelchairs, and crutches. Rental, or, at the option of the TPA, the purchase of Durable Medical Equipment is covered when required for therapeutic use, determined to be Medically Necessary by the Provider/Practitioner, and if Certified by the TPA. Only Durable Medical Equipment considered standard and/or basic items are covered. **Upgraded or deluxe items are not covered.**

Note: Participants employed outside the home for two or more hours on a given day shall be eligible for an additional or alternative oxygen system, if Medically Necessary and appropriate, as determined by the TPA.

Exclusions:

- Upgraded or deluxe items
- Items considered "for convenience." A convenience item is an appliance, device, object or service that is for comfort and ease and is not primarily medical in nature. Examples include, but are not limited to:
 - Shower stools/chairs/seats.
 - Bath grab bars.
 - Shower heads.
 - Vaporizers.
 - Wheelchair/walker/stroller accessories such as baskets, trays, seats or shades.
 - Duplicate DME items (i.e. for home and for office).

ORTHOTIC APPLIANCES (LIMITED)

Orthotic Appliances include pre-fabricated braces and other external devices used to correct a body function including clubfoot deformity. Benefits will be provided, if determined to be Medically Necessary by the Provider/Practitioner, and if Certified by the TPA. **Foot orthotics or shoe appliances are not covered**, except for Participants with diabetic neuropathy or other significant neuropathy. Custom-fabricated knee-ankle-foot orthoses (AFO and/or KAFO) are covered for Participants up to eight years old.

PROSTHETIC DEVICES

Prosthetic Devices are artificial devices that replace or augment a missing or impaired part of the body. The purchase, fitting and necessary adjustments of Prosthetic Devices and supplies that replace all or part of the function of a permanently inoperative or malfunctioning body extremity are covered when they replace a limb or other part of the body, after accidental or Surgical removal and/or when the body's growth necessitates replacement. Prosthetic Devices will be provided when determined to be Medically Necessary by the Provider/Practitioner and when Certified by the TPA.

Examples of Prosthetic Devices include but are not limited to: breast prostheses when required as a result of mastectomy, artificial limbs, prosthetic eye, prosthodontic appliances, penile prosthesis, joint replacements, heart pacemakers, tracheostomy tubes and cochlear implants. **Dental implants are not covered.**

REPAIR AND REPLACEMENT OF DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND ORTHOTIC DEVICES

Repair and replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices is covered when Certified by the TPA and when Medically Necessary due to change in the participant's condition, wear, or after the product's normal life expectancy has been reached.

EXCLUSIONS RELATED TO REPAIR AND REPLACEMENT OF MEDICAL EQUIPMENT, PROSTHETICS, AND ORTHOTIC DEVICES:

- Repair and replacement due to loss, neglect, theft, misuse, abuse, or to improve appearance or for convenience.
- Repair and replacement of items under the manufacturer or supplier's warranty.
- If the Participant has a functional wheelchair, regardless of the original purchaser of the wheelchair, additional wheelchair(s) are not covered.
 - One-month rental of a wheelchair is covered if a Participant owned the wheelchair that is being repaired.

SURGICAL DRESSING

Surgical dressings, which require a Provider/Practitioner's prescription and cannot be purchased Over-the-Counter, are covered when Medically Necessary for the treatment of a wound caused by or treated by a Surgical procedure.

Gradient compression stockings are covered up to **two pairs per Annual Plan Year for:**

- Severe and persistent swollen and painful varicosities, or lymphedema/edema or venous insufficiency not responsive to simple elevation.
- Venous stasis ulcers that have been treated by a Provider/Practitioner or other health care professional requiring Medically Necessary debridement (wound cleaning).

Note: Lymphedema wraps and garments prescribed under the direction of a lymphedema therapist are covered.

EXCLUSIONS RELATED TO SURGICAL DRESSINGS:

- Common disposable medical supplies that can be purchased Over-the-Counter, such as but not limited to, bandages, band aids, gauze (e.g. 4 by 4's), and ACE bandages. (Except when provided in a Hospital or Provider/Practitioner's office, or by a home health professional.)
- Gloves, unless part of a wound treatment kit.
- Elastic support hose.

EYEGASSES AND CONTACT LENSES (LIMITED)

All eyeglasses or contact lenses are **subject to the limitations in the Limitations section and Exclusions in the Exclusions section** of this PBB. The following will only be covered if received from **UNM Health Network** Providers/Practitioners.

- Contact lenses are covered for the correction of aphakia (those with no lens in the eye) or keratoconus. This includes the Eye Refraction examination.
- One pair of standard (non-tinted) eyeglasses (or contact lenses if Medically Necessary) is covered within 12 months after cataract surgery, or when related to Genetic Inborn Error of Metabolism.
- This includes the Eye Refraction examination, lenses, and standard frames.

EXCLUSIONS RELATING TO EYEGASSES AND CONTACT LENSES:

- Except as above, routine vision care, Eye Refractions, corrective eyeglasses, sunglasses, frames, lens prescriptions, contact lenses or the fitting thereof.
- Routine vision care and Eye Refractions for determining eyeglass or contact lens prescriptions.
- Eye refractive procedures including radial keratotomy, laser procedures, and other techniques.
- Visual training.

HEARING AIDS

Hearing Aids and the evaluation for the fitting of Hearing Aids are not covered except for school-aged children under age 18 (or under age 21 if still attending high school):

- Up to \$2,200 every 36 months “per hearing-impaired ear” for school-aged children under age 18 (or under age 21 if still attending high school).
 - Includes fitting and dispensing services and ear molds as necessary to maintain optimal fit, as provided by an In-Network Provider/Practitioner licensed in New Mexico.

Family, Infant And Toddler (FIT) Program

Coverage for children, from birth to age three, under the Family, Infant and Toddler Program (FIT) administered by the Department of Health, provided eligibility criteria are met, is provided for Medically Necessary early intervention services. These services are provided as part of an individualized family service plan and delivered by certified and licensed personnel as defined in NMAC Title 7, Chapter 30, Part 8: “Health, Family and Children Health Care Services.” Benefits used under this section will not be applied to any maximum lifetime or annual plan limits applicable to this Plan. This benefit is subject to an annual maximum. Refer to the *Schedule of Benefits* for the maximum dollar amount.

Genetic Inborn Errors Of Metabolism Disorders (IEM)

Coverage is provided for the diagnosing, monitoring, and controlling of disorders of Genetic Inborn Errors of Metabolism (IEM) where there are standard methods of treatment, when Medically Necessary and subject to the *Limitations and Exclusions* section. They are also subject to prior authorization (see in the *How the Plan Works* section) requirements listed in the PBB. Medical services provided by licensed health care professionals, including Providers/Practitioners, dietitians and nutritionists, with specific training in managing Participants diagnosed with Genetic Inborn Errors of Metabolism (IEM) are covered. *Covered Services* include:

- Nutritional and medical assessment.
- Clinical services.
- Biochemical analysis.
- Medical supplies.
- Corrective lenses for conditions related to Genetic Inborn Errors of Metabolism (IEM).
- Nutritional management.

EXCLUSIONS:

- Food substitutes for lactose intolerance including soy foods or formulas, or other Over-the-counter digestive aids.
- Organic foods.
- Ordinary foodstuffs that might be part of an exclusionary diet.
- Food substitutes that do not qualify as Special Medical Foods.
- Any product that does not require a Provider/Practitioner’s prescription.
- Special Medical Foods for conditions that are not present at birth.
- Food items purchased at a health food, vitamin or similar store.
- Foods purchased on the Internet.
- Special Medical Foods for conditions including, but not limited to, diabetes mellitus, hypertension, hyperlipidemia, obesity, and allergies to food products.

For prescription drug and special medical food coverage, contact **Express Scripts** at 1-800-232-6549 or visit www.express-scripts.com. Please refer to the *Schedule of Benefits* for applicable office visit, Inpatient Hospital, Outpatient facility, and other related Co-pays.

Home Health Care Services/Home Intravenous Services And Supplies

Home Health Care Services are services provided to a Participant confined to the home due to physical illness. **Private-duty nursing is not covered.** A Home Health Agency will provide Home Intravenous Services and Supplies at the participant's home when Certified by the TPA and when prescribed by a UNM Health Network or In-Network Provider/Practitioner. Any such prescription or prior authorization must be renewed at the end of each 60-day period. The TPA will not impose a limitation on the number of related hours per visit.

- Home Health Care Services are covered up to 100 visits per Annual Plan Year. Home Health Care Services shall include Medically Necessary skilled intermittent health care services provided by a registered nurse or a licensed practical nurse physical, occupational, and/or respiratory therapist and/or speech pathologists. Intermittent home health aide services are covered only when part of an approved plan of care that includes Medically Necessary skilled services. **Custodial Care needs that can be performed by non-licensed medical personnel to meet the normal activities of daily living do not qualify as home Health Care benefits. Examples of Custodial Care that are not covered include, but are not limited to, bathing, feeding, preparing meals, or performing housekeeping tasks.**
- Medical equipment, drugs, and medications, and supplies deemed Medically Necessary by an In-Network Provider/Practitioner for the provision of health services in the home are covered, **except Durable Medical Equipment.**
- Home Health Care Services or Home Intravenous Services as an alternative to hospitalization are covered, as determined by the Participant's In-Network Provider/Practitioner and as approved by their TPA.
- Total parenteral and enteral nutrition as the sole source of nutrition is covered, when Certified by the Participant's TPA.
- **Home Health Care Services are limited to an Annual Plan Year Maximum of 100 visits.**

Hospice Care (Where A Certified Hospice Program Is Available)

If the participant becomes terminally ill, Inpatient and In-home Hospice Care are *Covered Services* when services are provided by a Hospice program approved by the TPA during a Hospice benefit period (**and not covered to the extent that they duplicate other Covered Services available to the participant**). Benefits are provided for a participating Hospice or other facility when approved by the Provider/Practitioner and Certified by the TPA. The Hospice benefit period must begin while the participant is enrolled in this Plan, and coverage through the TPA must be continued throughout the benefit period in order for Hospice Care benefits to continue.

The Hospice benefit period is defined as:

- Beginning on the date the Provider/Practitioner certifies that the participant is terminally ill with a life expectancy of six months or less, and
- Ending six months after it began, except as described below, or upon the death of the participant.
 - If the participant requires an extension of the Hospice benefit period, the Hospice must provide a new treatment plan and the Provider/Practitioner must re-certify the medical condition. No more than one additional Hospice benefit period will be Certified by the TPA.

The following services will be covered under the Hospice Care benefit (where a certified Hospice program is available):

- Inpatient Hospice Care.
- Provider/Practitioner visits by an In-Network Hospice Provider/Practitioner
- Home health care services by approved home healthcare personnel.
- Physical therapy.
- Medical supplies.
- Drugs and medication for pain and discomfort specifically related to the terminal illness.
- Medical transportation (facility to facility for Inpatient Hospice benefits only).

THE FOLLOWING ARE NOT COVERED:

- Food, housing, and delivered meals.
- Volunteer services.
- Comfort items such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those covered under Durable Medical Equipment benefits).
- Homemaker and housekeeping services.
- Private-duty nursing.
- Pastoral and spiritual counseling.
- Bereavement counseling.
- Respite Care.

The following services are not covered under Hospice Care, but may be covered elsewhere in this PBB, subject to the participant's Deductible, Co-pay and Coinsurance requirements:

- Acute Inpatient Hospital care for curative services.
- Durable Medical Equipment.
- Provider/Practitioner visits by someone other than an In-Network Hospice Provider/Practitioner
- Ambulance Services.

Where there is not a certified Hospice program available, regular Home Health Care Services benefits will apply. Refer to the *Covered Services* section ("Home Health Care Services/Home Intravenous Services and Supplies") of this PBB.

Before the participant receives Hospice Care, the treating Provider/Practitioner or Hospice agency must request **prior authorization in writing** from the Participant's TPA. **Prior authorization** requires a written treatment program approved by the treating Provider/Practitioner. In-Network Providers/Practitioners request **prior authorization** for the participant.

