CHRISTUS
Health Plan

POLICY & EVIDENCE OF COVERAGE

New Mexico Health Insurance Exchange

Catastrophic Coverage

A Health Maintenance Organization Product

IMPORTANT PHONE NUMBERS AND ADDRESSES

Member Services	**Address:** CHRISTUS Health Plan Attn: Member Service Department 919 Hidden Ridge Irving, Texas 75038	**Toll-Free** 1-844-282-3025 **TTY** 1-800-659-8331
Prior Authorization	**Address:** CHRISTUS Health Plan Attn: Prior Authorization Department 919 Hidden Ridge Irving, Texas 75038	**Toll-Free** 1-844-282-3077 **TTY** 1-800-659-8331
Claims	**Address:** CHRISTUS Health Plan Attn: Claims Department 919 Hidden Ridge Irving, Texas 75038	**Toll-Free** 1-844-282-3025 **TTY** 1-800-659-8331
Appeals and Grievances	**Address:** CHRISTUS Health Plan Attn: Appeals & Grievances Department 919 Hidden Ridge Irving, Texas 75038	**Toll-Free** 1-844-282-3025 **TTY** 1-800-659-8331
Website www.christushealthplan.org		
Language Access Services Toll Free 1-866-874-3972		

CHRISTUS Health Plan

TABLE OF CONTENTS

WELCOME TO CHRISTUS Health Plan

We are glad you have chosen CHRISTUS Health Plan (CHP). We are pleased to serve you through our health plan.

When you join CHP, you are joining a health plan that is part of a larger health system. Our health system is faith-based and not-for-profit. As a health system, we can coordinate your care. Whether you are healthy and want preventive care, need to see a doctor, or have a more serious health need, we are there to serve you. We believe that you, your family, and your community are critical to your total well-being. We will engage you in your health care decisions and we will give you the tools and support you need to manage your health and benefits.

This Policy and Evidence of Coverage ("Policy") is offered by CHRISTUS Health Plan, a New Mexico licensed Health Maintenance Organization (HMO). This Policy describes Your rights and benefits under this individual and family HMO policy and CHRISTUS Health Plan. The Policy includes the *Summary of Benefits and Coverage* and is a legal contract between you (referred to as Member, You, or Your) and CHRISTUS Health Plan (referred to as CHP, We, Our, and Us).

Throughout this Policy, please refer to Your *Summary of Benefits and Coverage* provided with this Policy, which shows some specific Covered Benefits this Policy provides, the specific amounts You may have to pay (Cost Sharing), and certain Coverage **Limitations** and **Exclusions**. The *Summary of Benefits and Coverage* is part of this Policy, and together the Policy and *Summary of Benefits and Coverage* provide a full description of the Covered Benefits, Exclusions, and conditions of the Plan.

PLEASE READ THIS POLICY CAREFULLY and keep this Policy, along with the *Summary of Benefits and Coverage* in a safe place that you can access quickly. Please be aware that Your physicians and Providers do not have a copy of this Policy and are not responsible for knowing or telling you about Your Covered Benefits to You.

This Policy provides important information about:

- Your Rights and Responsibilities as a Member;
- Covered Benefits under the Plan and how to access them;
- Limitations and Exclusions from the Plan; and
- How to seek assistance from CHRISTUS Health Plan.

Understanding this Policy can help You make the most of Your Covered Benefits.

Key Terms Used in this Policy

Since this Policy is a legal document, there are certain key terms that have special meanings. These terms are defined in the DEFINITIONS section of this Policy. Please review this section carefully.

MEMBER RIGHTS AND RESPONSIBILITIES

CHRISTUS Health Plan (Plan) is committed to providing high-quality health care benefits to You. As a Member of the Plan, there are certain rights that you are entitled to, as well as some responsibilities. It is important that You fully understand both Your rights and Your responsibilities under this Policy. This Section explains Your rights and responsibilities under this Policy and how You can participate in Our Consumer Advisory Board.

Member Rights

As a Member of the Plan, You have the right to:

- Available and accessible services for Medically Necessary and Covered Services, including 24 hours per day, 7 days per week for Urgent or Emergency Services, and for other Health Care Services as defined by this Policy or *Summary of Benefits and Coverage*.
- Be treated in a prompt, courteous and responsible manner that respects Your dignity and privacy.
- Detailed information about Your coverage; benefits; and services offered under this Policy. This includes any Exclusions of specific Conditions; ailments or disorders, including restricted prescription benefits; the Plan's policies and procedures regarding products, services, Providers appeal procedures and other information about the Plan and the benefits We provide to You. This also includes access to a current list of Participating Providers in the Plan's network; information about a particular Participating Provider's education, training, and practice; and the Member Rights and Responsibilities, as well as the right to make recommendations regarding Our Member Rights and Responsibilities policies.
- Affordable health care including information regarding Your out-of-pocket expenses; plan limitations; and an explanation of Your financial responsibility when services are provided by a Non-Participating Provider or without Prior Authorization.
- Choose a Primary Care Provider within the limits of the Covered Services, the Plan's network, and as provided by the Policy, including the right to refuse care of specific Health Care Professionals. In addition, You have the right to participate with Your Providers in making decisions about Your health care.
- Be given an explanation of Your medical Condition, recommended treatment, risks of the treatment, expected results, and reasonable medical alternatives by Your Participating Provider in terms that You understand. If You are unable to understand the information, an explanation must be given to Your next of kin, guardian or another authorized person. This information shall be documented in Your medical records.
- All rights afforded by law, rule, or regulation as a patient in a licensed Health Care Facility, including the right to be informed about Your treatment by Your Participating Provider in terms that You understand; to request your consent (agreement) to the treatment; to refuse treatment, including medication; and to be told of possible consequences of refusing such

treatment. This right exists even if treatment is not a Covered Benefit or Medically Necessary under the Plan. The right to consent or agree to treatment by You or Your next of kin, guardian, or another authorized person may not be possible in an emergency where Your life and health are in serious danger.

- Voice Complaints, Grievances or Appeals with the Plan or the Superintendent of Insurance (Superintendent) about the Plan or the coverage We provide. You as a Member also have the right to receive an answer within a reasonable time and in accordance with existing law and without fear of retaliation.
- Be promptly notified of termination or changes in benefits, services or the Provider Network.
- Confidential handling of all communications, including medical and financial information maintained by the Plan. Privacy of Your medical and financial records will be maintained by Us and Our Providers in accordance with existing law.
- A complete explanation of why a benefit is denied, the opportunity to appeal the denial decision, to our internal review and the right to request help from the Superintendent.
- Know, upon request, of any financial arrangements or provisions between the Plan and Our Participating Providers, which may restrict referrals or treatment options or limit the services offered to You.
- Qualified Health Care Professionals for treatment and services that are Covered Benefits near where You live or work within the Plan's Service Area.
- Receive information about how benefits are authorized or denied. You have the right to know how new technology for Covered Benefits are evaluated. You can also request and receive information about the Plan's quality assurance plan and Utilization Review methodology.
- Receive detailed information about all requirements that you must follow for Prior Authorization and Utilization Review.

Member Responsibilities

As a Member of the Plan, You have the responsibility to:

- Provide honest and complete information to those providing You care.
- Review and fully understand the information You receive about Your Plan.
- Know the proper use of the services covered by the Plan.
- Present Your Plan ID card before You receive care.
- Consult Your Physician before receiving medical care, unless Your Condition is life threatening.
- Promptly notify Your Provider if You will be delayed or unable to keep an appointment.
- Pay all charges or Copay/Coinsurance amounts, including those for missed appointments. This also applies to Deductibles and any charges for non-Covered Benefits and Services.
- Express Your opinions, Complaints or Concerns in a constructive way to CHRISTUS Health Plan Member Services or to your Provider.

- Inform the Plan of any changes in family size, address, phone number or Membership status within thirty (30) calendar days of the change.
- Make Premium payments on time.
- Notify the Plan of other insurance coverage.
- Follow Our Grievance and Appeal process when displeased with the Plan or a Providers' actions or decisions.
- Understand Your health problems and participate in developing treatment goals that You agree to with Your Providers.
- Follow plans and instructions for care that You have agreed to with Your Provider.

All Members are responsible for understanding how the Plan works. You should carefully read and refer to this Policy and Your *Summary of Benefits and Coverage*. Contact the Customer Care Center when You have questions or Concerns about Your Plan.

Consumer Advisory Board

CHRISTUS Health Plan recognizes the importance of receiving feedback from Our Members and We want Your participation. We have created a Consumer Advisory Board that meets on a quarterly basis to obtain Members' perspectives on the products and services that We offer and to discuss how We might better serve You. The information We receive is very valuable to Us and helps Us improve the health of Our Members. As a Member of the Plan, You are eligible to participate on this Board. If You are interested in doing so, contact Our Members Services.

ELIGIBILITY AND ENROLLMENT

Eligibility

The Federal Exchange (Exchange) makes eligibility decisions based upon the application that You submit. You are responsible for notifying the Exchange about any changes that could affect eligibility such as an adoption, a birth, addition of another dependent, or a divorce. To be eligible for Covered Benefits in accordance with this Contract, You must be enrolled as a Member. In this context, the Member is the individual who has applied for coverage on behalf of his/herself and his/her Dependents, and to whom this Contract has been issued.

To be eligible to enroll as a Member, you must meet the criteria set forth below.

A Primary Subscriber must:

- Currently live or intend to live, or work in the Service Area;
- Be under age 30 or qualify for a hardship exemption under the Marketplace rules;
- Be ineligible for Medicare;
- Other than individuals with end stage renal disease not be eligible for coverage under Medicare due to age, illness or disability;
- Be a citizen or a natural of the United States;
- Not be incarcerated, other than incarceration pending disposition of charges;
- Be lawfully present in the United States, if not a citizen or natural of the United States; Be a Qualified Individual eligible for coverage through the Exchange;
- Continue to meet these criteria.

To be eligible as a Dependent, each dependent must meet the following criteria:

- Be a Dependent of a Qualified Individual eligible for coverage through the Exchange; AND either
- Be enrolled at the same time as the Member, OR
- Be enrolled within 31 days of a Qualifying Event as described under the Special Enrollment Period for Dependents.

A Dependent is a Member's lawful spouse, or Domestic Partner, and children under age 26. The term "child/children" includes:

- A natural child;
- A stepchild;
- A legally or adopted child of the Member or the Members' spouse or Domestic Partner; or
- A child for whom the Member or the Member's spouse or Domestic Partner are the legal guardian.

Any adopted child(ren) that You wish to enroll must be legally placed in Your home for adoption by a court of law within the United States. Any child(ren) for whom You are the permanent legal guardian must be supported pursuant to a court order imposed on You. An example of this is a Qualified Medical Child Support Order.

Dependents are limited to those under the age of twenty-six (26). Dependents over the age of twenty-six (26) may qualify for continued dependent coverage if the Dependent is incapable of self-sustaining employment due to a mental retardation or has a physical disability which existed prior to age twenty-six (26) and the Dependent is chiefly dependent upon the Subscriber for support and maintenance. You must submit proof of the child's mental or physical handicap and dependency. Send this within thirty-one (31) days after the date the child ceases to qualify as a Dependent. During the next two (2) years, We may require proof of the continuation of the child's disability and dependence. Thereafter, We may require such proof only once a year.

We will provide coverage to Dependent children as required due to a Qualified Medical Child Support Order in accordance with applicable federal or state laws or regulations. These Dependents are not bound by enrollment season restrictions.

A **Domestic Partner** is defined as a person of the same or opposite sex who meets all of the following criteria:

1) shares a permanent residence with the Member;
2) has resided with the Member for no less than one year;
3) is no less than eighteen years (18) of age;
4) is financially interdependent with the Member and has proven such interdependence by providing documentation of at least two of the following arrangements:
   a. common ownership of real property or a common leasehold interest in such property;
   b. common ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under a partner's will;
   c. assignments of a durable power of attorney or health care power of attorney; or such other proof as is considered by Us to be sufficient to establish financial interdependency under the circumstances of a particular case;
5) is not a blood relative any closer than would prohibit legal marriage; and

6) has signed jointly with the Member, a notarized affidavit in form and content satisfactory to Us and is provided to Us upon request.

A Dependent will include the Member's Domestic Partner and his or her Dependents as otherwise defined, as long as neither the Member nor his or her Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners under the Agreement;
- is currently legally married to another person; and
- has any other Domestic Partner, spouse or spouse-equivalent relationship with a person of the same or opposite sex.

The Rights of Custodial Parents

If a Dependent child has coverage under a noncustodial parent, or a parent that does not have primary custody of the child, We will provide information to the custodial parent, as necessary:

- for the child to obtain benefits;
- to permit the custodial parent or the Provider to submit claims for Covered Services without the approval of the noncustodial parent; and
- to make payments on claims submitted in accordance with New Mexico law directly to the custodial parent, the Provider or the state Medicaid agency.

The Rights of Non-Custodial Parents

We acknowledge the rights of the non-custodial parents of children who are covered under a custodial parent's policy, unless these rights have been rescinded per court order or divorce decree. Non-custodial parents are able to contact Us to obtain and provide necessary information including but not limited to

- Provider information,
- Claim information,
- claims payment, and
- benefits or services information for the child.

Enrollment

If you meet the Member or Dependent eligibility criteria, you may enroll by submitting a completed enrollment application to CHRISTUS Health Plan. Online enrollment for the Exchange is available at www.healthcare.gov/marketplace/index.html.

If approved, Members and Dependents will have coverage effective at 12:01 a.m. on the effective date set by CHRISTUS Health Plan.

Open Enrollment On the Exchange

There will be an open enrollment period for coverage on the Exchange. The annual open enrollment period begins November 1, 2017 and extends through December 15, 2017. This may be changed by the federal government. Additional information about the open enrollment period can be found at www.healthcare.gov/marketplace/index.html or https://bewellnm.com/.