Hospital Admissions – Inpatient Services

Inpatient means the participant has been admitted to a Hospital by a health care Provider/Practitioner for the purposes of receiving Hospital services. Eligible Inpatient Hospital services shall be those acute care services rendered to the participant as a registered bed patient, for which there is a room and board charge. Admissions are considered Inpatient and based on Medical Necessity, regardless of the length of time spent in the Hospital.

Hospital admissions must be Preauthorized by the TPA, unless such services constitute Emergency Health Services. Hospital services must be provided under the direction of the Participant's Provider/Practitioner.

Inpatient Hospital services include, but are not limited to, the following, when Medically Necessary, and, **subject to the prior authorization requirements listed in the How the Plan Works section, the limitations contained in the Limitations section and the exclusions contained in the Exclusions section:**

- Acute Medical Detoxification: Inpatient treatment for acute medical detoxification induced by alcohol or drug abuse shall be provided when Medically Necessary at an acute-care facility or a treatment center specializing in substance abuse. **Acute Medical Detoxification in a Residential Treatment Center is not covered.** Acute Medical Detoxification treatment must be approved in advance by the Participant's Provider/Practitioner and must be Certified by his/her TPA. **Acute Medical detoxification does not include rehabilitation.**
 - Anesthetics, oxygen, and covered medications.
 - Blood, blood plasma and blood components.
 - Diagnostic Services, as specified in the *Covered Services* section.
 - Dressings, casts and special equipment when supplied by the Hospital for use in the Hospital
 - Facilities: Use of operating, delivery, recovery, and treatment rooms and equipment and all other facilities.
 - Meals and special diets or parenteral (intravenous) nutrition.
 - Provider/Practitioner and surgeon services.
 - Private room and board accommodations when Medically Necessary and Certified by the TPA.
 - Semi-private room and board accommodations, including general duty nursing care.
 - Special services and procedures, such as special duty nursing, when Certified by the TPA.
 - Surgery, when Certified by the TPA.
 - **Note:** Cosmetic Surgery is not covered.
 - Examples of Cosmetic Surgery include but are not limited to breast augmentation, dermabrasion, dermaplaning, excision of acne scarring, acne surgery (including cryotherapy), asymptomatic keloid/scar revision, microphlebectomy, sclerotherapy (except when used for truncal veins), and nasal rhinoplasty.
 - Therapeutic and support care: services, supplies, appliances, and therapies including care in specialized intensive and coronary care units, radiation therapy, and inhalation therapy.
 - Physical Rehabilitation:
 - Inpatient benefits are available for Inpatient rehabilitation services that are Medically Necessary to restore and improve lost functions following illness or Accidental Injury and are provided in Participating facilities.
 - Hospitalization for rehabilitation must begin within one year after the onset of the condition and while the Participant is covered under this Plan.
 - Inpatient rehabilitation must be medically necessary and not for personal convenience.
 - **Note:** benefits are not available for care that is not provided by a participating facility. These inpatient services are not eligible for any additional benefits on an outpatient basis. There are no benefits for maintenance therapy or care provided after the patient has reached his/her rehabilitative potential. The patient is responsible for furnishing documentation from the treating physician supporting that the patient's rehabilitative potential has not been reached.

Medical Evacuation Reimbursement

Reimbursement of expenses for common carrier transportation and reasonable food and lodging in connection with a medical evacuation (world-wide) may be covered. Benefits are available if:

- The participant becomes sick or injured while covered under this Plan, and in the discretion of the TPA and the attending Provider/Practitioner, the participant is required to be taken to:
 - The nearest medical facility where appropriate medical treatment can be obtained, or...
 - A medical facility in the participant's home country.
- The medical evacuation is ordered by a treating Provider/Practitioner who certifies that the severity of the sickness or injury necessitates the medical evacuation, and the participant agrees.
- The participant obtains **prior authorization** for the method of transportation in advance. Please contact the TPA Customer Service Center to determine if prior authorization is required.

Note: Benefits are limited to \$10,000 per Covered Participant during the time the Plan is in effect. Prior authorization must be obtained from the TPA prior to being transported. If prior authorization is not received prior to being transported, the Participant will be responsible for all charges.

Mental Health, Alcoholism And Substance Abuse

MENTAL HEALTH SERVICES

Participants may obtain mental health related services from a UNM Health Network Provider/Practitioner or contact the TPA directly for participating Providers/Practitioners. The participating behavioral health Providers/Practitioners will be responsible for any additional prior authorization. For Blue Cross Blue Shield of New Mexico extended network or Out-of-Network services, participants must contact the TPA to obtain a Benefit Determination and prior authorization.

If Mental Health services are not Certified when required, they are **not covered**.

- Acute Inpatient Mental Health Services will be covered when Certified by the TPA or TPA's designee.
- Coverage is provided for Inpatient mental health and partial Hospitalization.
- Partial hospitalization can be substituted for the Inpatient mental health services when Certified by the TPA or TPA's designee. Partial hospitalization is a non-residential, Hospital-based day program that includes various daily and weekly therapies.
- Outpatient, non-Hospital based evaluative and therapeutic mental health services will be provided when deemed Medically Necessary and Certified by the TPA or TPA's designee.
- Acute medical detoxification benefits are covered under Inpatient and Outpatient Medical Services found in the *Covered Services* section of this PBB.

Exclusions: In addition to the exclusions listed in the Exclusions section of this PBB, the following are **not covered**:

- Co-dependency treatment.
- Sex, pastoral/spiritual, and bereavement counseling.
- Psychological testing when not Medically Necessary
- Special education, school testing or evaluations, counseling, therapy, or care for learning deficiencies or behavioral problems. (This applies whether or not associated with manifest mental illness or other disturbances.)
- Court-ordered evaluation or treatment, or treatment that is a condition of parole or probation or in lieu of sentencing, such as psychiatric evaluation or therapy.
- Alcohol and/or Substance Abuse Services are not considered mental health benefits.

ALCOHOL AND SUBSTANCE ABUSE SERVICES

Please check Alcohol and Substance Abuse Services included in the PBB for the applicable Co-pay/Coinsurance amount for these services.

The following benefits and limitations are applicable for Alcohol and Substance Abuse Services. In all cases, treatment must be Medically Necessary in order to be covered:

- To obtain Alcohol and Substance Abuse Services, Participants may contact the TPA or TPA's designee. The Behavioral Health Provider/Practitioner will be responsible for any additional prior authorizations.
- The following limitations apply:
 - Inpatient treatment in a Hospital or Substance Abuse treatment center will be covered when Certified by the TPA or TPA's designee.
 - Partial hospitalization can be substituted for Inpatient Alcohol and Substance Abuse Services if Certified by the TPA or TPA's designee. Partial hospitalization is a non-residential day program, attended by the patient at eight hours a day, based in a Hospital or treatment center, that includes various daily and weekly therapies. Two partial hospitalization days shall be the equivalent of one day of Inpatient.
 - Intensive and standard Outpatient evaluative and therapeutic services for Alcohol and Substance Abuse will be provided if Certified by the TPA or TPA's designee. Intensive Outpatient Alcohol and/or Substance Abuse services are defined as visits lasting three hours per visit and attended by the Participant three times per week. Standard Outpatient therapy visits are defined as Outpatient visits lasting up to 50 minutes.
- Acute Medical Detoxification Benefits are covered under Inpatient and Outpatient Hospital found in the *Covered Services* section: "Hospital Admission – Inpatient" and "Outpatient Medical Services."

EXCLUSIONS

In addition to the exclusions listed in the PBB, the following are not covered:

- Treatment in a halfway house.
- Residential treatment centers.
- Co-dependency treatment; sex, pastoral/spiritual, and bereavement counseling.
- Court-mandated treatment or treatment that is a condition of parole or probation, or in lieu of sentencing.

Nutritional Support And Nutritional Supplements

For information about Covered Services, call Express Scripts at 1-800-232-6549.

Outpatient Medical Services

Outpatient Medical Services are administered at a medical facility such as a Hospital or doctor's office, after which the Participant goes home without being admitted to the facility.

Outpatient Medical Services include reasonable Hospital services provided on an ambulatory basis, and preventive, Medically Necessary, diagnostic and treatment procedures that are prescribed by the Participant's attending Provider/Practitioner, subject to the prior authorization requirements listed in the **How the Plan Works section under "Authorization," the limitations listed in the Limitations section and the exclusions listed in Exclusions section of this PBB.**

Such services may be provided in a Hospital, Provider/Practitioner's office, any other appropriate licensed facility, or any other appropriate facility if the professional delivering the service is licensed to practice, is Certified, and is practicing as authorized by applicable law or authority of the TPA. These services may also be provided by a medical group, an independent practice association or other authority authorized by applicable law and includes the following:

- Anesthetics, oxygen, drugs, medications.
- Blood, blood plasma and blood components.
- Chemo and radiation therapy.
- Diagnostic Services, as specified in the *Covered Services* Section under "Diagnostic Services."
- Dressings, casts, and special equipment when supplied by the Hospital for use in .Hospital
- Facilities: use of operating, recovery and treatment rooms and equipment.
- Medical Detoxification, including Medically Necessary services for Alcohol and Substance Abuse detoxification.
- Observation Services as defined in the *Covered Services* section under "Observation Services."
- Sleep disorder studies.
- Surgeries, including use of operating, delivery, recovery, and treatment rooms, and equipment and supplies, including anesthesia, dressings and medications.
- Therapeutic and support care services, supplies, appliances, and therapies.

Provider/Practitioner Services

Provider/Practitioner Services are those services that are necessary to maintain good health. Provider/Practitioner Services include, but are not limited to, periodic examinations and office visits provided by:

- A licensed Physician.
- Specialist services provided by other health professionals who are licensed to practice, are certified, and are practicing as authorized by applicable law or authority.
- A Medical Group.
- An independent practice association, or other authority authorized by applicable state law.

The Provider/Practitioner Services, covered by this Section are **subject to the prior authorization requirements contained in the How the Plan Works section under "Prior Authorization," the limitations contained in Limitations section and the exclusions listed in Exclusions section of this PBB.** This Plan covers consultation, health care services, and supplies provided by the Participant's Provider/Practitioner including:

- Office visits provided by a qualified provider/practitioner.
- Services of a provider/practitioner for the diagnosis and treatment for mental illness or substance abuse shall be provided according to the covered services section under "Mental Health, Alcohol and Substance Abuse."
- Homes visits, if Medically Necessary

- Outpatient Surgery and Inpatient Surgery including necessary anesthesia services by a qualified Provider/Practitioner.
- Hospital and skilled-nursing home visits by Provider/Practitioners as part of continued supervision of covered care.
- FDA-approved injections in accordance with accepted medical practice, **except those specifically limited and/or excluded in the Covered Services section under “Covered Medications” and “Prescription Drug Benefit-Outpatient.”**
- **Family planning/infertility services including:**
 - FDA-approved Contraceptive devices and prescription medications **excluding over-the-counter items and investigational devices/medications.**
 - Sterilization procedures. **(Reversal of voluntary sterilization is not covered.)**
 - Infertility diagnosis and treatment for physical conditions causing infertility is limited to Surgery to open obstructed tubes, epididymis or vasectomy when not the result of sterilization and replacement of deficient hormones if there is documented evidence of a deficiency. **(Artificial insemination is not covered, Donor sperm, In-vitro, GIFT and ZIFT fertilization are not covered. Reversal of voluntary sterilization is not covered.)**
 - Elective abortions as identified under the “Women’s Healthcare” of this section.
 - Second medical opinions: The office visit deductible, copayment and coinsurance will not apply, if the TPA requires a second opinion to evaluate the medical appropriateness of a diagnosis or service. **(The office visit Deductible, Co-pay and Coinsurance of will apply when the participant or provider/practitioner requests the second opinion.)**

Covered Medications

Medications are covered when administered at Inpatient, Outpatient, office, or Home Health settings.

Prescription Drugs

Are administered by Express Scripts, Inc. Call 1-800-232-6549 or visit www.express-scripts.com for assistance.

Radiological Services

X-Ray, Lab, and diagnostic tests other than Magnetic Resonance Imaging (MRI) scans, Computed Axial Tomography (CAT) scans, Positron Emission Tomography (PET) scans or Nuclear Medicine are included in the office visit Co-pay when services are received from a participating provider.

Services for Magnetic Resonance Imaging (MRI) scans, Computed Tomography (CAT), Positron Emission Tomography (PET), and Nuclear Medicine are subject to the Co-pay and/or Coinsurance requirements as indicated in the *Schedule of Benefits* and may require prior authorization.

Reconstructive Surgery

Reconstructive Surgery from which an improvement in physiological function can reasonably be expected will be covered if performed for the correction of functional disorders. The Provider/Practitioner must prescribe Reconstructive Surgery and prior authorization must be obtained. For information regarding Reconstructive Surgery following a Mastectomy, refer to “Women’s Health Care” in the *Covered Services* section.

Cosmetic Surgery is not covered. Examples of Cosmetic Surgery include but are not limited to breast augmentation, dermabrasion, dermaplaning, excision of acne scarring, acne surgery (including cryotherapy), asymptomatic keloid/scar revision, microphlebectomy, sclerotherapy, and nasal rhinoplasty.

Therapy Services

Cardiac Rehabilitation Services: Coverage is provided for 36 visits per Participant per Annual Plan Year. **Long-term rehabilitation is not covered.**

Chemotherapy/Dialysis/Radiation Therapy: Benefits are available for the following Inpatient or Outpatient therapeutic services:

- Treatment of malignant disease by standard chemotherapy.
- Treatment for removal of waste materials from the body, including renal dialysis, hemodialysis, or peritoneal dialysis, and the cost of equipment rentals and supplies and...
- Treatment of disease by x-ray, radium, or radioactive isotopes.

PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY

Benefits are limited (as shown in the *Schedule of Benefits*) for Outpatient rehabilitation services including physical therapy from a licensed physical therapist, and occupation or speech therapy from a licensed or certified therapist. These services may also include treatment using cold, heat, or similar modalities to relieve pain, restore maximum function, and prevent disability following illness, accidental injury, or loss of a body part. Benefits are not available for speech therapy in connection with learning disabilities. Benefits are not available for Maintenance Therapy or any diagnostic, therapeutic, rehabilitative, or health maintenance service provided at or by a health spa or fitness center, even if the services is provided by a licensed or registered Provider.

SHORT-TERM REHABILITATION SERVICES

Short-term Rehabilitation benefits are available for physical therapy and occupational therapy, provided in a Rehabilitation Facility, Skilled-Nursing Facility, Home Health Agency, or Outpatient setting. Short-term Rehabilitation is designed to assist Participants in restoring functions that were lost or diminished due to a specific episode of illness or injury (for example, stroke, motor vehicle accident, or heart attack).

Coverage is subject to the following limitations:

- **Outpatient physical therapy, occupational therapy, and speech therapy coverage up to 70 visits combined per Annual Plan Year.**
- **Treatments delivered by athletic trainers are not covered.**

OUTPATIENT SPEECH THERAPY

Outpatient Speech Therapy means language, dysphagia (difficulty swallowing), and hearing therapy. Outpatient Speech Therapy is covered when provided by a licensed or certified speech therapist.

Outpatient Speech Therapy will be covered **only** for the following conditions:

- When speech or swallowing loss is due to or caused by:
 - Cleft palate.
 - Never speaking (when physical development is normal but the child is mute or speech is not understandable).
 - Speech disorders secondary to brain inflammation or infection.
 - Brain oxygen deprivation (anoxia).
 - Head injury.
 - Facial deformities.
- Delayed speech in children will be covered only for:
 - Failure to grow normally with significant language delay under age five.
 - Infants with failure to suck resulting in lack of sufficient oral muscular strength for beginning speech.

- Children with chronic or recurring otitis media with demonstrable hearing loss.
- Neurologically impaired children with documented diagnosed disorders of the nervous system.
- Myofunctional therapy (tongue thrust) post injury/illness will be covered in conjunction with Speech Therapy

Notes:

Outpatient Speech Therapy for stuttering is not covered.

Hearing aid evaluations are not covered except for school-aged children under age 18 (or under age 21 if still attending high school).

No additional benefits are available for speech therapy.

Speech therapy provided in an inpatient setting such as, but not limited to, rehabilitation facilities, skilled-nursing units, home health, or intensive day-hospital programs delivered by rehabilitation facilities, are not subject to the time limitation requirements of the outpatient therapies outlined above, and are not combined with outpatient services when calculating the total accumulated benefit usage.

Pulmonary Rehabilitation Services: Coverage is provided for 24 sessions of progressive exercises and monitoring of pulmonary functions per Participant per Annual Plan Year.

Long-term Rehabilitation Services are not covered. Therapies are considered long-term when the participant:

- Has reached maximum rehabilitation potential.
- Has reached a point where Significant Improvement is unlikely to occur.

Long-term therapy includes treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. **Treatment of chronic conditions is not covered.** Chronic conditions include, but are not limited to; Muscular Dystrophy, Down's Syndrome, Cerebral Palsy, and developmental delays not associated with a defined event of illness or injury.

The following are **not covered**:

- **Vocational Rehabilitation Services**
- **Athletic trainers.**
- **Inpatient Rehabilitation Services**

Repatriation Reimbursement

Repatriation Reimbursement is defined as coverage of expenses in connection with the transportation of the body of a deceased Covered Participant. Benefits are available if a Participant dies while covered under this Plan and:

- While away from their home state (permanent residence).
- As a United States citizen or resident alien away from their home country (permanent residence), if the participant is a foreign Covered Participant.

Benefits are limited to \$7,500 per deceased Participant and are payable only for expenses in connection with:

- The collection, storage, and preparation of the body (including embalming, cremation, or other preparation method).
- A container appropriate for storage/transportation (for example: urn, casket, etc.), limited to a maximum of the expenses for a container that meets the minimum Federal requirements for transportation of bodily remains, and...
- Transportation of the remains from the mortuary (or similar facility) closest to where death occurred to a mortuary (or similar facility) in the deceased Covered Participant's home country. All transportation must be Certified by the TPA in advance.

In the case of cremation of the remains, benefits will be paid for transportation of one person who travels with the urn or other similar transportation/storage vessel in his or her possession, in lieu of benefits for transportation of the urn or other similar transportation/storage vessel. Otherwise, no benefits will be provided for the transportation of any person (including a family member) to accompany the remains during transportation.

The participant or their representative must notify UNM Health and obtain prior authorization of the method of transportation before arranging the transportation. If they do not obtain prior authorization prior to arranging transportation, the participant will be responsible for all charges and no benefits will be paid by the Plan. Prior authorization is for the reimbursement only. The Participant or Participant's designee is solely responsible for arranging travel or transport of the deceased Participant or the deceased Participant's remains.

Skilled-Nursing Facility Care

Room and board and other necessary services furnished by a Skilled-nursing Facility will be provided if the participant requires skilled-nursing care of the type provided by the facility. Admission to the facility must be arranged and Certified by the TPA and by the Participant's Provider/Practitioner. Admission must be appropriate for the participant's Medically Necessary care and rehabilitation. **Skilled-Nursing Facility care is provided for up to 60 days per Participant, per Annual Plan Year. Custodial or Domiciliary Care is not covered.**

Smoking Cessation

Coverage is provided for Diagnostic services, smoking cessation counseling, hypnotherapy and pharmacotherapy. Medical services are provided by licensed health care professionals with specific training in managing the participant's Smoking Cessation program. The program is described as follows:

- Individual counseling at an In-Network Provider/Practitioner's office is covered under the medical benefit. The office visit Co-pay applies. There is no limit to the number of visits that are covered. **Out-of-Network Providers/Practitioners are not covered.**
- Employer Counseling, including classes or a telephone "quit line," are covered through an In-Network Provider/Practitioner. No Co-pay will apply and there are no dollar limits or visit maximums. Reimbursements are based on contracted rates.
- Some organizations, such as the American Cancer Society and Tobacco Use Prevention and Control (TUPAC), offer employer counseling services at no charge. Participants may want to utilize these services. (Contact the TPA's Customer Service Center for a list of programs).

PHARMACOTHERAPY BENEFITS (LIMITED)

- Prescription Drugs purchased at a Participating Pharmacy are administered by Express Scripts. Call 1-800-232-6549 for information.

EXCLUSIONS:

- Over-the-counter drugs.
- Acupuncture for smoking cessation counseling is not covered under the smoking cessation counseling benefit.
 - Refer to Complementary Therapies in the *Covered Services* section of this PBB for benefits available under the Acupuncture Benefit.

Transplants

- Human Organ transplant benefits are available for cornea, heart, heart/lung, lung, intestinal, kidney, liver, pancreas, and pancreas islet cell infusion. Bone marrow transplants are covered only for leukemia, aplastic anemia, lymphoma, severe combined immunodeficiency disease (SCID), **Wiskott Aldrich syndrome, and multiple myeloma**. Bone marrow transplant includes peripheral blood bone marrow stem cell harvesting and transplantation following high-dose chemotherapy.
- **Non-Human Organ transplants, except for porcine (pig) heart valve, are not covered.**
- **All transplants must meet Medical Necessity** criteria as determined by the TPA and be Certified.
- All Organ transplants must be deemed Medically Necessary by the Participant's Provider/Practitioner. **Transplant services shall be performed at a site approved by the TPA.**
- **Limited travel benefits** are available for the transplant recipient and one other person. Transportation costs will be covered **only if out-of-state travel is required**. Reasonable expenses for lodging and meals will be covered for both in-state and out-of-state transplants, up to a **maximum of \$150 per day for the transplant recipient and companion combined**. **All benefits for transportation, lodging, and meals are limited to a lifetime maximum of \$10,000.**
- **This benefit does not include transportation costs for deceased Participants, except as outlined in the Covered Services section under "Repatriation Reimbursement."**
- If there is a living donor that requires Surgery to make an Organ available for a covered transplant for a Participant, coverage is available for expenses incurred by the donor for travel, surgery, laboratory and x-ray services, Organ storage expenses, and Inpatient follow-up care only. The TPA will pay the Total Allowable Charges for a donor who is not entitled to benefits under any other health benefit plan or policy.
- **Transplant services obtained from Out-of-Network Providers/Practitioners are not covered.**

Women's Health Care

The following services are available for female Participants age 13 or over.

Obstetrical/Gynecological Care: includes annual exams, care related to pregnancy, miscarriage, therapeutic abortions, elective abortions up to 24 weeks and other obstetrical/gynecological services.

Women's Preventive Care, including but not limited to the following:

- Well-Woman Visits.
- Mammography.
- Gestational diabetes screening.
- HPV DNA testing.
- STI counseling.
- HIV Screening and Counseling.
- Contraception and contraceptive counseling.
- FDA approved women's Surgical sterilization procedures.
- Contraception implant insertion/reinsertion.
- Breastfeeding support, supplies, and counseling.
- Interpersonal and domestic violence screening and counseling.

Maternity And Newborn Care: Newborns and Mothers Health Protection Act of 1996 Notice

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending physician (i.e., the physician, nurse, midwife, or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

- **Maternity Coverage** is available to a mother and her newborn child (if enrolled) under this PBB for at least 48 hours of Inpatient care following a vaginal delivery and at least 96 hours of Inpatient care following a cesarean section. Hospital admissions must be Certified if in excess of this provision.

Inpatient care in excess of 48 hours following a vaginal delivery and 96 hours following a cesarean section will be covered if determined to be Medically Necessary by the Participant's attending Provider/Practitioner. In the event that the mother requests an earlier discharge, a mutual agreement must be reached between the mother and her Attending Provider/Practitioner. Such discharge must be made in accordance with the medical criteria outlined in the most current version of the "Guidelines for Prenatal Care," prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists including, but not limited to, the criterion that family members or other support person(s) will be available to the mother for the first few days following early discharge.

Postpartum care in the home is covered in accordance with accepted maternal and neonatal Provider/Practitioner assessments, by a person with appropriate licensure, training and experience to provide postpartum care. Services provided by such a person shall include, but not be limited to, parent education, assistance and training in breast and bottle feeding, and the performance of any necessary and appropriate clinical tests.