We will send written annual open enrollment notification to each Member between September 1st and September 30th.

Special And Limited Enrollment for Qualified Individuals participating in the Exchange

A Qualified individual has sixty (60) days to enroll as a result of one of the following events:

1) A Qualified Individual or Dependent suffers a loss of Minimum Essential Coverage;
2) A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption;
3) An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
4) A Qualified Individual's enrollment or non-enrollment in a Qualified Health Plan is unintentional, inadvertent, or erroneous. This could be the result of an error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
5) An enrollee adequately demonstrates to the Exchange that the Qualified Health Plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
6) An individual is determined newly eligible or newly ineligible for Advance Payments of the Federal Premium Tax Credit or has a change in eligibility for Federal Cost-Sharing Reductions, regardless of whether such individual is already enrolled in a Qualified Health Plan;
7) A Qualified Individual or enrollee gains access to new Qualified Health Plans as a result of a permanent move;
8) Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
9) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month; or
10) A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide.

Loss of Minimum Essential Coverage means in the case of a Member who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility does not include a loss due to the failure to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent Claim or an intentional misrepresentation of a material fact in connection with the Plan). Loss of eligibility for coverage includes, but is not limited to:

1) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the Plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a Service Area, loss of coverage because an individual no longer resides, lives, or works in the Service Area(whether or not within the choice of the individual);
3) A situation in which an individual incurs a Claim that would meet or exceed a lifetime limit on all benefits; and
4) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 54.9802-1(d)) that includes the individual.

In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent’s coverage terminates. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.
Qualified Individuals that enroll between the first and fifteenth day of the month will have coverage Effective Date of the first day of the following month. Qualified individuals that enroll between the sixteenth and last day of the month will have coverage Effective Date of the first day of the second following month.

In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption. Advance Payments of the Federal Premium Tax Credit and Federal Cost-Sharing Reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month.

In the case of marriage, or in the case where the Qualified Individual loses minimum essential coverage, the Effective Date is the first day of the following month.

The Exchange may provide a coverage Effective Date for a Qualified Individual earlier than specified in the paragraphs above, provided that either:

1) The Qualified Individual has not been determined eligible for Advance Payments of the Federal Premium Tax Credit or Federal Cost-Sharing Reductions; or
2) The Qualified Individual pays the entire premium for the first partial month of coverage as well as all cost sharing., Advance Payments of the Federal Premium Tax Credit and Federal Cost-Sharing Reduction payments are waived until the first of the next month.

Notification of Change of Status

Any change in a Member's status after the Effective Date of coverage should be reported to Member Services. Changes may also cause Your premiums to change. Examples include:

- Change in address or contact information;
- Change in eligibility status; or
- Change in tobacco use.

Termination of Coverage

A Member's coverage will end under this Policy on the earliest of the following dates:

1) The premium due date if premium is not paid when due. This is subject to the Grace Period provision of this Policy.
2) You request termination of this Policy in writing, or if later, the date such notice is received by Us. A thirty-day (30) notice is required for termination by the Member. We must receive this notice in writing. Terminations are granted for end of the month only. Any premiums received and applied to Your Plan after the approved termination will be refunded.
3) The Member is a Qualified Individual and requests termination of this Policy. Coverage will end on the date requested if notice was received by Us in writing 14 days prior to the requested Termination Date. If reasonable notice was not received, coverage will terminate fourteen (14) days after termination is requested.
4) The Member no longer resides or works in the Service Area.
5) The Member no longer meets the eligibility criteria in the *Eligibility* and *Enrollment* sections above. If You fail to meet the eligibility criteria, Your Termination Date will be the last day of the month in which the eligibility event occurred.
6) The Member is no longer a Qualified Individual and eligible for coverage through the Exchange.
7) The Member obtains other coverage through the Exchange.
8) The Member intentionally omitted, misrepresented, or provided materially false information in the enrollment application. We may rescind the Members' coverage back to the Effective Date of coverage subject to the Time Limit on Certain Defenses provision.
9) The Member permitted a non-Member to use his or her CHP ID card or to falsely obtain services and supplies.

10) The Member obtained or attempted to obtain services and supplies by means of false, misleading or fraudulent information, acts or omissions.
11) The Member's behavior is disruptive, unruly, abusive or uncooperative to such an extent that CHP and/or any of its Providers are seriously impaired in their ability to provide services to the Member or to any other Member.
12) The Member threatens the life or well-being of any CHP employee, Provider, or another Member.
13) On the date We end Our status as a Qualified Health Plan in the Exchange. We will provide a 30 day notice prior to termination.
14) On the date that We cease to offer this particular type of Plan in Service Area, as allowed by state law. This is subject to Our provision of ninety (90) days advance written notice of such termination to You and the beneficiary. In such case You will have the opportunity at the time of termination to purchase any other Plan We offer in New Mexico.
15) On the date that We cease to do business in the individual market in the Service Area, as allowed by state law. This is subject to Our provision of 180 days advance written notice of such termination to You and the beneficiary.

Coverage will end on at 11:59 pm on the last day of the month for which premiums were paid. The Member will be responsible for claims paid after the Termination Date.

We will not pay for any Covered Services provided to a Member or Dependent after the date of termination. Unless We agree, in writing, no Covered Benefits will be provided under this Policy following the date this Policy terminates. This includes if Your or Your Dependent are or remain in the hospital after the date of termination of this Policy.

Conversion of Coverage

Eligible Dependents under this Policy have a right to a conversion to a new Policy upon:

1) the death of the Member; or
2) divorce, annulment or dissolution of marriage or legal separation of the spouse from the Member.

The right to conversion does not apply if:

- coverage ends due to non-payment of premium,
- the Dependent is eligible for or enrolled in Medicare.

The Dependent must notify Us of their desire to convert their coverage. The Dependent must pay the applicable premium within thirty days.

A dependent who becomes a Member under the new Policy must continue to reside or work in the Service Area. Dependents of the Member are not required to reside in the Services Area. The conversion plan will be the same form of coverage offered by CHRISTUS Health Plan that the

original Member and his/her Dependents had, prior to conversion. Required Premiums must be paid on time. If the Dependent wishes to enroll on a different benefit plan, he/she may be required to reapply for coverage.

At the time of inception of coverage, We shall provide each covered family member eighteen years of age or older a statement setting forth in summary form the continuation of coverage and conversion provisions of this Policy. The eligible covered family member exercising the continuation or conversion right and must notify Us and make payment of the applicable premium within thirty (30) days following the date such coverage otherwise terminates as specified in the contract from which continuation or conversion is being exercised. Coverage shall be provided through continuation or conversion without additional evidence of insurability and shall not impose any preexisting condition, limitations or other contractual time limitations other than those remaining unexpired under the contract from which continuation or conversion is exercised. Any probationary or waiting period set forth in the converted or separate contract is deemed to commence on the effective date of the applicant's coverage under the original contract.

HOW YOUR PLAN WORKS

This section explains how your Plan works, how to access your Primary Care Provider to get healthcare services. It also includes requirements you must follow when getting care.

The Plan is an "HMO" style plan. This means that you select a Primary Care Provider (PCP) to coordinate all of your care. In addition, the Plan generally requires that:

- You must physically live or work in the Service Area, unless you are a Dependent, and meet all the terms and conditions for Coverage set forth in this Policy.

- You must receive healthcare services by our network of Participating Providers. Our network is made of doctors and hospitals that we contract with to provide You medical services. If You do not use Our network of Participating Providers, you may have to pay for the services you receive. You may obtain Covered Services from a Non-Participating Provider at the in-network benefit level when a Participating Provider is not available within Your geographic area. To get an Authorization for these Covered Services, Your PCP will submit a referral request to Us. Urgent Care and Emergency Care Services are covered even if the provider is not a Participating Provider.

Non-Participating Providers do not have a contract with Us. This means they may be able to charge You more than the Allowable Charge. When You use a Non-Participating Provider for Covered Services, You will be responsible for any difference between the Non-Participating Provider's Billed Charges and the Allowable Charge. This means that You may owe the Non-Participating Provider a large amount of money.

- You must pay your Cost Sharing (Deductible, Copayment, or Coinsurance) at the time you receive Covered Services. We will reimburse the Provider the balance due for Covered Services. Your *Summary of Benefits and Coverage* provides information on the Cost Sharing requirements.

- Some covered healthcare services will require Prior Authorization. For example, Prior Authorization is required for Hospitalizations and some types of outpatient care. Your Participating Provider will to make sure that any required Prior Authorization is in place. Please refer to the HOW PRIOR AUTHORIZATION WORKS section of this Policy for more details.

- Emergency Services and Urgent Care Services outside the Service Area are Covered, but other types of care may not be Covered.

Primary Care Providers

We want you to have a strong relationship with Your Primary Care Provider (PCP). This will help You and Your family make the most of Your Plan benefits. As a CHP Member, You can select a PCP for Yourself and each Covered Dependent.

You may consult Our Online Provider Directory by visiting Our website at www.christushealthplan.org. You may also contact Member Services at 1-844-282-3025. We will assist You in selecting a network PCP.

If You do not select a PCP at the time of Your enrollment, we will suggest one for you. You are not required to use the PCP we automatically assign to you. Please contact Member Services at 1-844-282-3025 to choose Your PCP.

PCPs include can include:

- family practice physicians;
- general practitioners;
- internists;
- pediatricians;
- doctors of Oriental Medicine; and
- obstetricians and/or gynecologists (OB/GYN).

Each Member may choose what type of PCP they prefer. Female Members may choose to have an OB/GYN as their PCP, if desired. For female Members who do not choose an OB/GYN as their PCP, no referral is required for services provided from OB/GYN Participating Providers.

Your PCP is responsible for providing Your Primary Care Services. These services include:

- annual examinations;
- routine immunizations; and
- treatment of non-emergency acute illnesses and injuries.

If You are a new Member and have a medical problem or are on medication, You should contact Your PCP's office. They will arrange for an appointment as soon as possible following Your Effective Date.

Specialist as PCP

Some Specialists may act as a PCP for Members with a severe chronic medical Condition. This is permitted if the Specialist provides all basic Health Care Services. They must also be contracted with CHP to perform PCP duties. Contact Member Services to find out which Providers serve in both roles.

CHRISTUS Health Plan Provider Directory

Our Provider directory is a list of Physicians, Hospitals, pharmacies, and other Providers that are contracted with Us. The Provider directory can change as new Providers become contracted or their contracts end. If a Provider is listed in the directory, it does not guarantee that the Provider is still contracted or that the Provider is accepting new patients.

To check the status of a Participating Provider, You can access the online Provider directory. This is on Our website at www.christushealthplan.org. You can also contact Member Services at 1-844-282-3025 for information about Participating Providers.

ID Cards

You have been issued a Plan ID card. If additional cards are needed, please contact Member Services at 1-844-282-3025. Always carry Your Plan ID card with You.

The Plan ID card lists some of those benefits to which Members are entitled that may require Copayment/Coinsurance amounts. Additional Copayment/Coinsurance amount information can be found in Your *Summary of Benefits and Coverage*.

Contact Member Services at 1-844-282-3025 if you have questions about Your benefits.

You are entitled to Plan benefits for Covered Services if all applicable Premiums, Deductibles and Copayment/Coinsurance amounts have been paid and You are eligible to receive Plan benefits. Possession of a Plan ID card alone does not entitle You to benefits.

Do not allow others to use Your Plan ID card. By doing so, You will be responsible for the cost of services provided to the non-Member. In addition, Your Plan Membership and that of Your covered Dependents, may be terminated.

Contact Member Services at 1-844-282-3025 immediately if Your Plan ID card is lost or stolen.

Unauthorized, Fraudulent, Improper, or Abusive Use of Identification (ID) Cards

1. The unauthorized, fraudulent, improper, or abusive use of ID cards issued to Members include, but are not limited to, any of the following actions, when intentional:

    a. Use of the ID card prior to Your effective date;
    b. Use of the ID card after Your termination of coverage under the Plan;
    c. Obtaining Prescription Drugs or other benefits for persons not covered under the Plan;
    d. Obtaining Prescription Drugs or other benefits that are not covered under the Plan;
    e. Obtaining Prescription Drugs for resale or for use by any person other than the person for whom the drugs are prescribed, even though the person is otherwise covered under the Plan;

f. Obtaining Prescription Drugs without a prescription or through the use of a forged or altered prescription;
g. Obtaining quantities of prescription drugs in excess of Medically Necessary or prudent standards of use or in circumventions of the quality limitations of the Plan;
h. Obtaining prescription drugs using prescriptions for the same drugs from multiple providers; or
i. Obtaining prescription drugs from multiple Pharmacies through the use of the same prescription.

2. The fraudulent or intentionally unauthorized, abusive, or other improper use of ID cards by any Member can result in, but is not limited to:

a. Denial of benefits;
b. Cancellation of coverage;
c. Limitation on the use of the ID card to one designated Physician, other Provider, or In-Network Pharmacy;
d. Recoupment from You of any benefit payment made;
e. Pre-approval of drug purchases and medical services; or
f. Notice to proper authorities of potential violations of law or professional ethics.

YOUR COST SHARING OBLIGATIONS

Cost Sharing is the share of the cost that You pay for Covered Benefits under the Plan. The Cost Sharing payments under Your Plan include the Deductible, Coinsurance, and Copayment amounts for each type of service as listed in Your *Summary of Benefits and Coverage*.

Annual Deductible

Certain services are subject to an Annual Deductible. This is the amount a Member must pay each Calendar Year for Covered Services before some Covered Services are paid under this Policy. It is also referred to as the Deductible.