Coverage for postpartum care in the home includes a minimum of three home visits, unless one or two home visits are determined to be sufficient by the Attending Physician or person with appropriate licensure, training and experience to provide postpartum care, and the mother. The home visits shall be conducted within the time period ordered by the Attending Physician or person with appropriate licensure, training and experience to provide postpartum care.

Newborns of a Participant or a Participant's spouse will be covered from the moment of birth when enrolled as follows:

- The newborn must be enrolled within 31 calendar days from the date of birth.
- If enrollment of a newborn results in an increase to the amount of payment due, the applicable payment must be paid.
- If conditions listed above are not met, the newborn cannot be enrolled for coverage until the next annual Open Enrollment period
- Neonatal care is available for the newborn of a Participant for at least 48 hours of Inpatient care following a vaginal delivery and at least 96 hours of Inpatient care following a cesarean section. If the mother is discharged from the Hospital and the newborn remains in the Hospital, the newborn stay must be Certified.
- Benefits for enrolled newborns shall include coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, and transportation where necessary to protect the life of the infant - including air transport to the nearest available tertiary facility. Enrolled newborn benefits also include newborn visits in the Hospital by the baby's Provider/Practitioner, or those in charge of circumcision and , incubators, and other routine Hospital nursery charges.
 - **Note: Circumcisions performed other than during the newborn's Hospital stay are only covered when Medically Necessary.**

High-Risk Ambulance Services are covered in accordance with the *Covered Services* section under "Ambulance Services."

Midwives: midwifery is the provision of women's health care management in the antepartum, intrapartum, postpartum, and interconceptual periods, and infants up to six weeks of age.

The services of a Licensed Midwife or Certified Nurse Midwife are covered, **subject to the following limitations:**

- The Midwife's services must be provided under the supervision of a licensed obstetrician or licensed family Provider/Practitioner.
- The services must be provided in preparation for or in connection with the delivery of a newborn infant.
- For purpose of coverage under this Plan, the only allowable sites of delivery are a Hospital or a licensed birthing center. Elective Home Births and any prenatal or postpartum services connected with Elective Home Births are not covered. "Elective Home Birth" means a birth that was planned or intended by the Participant or Provider/Practitioner to occur in the home.
- The combined fees of the midwife and any attending or supervising Provider/Practitioner, for all services provided before, during, and after the birth, may not exceed the allowable fee(s) that would have been payable to the Provider/Practitioner had he/she been the sole Provider/Practitioner of those services.
- **The services of a lay Midwife or an unlicensed Midwife are not covered.**

PRENATAL MATERNITY CARE

Benefits which include prenatal care, pregnancy related diagnostic tests, (including an alpha-fetoprotein IV screening test for women, generally between 16 and 20 weeks of pregnancy, to screen for certain abnormalities in the fetus), visits to an Obstetrician, certified nurse-midwife, or Licensed Midwife, **Medically Necessary** nutritional supplements as determined by the attending Provider/Practitioner, childbirth in a Hospital or in a licensed birthing center. Please see *Schedule of Benefits* for special Co-pay information. **Elective Home Births are not covered.**

Elective Abortions are covered when performed prior to the 24th week of pregnancy.

Also covered are: Cytologic Screening (Pap Smear), Human Papillomavirus (HPV) Screenings, the HPV Vaccine Coverage for females 9-14 years of age, and other populations *in accordance with guidelines established by* The Advisory Committee on Immunizations Practices (ACIP), and mammography coverage described in the *Covered Services* section under "Cytologic (Pap Smear) Screening, Human Papillomavirus (HPV) Screening and HPV Vaccine Coverage."

MASTECTOMY, PROSTHETIC DEVICES AND RECONSTRUCTIVE SURGERY: WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

If the participant has had or is going to have a mastectomy, they may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- *All stages of reconstruction of the breast on which the mastectomy was performed.*
- *Surgery and reconstruction of the other breast to produce a symmetrical appearance.*
- *Prostheses.*
- *Treatment of physical complications of the mastectomy, including lymphedemas.*

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other Covered Services provided under this Plan.

Coverage for Medically Necessary Surgical removal of the breast (mastectomy) is for not less than 48 hours of Inpatient care following a mastectomy and not less than 24 hours of Inpatient care following a lymph node dissection for the treatment of breast cancer, unless the attending physician and patient determine that a shorter period of Hospital stay is appropriate.

Coverage for minimum Hospital stays for mastectomies and lymph node dissections for the treatment of breast cancer **is subject to the Deductible, Co-pay and Coinsurance** consistent with those imposed on other benefits.

Coverage is provided for external breast prostheses following Medically Necessary Surgical removal of the breast (mastectomy). As an alternative, post-mastectomy reconstructive breast surgery is provided, including nipple reconstruction and/or tattooing, tram flap (or breast implant if necessary), and reconstruction of the opposite breast if necessary to produce symmetrical appearance.

Prostheses and treatment for physical complications of mastectomy, including lymphedema, are covered at all stages of mastectomy. Two bras per year are covered for Participant's with external breast prosthesis. **All care must be provided by or under the direction of the Participant's Provider/Practitioner and with appropriate prior authorization from the Participant's TPA.**

Osteoporosis Coverage covers services related to the diagnosis, treatment, and appropriate management of **osteoporosis, when such services are determined to be Medically Necessary** by the Participant's Provider/Practitioner in consultation with the Participant's TP.

Limitations And Exclusions

Limitations

The following benefits have limits applied:

Acupuncture Treatment: benefits are limited to an Annual Plan Year maximum of 20 visits per Participant for covered expenses.

Air Ambulance: charges for non-emergencies will be covered only if Medically Necessary.

Autism/Applied Behavioral Analysis: short-term rehabilitation services are subject to the combined 70-visit limitation. Refer to the *Schedule of Benefits*.

Prior authorization: Availability of certain services and supplies are subject to prior authorization as specified in the How the Plan Works section under "Prior Authorization."

Benefit Limitations: Some services may be subject to dollar amount and/or visit limitations or may not be available from Out-of-Network Provider/Practitioners. Refer to the *Schedule of Benefits* and the *Covered Services* section for these limitations. All services are subject to the requirements identified in the *Covered Services* section, the prior authorization requirements listed in the How the Plan Works section, the plan limitations listed in this section and the exclusions listed in the Exclusions section.

Chiropractic Services are limited to an Annual Plan Year of 20 visits per Participant for covered expenses.

Cochlear Implants (and related care) are limited to implantation of a hearing device to facilitate communication for the profoundly hearing impaired, including any necessary training required to use the device.

Consumable Medical Supplies are covered during hospitalization. They are also covered during an office visit or authorized home health visit. This Plan does **not cover** supplies used at other times by the Participant or Participant's family. Consumable medical supplies are (1.) usually disposable, (2.) cannot be used repeatedly by more than one individual, (3.) are primarily used for a medical purpose, (4.) generally are useful only to a person who is ill or injured and (5.) are ordered or prescribed by a licensed Provider/Practitioner.

Contact Lenses or Eyeglasses are limited to services necessary to replace lenses absent at birth or lost through cataract or other intraocular Surgery, or prescribed by a Physician as the only treatment available for keratoconus. Duplicate lenses are not covered, and replacement is covered only if a physician or optometrist recommends a change in prescription due to the medical condition.

Dental Services cover only those procedures listed as *Covered Services*, as indicated in the *Covered Services* section under "Dental Services."

Diagnostic Testing for Infertility is limited to testing needed to diagnose the cause of infertility. Once the cause has been established and the TPA determines that the recommended treatment is not covered, no further testing will be covered under this Plan.

Durable Medical Equipment, Orthotic And Prosthetic Devices and External Prostheses require **prior authorization**. Discuss the need for prior authorization with the Provider/Practitioner.

Family Planning coverage is limited to Depo-Provera injections, diaphragms, implantable contraceptive devices (insertion and removal), intrauterine devices (IUDs), genetic testing, and sterilization procedures.

Home Health Care services require **prior authorization**. Discuss the need for prior authorization with the Provider/Practitioner.

Hospice Care benefits are limited to patients who are terminally ill as described in the *Covered Services* Section. Prior authorization is required. Discuss the need for prior authorization with the Provider/Practitioner.

Infertility Testing is limited to testing needed to diagnose the cause of infertility. Once the cause has been established and the treatment is determined not covered by this Plan, no further testing will be covered under this Plan.

Infertility Treatment is limited to Surgery to open obstructed tubes, epididymis or vasectomy when not the result of sterilization and replacement of deficient hormones if there is documented evidence of a deficiency.

Major Disasters: In the event of any Major Disaster, epidemic or other circumstances beyond the TPA's control, the TPA shall render or attempt to arrange *Covered Services* with In-Network Providers/Practitioners insofar as practical, according to its best judgment, and within the limitations of facilities and personnel as are then available. However, no liability or obligation shall result from nor shall be incurred for the delay or failure to provide any such service due to the lack of available facilities or personnel, if such lack is the result of such disaster, epidemic or other circumstances beyond the TPA's control, and if the TPA has made a good-faith effort to provide or arrange for the provision of such services. Such circumstances include complete or partial disruption of facilities, war, acts of war, acts of terrorism, riot, civil insurrection, and disability of a significant part of a Hospital, the TPA personnel, or In-Network Providers/Practitioners, or similar causes. This provision does not impose any limitation on the availability of coverage for services provided by Out-of-Network Providers/Practitioners.

Organ Transplants are limited to those procedures and benefits described in the *Covered Services* section under "Transplants."

Physical, Occupational and Speech Therapy are limited to 70 visits combined per Participant per Annual Plan Year and services require **prior authorization**.

Reconstructive Surgery requires **prior authorization** or no benefits are payable through the Plan.

Repairs Or Replacement Of Non-Rental Durable Medical Equipment, Orthotics and Prosthetic Devices, when Medically Necessary, due to wear and damage, requires **prior authorization** or no benefits are payable under this Plan.

Routine Eye Screenings are limited to Dependents through age 17.

Routine Hearing Screenings are limited to Dependents through age 21, if still attending high school.

Skilled-Nursing Care is limited to 60 days per Annual Plan Year and is subject to prior authorization. Discuss the need for prior authorization with the Provider/Practitioner.

Transplants Benefits for travel, lodging, and meals are limited to an adult transplant recipient and one other person. For minor children, benefits are payable for two adults. Lodging and meals are limited to \$150 per day combined, including the transplant patient, to a maximum lifetime benefit payment of \$10,000 including transportation. Donor organ procurement costs for the Surgical removal, storage, and transportation of the donated organ are covered for Reasonable and Customary Charges.

Exclusions

Any service, treatment, procedure, facility, equipment, drugs, drug usage, device or supply determined to be **not Medically Necessary** or accepted medical practice. This includes any service that is not generally recognized by the medical community as conforming to accepted medical practice or any service for which the required approval of a government agency has not been granted at the time the service is provided.

Activities of Daily Living, are not a Covered Service, including assistance in bathing, dressing, feeding, exercising, preparing meals, homemaking, moving the patient, giving medications, or acting as a sitter, are not a covered service.

Adoption/Surrogate Expenses are not a Covered Service.

Alternative/Complementary Therapies, except as specified in the *Covered Services* section under "Complementary Therapies" of this PBB.

Ambulance (including air ambulance) charges that are not Medically Necessary are not a Covered Service.

Amniocentesis and/or Ultrasound to determine the gender of a fetus are not *Covered Services* under this Plan.

Any Condition, disability, or expense sustained as a result of being engaged in: an illegal occupation, commission or attempted commission of an assault or other illegal act, participation in a civil revolution or riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.

Artificial Aids including speech synthesis devices (except items identified as being covered in the *Covered Services* section under “Durable Medical Equipment” of this PBB).

Artificial Conception including fertilization and/or growth of a fetus outside the mother’s body in an artificial environment, such as artificial insemination, in-vitro (“test tube”) or in-vivo fertilization, GIFT, ZIFT, all drugs, hormonal manipulation, donor sperm or embryo transfer are not *Covered Services*. Any Artificial Conception method not specifically listed is also excluded.