Not all Covered Services are subject to the Deductible, such as Preventive Services.

Please refer to Your *Summary of Benefits and Coverage* for Your Plan's Deductible amounts. Here you can also find information about which services are not subject to the Deductible.

Copayments and any balance of charges (the difference between the Billed Charges and the Allowable Charge) are not considered when determining if You have satisfied Your Deductible.

Per-Person Deductible

You have an individual Deductible. Once Your individual Deductible has been met, the Plan will pay benefits for Your Covered Services. Refer to Your *Summary of Benefits and Coverage* for Your Deductible amount.

Family Deductible

If You have enrolled in family coverage, or coverage for two (2) or more people; Your Plan has a Family Deductible.

Some Covered Services will not be eligible for payment by the Plan until either the Per-Person Deductible or the Family Deductible has been met. Amounts paid by any Member in Your family toward their Per-Person Deductible will also apply to the Family Deductible. For example, if the individual Member's Per-Person Deductible is $500, then up to $500 per Member can be applied to the Family Deductible.

Once the Family Deductible has been met no Per-Person Deductible will apply. We will pay for Covered Services.

Changes to the Deductible

Changes to the Deductible may only be made at renewal.

Annual Out-of-Pocket Maximum

Your Plan includes an Annual Out-of-Pocket Maximum to protect you and your Dependents from the high cost of a catastrophic event. The Annual Out-of-Pocket Maximum is the most you will pay for Cost Sharing in a Calendar Year for certain Covered Benefits.

Please refer to Your *Summary of Benefits and Coverage* for the Out-of-Pocket Maximum.

Only Deductible, Copay and Coinsurance amounts paid out of Your pocket for Covered Benefits are applied to the Annual Out-of–Pocket Maximum. Once this amount is met then Covered Benefits are paid at 100% for the remainder of the Calendar Year.

Deductibles, Copays and Coinsurance amounts paid for vision services do apply toward this Plan Out-of-Pocket Maximum as well.

Copay and Coinsurance payments that You pay for Covered Services will apply to Your Out-of-Pocket Maximum. This occurs after You meet your Deductible.

Amounts or services that do not apply to Your Out-of-Pocket Maximum are:

- premium payments; and
- amounts paid for non-Covered Benefits.

Per Person Out-of-Pocket Maximum

If You have single coverage, You have an Individual Per Person Out-of Pocket Maximum to meet. Once You have met this amount, Covered Benefits are paid at 100% for the remainder of the Calendar Year.

Family Coverage Out-of-Pocket Maximum

For Members who have family coverage, there is a Family Out-of-Pocket Maximum. Each individual Member's Per-Person Out–of-Pocket Maximum applies until the Family Out-of-Pocket Maximum has been met. Any combination of family Members can contribute toward meeting the Family Out-of-Pocket Maximum.

Once the Family Out-of-Pocket Maximum is met, Covered Benefits are paid at 100% for the remainder of the Calendar Year. For example, if the individual Member's Per Person Out-of-Pocket Maximum is $2,000, then up to $2,000 per Member can be applied to the Family Out-of-

Pocket Maximum. Any remaining amount on the Family Out-of-Pocket Maximum must be satisfied by other family Members.

If You have questions, or wish to report that You have reached Your Out-of-Pocket Maximum, please contact Member Services at 1-844-282-3025.

Copayments

The Copayment or Copay is the fixed amount shown on Your *Summary of Benefits and Coverage* that must be paid by You directly to the Provider each time certain Covered Services are received.

Copays may be due for visit with Your Provider. This happens even if You have more than one appointment in the same day. Copays apply toward the Out-of-Pocket Maximum.

Coinsurance

Coinsurance is the percentage of a Provider's Allowable Charge that You must pay for Covered Services after the Deductible has been met.

Please refer to Your *Summary of Benefits and Coverage* for Your Coinsurance amounts. Coinsurance amounts do apply toward meeting Out-of-Pocket Maximums.

HOW TO SEEK HEALTH CARE

The Plan offers You a network of doctors, healthcare facilities, labs and pharmacies. This section of the Policy explains how and where You can get care.

Please also refer to the *Summary of Benefits and Coverage* and *Formulary* attachments to this Policy for specific information.

When You need care:

- Contact Your Primary Care Provider (PCP).
- Identify Yourself as a Member. Your PCP may ask for information on Your Member ID Card. Have it ready.
- At the healthcare visit, show your Member ID Card.
- If necessary, get a Prior Authorization from your PCP. More information on this is available in the HOW PRIOR AUTHORIZATION WORKS section of this Policy.
- Please contact Member Services at 1-844-282-3025 if you have any questions or wish to file a complaint.

Emergency Care

If You have an emergency, you should call 911. Or You can seek treatment at an emergency room. An emergency is any medical problem that you reasonably believe could cause death or permanent injury if not treated quickly.

If You are able, tell the emergency room staff that You are a Member. Provide them Your Member ID Card.

Emergency Services may be required to treat an accidental injury, or the sudden onset of a medical Condition causing severe symptoms such as new, severe pain. A reasonable layperson would expect the lack of immediate medical attention to result in:

- jeopardy to a Member's health,
- impairment of bodily functions,
- dysfunction of a bodily organ or part,
- disfigurement to a person, or
- for a pregnant person, serious jeopardy to the health of the fetus.

Emergency Services may also be required to treat Conditions that may become more serious or life threatening if not treated promptly. These may include:

- severe bleeding,
- severe abdominal pain,
- chest pain,

- a severe eye injury, or
- the sudden inability to breathe.

If You seek Emergency Care the services will be covered by Your Plan. Emergency Care does not require Prior Authorization.

If Your emergency causes You to be admitted to the Hospital, notification and authorization will be required for Your Hospital Admission.

Notify Us of an emergency admission within forty-eight (48) hours, or as soon as You are able, of being admitted to a Hospital.

Emergency Services at a Non-Participating Provider/Facility

In an emergency, You should go to the nearest available Provider or Facility. You do not need Prior Authorization to obtain any Emergency Services.

Emergency Services obtained from Non-Participating Providers will be paid by CHP at the same level as Emergency Services from Participating Providers. You may be transferred to a Participating Provider for continued care if it is medically wise to do so.

Make sure You contact Us. We will determine in consult with Your Provider if arrangements should be made to transfer You. If You receive non-emergency follow-up care from an Out-of-Network Provider after You are discharged, You will be responsible for the cost of those services.

Non-Emergency Services, such as follow-up care from a prior emergency require Prior Authorization from the Plan. If You do not receive Prior Authorization for non-emergency services, that require Prior Authorization, We may not pay for the services.

All Inpatient admissions require Prior Authorization. If You are admitted to an Out–of-Network Facility, You must contact the Plan for Prior Authorization. An authorized family member or caregiver should contact Us if You are not able to do so. Prior Authorization must be obtained in order for Covered Services to be paid at the highest benefit level.

Urgent Care

Urgent Care includes Medically Necessary services provided to treat Urgent Illness or Injury that are not life-threatening but may require prompt medical attention. Care that is needed after a PCP's normal business hours is also considered to be Urgent Care.

A few examples or Urgent Illness or Injury are:

- Sprains or a possible broken bone
- A cut that may need stitches
- A rising fever
- Severe vomiting or diarrhea
- Ear pain
- Flu symptoms

Urgent Care is not limited to these situations. If You need assistance finding an Urgent Care Provider, please contact Member Services at 1-844-282-3025.

Contact Your PCP for an appointment before seeking care from another Provider. If PCP is not available and the Condition persists, call the Nurse Line toll-free at:

(844) 581-3175

The Nurse Advice Line is available twenty-four (24) hours a day, seven (7) days a week. A Registered Nurse can help You decide the kind of care most appropriate for Your specific need.

Office Visits

Physicians and other Providers who You see in an office setting will provide You with both primary care and specialty care services. These Covered Services may include:

- annual examinations,
- routine immunizations, and
- treatment of non-emergency/acute illnesses and injuries.

For preventive, routine or specialty care, call or make an appointment with Your Physician or other Provider. Your Provider will arrange for Prior Authorization as needed.

If You need a same day appointment or have an Urgent Illness, call Your Physician's office. If Your Provider is unable to see You, You may be offered an appointment with another Physician, Certified Nurse Practitioner or Physician Assistant in his/her group. After hours, Your Physician may offer an answering service.

When You arrive for Your appointment show Your Plan ID card to the receptionist. You may be required to make a Copay before receiving services. If You are unable to keep an appointment, cancel as soon as possible. If you do not, missed appointment charges may apply. Those charges are not covered under the Plan.

Ambulance Service

If you need an Ambulance, call 911 or a local Ambulance service. This service is covered if it is Medically Necessary because of an emergency. The Medical Director determines this by reviewing Ambulance and medical records.

Non-emergency Ambulance transport requires Prior Authorization. You are responsible for payment for services that are not authorized or are not Medically Necessary.

Transition of Care

If You are receiving treatment from Provider whose contract ends during an on-going or active course of treatment, You may be eligible to continue to receive services. These services can be provided as though Your Provider was still a Participating Provider. This is called a Transition of Care. Determinations for Transition of Care are made based on established criteria. The Transition of Care Period will be for a period of no less than thirty (30) days. Transition of Care also applies to Members who have entered the third trimester of pregnancy. This includes post-partum care directly related to the delivery.

For New Members

If You are receiving an ongoing course of treatment with a Provider that is not within the CHP Provider Network, You may be able to receive services from that Provider and have them paid for at the Participating Provider benefit level.

Members with certain Conditions may request for Transition of Care. This should be done within thirty (30) days of the date of enrollment.

For Existing Members

If Your Provider's network participation ends during Your course of treatment, You may be eligible to continue seeing that Provider. Existing Members with certain medical Conditions may be eligible for Transition of Care. This transitional period will allow a Member to have continued access to a Provider.

You do not need to request for care to be continued. The Plan will coordinate Your care.

Access to Non-Participating Providers

If a Covered Service is Medically Necessary and is not available from a Participating Provider, We will refer You to a Non-Participating Provider. The Plan will coordinate this referral.

You must have Our approval before receiving the services. Otherwise, you will be responsible for payment.

We will pay the Provider at the Allowable Charge or at a rate agreed upon by Us and the Provider. You will pay the same Cost Sharing you would pay for a Participating Provider.

Before We deny a referral to a Non-Participating Provider, We will ensure that the request is reviewed by a Specialist. This Specialist will be familiar with Your medical Condition.

Costs for Non-Participating Providers

Covered Services that You received from a Non-Participating Provider are covered only up to Your Plan's Allowable Charge.

The Allowable Charge is the amount that We have determined to be the maximum amount payable for a Covered Service. For Covered Services provided by Non-Participating Providers, the amount payable will be based upon Our out-of-network fee schedule. For out-of-network Emergency Services, the Allowable Charge is based upon the greater of 1.) the median amount negotiated with Participating Providers for similar Emergency Services; 2) the amount for the Emergency Services calculated using the same method generally used to determine payments for out-of-network services; or (3) the amount that would be paid under Medicare for the Emergency Services.

Since Providers that are outside the Provider Network have not contracted with Us or agreed to accept Our discounted rates, You will be fully responsible for the Deductible and Coinsurance amounts. You will also have to pay for charges that the Non-Participating Provider bills above of the Allowable Charge amount.

Terminated Providers

For Your safety, We will not be required to permit You to continue treatment with the current provider if the provider's disaffiliation with Us was for reasons related to medical competence or professional behavior.

HOW PRIOR AUTHORIZATION WORKS

Under Your Plan, some healthcare services are not Covered Benefits unless You have Prior Authorization. This Section explains the Prior Authorization process. It also explains what services require Prior Authorization.

This is not a complete list. More information can be found at www.christushealthplan.org or by calling Member Services at 1-844-282-3025.

What is Prior Authorization?

Prior Authorization is a clinical review process. In this process, We review Your case to determine if a healthcare service is Medically Necessary. We also check to see if the service is a Covered Service before that healthcare service is provided to You.

Our Medical Director or other clinical professionals will review:

- the proposed healthcare service,
- Your medical information,
- the proposed treatment setting, and
- other information.

This will help Us decide whether to approve the proposed care.

Without Prior Authorization, the proposed healthcare service may not be covered. However, a Prior Authorization does not guarantee that the services will be covered, such as if Your coverage is terminated on the date You received the service.

If you have questions the Prior Authorization process, please contact Member Services at 1-844-282-3025.

How Do You Get Prior Authorization?

The Participating Provider will contact Us for the approval of a Prior Authorization. Your Provider is required to notify Us and obtain approval prior to receiving these services. We may need to talk about the Prior Authorization request with Your Provider.

If You obtain Covered Services from a Non-Participating Provider, you must get a Prior Authorization for those services. Otherwise, Your care may not be covered by Us.

After the Prior Authorization has been requested and any required documentation has been submitted, We will notify You and Your Provider if the request has been approved. We will also tell

You and Your Provider if continued review of the Member's services will be required throughout the course of treatment.

NOTICE REGARDING INDIAN HEALTH PROVIDERS AND LIMITED COST SHARE PLANS: If You receive Covered Services from an Indian healthcare provider or from another provider if You have a referral from an Indian healthcare provider, You pay no out-of-pocket costs.

Please contact Member Services at 1-844-282-3025 for a Prior Authorization at least fourteen (14) days prior to obtaining services.

How Does The Process Work?

When We receive a request for Prior Authorization, Our clinical staff reviews the request using nationally recognized guidelines. These guidelines are consistent with sound clinical principles. They have been developed by the Plan and practicing health care Providers.

If guidelines do not exist for a certain service or treatment, resource tools based on peer-reviewed, scientific medical evidence are used.

A Prior Authorization will specify the length of time for which it is valid. This period will be for more than twenty-four (24) months. A Prior Authorization may also be for only a certain number of treatments or services.

What Services Require Prior Authorization?

The following services require Prior Authorization. They are subject to the Coverage rules in this Policy:

- All Inpatient Acute Care Hospitalizations;
- All Inpatient Rehabilitation Hospitalizations;
- All Inpatient Long Term Acute Care Hospitalization;
- Bariatric or weight loss surgical procedures and treatment of morbid obesity;
- Clinical Trial Services;
- Cosmetic or reconstructive surgery;
- Craniomandibular Joint (CMJ) and Temporomandibular Joint Dysfunctions (TMJ);
- Dental Services;
- Durable Medical Equipment;
- Genetic Testing and counseling and treatment of Genetic Inborn Errors of Metabolism Disorders (IEM);
- Home Health Care;
- Hospice Services, Inpatient and outpatient;
- Non-emergency Ambulance transport;

- Organ Transplant Services;
- Outpatient Physical Therapy;
- Outpatient Occupational Therapy;
- Pain management;
- Prosthetic appliances and orthotics;
- Other services provided during a Medical Office Visit;
- Skilled Nursing Facility Care; and
- Surgical Procedures.

This list may not include all services requiring Prior Authorization. If You need help determining if a service requires Prior Authorization, please contact Member Services at 1-844-282-3025.

Prior Authorization for Prescription Drugs

Prior Authorization is required for certain Prescription Drugs. This includes restricted drugs or other prescriptions that are not on the *Formulary*, but which are determined to be Medically Necessary and appropriate by the Provider. The Prior Authorization should be submitted for Prior Authorization to the Pharmacy Exceptions Center. These can be sent via fax, phone or mail.

Please send the appropriate documentation to support Medical Necessity.

If You do not get this approval, Your drug might not be covered by the Plan. Please contact Member Services at 1-844-282-3025.

Decisions About Prior Authorizations

If Our clinical staff is not able to approve Your Prior Authorization for clinical reasons, Your case will be referred to Our Medical Director. The Medical Director will consider Your case. He or she will also review information including information provided to Us by Your Provider. He or she may speak with Your Provider for more information.

You and Your Provider will be notified in writing or by electronic means if Prior Authorization is approved.

You and Your Provider will be notified if the request for Prior Authorization cannot be approved based on the information We received. You and Your Provider will also be notified if Your Plan does not cover the service. This notification could be by telephone or other means, depending on the service.

Non-Emergency Services

We will evaluate non-emergent Prior Authorizations requests. We will notify You and Your Provider of our decision within 3 business days.

Review of Ongoing Services

Concurrent review occurs when We receive a request for authorization while You are receiving care. An example is when you are admitted to the Hospital. We will make Prior Authorization decisions within 5 working days of receipt of a review request.

Expedited Requests

If Your Condition requires that we make a Prior Authorization decision quickly, we will notify you and your Provider of an expedited decision within 24 hours of our receipt of a written or verbal request for a Prior Authorization.

NOTE: Emergency Care and In-Network Urgent Care do not require Prior Authorization.

What if Prior Authorization is Denied?

If You disagree with the decision, You may appeal the decision through the formal Appeals Process. Or, You can have Your Provider contact Us to provide more information. This may allow Us to approve the request.

Your request for Prior Authorization may be denied by Us because the requested services are not Medically Necessary. Any appeal of that decision will be decided based on whether the services were Medically Necessary or not. However, if Your Provider fails to ask for approval or fails to provide enough information for Us to review Your request, We may uphold the denial of coverage.

A PRIOR AUTHORIZATION DOES NOT GUARANTEE THAT BENEFITS WILL BE PAID.

- You must be eligible for Coverage and covered by this Policy on the date services are provided.
- All the terms of this Policy determine whether a serviced is a Covered Benefit.
- A Member shall not rely on verbal communications from a representative of CHP that conflict with the written terms of this Policy.
- In any instance where a verbal communication from a representative of CHP differs from the terms of this Policy, the terms of this Policy shall prevail.

COVERED BENEFITS

Your Plan offers Coverage for a wide range of Health Care Services. This Section gives You the details about Your Covered Benefits and other requirements, Limitations and Exclusions. You will be required to pay Your Copay, Coinsurance, Deductible and certain other charges.

Specifically Covered

Your Plan helps pay for health care expenses that are Medically Necessary and Specifically Covered in this Policy. Specifically Covered means only those Health Care Services that are expressly listed and described in the Benefits Sections of the Policy. The Benefits and Services are subject to Limitations, Exclusions, Prior Authorization and other provisions of this Policy.

Refer to the Exclusions section that lists services that are not Covered Benefits under the Plan. All other benefits and services not specifically listed as Covered in this Section are excluded.

We determine whether a Health Care Service or supply is a Specifically Covered Benefit. The fact that a Provider prescribes, orders, recommends, or approves a Health Care Service or supply does not guarantee that it is a Covered Benefit. This is true even if it is not listed as an exclusion.

Medical Necessity

Covered Services must be Medically Necessary, except for Preventive Care Services.

Medical Necessity or Medically Necessary means:

Health Care Services determined by a Provider, in consultation with CHP, to be appropriate or necessary. We rely on generally accepted principles and practices of good medical care or practice guidelines developed by:

- the federal government,
- national or professional medical societies,
- boards and associations, or
- any other applicable clinical protocols or practice guidelines We develop.

This is consistent with federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral or mental health Condition, illness, injury or disease.

Experimental, Investigational or Unproven drugs, medicines, treatments, procedures or devices are not covered.

You must receive Prior Authorization in order for some services to be Covered Services. The Plan will not pay for any of these services received without Prior Authorization.

Please refer to Your *Summary of Benefits and Coverage* or call Member Services at 1-844-282-3025 for more information.

Specific Covered Benefits:

Accidental Injury (Trauma), Urgent Care, Emergency Services, and Observation Services

Urgent Care

Urgent Care is Medically Necessary medical or surgical procedures, treatments, or Health Care Services You receive in an Urgent Care center or in a Provider's office for an unforeseen sudden Condition due to illness or injury. Urgent Conditions require prompt medical attention to prevent a serious deterioration in Your health but do not have to be life threatening.

We encourage You to contact Your Primary Care Provider for an appointment, if available, before seeking care from another Provider. Prior Authorization is required for follow-up care by a Non-Participating Provider.

You will be responsible for charges that We do not cover. If You believe Your Condition is life threatening, You should seek Emergency Services.

Emergency Services

This Policy covers Emergency Services. These Services are available 24 hours per day, 7 days per week. You should use Emergency Service when needed to prevent jeopardy to Your health.

You should seek medical treatment from a Participating Provider whenever possible. If You cannot reasonably access a Participating Provider, We will arrange to Cover the care at a Non-Participating Provider. Whether an Emergency Service is appropriate at a Non-Participating Provider will be determined by a reasonable and prudent layperson standard discussed below.

In determining whether You acted as a Reasonable and Prudent Layperson, We will consider the following factors:

- A reasonable person's belief that immediate medical care was needed that could not wait until the next working day or the next available appointment
- Your symptoms
- Any reasons that prevented You from using Our established procedures for obtaining Emergency Care Services.

Coverage for trauma services and all other Emergency Services will continue at least until You:

- Are medically stable,
- Do not require critical care, and
- Can be safely transferred to a Participating Provider

This is based on the judgment of the attending Physician in consultation with Us and in accordance with state or federal law.

We will provide reimbursement when You, acting in good faith, obtain Emergency Services for what reasonably appears to be an acute Condition that requires immediate medical attention, even if Your Condition is later determined to not be an emergency.

Prior Authorization is not required for Emergency Services. If You are admitted as an Inpatient to a Hospital, You or Your Practitioner needs to notify Us as soon as possible. We will review Your Hospital stay.

We will not deny a claim for Emergency Services when You are referred to the emergency room by Your PCP or by Our representative. If Your Emergency Services results in a hospitalization directly from the emergency room, You are responsible for paying the Inpatient Hospital Cost Sharing amounts (Deductible, Coinsurance and/or Copayment). In this situation, You do not pay the emergency room visit Copayment. Refer to Your *Summary of Benefits and Coverage* for the Cost Sharing amount.

For Emergency Services received from a Non-Participating Provider and/or outside of New Mexico, You may seek Emergency Services from the nearest appropriate facility where Emergency Services can be rendered. Non-emergent follow-up care received outside of New Mexico is not a Covered Benefit for Your convenience or preference. Follow-up care from a Non-Participating Provider requires Our Prior Authorization. You are responsible for any charges that We do not authorize.

Whether You require hospitalization or not, You should notify Your PCP or Physician within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so he can recommend the continuation of any necessary medical services.

Observation Services

Observation Services are provided by a Hospital and a Provider on the Hospital's premises. These services may include the use of a bed and monitoring by a Hospital's nursing staff. The services are reasonable and necessary to evaluate Your Condition, determine the need for a possible admission to the Hospital, or when rapid improvement of the Your Condition is expected.

When a Hospital places You under Outpatient Observation, it is based upon the Provider's written order. To move from Observation to an Inpatient admission, Our level of care criteria must be met. The length of time spent in the Hospital is not the only factor determining Observation instead of an Inpatient stay. Medical criteria will also be considered.

Observation Services for more than 24 hours will require Prior Authorization. It is the responsibility of the facility offering Observation Services to notify Us.

All Accidental Injury (trauma), Urgent Care, Emergency Services, and Observation Services whether provide within or outside of the Plan's Service Area are subject to the Limitations listed in the Limitations Section and the Exclusions listed in the Exclusions Section.

Ambulance Services

The Plan covers the following types of Ambulance Services:

- Emergency Ambulance Services,
- High-Risk Ambulance Services, and
- Inter-facility Transfer services.

Emergency Ambulance Services

Emergency Ambulance Services are defined as ground or air Ambulance Services delivered to a Member who requires Emergency Services under circumstances. These circumstances would lead a Reasonable and Prudent Layperson acting in good faith to believe that transportation in any other vehicle would endanger Your health. Emergency Ambulance Services are Covered only under the following circumstances:

- Within New Mexico:
  - to the nearest In-network facility where Emergency Services and treatment can be rendered, or
  - to an Out-of-network facility if an In-network facility is not reasonably accessible.
  - Such services must be provided by a licensed Ambulance Service. Services must be provided in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.
- Outside of New Mexico:
  - to the nearest appropriate facility where Emergency Services and treatment can be rendered.
  - Such services must be provided by a licensed Ambulance Service. Services must be provided in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.

- We will not pay more for air Ambulance Services than We would have paid for ground Ambulance services over the same distance unless Your Condition renders the utilization of such ground transportation services medically inappropriate.
- In determining whether You acted in good faith as a Reasonable and Prudent Layperson when obtaining Emergency Ambulance Services, We will take the following factors into consideration:
  - Whether You required Emergency Services, as defined above
  - The presenting symptoms
  - Whether a Reasonable and Prudent Layperson who possesses average knowledge of health and medicine would have believed that transportation in any other vehicle would have endangered Your health
  - Whether You were advised to seek an Ambulance service by Your Practitioner/Provider or by Our staff. Any such advice will result in reimbursement for all Medically Necessary services rendered, unless otherwise limited or excluded under this Policy.
  - 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.

Ambulance Services (ground or air) to the coroner's office or to a mortuary is not Covered. The exception is if the Ambulance had been dispatched prior to the pronouncement of death by an individual authorized under state law to make such pronouncement.

High-Risk Ambulance Services

High-Risk Ambulance Services are defined as non-emergency Ambulance Services prescribed by Your Practitioner/Provider. These services are Medically Necessary for transporting a high-risk patient.

Coverage for High-Risk Ambulance Services is limited to:

- Air Ambulance Services when Medically Necessary. However, We will not pay more for air Ambulance Services than We would have paid for transportation over the same distance by ground Ambulance Service, unless Your Condition renders the utilization of such ground Ambulance Services medically inappropriate.
- Neonatal Ambulance Services. This includes ground or air Ambulance Service to the nearest Tertiary Care Facility 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 Ambulance Services

Inter-facility Transfer Ambulance Services are defined as ground or air Ambulance Service between Hospitals, Skilled Nursing Facilities or diagnostic facilities. Inter-facility transfer services are Covered only if they are:

- Medically Necessary
- Prescribed by Your Practitioner/Provider
- Provided by a licensed Ambulance Service. Services must be provided in a vehicle which is equipped and staffed with life-sustaining equipment and personnel.

Bariatric Surgery

Surgical treatment of morbid obesity (bariatric surgery) is Covered only if it is Medically Necessary.

Bariatric Surgery is Covered for patients with a Body Mass Index (BMI) of 35 kg/m^2 or greater who are at high risk for increased morbidity due to specific obesity related co-morbid medical Conditions. It is a Covered Benefit only if a Member meets this criteria and all other requirements of this Policy.

Prior Authorization is required and services must be performed at a Participating Provider Health Care Facility.