Athletic Trainers are not covered under this Plan.

Autism/Applied Behavioral Analysis:

- Any experimental, long-term, or maintenance treatments
- Services that are not Medically Necessary
- Any services received under the federal Individuals with Disabilities Education Improvement Act of 2004
- Related state laws that place responsibility on state and local school boards for providing specialized education and related services to children 3- 22 years old who have Autism Spectrum Disorder
- Respite services or care
- Services in accordance with a treatment plan that has not been Pre-authorized by the TPA
- Sensory Integration Therapy (SIT) or Auditory Integration Therapy (AIT)
- Music therapy, vision therapy, touch or massage therapy
- Floor time
- Facilitated communication
- Elimination diets, nutritional supplements, intravenous immune globulin infusion, secretin infusion
- Chelation therapy
- Hippotherapy, animal therapy, or art therapy

Autopsies and/or Transportation Costs for deceased Participants, except as outlined in the *Covered Services* section under “Repatriation Reimbursement.”

Baby Food (including baby formula or breast milk) or other regular grocery products that can be blenderized for oral or tube feedings.

Before Effective Date, Benefits Are Not Available for that portion of any Inpatient treatment provided before the Participant’s coverage effective date, or for any service or supply received before the Participant’s effective date under this Plan.

Behavioral Health Services are not a Covered Service under this Plan unless associated with a manifest behavioral/ mental health disorder.

BEHAVIORAL HEALTH SERVICES:

- **Halfway Houses**
- **Residential Treatment Centers**
- **Co-Dependency Treatment**
- **Counseling, including** sex, pastoral/spiritual, and bereavement counseling
- **Psychological Testing** when not Medically Necessary
- **Special Education**, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary problems.
 - This applies whether or not associated with manifest mental illness or other disturbances except as covered under the Family, Infant and Toddler Program. Refer to the *Covered Services* section under “Family, Infant and Toddler (FIT) Program.”

Benefits and Services Not Specified As Covered Services.

Bereavement Counseling is not a Covered Service under this Plan.

Biofeedback is not a Covered Service under this Plan.

Blood charges if the blood has been replaced and blood donor storage fees when there is not a scheduled procedure.

Care for conditions which state or local law requires be treated in a public or correctional facility.

Care for Military Service connected disabilities to which the Participant is legally entitled and for which facilities are reasonably available to the Participant.

Charges that are determined to be unreasonable by the TPA and charges in excess of Reasonable and Customary Charges.

Circumcisions performed other than during the newborn's Hospital stay, unless Medically Necessary.

Clinic or Other Facility Services that the Participant is eligible to have provided without charge.

Clothing Or Other Protective Devices including prescribed photo-protective clothing, windshield tinting, lighting fixtures and/or shields, and other items or devices whether by prescription or not.

Common Disposable Medical Supplies that can be purchased over-the-counter such as but not limited to bandages, band aids, gauze (e.g. 4 by 4's), and Ace bandages, except when provided in a Hospital or Provider/Practitioner's office or by a home health professional.

Complications of Non-Covered Services, supplies and treatment received including but not limited to complications for non-covered transplants, cosmetic, Experimental, or Investigational procedures, sterilization reversal, infertility treatment, or gender changes are not *Covered Services*, unless authorized by the Plan.

Contact Lenses Or Eyeglasses unless specifically listed as a Covered Service under this Plan.

Convalescent Care or rest cures are not *Covered Services* under this Plan.

Convenience Items: An appliance device, object or service that is for comfort and ease and is not primarily medical in nature, such as, shower or tub stools/chairs/seats, bath grab bars, shower heads, hot tubs/jacuzzis, vaporizers, accessories such as baskets, trays, seat or shades for wheelchairs, walkers and strollers, clothing, pillows, fans, humidifiers, and special beds and chairs (excluding those covered under Durable Medical Equipment benefits).

Corrective Eyeglasses or sunglasses, frames, lens prescriptions, contact lenses or the fitting thereof, except as identified in the *Covered Services* section under "Durable Medical Equipment" of this PBB.

Cosmetic Surgery including but not limited to breast augmentation, dermabrasion, dermaplaning, excision of acne scarring, acne surgery (including cryotherapy), asymptomatic keloid/scar revision, microphlebectomy, sclerotherapy (except when used for truncal veins), and nasal rhinoplasty.

Cosmetic Treatments, devices, orthotics, and medications are not covered.

Counseling Services unless listed as a Covered Service.

Court-Ordered Evaluation or Treatment, or treatment that is a condition of parole or probation or **in lieu of sentencing**, such as Alcohol or Substance Abuse programs and/or psychiatric evaluation or therapy.

Custodial Care such as sitters, homemaker's services, or care in a place that serves the patient primarily as a residence when the Participant does not require skilled nursing care.

DENTAL SERVICES:

- **Dental care** and dental x-rays, except as provided in the *Covered Services* section under "Dental Services/TMJ/CMJ" hospitalization, day surgery, Outpatient services, and/or anesthesia for non-Covered dental services **are covered if provided in a hospital or ambulatory Surgical center for dental surgery when approved by the TPA.**
- **Dental implants.**
- **Malocclusion Treatment**, if part of routine dental care and orthodontics.

- **Orthodontic Appliances And Orthodontic Treatment (Braces)**, crowns, bridges and dentures used for the treatment of Craniomandibular and Temporomandibular Joint disorders, unless the disorder is trauma related.

Diagnostic Testing for infertility is limited to testing needed to diagnose the cause of infertility. Once the cause has been established and if the treatment is determined to not be covered by this Plan, no further testing will be covered under this Plan.

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/Practitioner.

Domiciliary Care or care provided in a residential institution, treatment center, halfway house, or school because a Participant's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Donor Expenses incurred by a Participant are not a Covered Service under this Plan, except as specified in this PBB.

Duplicate Coverage including, but not limited to:

- Services already covered by other valid coverage.
- Services already paid under Medicare or services that would have been paid if the Participant was entitled to Medicare, had applied for Medicare, and had claimed Medicare benefits.
- If the Participant's prior coverage has an extension of benefits provision, this Plan will not cover charges incurred after the Participant's effective date under this Plan that are covered under the prior plan's extension of benefits provision.

Duplicate Diagnostic Tests or over-reads of laboratory, pathology, or radiology tests are **not covered**.

DURABLE MEDICAL EQUIPMENT:

- **Duplicate Durable Medical Equipment** items (i.e. for home and office). **Duplicate equipment** is not covered under this Plan for Participant convenience, comfort or travel purposes. Participants who are employed outside the home for two or more hours on a given day shall be eligible for an additional or alternative oxygen system, as medically appropriate, as determined by the TPA.
- **Functional Foot Orthotics**, including those for plantar fasciitis, pes planus (flat feet), heel spurs and other conditions (as determined by the TPA), orthopedic or corrective shoes, arch supports, shoe appliances, foot orthotics, and custom-fitted braces or splints except for patients with diabetes or other significant peripheral neuropathies.
- **Upgraded or Deluxe Durable Medical Equipment is not covered.**
- **Additional Wheelchairs**, if the Participant has a functional wheelchair, regardless of the original purchaser of the wheelchair.
- **Repair or Replacement of Durable Medical Equipment**, orthotic appliances and Prosthetic Devices due to loss, neglect, misuse, or abuse, or to improve appearance or convenience.
- **Repair and Replacement** of items under the manufacturer or supplier's warranty.

Educational or Institutional Services, except for diabetes education and preventive care provided under routine services as described in the *Covered Services* section.

Elastic Support Hose are not covered under this Plan.

Elective Abortions after the 24th week of pregnancy.

Elective Home Birth and any prenatal or postpartum services connected with an Elective Home Birth. Allowable sites for a delivery of a newborn are Hospitals and licensed birthing centers. Elective Home Birth means a birth that was planned or intended by the Participant or Provider/Practitioner to occur in the home.

Emergency Facilities for non-emergent services are not *Covered Services*.

Environmental Control expenses are not *Covered Services* under this Plan.

Exercise Equipment, videos, personal trainers, club membership and weight reduction programs are not *Covered Services* under this Plan.

Experimental or Investigational or Unproven Drugs, Medicines, Procedures, Devices, and/or Other Services as Determined by the TPA On Behalf Of the Plan. This means that one or more of the following is true:

- The independent assessment organization used by the TPA has rated the treatment, procedure or device as being a “C” or “D,” which indicates unproven benefit (unless the TPA has otherwise determined that coverage should be provided based on their assessment).
- The drug, medicine or device cannot be marketed lawfully without approval of the U.S. Food and Drug Administration (FDA), approval marketing has not been given at the time the drug, medicine, or device is furnished, or the FDA has determined that use of the drug, medicine, or device is contraindicated for the particular indication for which it has been prescribed.
- Reliable evidence shows that the drug, medicine, and/or device, treatment, or procedure is the subject of ongoing Clinical Trials (under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis), except as specified in the *Covered Services* section under Clinical Trials.
- Reliable evidence shows that the consensus of opinion among experts (such as the FDA) regarding the drug, medicine, and/or device, medical treatment, or procedure, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis. (Reliable evidence 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 protocols of another facility studying substantially the same treatment, procedure or device; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure or device. Reliable evidence does not include the results of coverage determinations from other health care insurers.)
- An Experimental or Investigational or unproven drug, medicine, treatment, procedure, or device will not be covered, even if it is the only treatment available for a specific medical condition.

Extracorporeal Shock Wave Therapy involving the musculoskeletal system is not covered under this Plan.

Eye Exercises and Refractions are not *Covered Services* under this Plan.

Food and Lodging Expenses are not covered except for those that are eligible for per diem coverage under the “Transplant Services” provision in the *Covered Services* section.

Foot Care, including all routine services such as the treatment of flat foot conditions, supportive devices, accommodative orthotics, orthopedic shoes (unless jointed to braces), partial dislocations, bunions (except capsular or bone Surgery), fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet, and the trimming of corns, calluses, or toenails (unless medical conditions such as diabetes exist).

GENETIC INBORN ERRORS OF METABOLISM:

- Food substitutes for lactose intolerance including soy foods or formulas or other Over-the-Counter digestive aids.
- Organic foods.
- Ordinary foodstuffs that might be part of an exclusionary diet.
- Food substitutes that do not qualify as Special Medical Foods.
 - Any product that does not require a Provider/Practitioner’s prescription.
- Special Medical Foods for conditions that are not present at birth.
- Food items purchased at a health food, vitamin or similar store.
- Foods purchased on the Internet.
- Special Medical Foods for conditions including, but not limited to, diabetes mellitus, hypertension, hyperlipidemia, obesity, and allergies to food products

Gloves, unless part of a wound treatment kit, are not covered under this Plan.

Hair-loss (or Baldness) treatments, medications, supplies and devices, including wigs, and special brushes are not covered under this Plan.

Health Care that is associated with an injury that is obtained or associated in the commission of a crime.

Hearing Aids and the evaluation for the fitting of Hearing Aids **except for school-aged children under age 18** (or under age 21 if still attending high school).

Home Health Care Services for care that:

- Is provided primarily for the convenience of the Participant or the Participant's family.
- Consists mostly of bathing, feeding, exercising, preparing meals, homemaking, moving the patient, giving medications, or acting as a sitter.
- Is provided by a nurse who ordinarily resides in the Participant's home or is a member of the Participant's immediate family.

Hospice Care benefits are **not covered** for the following services:

- Food, housing, and delivered meals.
- Volunteer services.
- Comfort items such as (but not limited to) aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those Covered under Durable Medical Equipment benefits).
- Homemaker and housekeeping services.
- Private duty nursing.
- Pastoral and spiritual counseling.
- Bereavement counseling.
- Respite Care.

Human Chorionic Gonadotrophin (HCG) injections are not a Covered Service under this Plan.

Hypnotherapy or services related to hypnosis, whether for medical or anesthetic purposes, except as covered in the *Covered Services* section under "Smoking Cessation Treatment."