Cancer Clinical Trials

The Plan provides coverage for Medically Necessary routine patient care at a New Mexico facility, incurred as a result of the Member's participation in a clinical trial if:

- The clinical trial is undertaken for the purpose of prevention, early detection or treatment of cancer or other life threatening Illnesses or Condition for which no standard treatment exists or more effective standard treatment exists;
- The clinical trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology;
- The clinical trial is being provided in this state as part of a scientific study of a new therapy or intervention that is being conducted at an institution in this state and is for the treatment, palliation or prevention of cancer or disease in humans with:
  - specific goals;
  - a rationale and back ground for the study;
  - criteria for patient selection;
  - specific direction for administering the therapy or intervention and for monitoring patients;
  - a definition of quantitative measures for determining treatment response;
  - methods for documenting and treating adverse reactions; and

  - a reasonable expectation that the treatment will be at least as efficacious as standard cancer treatment.
- The clinical trial is being provided as part of a clinical trial being conducted in accordance with a clinical trial approved by at least one of the following:
  - One of the federal National Institutes of Health;
  - A federal National Institute of Health Cooperative Group or center;
  - The United States Food and Drug Administration in the form of an investigational new drug application;
  - The United States Department of Defense;
  - The United States Department of Veteran Affairs; or
  - A qualified research entity that meets the criteria established by the federal National Institutes of Health for grant eligibility.
- The clinical trial or study has been reviewed and approved by an Institutional Review Board that has a multiple project assurance contract. The contract must be approved by the Office of Protection from Research Risks of the federal National Institutes of Health;
- The personnel providing the clinical trial or conducting the study:
  - Are providing the clinical trial or conducting the study within their scope of practice, experience and training and are capable of providing the clinical trial because of their experience, training and volume of patients treated to maintain their expertise; and
  - Agree to accept reimbursement as payment in full from the Plan and that is not more than the level of reimbursement applicable to other similar services provided by the Participating Providers within the Plan's network;
  - agree to provide written notification to the health plan when a patient enters or leaves a clinical trial;
- There is:
  - no non-investigational treatment equivalent to the clinical trial;
  - the available clinical or preclinical data provide a reasonable expectation that the clinical trial will be at least as efficacious as any non-investigational alternative; and
  - there is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial will be at least as effective as any other medical treatment;
- Pursuant to the patient informed consent document, no third party is liable for damages associated with the treatment provided during a phase of a clinical trial; provided during a phase of a clinical trial;
- If a Member is denied coverage of a cost and contends that the denial is in violation of New Mexico law, the Member may appeal the decision to deny the coverage of a cost to the Superintendent. That appeal shall be expedited to ensure resolution of the appeal within no more than thirty (30) days after the date of the appeal to the Superintendent.
- In no event shall We be responsible for out-of-state or out-of-network costs unless We pay for standard treatment out-of-state or out-of-network.

For the purposes of this specific Covered Benefit and Service, the following terms have the following meaning:

"*Routine Patient Care Cost*" – means (1) A medical service or treatment that is a benefit under the Plan that would be covered if the patient were receiving standard cancer or life-threatening Illness treatment; or (2) A drug provided to a patient during a clinical trial if the drug has been approved by the United States Food and Drug Administration, whether or not that organization has approved the drug for use in treating the patient's particular Condition, but only to the extent that the drug is not paid for by the manufacturer, distributor or Provider of the drug. Routine Patient Care Cost does not include (1) The cost of an investigational drug, device or procedure; (2) The cost of a non-health care service that the patient is required to receive as a result of participation in the clinical trial; (3) Costs associated with managing the research that is associated with the clinical trial; (4) Costs that would not be covered by the patient if non-investigational treatments were provided; or (5) Costs paid or not charged for by the clinical trial Providers.

Certified Hospice Care

This Plan covers Hospice Care Program Services. To be covered, these services must be provided due to terminal illness. These services are limited as stated in Your *Summary of Benefits and Coverage*. The services must be given under a Hospice Care Program and provided by a licensed and qualified Provider.

Hospice care services include Inpatient care and outpatient services. Also included are the professional services of a Physician. Other Covered Services include those of a psychologist, social worker or family counselor. The following services are not covered by the Plan:

- Services provided by a family member or someone who usually lives in Your home or Your Dependent's home;
- Services or supplies not listed in the Hospice Care Program;
- Curative or life prolonging procedures;
- Services for which any other benefits are payable under the Plan;
- Services or supplies that are primarily to aid in daily living;
- Bereavement counseling;
- Nutritional supplements, non-Prescription Drugs or substances, medical supplies, vitamins or minerals; or
- Respite care.

Preventive Care Services

The Plan covers Primary Care and Specialist services for preventive care and periodic health exams. Preventive Care is covered at no charge. An office visit Copay may apply for other Covered Services

provided during Your visit. A complete list of preventive services can be found at http://www.uspreventiveservicestaskforce.org/tools.htm.

Preventive Services for Adult Members include:

- Abdominal Aortic Aneurysm screening for male Members of specific ages (one time screening);
- Alcohol Misuse screening and counseling;
- Aspirin use for Members of certain ages;
- Blood Pressure screening;
- Cholesterol screening for Members of certain ages or at higher risk;
- Colorectal Cancer screening for Members over 50, including Colonoscopies;
- Depression screening;
- Type 2 Diabetes screening for Members with high blood pressure;
- Diet counseling for Members at higher risk for chronic disease;
- HIV screening for all Members at higher risk;
- Immunization vaccines – doses, recommended ages and recommended populations vary;
- Obesity screening and counseling;
- Sexually Transmitted Infection (STI) prevention counseling for Members at higher risk;
- Tobacco use screening for all Members. This includes cessation interventions for tobacco users, and expanded counseling for pregnant tobacco users; and
- Syphilis screening for all adults at higher risk.

Additional Preventive Services include but are not limited to:

- Annual physical examinations, one per Calendar Year;
- Educational materials or consultations from Providers to promote healthy living;
- Periodic glaucoma eye tests for all Members thirty-five (35) years of age or older;
- Periodic laboratory screening tests. This includes tests that determine metabolic, blood hemoglobin, blood glucose level, and blood cholesterol level; and
- Periodic radiological screening tests.

Preventive Services Specifically for Women include:

- Routine Anemia screening;
- Bacteriuria urinary tract or other infection screening;
- Breastfeeding comprehensive support, supplies and counseling;
- Folic Acid supplements for Members who may become pregnant;
- Hepatitis B screening for pregnant Members at their first prenatal visit; and
- RH Incompatibility screening and follow-up testing for Members at higher risk.

Preventive Services for Children include:

- Well baby and well childcare from birth in accordance with recommendations of the American Academy of Pediatrics;
- Alcohol and drug use assessments for adolescents;
- Autism screening for children at 18 and 24 months;
- Behavioral assessments for children of all ages;
- Blood pressure screening;
- Cervical dysplasia screening for sexually active females;
- Congenital hypothyroidism screening for newborns;
- Depression screening for adolescents;
- Developmental screening for children under age 3 and surveillance throughout childhood;
- Dyslipidemia screening for children at higher risk of lipid disorders;
- Fluoride Chemoprevention supplements for children without fluoride in their water source;
- Gonorrhea preventive medication for the eyes of all newborns;
- Hearing screening for all newborns up to Members age 17;
- Height, Weight and Body Mass Index measurements for children;
- Hematocrit or Hemoglobin screening for children;
- Hemoglobinopathies or sickle cell screening for newborns;
- HIV screening for adolescents at higher risk;
- Immunization vaccines for children from birth to age 18 – doses. The recommended ages and recommended populations vary;
- Iron supplements for children ages 6 to 12 months at risk for anemia;
- Lead screening for children at risk of exposure;
- Medical History for all children throughout development;
- Obesity screening and counseling;
- Oral health risk assessment for young children (newborns to children age 10);
- Phenylketonuria (PKU) screening for this genetic disorder in newborns;
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
- Tuberculin testing for children at higher risk of tuberculosis;
- Vision screening for all children; and
- Educational materials or consultations from Providers to promote a healthy lifestyle.

Complementary Therapies

Acupuncture

Acupuncture is treatment by means of inserting needles into the body to reduce pain or to induce anesthesia. It may also be used for other diagnoses as determined appropriate by the Practitioner/Provider. It is recommended that Acupuncture be part of a coordinated plan of care approved by Your Practitioner/Provider.

Acupuncture services are limited to twenty (20) services per Calendar Year. However, acupuncture services received as rehabilitative and/or habilitative treatments are not subject to limitations.

Biofeedback

Biofeedback is only Covered for treatment of Raynaud's disease or phenomenon and urinary or fecal incontinence.

Chiropractic Services

Chiropractic Services are available for specific medical Conditions covered by the Plan and provided by a Participating Provider. Chiropractic Services are subject to the following:

- The Practitioner/Provider determines in advance that Chiropractic treatment can be expected to result in Significant Improvement in Your Condition within a period of two months.
- 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 Us including, but not limited to, ultrasound therapy.
- Subluxation must be documented by Chiropractic examination and documented in the chiropractic record. We do not require Radiologic (X-ray) demonstration of Subluxation for Chiropractic treatment.

Chiropractic services are limited to twenty (20) services per Calendar Year. However, chiropractor services received as rehabilitative and/or habilitative treatments are not subject to limitations.

Craniomandibular (CMJ) and Temporomandibular Joint Disorders (TMJ)

CMJ and TMJ surgical and non-surgical services are Covered Services. These services are subject to the same conditions, limitations, and Prior Authorization requirements as other surgical procedures. Orthodontic appliances and treatments, crowns, bridges, and dentures are subject to the same limitations outlined in Dental Services, unless the disorder is trauma related.

Dental Services (Limited)

Please refer to Your 2018 Pediatric Dental Benefits Rider for Cost Sharing amounts, limitations, and maximums. Dental services are limited to eligible members age 18 and under. As set forth below, dental services may include:

- Diagnostic and Preventive Services to diagnose or to prevent tooth decay and other forms of oral disease.

- Restorative Services and Other Basic Services to treat oral disease including: (a) restore decayed or fractured teeth; (b) repair dentures or bridges; (c) rebase or reline dentures; (d) repair or re-cement bridges, crowns and onlays; and (e) remove diseased or damaged natural teeth.
- Complex Dental Services to treat oral disease including: replace missing natural teeth with artificial ones; remove diseased or damaged natural teeth; and restore severely decayed or fractured teeth.

  In addition, subject to the terms of this EOC, We cover Hospital Services and general anesthesia provided in the hospital or ASC setting for dental surgery for (1) Members exhibiting 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; (2) Members for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy; (3) Member children or adolescents who are extremely uncooperative, fearful, anxious or uncommunicative with dental needs 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;(4) Members with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; and (5) other dental surgery procedures for which hospitalization or general anesthesia in a hospital or ambulatory surgical center is Medically Necessary.

Diabetes Services

When used to treat insulin dependent diabetes, non-insulin dependent diabetes, or high blood glucose levels induced by pregnancy, the Plan will cover the following Medically Necessary services and supplies:

- Blood glucose monitors, including those for the legally blind, and test strips;
- Glucagon emergency kits;
- Insulin;
- Prescriptive oral agents;
- Injection aids, including those adaptable to meet the needs of the legally blind;
- Lancet and lancet devices;
- Podiatric appliances for the prevention of foot complications associated with diabetes. This includes:
  - therapeutic molded or depth-inlay shoes,
  - functional orthotics,
  - custom molded inserts,
  - replacement inserts,

  - preventive devices and
  - shoe modifications for prevention and treatment;
- Physician visits and post-diagnosis follow-up care;
- Self-management training, including:
  - medical nutritional therapy related to diabetes management;
  - Medically Necessary visits upon diagnosis of diabetes;
  - visits following a Physician diagnosis that represents a significant change in patient; and
  - visits for re-education;
- Syringes; and
- Visual reading Urine and Ketone strips.

Contact Member Services at 1-844-282-3025 for questions regarding these requirements.

The Food and Drug Administration (FDA) approves new or improved equipment. This may include new or improved appliances, Prescription Drugs, insulin or diabetic supplies. The Plan will evaluate if changes are needed to the *Formulary* or Policy.

Diagnostic Services

Laboratory, x-ray and other diagnostic tests are a Covered Service when Medically Necessary. These are provided under the direction of Your Provider. They include, but are not limited to:

- Blood tests;
- Urinalysis;
- Pathology tests;
- X-rays, ultrasounds, and other imaging studies;
- Electrocardiograms (EKGs), Electroencephalograms (EEGs), and other electronic diagnostic procedures; and
- CT scans; PET scans; MRIs; and CT colonoscopies (virtual colonoscopies).

Some Diagnostic Services require Prior Authorization. Refer to the Prior Authorization Section for more information.

Durable Medical Equipment

DME is a Covered Service when it is Medically Necessary and Prior Authorized by the Plan. Equipment must be necessary for a person's case or health status. DME includes:

- Durable medical equipment;
- Orthotic appliances;
- Prosthetic devices;
- Repair and replacement of durable medical equipment;

- Prosthetics and orthotic devices; and
- Hearing aids.

Coverage includes the rental or purchase of DME, at Our option. Examples of DME include, but are not limited to:

- Crutches;
- Hospital beds;
- Oxygen equipment;
- Wheelchairs; and
- Walkers.

Durable Medical Equipment should be Medically Necessary and Prior Authorized by the Plan. These services should meet the following criteria:

- Be able to withstand repeated use;
- Be reusable by other people;
- Be used to serve a medical purpose; and
- The equipment is generally not useful to a person who is not ill or injured.

There are some Exclusions and limitations to DME coverage. These are:

- DME coverage is for medically appropriate equipment only. It and does not include special features, upgrades or equipment accessories unless Medically Necessary.
- The Plan will cover the rental or purchase of Medically Necessary DME. This includes repair and adjustment of DME. We will not cover repairs that exceed the purchase price.
- Repair or replacement of DME is covered if it is Medically Necessary. We also cover repairs or replacement due to a change in the Member's physical or medical Condition. This is determined by Us.
- Repair of DME or prosthetic or orthotic devices which were previously owned by the Member and not supplied to them through the Plan may be covered, except as defined under Diabetes Supplies and Treatment. Coverage for these repairs shall be at Our discretion.
- The Plan follows guidelines established by Medicare for the lifetime of DME. Equipment is expected to last at least 5 years.
- Replacement due to loss, theft, misuse, abuse, or destruction is not covered. The Plan also will not cover replacement in cases where the patient improperly sells or gives away the equipment.
- The Plan does not cover replacement of DME solely for warranty expiration. We also do not cover replacement when new or improved equipment becoming available.
- The Plan does not cover duplicate or extra DME for the purpose of Member comfort, convenience or travel.

Orthotic Appliances

Medically Necessary orthotic appliances are Covered. Orthotic appliances include braces and other external devices used to correct a body function. This includes clubfoot deformity. Orthotic appliances are subject to the following limitations:

- Foot Orthotics or shoe appliances are not Covered, except for Our Members with diabetic neuropathy or other significant neuropathy.
- Custom fabricated knee-ankle-foot orthoses (KAFO) and ankle-foot orthoses (AFO) are Covered for Our Members in accordance with nationally recognized guidelines.

Prosthetic Devices

Internal prosthetics and/or medical appliances are covered when ordered by a Physician. These must be Prior Authorized by Us.

An External Prosthetic Appliance (EPA) is covered with Prior Authorization by Us and Medically Necessary for a person's case or health status. External Prosthetic Appliances are artificial substitutes worn on, or attached to the outside of the body; are used to replace a missing part (such as the leg, arm, or hand); or are needed to alleviate or correct an illness, injury, or congenital defect.

The Plan covers EPA that is necessary to accomplish ordinary activities of daily living. Braces are considered EPA. (This does not include orthodontic braces.)

There are some Exclusions and limitations that apply to coverage for EPA:

- We cover EPA for K1-3 ambulators. EPA for Level 0 or Level 4 ambulators are not covered.
- We cover replacement of EPA if it is needed due to normal body growth or for changes due to illness or injury.
- We follow Medicare guidelines to determine the lifetime of EPA.
- We cover pre-fabricated EPA unless there is clinical documentation supporting that custom EPA is Medically Necessary. This includes upgrades or accessories that do not serve a therapeutic purpose.
- EPA for the purpose of being able to participate in recreational or leisure activities is not covered.
- EPA for the purpose of being able to play a sport is not covered.
- Repair or replacement of EPA is covered if We determine it is Medically Necessary.
- Repair or replacement of EPA is not covered if due to loss, theft or destruction.
- We do not cover duplicate or extra EPA for the Member convenience or comfort.
- Benefit is limited to one (1) item per year.

Implanted Medical Devices

The Plan covers Implanted medical devices when Medically Necessary. These must be ordered by a Participating Provider. These devices include, but are not limited to:

- Pacemakers;
- artificial hip joints;
- cochlear implants; and
- cardiac stents.

Coverage consists of permanent or temporary internal aids and supports for defective body parts. We will also cover the cost for repairs or maintenance of covered appliances. Services require Prior Authorization.

Refer to the Prior Authorization Section for more information.

Hearing Aids

We cover Hearing aids and certain related services for Dependent children under eighteen (18) years of age (or under age twenty-one (21) if still attending high school). Services include fitting and dispensing fees; and ear molds, as necessary, to maintain optimal fit of the hearing aids. Benefit is limited to one (1) item every three (3) years.

Hearing aids are durable medical equipment. They are of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children. Services must be provided by an audiologist, hearing aid dispenser or Physician.

Family, Infant and Toddler (FIT) Program

Members from birth through three (3) years of age may qualify for up to $3,500 of annual coverage for services through the FIT Program. Providers must be certified and licensed as defined by New Mexico regulations and must work in early intervention programs approved by the New Mexico Department of Health.

The program provides intervention services for children who have or are at risk for early developmental delays and/or disabilities. Children must be enrolled in the FIT Program with the New Mexico State Department of Health and must receive services from designated FIT Program Providers as defined in 7.30.8. of the New Mexico Administrative Code.

More information can be obtained from the New Mexico State Department of Health.

Genetic Inborn Errors of Metabolism Disorders (IEM)

A genetic IEM is a rare, inherited, disorder that is present at birth. It can result in death if untreated. Inherited or genetic errors of metabolism are genetic conditions. This results in metabolism problems.

Most people with inherited metabolic disorders have a defective gene. This gene results in an enzyme deficiency. There are many different metabolic disorders, but each disorder is usually rare in the general population.

Covered Services for Genetic IEM include:

- treatment of genetic inborn errors of metabolism that involve amino acids;
- carbohydrate and fat metabolism for which medically standard methods of diagnosis;
- treatment; and
- monitoring.

Treatment for a genetic IEM includes:

- special diets that eliminate or replace certain nutrients;
- taking enzyme replacements or other supplements to support metabolism;
- treating the blood to remove toxic products of metabolism;
- clinical services;
- biochemical analysis;
- medical supplies;
- prescription drugs; and
- corrective lenses for Conditions related to the genetic inborn error of metabolism.

An IEM is not just allergy or intolerance to certain foods, such as lactose intolerance or gluten sensitivity.

Covered Services under this section must be performed by Providers with specific training in managing patients diagnosed with genetic IEM diagnosing, monitoring, and controlling disorders by nutritional and medical assessment.

Special Medical Foods for Genetic Inborn Errors of Metabolism (IEM)

The Plan will cover Special medical foods to treat IEM. Special medical foods include nutritional substances that:

- Are intended for the medical and nutritional management of a patient with limited capacity to metabolize ordinary food;
- Are specifically processed or formulated to be distinct in one or more nutrients that is present in natural foods;
- Are formulated to be consumed or administered internally; and
- Are essential for optimal growth, health and metabolic homeostasis.

Special medical foods must be obtained from a Plan Participating vendor or Provider. They must be prescribed by a Physician for the treatment of an IEM.

Habilitative Services

Habilitative Services help a person keep, learn or improve the skills and functions required for daily living. Such functions may include eating and bathing. The Plan covers Habilitative Services such as Physical and Occupational Therapy; speech-language pathology; and other services for people with disabilities.

Autism Spectrum Disorder

Coverage for the diagnosis and treatment of Autism Spectrum Disorder is covered for Members nineteen years (19) of age or younger. It is also covered for Members twenty-two (22) years of age or younger, if they are enrolled in high school. Coverage is limited to the Treatment Plan as prescribed by the Member's Physician. Some services may need to be Prior Authorized by the Plan.

Coverage includes well-baby and well-child screenings for diagnosing the presence of Autism Spectrum Disorder as well as treatment of Autism Spectrum Disorder through Speech, Occupational, and Physical Therapy and applied behavioral analysis. Providers of these services must be certified, registered or licensed to provide these services.

Coverage is limited to the treatment plan as prescribed by the Member's Physician. Some services may need to be Prior Authorized by the Plan. Coverage for the diagnosis and treatment of Autism Spectrum Disorder is covered for Members nineteen years (19) of age or younger. It is also covered for Members twenty-two (22) years of age or younger, if they are enrolled in high school (a school providing instruction for any of the grades nine through twelve).

Home Health Care Services

Medically Necessary home health services are covered for a Member under certain conditions. The Member must be confined to the home, require Skilled Care and be unable to receive medical care on an Ambulatory outpatient basis.

The Member does not need to be confined in a Hospital or other Health Care Facility. Home health services must be provided by a licensed and qualified Provider. Coverage is limited under this Plan. There is a limited number of home health visits during a Calendar Year to least one hundred (100), four (4) hour home visits per insured.

Please review Your *Summary of Benefits and Coverage* for details.

Home health services may include:

- Visits from professional nurses including but not limited to:
  - Registered Nurses,
  - licensed professional nurses, and
  - other Participating health professionals such as:
    - physical, occupational and respiratory therapists,
    - speech pathologists,
    - home health aides,
    - social workers and
    - dieticians;
- The administration or use of consumable medical supplies and DME by professional staff during an authorized home health visit; and
- Covered Drugs and medications prescribed by a Participating Provider for the duration of home health services.

Physical, Occupational, Respiratory, and Speech Therapy provided in the home is covered by the Plan. These are limited to services provided on the written order of a Provider. The order should be renewed at least every sixty (60) days.

Inpatient Hospital Services

The Plan covers Medically Necessary Inpatient Hospital services. Services include the treatment and evaluation of Conditions for which outpatient care would not be appropriate.

The Plan provides coverage for:

- Semi-private room and board;
- Intensive care unit services;
- Physician and surgeon services;
- Medications, biologicals, fluids and chemotherapy;
- Meals;
- Medically Necessary special diet and nutritional supplements;
- Dressings and casts;
- Medically Necessary general nursing care and special duty nursing;
- The Use of the operating room and related facilities;

- Administration of blood and blood products;
- X-rays, laboratory and other diagnostic services;
- Anesthesia and oxygen services;
- Inhalation therapy (Respiratory Therapy);
- Radiation therapy; and
- Other services provided in an acute care Hospital.

Inpatient Acute Care Hospital Services require Prior Authorization. Please refer to the Prior Authorization Section for more information.

Inpatient Long Term Acute Care

The Plan covers Long Term Acute Care (LTAC) hospitalizations when Medically Necessary. LTAC Hospitals provide care for Members that require longer-term Inpatient care due to complex Conditions. These conditions cannot be treated at a facility with a lower level of care. LTAC may include pulmonary care, advanced wound care, and critical care services.

Services that are covered by the Plan include:

- Laboratory testing;
- Respiratory therapy;
- 3 or more IV antibiotics, other IV medications, TPN, and IV fluids;
- Pain management;
- Limited Rehabilitation, including Physical, Occupational, cognitive, and Speech therapy;
- Frequent vital sign, neurologic sign, or vascular checks;
- Cardiac monitoring;
- Medication monitoring;
- Nutrition management;
- Fluid management, intake and output, and daily weights; and
- Education for the Patient, family, and/or the patient's caregivers.

Inpatient LTAC Services require Prior Authorization. Please refer to the Prior Authorization Section for more information.

Inpatient Rehabilitation Services

The Plan covers Inpatient services at an acute Rehabilitation facility. These services must be Medically Necessary.

Services must be rendered by a licensed and qualified Provider and include the following:

- Semi-private room and board;

- Physician services;
- Skilled nursing services;
- Skilled therapy services (PT/OT/ST);
- Multidisciplinary team services (dietician, MSW services);
- Medications, biologicals, fluids;
- Meals, including Medically Necessary diet and nutritional supplements;
- X-rays, laboratory and other diagnostic services; and
- Oxygen and inhalation therapy (Respiratory Therapy services).

Inpatient Rehabilitation Services require Prior Authorization. Please refer to the Prior Authorization Section for more information.

Hyperbaric Oxygen Therapy

Hyperbaric Oxygen Therapy is a covered benefit only if the therapy is proposed for a Condition recognized as one of the accepted indications. These indications are defined by the Hyperbaric Oxygen Therapy Committee of the Undersea and Hyperbaric Medical Society (UHMS).

Hyperbaric Oxygen Therapy is Excluded for any other Condition. Hyperbaric Oxygen Therapy requires Prior Authorization. The services must be provided by a Participating Provider in order to be Covered.

Mental Health Services, Behavioral Health Treatment, Alcoholism and Substance Abuse Services

Inpatient mental health services may require Prior Authorization. Please contact Member Services at 1-844-282-3025 for more information.

Alcohol and Substance Abuse Services

Your Plan covers the diagnosis and treatment of Substance Abuse. This includes alcohol and drug abuse disorders in an Inpatient and outpatient setting.

Inpatient services include Hospitalization for alcohol and drug abuse detoxification, Rehabilitation partial Hospitalization. Rehabilitation does not include a Residential Treatment Center or other facility using a social model to provide Rehabilitation. Inpatient services require Prior Authorization. All services must be furnished by a licensed and qualified Provider.

Outpatient services include assessment, outpatient detoxification, individual, family or couple therapy and counseling, intensive outpatient program (IOP), group therapy, as well as medication management by a licensed and qualified Provider.

Behavioral Health Treatment

Your Plan covers the diagnosis and treatment of Behavioral Disorders or Mental Illness disorders. These may be provided in an Inpatient and outpatient setting. The services must be furnished by a licensed and qualified Provider.

Inpatient services include Hospitalization, partial Hospitalization, and electroconvulsive therapy (ECT). Inpatient and ECT services require Prior Authorization. They must be furnished by a licensed and qualified Provider.

Outpatient services include:

- assessment;
- individual, group, family or couple therapy and counseling;
- intensive outpatient program (IOP);
- electroconvulsive therapy (ECT); and
- medication management.

Nutritional Support and Supplements

Your Plan covers the following Nutritional Supplements. These should be prescribed by a licensed and qualified Provider:

- Nutritional Supplements for prenatal care for a pregnant Member;
- Nutritional Supplements when Medically Necessary to replace a specific documented deficiency;
- Nutritional Supplements when Medically Necessary and administered by injection at the Provider's office;
- Enteral formulas or products, as Nutritional support, when administered by enteral tube feedings;
- Total Parental Nutrition (TPN) through intravenous catheters via central or peripheral veins; and
- Special Medical Foods as listed in the IEM Benefit section of this Policy.

Some Nutritional Support and Supplements require Prior Authorization. Please refer to the Prior Authorization Section for more information.

Nutritional Evaluation

Your Plan covers dietary evaluations and counseling for the medical management of a documented disease. This includes coverage for obesity. These services must be obtained from a licensed and

qualified Provider or a registered dietician. Refer to the Exclusions section of this Policy for further details.

Outpatient Medical Services

Your Plan covers Outpatient Hospital and/or ambulatory surgical procedures. These services must be Medically Necessary. They must be prescribed by Your Primary Care Provider or attending Health Care Professional.

Services may be provided at a Hospital; a Physician's office; or any other appropriately licensed facility. The Provider delivering services must be licensed to practice. He or she must be practicing under authority of the health care insurer, a medical group, an independent practice association or other authority as applicable by New Mexico law.