Implantation of artificial organs or mechanical devices, except as specified in this booklet, are not a Covered Service under this Plan unless as a result of illness or injury, and **prior authorization** is obtained from the TPA prior to services being provided.

Infertility Testing and Treatment, unless specifically listed as a Covered Service. Also, see "Artificial Conception" under the Exclusion section of this booklet.

Late Claims Filing: This Plan does not cover services submitted for benefit determination if the TPA receives the claim **more than 12 months** after the date of service. **Note:** If there is a change in the Claims Administrator, the length of this timely filing period may also change.

Lay Midwife or unlicensed Midwife Services are **not covered** under this Plan.

Learning Disabilities and Behavioral Problems: This Plan does not cover special education, counseling, therapy, or care for learning or behavioral problems.

Legal Payment Obligations: Services for which the Participant has no legal obligation to pay or that are free, charges made only because benefits are available under this Plan, services for which the Participant has received a professional or courtesy discount, services provided by the Participant upon oneself or a covered family Participant, by one ordinarily residing in the Participant's household, by a family member, or Provider/Practitioner charges exceeding the amount specified by the Health and Human Services Department when benefits are payable under Medicare.

Local Anesthesia charges that have been included in the cost of the Surgical procedure are **not covered**.

Long-Term Rehabilitation Services are **not covered**. 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**.

Maintenance or Long-Term Therapy or care or any treatment (Inpatient or Outpatient) that does not significantly improve the Participant's function or productivity, or care provided after the Participant has reached his/her rehabilitative potential (unless therapy is Covered during an approved Hospice Benefit Period) is **not covered** under this Plan.

In a dispute about whether the Participant's rehabilitative potential has been reached, he/she is responsible for furnishing documentation from his/her Provider/Practitioner supporting his/her opinion that his/her rehabilitative potential has not been reached. **Note:** Even if the Participant's rehabilitative potential has not yet been reached, this Plan does not cover services that are in excess of maximum benefit limitations.

Massage Therapy is **not covered** under this Plan, except when performed by a Licensed Physical Therapist under the Physical Therapy benefit.

Medical Equipment, including, but not be limited to, stethoscopes and blood pressure monitors, unless listed as a covered item under this Plan.

Medically Unnecessary Services: This Plan does not cover services that are not Medically Necessary as defined in the *Covered Services* section, unless such services are specifically listed as covered (e.g., see "Preventive Services").

Membership Fees are not a Covered Service under this Plan.

Non-Human Organ Transplants except for porcine (pig) heart valve.

Non-Medical Equipment is **not a Covered Service** under this Plan.

Non-Medical Expenses: This Plan does not cover non-medical expenses (even if medically recommended and regardless of therapeutic value), including charges for services such as, but not limited to, missed appointments, "get-acquainted" visits without physical assessment or Medical Care, the provision of medical information to perform pre-admission or concurrent review, filling out of claim forms, mailing and/or shipping and handling charges, interest expenses, copies of medical records, modifications to home, vehicle, or workplace to accommodate medical conditions, voice synthesizers, other communication devices, membership fees at spas, health clubs, or other such facilities even if medically recommended.

Nonprescription and Over-the-Counter Drugs are excluded.

Nonstandard or Deluxe Equipment is **not a Covered Service** under this Plan.

Nutritional Supplements are **not a Covered Service** under this Plan unless the supplement is the sole source of nutrition. Infant formulas are not a Covered Service.

Organ Transplant Donor medical and/or Hospital services are not covered when the recipient of an Organ Transplant is not a Participant or when the transplant procedure is not covered.

Orthodontic Appliances and Treatment, Crowns, Bridges, or Dentures for the treatment of craniomandibular joint (CMJ) or temporomandibular joint (TMJ) disorders, unless the disorder is trauma related. Nonstandard diagnostic, therapeutic, and Surgical treatments of TMJ are not *Covered Services* under any circumstances.

Orthopedic or corrective shoes, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints are not covered except for Participants with diabetes or other significant neuropathies.

Orthoptics are **not a Covered Service** under this Plan.

Personal Convenience items such as air conditioners, humidifiers, physical fitness exercise equipment, or **personal services** such as haircuts, shampoos and sets, guest meals, and radio or television rentals are **not covered**.

Personal Trainers are **not covered** under the provisions of this Plan.

Photopheresis for all conditions other than mycosis fungoides.

Physical Examinations, Vaccinations, Drugs and Immunizations, for the primary intent of medical research or non-Medically Necessary purposes such as, but not limited to, licensing, certification, employment, insurance, flight, travel, passports or functional capacity examinations related to employment and/or immunizations.

Post-Termination Care: Except as otherwise required by applicable law, this Plan does not cover services received after the participant's coverage is terminated, even if prior authorization for such services were needed because of an event that occurred while they were covered.

Prescription Drugs: contact Express Scripts at 1-800-232-6549.

Private-Duty Nursing charges are **not covered** under this Plan unless services are considered Medically Necessary.

Private Room Expenses are **not a Covered Service** under this Plan unless there is documented medical necessity.

Protective Clothing or Devices are not covered under this Plan.

Radial Keratotomy, LASIK, and other eye refractive surgeries are **not Covered Services** under this Plan.

Residential Treatment Center Services are excluded.

Respite Care is excluded.

Reversal of Voluntary Sterilization is not covered.

Rolfing is not a Covered Service under this Plan.

Routine Foot Care, such as treatment of flat feet or other structural misalignments of the feet, removal of corns and calluses is not covered unless Medically Necessary due to diabetes or other significant neuropathies.

Self-Help Programs and Therapies not specifically covered in this booklet, such as behavior modification; music, art, dance, recreation therapy, and Z therapy; massage therapy (except when performed by a Licensed Physical Therapist, a Medical Doctor, Doctor of Osteopathy, Doctor of Oriental Medicine, or Chiropractor).

Services rendered to a Participant for treatment from injuries sustained in the **commission of a crime** are not covered.

Services for which the Participant or Dependent is **eligible under any governmental program (except Medicaid)**, or services for which, in the absence of any health service plan or insurance plan, **no charge would be made** to the Participant or Dependent.

Services not specifically identified as a benefit in this booklet, or services not listed as a Covered Service in this booklet.

Services Requiring prior authorization when prior authorization was not obtained. Participants are not liable when an In-Network Provider/Practitioner does not obtain prior authorization.

Sex-Change Operations, and reversals of such procedures are not *Covered Services*.

Sexual Dysfunction treatment, including medication, counseling, and clinics, except for penile prosthesis as listed in the *Covered Services* section under "Durable Medical Equipment" of this PBB.

Speech Therapy charges not otherwise listed as a Covered Service under this Plan.

Standby Professional Services are **not covered** under this Plan.

Storage or Banking of sperm, ova (human eggs), embryos, zygotes or other human tissue.

Surgical Sterilization Reversal of voluntary infertility procedures is **not covered** under this Plan.

Telephone Visits and Electronic Mail (Email), by a Provider/Practitioner or "environmental intervention" or "consultation" by telephone for which a charge is made to the patient. Also, "**get acquainted**" visits without physical assessment or diagnostic or therapeutic intervention provided.

Thermography (a technique that photographically represents the surface temperatures of the body) is **not covered** under this Plan.

Transplants not specifically listed as a Covered Service under this Plan are **not covered**.

Transportation Costs for deceased Participants, except as outlined in the *Covered Services* section under “Repatriation Reimbursement” of this PBB.

Travel and Lodging Expenses, except as provided in the *Covered Services* section under “Transplants” of this PBB.

Travel and Other Transportation Expenses, except as covered under “Ambulance Services” and “Medical Evacuation” are **not covered**.

Unreasonable Charges will not be covered by this Plan.

Untimely Filing: Claims filed more than 12 months after the date of service are **not covered**.

Veterans Administration Facility Services, or supplies furnished by a Veterans Administration facility for a service-connected disability, or while a Participant is in active military service are **not covered**.

VISION SERVICES:

- **Eye Movement Therapy.**
- **Eye Refractive Procedures**, including radial keratotomy, laser procedures, and other techniques.
- **Routine Vision Care and Eye Refractions** for determining prescriptions for corrective lenses, except as identified in the *Covered Services* section under “Durable Medical Equipment” and “Clinical Preventive Services” of this PBB.
- **Visual Training.**

Vitamins, dietary/nutritional supplements, special foods, formulas, or diets are not covered under this Plan.

Vocational Rehabilitation Services and Long-Term Rehabilitation are **not covered** under this Plan.

Weight-Loss Treatment For Obesity or bariatric surgery is not a Covered Service under this Plan.

Weight Reduction Or Control. Treatment and medications for the purpose of weight reduction or control are not covered under this Plan.

Work-Related Conditions, injuries, occupational illness or disease, if the Participant is required to be covered under Worker’s Compensation Insurance, whether or not such coverage actually exists.

FILING CLAIMS

Claims Submission

BCBSNM is the claims administrator for UNM Health and they encourage the electronic submission of claims. Claims may be submitted electronically 24/7. All facility (UB-04) and professional (CMS-1500) claims (excluding adjustments) can be filed electronically at no charge through the Availity Health Information Network. *Availity is a registered trademark of Availity, LLC. Availity is a partially owned subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an independent licensee of the Blue Cross and Blue Shield Association. Availity operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to Blue Cross and Blue Shield of New Mexico (BCBSNM), a Division of HCSC. Availity is solely responsible for the products and services it provides.*

Submit encounters and paper claims via mail to:
Blue Cross and Blue Shield of New Mexico
P.O. Box 27630
Albuquerque, NM 87125-7630

Corrected Claims

Corrected claims must be submitted within 180 calendar days of the date of service. **CMS-1500 corrected claims** may be submitted electronically by using the Claim Inquiry Resolution (CIR) tool. If you must file CMS-1500 corrections on paper, complete the Claim Review Form and attach the form to the top of the claim. Mail the form and the corrected claim to the address indicated on the form. Claims that are submitted with a “corrected claim” stamp or notation are not recognized by our system and could delay the processing of your corrected claim. **UB-04 corrected claims** should be submitted electronically whenever possible, using the appropriate Type of Bill indicating a corrected claim (e.g., 117 vs. 111). If you must file the UB-04 corrections on paper, please attach the Claim Review Form following the same instructions above as for the CMS-1500 claims.

Emergency Services Or Out-Of-Network Providers/Practitioners

Hospital, laboratory, x-ray, and clinic claims may be filed by Out-of-Network Providers/Practitioners, as well as In-Network. Out-of-Network Provider/Practitioners may also file claims for the participant.

Participants will be required to submit claim forms when Out-of-Network Providers/Practitioners do not file them.

The Member Claim Forms are available from the TPA's Customer Service Center Representative. They can also be printed out from the TPA's website. Participants may mail the claim forms and itemized bills to the TPA's Claim address: Blue Cross and Blue Shield of New Mexico P.O. Box 27630 Albuquerque, NM 87125-7630 .

Out-Of-Network Service Claims

When participants obtain *Covered Services* from an Out-of-Network Provider/Practitioner, the Provider/Practitioner, Hospital, or participant should file the claims with the TPA. If the Provider/Practitioner or Hospital does not file the claims, the participant should request an itemized statement and complete it the same way that they would for services received from an Out-of-Network Provider/Practitioner. **Payments for these services may be required to be made by the participant.**

Prescription Drug Claims

Claims for Prescription Drugs must be sent to the pharmacy benefit manager. Please call **Express Scripts** at 1-800-232-6549 for the claims filing procedures for Prescription Drugs.

How Payments Are Made

Payments to Out-of-Network Provider/Practitioners are sent to the Participant unless the Participant has assigned benefits to the Provider/Practitioner. When possible, this Plan will honor an Assignment of Benefits. However, the TPA reserves the right to pay the Participant directly and to refuse to honor an Assignment of Benefits to pay anyone other than the Participant in any circumstances.

Provider/Practitioner payments are based on In-Network Provider/Practitioner agreements and the Negotiated Fee Schedule as determined by the TPA. The participant is responsible for paying all Co-pays, Coinsurance, and non-Covered Services.