Outpatient Hospital or Ambulatory Surgical Procedures may include:

- Operating, recovery and other treatment rooms;
- Physician and surgeon services;
- Diagnostic laboratory tests, x-rays and pathology services;
- Pre-surgical testing;
- Administration of blood, blood plasma and other biologicals;
- Dressings, casts and sterile tray services;
- Medical supplies; and
- Anesthetics and/or anesthesia services.

Some Outpatient Hospital or Ambulatory Services require Prior Authorization. Please refer to the Prior Authorization Section for more information.

Practitioner/Provider Services

Practitioner/Provider services are those services that are reasonably required to maintain good health. These services include, but are not limited to, periodic examinations and office visits.

Medical Office Visits

Your Plan covers Primary Care and Specialist services for the diagnosis and treatment of an Illness or injury.

Allergy Treatment

Coverage is provided for allergy consultation, testing, treatment and injections by an allergy Specialist or Immunologist.

Second Opinions

Second Opinions can be obtained from In-Network Participating Providers without need for Prior Authorization. If We determine, in consultation with a Participating Provider, that a Second Opinion is not available in network, coverage is limited to one out of network consultation per diagnosis.

An out of network Second Opinion requires Prior Authorization.

Prescription Drugs/Medications

Your Plan provides coverage for drugs, supplies, supplements and administration of a drug (if such services would not otherwise be excluded from coverage) when prescribed by a licensed and qualified Provider and obtained at a Pharmacy or through the Plan's Mail Order program. Coverage for Prescription Drugs includes generic, brand name or non-preferred drugs.

We use a *Formulary*, which is a list of Prescription Drugs that are covered by the Plan. The *Formulary* includes drugs for a variety of disease states and conditions. Periodically, the *Formulary* is reviewed and updated to assure that the most current and clinically appropriate drug therapies are being used.

Sometimes it is Medically Necessary for You to use a drug that is not on the *Formulary*. When this occurs, the prescribing Physician may request an exception for coverage through the Plan's Pharmacy Exception Center. In addition, some of the *Formulary* drugs may require a Prior Authorization, a Step Therapy requirement, or may have quantity limits before coverage. See the Exclusions Section for more information on Prescription Drugs that are not Covered.

Some Prescription Drugs may be limited to a Specialty Pharmacy or a specific pharmacy based upon FDA approval. These drugs will be designated in the *Formulary* with such limitations.

If You received out-of-area Emergency Care and had a prescription filled, the Plan requires that the Claim be submitted for reimbursement no later than 1 year (365 days) following the date of service. The Claim must contain an itemized statement of expenses.

There are certain medications that are not required to be covered by law. These drugs are related to the treatment of cancer, diabetes and smoking cessation.

Additional information regarding Your Prescription Drug cost sharing including Copays, Out of Pocket Limits, Mail Order program, Limitations and Exclusions can be found in *Summary of Benefits and Coverage*.

If You have questions regarding the *Formulary* or regarding Your Prescription Drug benefits, call Member Services at 1-844-282-3025.

Reconstructive Surgery

Your Plan covers Medically Necessary services for surgery from which an improvement in physiologic function can reasonably be expected and performed for the correction of functional disorders resulting from accidental injury or from congenital defects or disease.

Rehabilitation Therapy

Rehabilitation Therapy includes:

- physical therapy;
- speech therapy;
- occupational therapy; and
- cardiac and pulmonary therapy.

These therapies are covered by the Plan when it has been determined that they can be expected to result in significant improvement of a Member's physical condition. These services may be needed as a result of an injury, surgery, or an acute medical condition.

Related occupational therapy is provided for the purpose of training Members to perform the activities of daily living.

Skilled Nursing Facility (SNF) Care

Inpatient SNF services are covered under Your Plan. These services must be Medically Necessary and furnished by a licensed and qualified Provider. Prior Authorization is required. ,

Services are limited as stated in the *Summary of Benefits and Coverage* and include:

- Semi-private room and board;
- Skilled and general nursing services;
- Physician visits;
- Limited rehabilitative therapy;
- X-rays; and
- Administration of covered drugs, medications, biologicals and fluids.

Smoking Cessation Counseling/Program

Your Plan covers smoking cessation and counseling. This includes diagnostic services necessary to identify tobacco use, use-related Conditions and dependence. Your Plan also covers certain smoking cessation drugs as set forth on the *Formulary*.

Group counseling, including classes or a telephone Quit Line, are covered through a Participating Provider. No Cost Sharing applies and there are no dollar limits or visit maximums.

Please contact Member Services at 1-844-282-3025 for more information.

Transplants

Your Plan covers human organ and tissue transplant services. These must be Prior Authorized. Services must also be received from Plan-approved facilities within the United States.

Organ transplant recipients must be a Member at the time of services. The term recipient is defined to include a Member receiving authorized transplant-related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care.

Coverage is subject to the conditions and limitations outlined in the *Summary of Benefits and Coverage* and in this Policy.

Benefits are not available when the Member is a donor.

Transplant services include medical, surgical and Hospital services for the recipient. This Plan also covers organ procurement needed for human-to-human organ or tissue transplant. The types of transplants covered include, but are not limited to:

- kidney,
- kidney/pancreas,
- cornea,
- bone marrow,
- heart,
- heart/lung,
- liver, and
- pancreas.

Transplant services must be Prior Authorized. Prior Authorization is based on an evaluation conducted by a Plan-approved transplant facility and on the relevant evidence-based medical guidelines.

You may seek authorization from the health plan for dual transplant listing. The second listing must be within a separate or different Organ Procurement Organization. While dual listing is authorized, payment will be made to only one facility for the actual transplant event.

Organ Procurement Costs

The Plan will cover costs directly related to the procurement of an organ from a cadaver or from a live donor. Surgery needed for organ removal; organ transit and the transportation; hospitalization and surgery of a live donor are also covered by the Plan. Compatibility testing that is done prior to procurement is covered if it is determined to be Medically Necessary by the Plan.

Transplant Travel

Travel expenses incurred in connection with a pre-approved transplant are covered up to $10,000 per lifetime. Benefits for transportation; lodging; and food are available to Members only if they are the recipient of a pre-approved organ/tissue transplant from a Plan approved Provider. Transplant Travel must be Prior Authorized.

Covered Travel expenses for a Member receiving a transplant include charges for:

- Transportation to and from the transplant site, including charges for a rental car used during a period of care at the transplant facility;
- Lodging while at, or traveling to and from the transplant site;
- Food while at, or traveling to and from the transplant site.

The Plan will also cover travel expenses for one companion to accompany the patient as described above. Patients that are minors are allowed travel benefits for themselves, one or both parents, or a parent and a designated companion. A companion may be a spouse; a family member; a legal guardian; or any person not related to the Member but actively involved in the Member's care.

The following travel expenses travel expenses are excluded from coverage:

- travel costs incurred due to travel within sixty (60) miles of the Member's home;
- laundry bills;
- telephone bills;
- alcohol or tobacco products; and
- charges for transportation that exceed coach rates.

Immunosuppressive Drugs for Organ Transplants

The Plan will cover Inpatient immunosuppressive drugs for organ transplants. Prescription Drugs may be covered.

Please refer to Your *Summary of Benefits and Coverage* for information regarding Your Prescription Drug benefits.

Vision Care (Limited)

Please refer to Your *Summary of Benefits and Coverage* for Cost Sharing amounts, limitations, and maximums. Vision services may include:

- One wellness eye exam per year for children Members, one wellness eye exam every 24 months for adult Members.
- One pair of glasses per year for children, one every 24 months for adults, with a limit of $100 allowance for frames and lenses or $150 for contact lenses.
- Vision services for Dependent children that are Essential Health Benefits. These services include:
  - 1 routine eye exam for children per year.
  - 1 pair of eye glasses for children every 12 months.
  - Minor repairs to eyeglasses.
  - Lens tinting only if certain Conditions are present such as diseases, injuries, syndromes, or anomalies which are documented on the exam record and the prescription meets the dipodic correction purchase criteria.
  - Lenses to prevent double vision.

Women's Health Care

Please see the SPECIAL NOTICE ABOUT REPRODUCTIVE & FAMILY PLANNING SERVICES Section of this Policy.

The Plan covers certain services related to women's health care. Some Covered Services are:

- Prenatal care, including nutritional supplements that are Medically Necessary and prescribed by a Physician.
- Mammograms for screening and diagnosis. These services include, but are not limited to:
  - low-dose mammography screenings performed at a designated imaging facility; and
  - mammograms for screening and diagnostic purposes, including but not limited to low-dose mammography screenings performed at designated and approved imaging facility.
- At a minimum, the Plan shall cover:
  - one baseline mammogram to persons age thirty-five (35) through thirty-nine (39);

  - one mammogram biennially to persons age forty (40) through forty-nine (49); and
  - one mammogram annually to persons age fifty (50) and over.
- Breast Cancer Chemoprevention counseling for women at higher risk.
- Cytologic Screenings (Pap tests) including a screening for papillomavirus to determine the presence of precancerous or cancerous Conditions and other health problems. These tests are available for women age thirteen (13) or older; and for women who are at risk of cancer, or at risk of other health Conditions that can be identified through a Cytological Screening.
- Human papillomavirus vaccine available to female Members age nine (9) to fourteen (14) years of age.
- Breast and Ovarian cancer genetic testing and genetic counseling based on family history.
- Screening for gestational diabetes.
- Counseling and screening for HIV and other sexually transmitted diseases.
- Screening and counseling for interpersonal and domestic violence and abuse.
- Forty-eight (48) hours of Inpatient care following a mastectomy; and twenty-four (24) hours of Inpatient care following lymph node dissection for the treatment of breast cancer;
- Mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts; prostheses; and complications resulting from a mastectomy, including lymphedema; Direct access to qualified obstetric and gynecological care for female Members age thirteen (13) or older.
- Human papillomavirus vaccine available to female Members age nine (9) to fourteen (14) years of age; screenings once every 3 years for female Members age thirty (30) or older.

Maternity Care

Maternity Care is covered as shown on Your *Summary of Benefits and Coverage*. You are entitled to receive the maternity services and benefits listed in this section. Some Covered Services may require Prior Authorization by the Plan.

Prenatal Maternity Care

Coverage for Prenatal Care includes:

- a minimum of one prenatal office visit per month during the first two trimesters of pregnancy
- a minimum of two office visits per month during the seventh and eighth months
- a minimum of one office visit per week during the ninth month and until term by a Participating Provider.

Each office visit shall also include; prenatal counseling and education, necessary and appropriate screening, including history, physical examination and the laboratory and diagnostic procedures deemed appropriate by the Participating Provider/Practitioner. This is based upon recognized medical criteria for the risk group of which the patient is a Member.

Obstetrical Care

Maternity Care includes coverage for Obstetrical care, including Participating Physician's, Participating Licensed Certified Nurse Midwife's, and Participating delivery room and other Medically Necessary services directly associated with delivery.

Services Provided by a Licensed Certified Nurse Midwife

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

- The Licensed Certified Nurse Midwife is a Participating Provider.
- The Licensed Certified Nurse Midwife's services must be provided under the supervision of a Participating licensed Obstetrician or a licensed Family Practice Provider.
- The services must be provided in preparation for, or in connection with, the delivery of a newborn infant at a site that is covered under this Maternity benefit.
- For the purposes of this Maternity benefit, the only allowable sites of delivery are a Participating Hospital or a licensed birthing center. The combined fees of the Licensed Certified Nurse Midwife and any attending or supervising Physician(s), for all services provided before, during and after the birth, may not exceed the allowable fee(s) that would have been payable to the Physician had he/she been the sole Provider of those services.

Delivery Services

Medical, surgical and Hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, miscarriage, and complications of pregnancy are covered. Coverage for a mother shall be available for a minimum of forty-eight (48) hours of Inpatient care following a vaginal delivery and a minimum of ninety-six (96) hours of Inpatient care following a Cesarean section. Any decision to shorten the period of Inpatient care for the mother or the newborn must be made by the attending Physician or Provider in consultation with the mother.

Transportation, including air transport to the nearest available contracted appropriately licensed Health Care Facility, is available for medically high-risk pregnant women with an impending delivery of a potentially viable infant. When necessary to protect the life of the infant, transportation, including air transport, to the nearest available tertiary care Health Care Facility, is covered.

Postpartum Care

Maternity Care includes postpartum visits. Postpartum care in the home is covered in accordance with accepted maternal and neonatal Physician assessments, by a person with appropriate licensure, training and experience to provide postpartum care. Services provided by such 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.

Breast feeding support, supplies and counseling

The following benefits and services are covered at no cost to the Member when received from a Participating Provider:

- Member must have a prescription for a manual breast pump, supplies, and counseling to prove that the Member gave birth.
- Member will be provided with one (1) manual breast pump. One (1) replacement manual breast pump is allowed the following year and every year thereafter. A replacement set of associated supplies is allowed per Member per year. Supplies include such items as breast pump, tubing and pads.
- If it is deemed Medically Necessary for the Member to use an electric breast pump, the Member's Durable Medical Equipment benefit would apply and may include a cost share.
- Breastfeeding counseling services are limited to a duration of one year.

Alpha-fetoprotein IV Screening

The alpha-fetoprotein IV screening test for pregnant women. The test screens for certain genetic abnormalities in the fetus. This test generally occurs between the sixteenth (16th) and twentieth (20th) week of pregnancy.

Newborn and Adopted Children Coverage

The Plan will cover injury or illness of a newborn child. The child can be natural or adopted or in a "placement for adoption" status. This includes circumcision for newborn males, and the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Ground or air transportation to the nearest available Tertiary Care Facility is covered when necessary to protect the life of the infant.

Nutritional Supplements

This Maternity Benefit includes coverage for Medically Necessary nutritional supplements listed on the *Formulary* (as directed by the attending Participating Provider/Practitioner).