If a participant obtains services from an Out-of-Network Provider/Practitioner, they are responsible for any amounts greater than Reasonable and Customary amounts. They are also responsible for paying all Co-pays, Deductibles, Coinsurance and Non-Covered Services.

Payment of benefits for Participants eligible for Medicaid is made to the New Mexico Human Services Department or to the Medicaid Provider when required by law.

Participants may request to have another Provider/Practitioner examine them if there are questions about a **prior authorization** review or about a particular service or supply for which they are claiming benefits. In this event, the Plan will cover the requested examination.

If a participant obtains services from a UNM Health Network Provider/Practitioner in New Mexico, the Tier 1 UNM Health Network Provider will request prior authorizations from the TPA when required. If a participant obtains services from a Blue Cross Blue Shield of New Mexico extended network or Out-of-Network Provider/Practitioner, then it is the participant's responsibility to obtain a Benefit Determination and prior authorization when required. If the participant fails to obtain approval when required, services will not be covered.

Coordination Of Benefits

If a Participant is also covered under any other health benefit plan, other public or private Employer programs, or any other health insurance policy, the benefits provided or payable hereunder shall be reduced to the extent that benefits are available to the Participant under such other plan, policy or program whether or not a claim is made for the same.

The rules establishing the order of benefit determination between this Plan and any other plan covering a Participant not on COBRA Continuation Coverage, on whose behalf a claim is made, are as follows:

- **Employee/Dependent Rule**

- The plan that covers the Participant as an employee pays first.
- The plan that covers the Participant as a Dependent pays second.

- **Birthday Rule for Dependent children of parents NOT separated or divorced**

- The plan that covers the parent whose birthday falls earlier in the year, pays first. The plan that covers the parent whose birthday falls later in the year pays second. The birthday order is determined by the month and the day of birth, not the year of birth.
- If both parents have the same month and day of birth, the plan that covered the parent longer will pay claims first. The plan that covered the parent for a shorter period of time pays second.

- **Dependent children of separated or divorced parents.**
 - The plan of the parent decreed by a court of law to have responsibility for medical coverage pays first.
 - In the absence of a court order:
 - The plan of the parent with physical custody of the child pays first.
 - The plan of the spouse of the parent with physical custody (i.e., the step-parent) pays second.
 - The plan of the parent not having physical custody of the child pays third.
- **Active/Inactive.**
 - The plan that covers the Participant as an active employee (or Dependent of an active employee) pays first.
 - The plan that covers the Participant as a retired or laid-off employee (or Dependent of a retired or laid-off employee) pays second.
- **Longer/Shorter**
 - In the case of a Participant who is the contract holder under more than one Employer health insurance policy, then the plan that has covered the Participant for a longer period of time will pay first. The start of a new plan does not include a change of insurance carrier by the employer.
- **No Coordination Provision**
 - In spite of rules listed above, the plan that has no provision regarding coordination of benefits will pay first.
- **If a Participant is covered under a motor vehicle or homeowners insurance policy** which provides benefits for medical expenses resulting from a motor vehicle accident or accident in the Participant's own home, the Participant shall not be entitled to benefits under this Plan for injuries arising out of such accident to the extent they are covered by their motor vehicle or homeowners insurance policy.
 - If such benefits have been provided by the TPA, the participant's TPA shall have the right to recover any benefits provided from the motor vehicle or homeowner's insurer or the Participant, to the extent they are available under the motor vehicle or homeowner's insurance policy.
 - In no event shall the benefits received under this Plan and all other plans combined exceed the total reasonable actual expenses for the services provided under this Plan.
- **For purposes of Coordination of Benefits, the participant's TPA:**
 - May release, request, or obtain claim information from any individual or organization. In addition, any Participant claiming benefits shall furnish the TPA with any information that it may require.
 - Has the right, if overpayment is made by the TPA because of the Participant's failure to report other coverage or any other reason, to recover such excess payment from any individual to whom, or for whom, such payments were made.
 - Will not be obligated to pay for *non-Covered Services* or *Covered Services* not obtained in compliance with the TPA's policies and procedures.
- **Participants who are on COBRA Continuation Coverage** and are covered by another Employer plan shall receive benefits to the extent that this Plan is secondary payer of all eligible charges, subject to the terms, conditions, and limitations of this Plan.

MEDICARE

The benefits under this Plan for Participants enrolled in Medicare are not designed to duplicate any benefit to which the Participant is entitled under the Social Security Act. Benefits will be coordinated in compliance with current applicable federal regulations.

MEDICAID

Benefits payable by this Plan on behalf of an Enrollee who is qualified for Medicaid will be paid to the state Human Services Department or its designee when:

- The Human Services Department has paid or is paying benefits on behalf of the Enrollee under the state's Medicaid program pursuant to Title XIX and/or Title XXI of the Federal Social Security Act.
- The payment for the services in question has been made by the state Human Services Department to the Medicaid Provider/Practitioner.

Subrogation (Recovering Health Care Expenses from Others)

The benefits under this Plan will be available to a Participant who is injured by the act or omission of another person, firm, operation or entity. If a Participant receives benefits under this Plan for treatment of such injuries, the Plan will be subrogated to the rights of the Participant or the Personal Representative of a deceased Participant, or Dependent Participant, to the extent of all such payments made by the Plan for such benefits. This means that if the Plan provides or pays benefits, the participant must repay the Plan the amounts recovered in any lawsuit, settlement, or by any other means. This rule applies to any and all monies a Participant may receive from any third party or insurer, or from any uninsured or underinsured motorist insurance benefits, as well as from any other person, organization or entity.

By way of illustration only, the Plan's right of subrogation includes, but is not limited to, the right to be repaid when a Participant recovers money for personal injury sustained in a car accident. The subrogation right applies whether the Participant recovers directly from the wrongdoer or from the wrongdoer's insurer, or from the Participant's uninsured motorist insurance coverage. The Participant agrees to sign and deliver to the TPA, on behalf of the Plan, such documents and papers as may be necessary to protect the Plan's subrogation right. The Participant also agrees to keep the TPA advised of:

- Any claims or lawsuits made against any person, firm, or entity responsible for any injuries for which the Plan has paid benefits.
- Any claim or lawsuit against any insurance company, or uninsured or underinsured motorist insurance carrier.

Settlement of a legal claim or controversy without prior notice to the TPA, on the Plan's behalf, is a violation of this Plan. In the event a Participant fails to cooperate with the TPA or takes any action, through agents or otherwise, to interfere with the exercise of the Plan's subrogation right, the Plan may recover its benefit payments from that Participant.

When reasonable collection costs and reasonable legal expenses have been incurred in recovering sums which benefit both the Participant and the Plan, the Plan will, upon request by the Participant or the Participant's attorney, share such collection costs and legal expenses, in a manner that is fair and equitable, but only if the plan receives appropriate documentation of such collection costs and legal expenses.

Appeals And Grievances

APPEALS

The TPA will administer Level I and Level II appeals on behalf of the Plan, according to the procedures set forth below. These procedures apply to appeals of adverse prior authorization determinations based on medical necessity, appropriateness, health care setting level of care, effectiveness of a Covered Service, and/or rescission of coverage in the event of fraud or intentional misrepresentation of material fact. (**Note:** The TPA responds to all urgent or expedited requests within 24 hours of receiving the request.)

LEVEL I APPEALS

To initiate a Level I appeal, a Plan Participant (all references to Participant in the Appeals and Grievance section of the PBB include the Employee and/or covered Dependent(s)), must submit a request for an appeal to the TPA within one hundred eighty (180) days of receipt of a notice of denial of items or services under the Plan. The Participant must tell the TPA the reason why the denial should be overturned and include any information supporting the appeal. The TPA will acknowledge to the Participant in writing within one working day that it has received a request for an Appeal. The acknowledgement letter will contain the name, address, and direct telephone number of an individual at the TPA who may be contacted regarding the appeal.

• Timeframes for Processing Appeals of Adverse Determinations

Level I appeals involving the review of a denial of coverage for services before they are received (pre-service) will be completed within fifteen (15) working days of receipt of a standard appeal request. Appeals involving the review of a denial of coverage of services after they are received (post-service) will be completed within forty (40) working days. The TPA may extend the review period for a maximum of ten (10) working days for pre-service requests and twenty (20) working days for post-service requests if the TPA can: (1.) show reasonable cause beyond the TPA's control for the delay (2.) can show that the delay will not result in increased medical risk to the Participant and (3.) provide a written progress report to the Participant and the related provider within the twenty-five (25) or sixty (60) day review period. Participants must agree, in writing, to a request to extend a deadline.

Some appeals of pre-service denials relating to claims involving urgent care are processed on an expedited basis. Expedited decisions are made when a Participant's life or health, or ability to regain maximum function, would be jeopardized by following the standard appeal process and time frames, or, in the opinion of a physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. In cases that require an expedited decision of a pre-service request, based at the request of a participating provider or Participant, a decision will be made within seventy-two (72) hours of the receipt of the request. The TPA will not conduct expedited appeals for services already provided ("post-service") to a Participant. If a Participant requests an expedited decision, the TPA medical director will review the request. If the medical director determines that the request for an expedited appeal is Medically Necessary, a decision will be made within seventy-two (72) hours of the request. All required information will be transmitted between the TPA, the applicable provider, and the Participant by the quickest means possible. If the medical director determines that a request for an expedited appeal is not medically necessary, the TPA will notify the applicable Participant and then process the appeal within fifteen (15) working days.

• Internal Review of Appeal of Adverse Determination by Medical Director Level I

The appeal will be reviewed by the TPA medical director not involved in the initial determination, nor by a subordinate of the person resolving the claim initially. The medical director will re-review the request to make a determination regarding whether the requested health care services are medically necessary and covered under the Plan. If medical judgment is involved, the TPA medical director will utilize input from a health care professional with training and experience in the relevant field.

• Notice of Decision on Appeal of Adverse Determination by Medical Director

If the medical director decides to reverse an initial adverse determination, the TPA will approve coverage of the services. The applicable Participant and the applicable provider will be notified by mail or electronic means (fax, email, etc.) within two (2) working days of such decision.

If the medical director decides to uphold an initial adverse determination, the applicable Participant and the applicable provider will be notified by telephone within twenty-four (24) hours that the adverse determination has been upheld and by written or electronic means within one (1) working day of the telephone notification. Written notification must be provided in a linguistically appropriate manner. The notice will provide the opportunity to request diagnosis and treatment codes and their meanings. The Participant will be given the choice of whether or not to pursue a Level II appeal. If the Participant does not wish to pursue the appeal, the TPA will mail to the participant written notification of the decision and confirmation of the Participant's decision not to pursue the appeal within three (3) working days of the medical director's decision.

If the TPA is unable to contact the Participant by telephone within seventy-two (72) hours after making the decision to uphold the initial adverse determination, then the TPA will notify the Participant by mail of the decision. Included in the notification will be a self-addressed stamped response letter, which asks whether the Participant wants to pursue the level II appeal by asking the Participant to check “yes” or “no” on the letter. If the Participant does not return the letter within ten (10) working days, the TPA will again try to contact the Participant by telephone. If the Participant does not respond to the TPA’s telephone calls and does not return the response letter within twenty (20) working days of the written notification to uphold the initial decision, the TPA will close the file, documenting that the Participant has not responded.

If the appeal was processed on an expedited basis, then a Level II appeal will automatically proceed. This review will be completed within seventy-two (72) hours. If an expedited review is conducted during a Participant’s stay or course of treatment, coverage for health care services will be continued subject to applicable co-payments and deductibles until the TPA makes a decision and notifies the Participant. If the Participant does not make an immediate decision to pursue a Level II appeal, or if the Participant requests additional time to supply supporting documents or information, the timeframes described above for completing an appeal will be extended to include the additional time the Participant needs.

INTERNAL PANEL REVIEW OF ADVERSE DETERMINATION - LEVEL II

If the Participant requests a Level II appeal, then the TPA will conduct the appeal on behalf of Employer according to the process set forth below.

- **Internal Panel Review Committee**

An internal panel review committee will consider the appeal. The internal panel review committee will consist of the TPA staff and one (1) or more health care or other professionals. At least one (1) of the health care professionals will have training and experience in the relevant field and practice in a specialty that would typically manage the case that is the subject under appeal or be mutually agreed upon by the Participant and the TPA. Panel members must be present physically or by video or telephone conferencing to hear the appeal. A panel member who is not present to hear the appeal either physically or by video or telephone conferencing will not participate in the decision.

- **Notice of Internal Panel Review Hearing**

The TPA will notify the Participant in writing of the date, time, and place of the internal panel review hearing. The notice will also advise the Participant of the Participant’s appeal rights. Such rights include: attending and participating in the internal panel review, presenting a case to the internal panel review committee, submitting supporting material both before and at the internal panel review, asking questions of any representative of the TPA, asking questions of the health care professionals on the internal panel review committee, and being assisted or represented by a person of the Participant’s choice, including legal representation. A Participant may hire a specialist to participate in the internal panel review at the Participant’s own expense. This specialist may not participate in making the decision.

If the Participant chooses to have legal representation at the hearing, the Participant must notify the TPA prior to the hearing. Failure to notify may require rescheduling of the hearing within the timeframe allowed to complete the appeal. If the TPA or Employer has an attorney present to protect its interests, a notice will advise the Participant of that and advising that the Participant may wish to obtain legal representation of his or her own. The TPA will notify the Participant of this at least three (3) working days before the hearing.

The TPA will accept a Participant’s reasonable request for postponement of a hearing. Timeframes previously described for completing an appeal will be extended during the period of any postponement.

- **Timeframes for Internal Panel Review Committee**

No fewer than three (3) working days prior to the internal panel review, the TPA will provide the Participant with: pertinent records; treating provider’s recommendation, the PBB, a copy of the notice of the adverse determination, uniform standards relevant to the Participant’s medical condition used by the internal panel in reviewing the adverse determinations, information provided to or received by any medical consultants retained by the TPA, and all other evidence or documentation relevant to reviewing the adverse determination. The Participant may review the claim

file and present evidence and testimony as part of the appeals process, to the extent required by Applicable Law. Applicable Laws as related to Appeals are defined as the regulations issued in the July 23, 2010 Federal Register, June 24, 2011 Federal Register, and subsequent guidance, including any superseding regulations. In addition to the claim file, the Participant may review any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim.

The internal panel review committee will complete its review for expedited cases within seventy-two (72) hours of receipt of the request, if the Participant's life or health would be jeopardized or the participant's ability to retain maximum function would be jeopardized by a delay, or, in the opinion of physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The internal panel review committee will complete its review of a standard appeal within timeframes previously noted. The TPA will notify the participant and the treating provider of the internal panel review committee's decision by telephone within twenty-four (24) hours of making a decision, and in writing or by electronic means within one (1) working day of the telephone notice.

Individuals in urgent care situations and individuals receiving an ongoing course of treatment may proceed with an expedited external review by an Independent Review Organization (IRO) at the same time as the internal review process occurs.

- **Notice of Decision of Internal Panel Review Committee**

The written notice will contain the following: the names, titles, and qualifying credentials of the persons on the internal panel review committee;; a statement of the internal panel review committee's understanding of the nature of the appeal and all pertinent facts;; an explanation of the clinical or other rationale for the decision; and for coverage determinations, identification of the Plan provision relied upon in reaching the decision;; and the opportunity to request diagnosis and treatment codes and their meanings. The notice will also explain why each provision did or did not support the decision regarding coverage of the requested service. For medical necessity determinations, it will include the uniform standards relevant to the Participant's medical condition, an explanation whether each supported or did not support the decision regarding the medical necessity of the coverage decision, and reference to evidence or documentation considered by the internal panel review committee in making the decision. The notice will also explain the Participant's right to request an external review by an Independent Review Organization (IRO). Review by an IRO is voluntary and explained in the next section. The Participant must receive the written notice in a linguistically appropriate manner.

LEVEL III – EXTERNAL REVIEW

If the Participant is dissatisfied with the decision of the Internal Panel Review Committee, the Participant may request an external review by an Independent Review Organization (IRO) as defined by Applicable Law. An IRO is an independent review organization, external to the Employer and the TPA, that utilizes independent physicians with appropriate expertise to perform external reviews of appeals. The IRO will, with respect to claims involving investigational or experimental treatments, ensure adequate clinical and scientific experience and protocols are taken into account as part of the External Review process. In rendering a decision, the IRO will consider any appropriate additional information submitted by the Participant and will follow the plan documents governing the Participant's benefits.

For claims involving urgent care, a Participant may request an expedited external review if the adverse benefit determination involves a medical condition of the Participant for which the regular time frame would seriously jeopardize the life or health of the Participant or would jeopardize the Participant's ability to regain maximum function, and the Participant filed a request for an expedited internal appeal, or, if the final internal adverse benefit determination involved a situation where the Participant had a medical condition where that time frame would pose such jeopardy, and if the final internal adverse benefit determination concerned an admission, availability of care, continued stay, or health care service for which the Participant received emergency services and was not discharged from a facility.

Individuals in urgent care situations and individuals receiving an ongoing course of treatment may proceed with an expedited external review by an IRO at the same time as the internal review process occurs.

There are no fees or costs imposed on a Participant for the external review of an appeal. The Participant's decision as to whether or not to submit a denial of an appeal for external review will have no effect on the Participant's rights to any other benefits under the Plan.

When an appeal is denied by the TPA, the Participant will receive a letter that describes the process to follow if the Participant wishes to pursue an external review of an appeal through an IRO.

If a Participant files a request for an external review of an appeal with an IRO:

- The external review may only be requested after exhaustion of the required Internal Appeal procedures under the Plan, unless an expedited external review of a claim involving urgent care or an ongoing course of treatment is requested. Accordingly, the Participant must first submit an appeal with the TPA and receive a denial of appeal before requesting an external review of an appeal with an IRO.
- After a Participant receives a denial of an appeal, the Participant must submit the request for external review of appeal with the TPA in writing within 4 months from the date of receipt of the adverse benefit determination, extended to the next working day if the date falls on a weekend or federal holiday.
- The TPA will forward a copy of the final appeal denial letter, and all other pertinent information that was reviewed, in the appeal to the IRO. The Participant may also submit additional information to be considered. The Participant will have at least five (5) business days to submit additional information to the IRO.
- Within five (5) days after receipt of the request for external review, the TPA will complete a preliminary review to determine if the Participant was covered under the Plan at the time the service was requested or provided, whether the adverse benefit determination relates to the Participant's failure to meet the eligibility requirements of the Plan; whether the Participant has exhausted the Plan's internal appeal process, and whether the Participant has provided all of the information and forms required to process an external review. Within one (1) business day after completion of this preliminary review, the TPA will provide the Participant written notification, giving any reasons for the ineligibility of the request for external review, and describing the information or materials required. The Plan will allow the Participant to perfect a request for external review within the four month filing period, or within the 48-hour period following receipt of the notification, whichever is later.
- The Participant will be notified of the decision of the IRO within 45 days of the receipt of the request for the external review of an appeal. The IRO's decision will include:
 - a) A general description of the reason for the request for external review.
 - b) The dates the IRO received the assignment to conduct the external review and the date of their decision.
 - c) Reference to the evidence or documentation, including specific coverage provisions and evidence-based standards considered in reaching their decision, taking into account adequate clinical and scientific experience and protocols with respect to claims involving experimental or investigative treatments.
 - d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision.
 - e) A statement that judicial review may be available.
 - f) Current contact information, including the phone number for any ombudsman established under the PHS Act.
 - g) In the event of an expedited external appeal for claims involving urgent care, the IRO will make the decision as expeditiously as the Participant medical condition or circumstances require, but not more than 72 hours after the IRO receives the request for an expedited external review and, if the notice is not in writing within 48 hours after the date of providing the verbal notice, the IRO will provide written confirmation of the decision to the Participant and the Plan. Written notice must be provided in a linguistically appropriate manner. The notice will provide the opportunity to request diagnosis and treatment codes and their meanings.
 - h) The decision of the IRO will be binding on the Participant as well as the Plan, except to the extent there may be other remedies available under state law.
- The statute of limitations or other defense based on timeliness is suspended during the time that an external review of the Participant's appeal is pending.

If the Participant does not submit a request for external review of an appeal:

- The Employer and the TPA waives any right to assert that the Participant failed to exhaust administrative remedies.

GRIEVANCES

Participants may file a grievance if they are dissatisfied with any aspect of the Plan other than a request for health care services, including, but not limited to: administrative practices that affect the availability, delivery or quality of health care services, claims payment, handling or reimbursement for health care services, and terminations of coverage. If the Participant is unable to resolve the grievance with a customer care representative, the Participant may file a formal grievance by notifying a customer care representative.

INITIAL INTERNAL REVIEW - LEVEL I

Once the request has been received, the TPA will send the Participant written acknowledgement of the grievance within three (3) working days after receipt. The letter will contain the name, address, and direct telephone number of a TPA representative who may be contacted regarding the administrative grievance. The review of the grievance will be conducted by a TPA representative authorized to take action related to the grievance, if applicable, and will allow the Participant to provide to the TPA any information relevant to the grievance.

The TPA will mail a written response to the Participant within fifteen (15) working days of receipt of the grievance. The TPA may extend the fifteen (15) day timeframe when there is a delay in obtaining documents or records necessary for the review of a grievance, provided that the TPA notifies the Participant in writing of the need and reasons for the extension and the expected date of resolution, or by mutual written agreement of the Participant and the TPA.

The TPA's response letter to the Participant shall contain: the name, title, and qualifications of the person conducting the initial review, a statement of the reviewer's understanding of the nature of the grievance and pertinent facts, a clear and complete explanation of the reason for the response/decision, the Plan provisions relied on in reaching the response;; a statement that the initial decision will be binding unless the Participant submits a request for reconsideration within twenty (20) working days of the receipt of the initial response;; and a description of the procedures and deadlines for requesting reconsideration, including any necessary forms.

RECONSIDERATION OF INTERNAL REVIEW – LEVEL II

If the Participant is not satisfied with the outcome of the initial review, the TPA will appoint a reconsideration committee, consisting of TPA representatives who have not participated in the initial internal review, to review the grievance. The Participant must request this committee hearing within twenty (20) days after receiving the response letter, or the initial review decision will be final.

• Reconsideration Committee

Upon receipt of a request for a reconsideration committee hearing, the TPA will schedule and hold a hearing within fifteen (15) working days. The hearing will be held during regular business hours at a location reasonably accessible to the Participant. The Participant will have the opportunity to participate at the committee meeting in person, by conference call, video conferencing, or other technology, at the TPA's expense. The TPA will not unreasonably deny a request for postponement of the hearing.

- **Reconsideration Committee Hearing**

The TPA will notify the Participant in writing of the hearing date, time, and place of the reconsideration committee hearing at least ten (10) working days in advance. The notice will advise the Participant of his or her rights: to attend the hearing, to present a case to the committee, to submit supporting material both before and at the hearing, to ask questions of any representative of the TPA, and be assisted or represented by a person of the Participant's choice that may or may not be a legal representation. If the TPA has an attorney to represent its interests, the notice will advise the Participant of this, so that the Participant may, if he/she wishes, obtain legal representation of his or her own. If the Participant chooses to have legal representation at the hearing, the Participant must notify the grievance department representative prior to the hearing. Failure to notify may require rescheduling of the hearing within the timeframe allowed for administrative grievances. No fewer than three (3) working days prior to the hearing, the TPA will provide the Participant with all the documents and information that the reconsideration committee will rely on in reviewing the grievance.

- **Decision of Reconsideration Committee**

The TPA will mail a written decision to the Participant within seven (7) working days after the committee hearing. The written decision will include the following: the names, titles, and qualifications of the persons on the committee, the committee's statement of the issues involved in the grievance, a clear and complete explanation of the rationale for the decision, the Plan provision(s) relied on in reaching the decision, references to the evidence or documentation relied on in reaching the decision, and a statement that the initial decision will be binding, unless the participant submits a request for external review by employer.