Transition of Care

For a Member who is in the third trimester of pregnancy when her Participating Provider/Practitioner leaves the Plan's network, the transitional period will include postpartum care directly related to the delivery. Determinations for Transition of Care are made based on established criteria. The Transition of Care Period will be for a period of no less than thirty (30) days.

Additional Women's Health Care Benefits

Mastectomy Care

The Plan shall offer forty-eight (48) hours of Inpatient care for a mastectomy; and twenty-four (24) hours of Inpatient care following lymph node dissection for the treatment of breast cancer. The Plan will also cover mastectomy-related services; including all stages of breast reconstruction and surgery to achieve symmetry between the breasts; prostheses; and any complications resulting from a mastectomy, including lymphedema.

Requests for reconstructions after initial reconstruction post-mastectomy require prior authorization, and clinical information must be reviewed by a Medical Director for Medical Necessity. Requests that are not an initial reconstruction that are cosmetic in nature are not a Covered Benefit.

Osteoporosis Coverage

Services related to the diagnosis, treatment, and appropriate management of osteoporosis when Medically Necessary.

SPECIAL NOTICE ABOUT REPRODUCTIVE & FAMILY PLANNING SERVICES

CHRISTUS Health Plan is an affiliate of a Catholic health care system, which is subject to the Ethical and Religious Directives for Catholic Health Care Services. Based on religious beliefs, we limit performance of certain services. Such services include sterilization, tubal ligation and artificial contraceptives, or any counseling or referrals for such services, when performed for family planning purposes. However, certain of these services are designated under federal law as covered Essential Health Benefits for women with reproductive capacity; these covered services may include:

- FDA-approved contraceptive methods (not including abortifacient drugs), such as:
  - Barrier methods (used during intercourse), like diaphragms and sponges
  - Hormonal methods, like birth control pills and vaginal rings
  - Implanted devices, like intrauterine devices (IUDs)
  - Emergency contraception, like Plan B® and Ella®
  - Sterilization procedures
  - Patient education and counseling

- FDA-approved sterilization procedures
- Patient education and counseling

Direct abortion is not a covered benefit. The termination of a pregnancy is a covered benefit only in the following circumstances: 1) as a result of treating a proportionately serious pathological condition of a pregnant woman, and 2) when the intervention cannot be safely postponed until the fetus is viable.

If you are in need of these services, please consult with your Primary Care Provider.

EXCLUSIONS

This Policy only covered certain Medically Necessary healthcare benefits. This EXCLUSIONS Section lists services that are specifically excluded from coverage under this Policy. All other benefits and services not specifically listed in the COVERED BENEFITS section of this Policy are also Excluded Services.

If you are uncertain about whether a service or item is covered by this Policy, please contact Member Services at 1-844-282-3025 before the service or item is provided.

The following are specifically excluded from coverage:

- **Abortions**
  - Direct abortions are not a covered benefit. See Covered Benefits for more exceptions.

- **Accident and Emergency Services**
  - Use of an emergency facility for non-emergent services (including without limitation, Urgent Care or observation)

- **Autopsies and Ambulance Services**
  - Autopsy costs for deceased Members.
  - Ambulance services to the coroner's office or to a mortuary, unless the Ambulance has been dispatched prior to the pronouncement of death by an individual authorized under state law to make such pronouncements.

- **Before or After Coverage Period**
  - Services received, items purchased, prescriptions filled or expenses incurred before the effective date of coverage under this Policies or after the effective date of termination of Coverage.

- **Certified Hospital Care Benefits**
  - Food, housing and delivered meals.
  - Volunteer services.
  - Personal or comfort items.
  - Homemaker or housekeeping services.
  - Private duty nursing.
  - Bereavement counseling.

- **Clinical Trials**
  - Any Cancer Clinical Trials provided outside of New Mexico, as well as those that do not meet the requirements of the COVERED BENEFITS section of this Policy.
  - Costs of Clinical Trials that are customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources.

- Services from non-Participating Providers, unless services are not available from a Participating Provider. Prior Authorization is required for any Out-of-Network Services, which must be provided in New Mexico.
- Costs of a non-FDA approved Investigational drug, device or procedure.
- Costs associated with managing the research associate with the Clinical Trial.
- Costs of tests necessary for the research of the Clinical Trial.
- Costs paid for or not charged by the Clinical Trial Providers.

- **Clothing or Protective Devices**
  - Clothing or other protective devices, including photoprotective clothing, windshield tinting, lighting fixtures or other items or devices whether prescribed or not.

- **Complementary Therapies**
  - Biofeedback, except as specified in COVERED BENEFITS.

- **Cosmetic Surgery**
  - Cosmetic therapy, drugs or medications, or procedures for the purpose of changing appearance.
  - Any surgical or non-surgical procedures that are primarily for the purpose of altering appearance and not performed for the purpose of correcting functional disorders resulting from injury, congenital defects or disease.
  - Reconstructive surgery following a mastectomy is not considered Cosmetic Surgery and will be covered.

- **Circumcisions**
  - Performed other than for newborn stays, unless Medically Necessary.

- **Dental Services**
  - There is no dental coverage for adults.
  - Dental care and dental x-rays are allowable for children only, as specified in COVERED BENEFITS.

- **Durable Medical Equipment**
  - Upgraded or deluxe Durable Medical Equipment
  - Convenience items, including items for comfort and ease and not primarily medical in nature, such as shower seats, bath grab bars, shades for wheelchairs, pillows, fans, special beds and chairs, and other items.
  - Duplicate Durable Medical Equipment items.
  - Repair or replacement of Durable Medical Equipment due to loss, neglect, misused, abuse to, or to improve appearance or convenience.
  - Repair or replacement of items under the manufacturer or supplier's warranty.
  - Additional wheelchairs, if the Member has a functional wheelchair.

- **Excessive Charges**
  - Charges or costs in excess of Usual, Customary and Reasonable Charges.

- **Exercise Equipment and Services**
  - Exercise equipment, videos, personal trainers, club memberships and weight reduction programs.

- **Experimental, Investigational or Unproven Drugs, Medicines, Treatments, Procedures, Devices or Services**

- **Extracorporeal shock wave therapy**

- **Foot Care**
  - Routine foot care, such as treatment of flat feet or other structural misalignments of the removal of corns, and calluses, unless Medically Necessary due to diabetes or other significant peripheral neuropathies.

- **Genetic Inborn Errors of Metabolism**
  - Food substitutes for lactose intolerance or other carbohydrate intolerances
  - Food substitutes that do not qualify as Special Medical Foods for the treatment of IEM.
  - Special Medical Foods for Conditions that are not present at birth.
  - Dietary supplements and items for Conditions including diabetes, hypertension, hyperlipidemia, obesity, autism spectrum disorder, celiac disease, and food allergies.

- **Hair Loss**
  - Hair loss or baldness treatments, medications, supplies and devices, regardless of medical cause of hair loss or baldness.

- **Home Health Care Services**
  - Private duty nursing.
  - Custodial Care needs that can be performed by non-licensed medical personnel to meet normal activities of daily living.
  - Respite care.

- **Hospital Services**
  - Acute medical detoxification in a residential treatment center.
  - Rehabilitation as part of acute medical detoxification.

- **Infertility Services**

- **Male Health Care**
  - Contraceptive Coverage
  - Family planning services
  - Sterilization procedures

- **Mental Health and Alcoholism and Substance Abuse**
  - Codependency treatment.
  - Bereavement and sexual counseling.
  - Psychological testing when not Medically Necessary.
  - Special education, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary or behavioral problems.
  - Court ordered evaluation or treatment, or a treatment that is a condition of parole or probation in lieu of sentencing.

- Alcohol or Substance Abuse Services (Except as specified in COVERED BENEFITS)
  - Treatment in a halfway house.
  - Residential Treatment Centers, for services other than the treatment of Alcoholism or Substance Abuse.
  - Codependency treatment.
  - Bereavement and sexual counseling.
  - Court-ordered treatment, or treatment that is a condition of parole or probation in lieu of sentence.
  - Any treatment for Alcoholism or Substance Abuse services after the maximum episodes of treatment allowed under this Policy.

- **Military Service Disabilities**
  - Care for military service connected disabilities to which You are legally entitled to and for which facilities are reasonable available to You.

- **Nutritional Supports and Supplements**
  - Baby food (including formula or breast milk) or other regular grocery products that can be used with the enteral system for oral or tube feedings.

- **Out-of-Network Services Not Authorized**
  - Services received out of network, if Prior Authorization was not obtained.

- **Orthotic Appliances**
  - Functional foot Orthotics, including those for plantar fascitis, pes planus (flat feet), heel spurs and other Conditions, Orthopedic or corrective shoes, arch supports, shoe appliances, foot Orthotics, and custom fitted braces or splints, except for Members with diabetes or other significant peripheral neuropathies.
  - Custom-fitted Orthotics, except for knee-foot-ankle Orthosis (KAFO) and/or ankle-foot Orthosis (AFO) for Members who meet nationally recognized guidelines.

- **Prescription Drugs/Medicines**
  - Compounded Prescription Drugs/Medicines.
  - New Medications for which the determination of criteria for Coverage have not yet been established by Us.
  - Over the counter (OTC) medications and drugs, except as listed on the *Formulary*.
  - Prescription Drugs/Medicines that require a Prior Authorization if no Prior Authorization was obtained.
  - Prescription Drugs/Medicines purchased outside the United States.
  - Replacement Prescription Drugs/Medicines resulting from loss, theft or destruction.
  - Prescription Drugs/Medicine, medicines, treatments, or devices that We determine are Experimental, Investigational or Unproven.
  - Disposable medical supplies, except when provided in a Hospital or a Participating Provider's office.
  - Treatments and medications for the purpose of weight reduction or control, except as specified in COVERED BENEFITS.
  - Nutritional supplements as prescribed by the attending Provider or as sole source of nutrition.

- Infant formula, under any circumstance.
- Prescription Drugs/Medicines for the treatment of sexual dysfunction.
- Prescription Drugs/Medicines for cosmetic purposes.

- **Provider Services**
  - Services provided by an Excluded Provider.
  - Telephone visits, except as set forth in COVERED BENEFITS.
  - Electronic mail by a Provider or consultation by telephone for which a charge is made to the patient.
  - Get acquainted visits without physical assessment or diagnostic or therapeutic intervention.

- **Prosthetic Devices**
  - Artificial aids including speech synthesis devices, except as specified in COVERED BENEFITS.

- **Reconstructive Surgery for Cosmetic Purposes**
  - Cosmetic Surgery (examples include breast augmentation, dermabrasion, dermaplaning, excision of acne scarring, acne surgery, asymptomatic scar revision, microphlebectomy, sclerotherapy (except for truncal veins), and nasal rhinoplasty.

- **Rehabilitation and Therapy**
  - Athletic trainers or treatments by athletic trainers.
  - Vocational rehabilitation services
  - Long-term therapy or rehabilitation services, including treatment for chronic or incurable Conditions for which rehabilitation produces minimal or temporary change or relief. If You have reached maximum rehabilitation potential, a point where a significant improvement is unlikely to occur, or therapy for 4 consecutive months, additional therapy is considered long-term therapy or rehabilitation.
  - Treatment of chronic Conditions (such as muscular dystrophy, down syndrome, cerebral palsy).

- **Services Covered Under Another Program**
  - Services for which You or Your Dependent are eligible under any governmental program (except Medicaid), to the extent determined by law.
  - Services for which, in the absence of any health service plan or insurance, no charge would be made to You or Your Dependent.

- **Services Provided Outside the United States**
  - Any services or materials for non-Emergency Care or non-Urgent Care received outside the United States.

- **Sex Dysfunction**
  - Treatment for sexual dysfunction, including medication, counseling and clinics.

- **Sex Transformation**
  - Surgery and drugs related to sex transformation.

- **Skilled Nursing Facility Care**
  - Custodial or domiciliary care.

- **Speech Therapy**
  - Therapy for stuttering.
  - Hearing aids and evaluation for fitting, except for Dependents under 18 years old.
  - Additional benefits beyond those listed in COVERED BENEFITS.

- **Smoking Cessation (Except as specified in COVERED BENEFITS)**
  - Hypnotherapy for smoking cessation counseling
  - Over the counter drugs, unless listed on the *Formulary*.
  - Acupuncture for smoking cessation purposes.

- **Transplant Services**
  - Non-human organ transplants, except for porcine (pig) heart valve
  - Transportation costs for deceased Members
  - Medical and Hospital Services of an organ transplant donor when the transplant recipient is not a Member or the transplant procedure is not a Covered Benefit.
  - Travel and lodging, except as specified in COVERED BENEFITS.

- **Treatment While Incarcerated**
  - Services or supplies a Member receives while in custody of any state or federal law enforcement authorities, including while in jail or prison.

- **Vision Care**
  - Routine vision care and eye refractions, except as specified in COVERED BENEFITS.
  - Corrective eyeglasses or sunglasses, frames, lenses, contact lenses, or fittings, except as specified in COVERED BENEFITS.
  - Eye refractive procedures, including radial keratotomy, laser procedures and other techniques.
  - Eye movement therapy.

- **Women's Health Care**
  - Elective abortions under any circumstances.
  - Abortifacient drugs.
  - Family planning services, excepted as specified in SPECIAL NOTICE ABOUT REPRODUCTIVE & FAMILY PLANNING SERVICES Section of this Policy.

- **Work-Related Illnesses or Injuries**, under any circumstances.

CLAIMS

Notice of Claim

Written notice of any Claim must be given to Us within **20 days** after the occurrence or commencement of any loss covered by the Plan, or as soon thereafter or as reasonably possible. Failure to give notice within 20 days will not invalidate or reduce a claim is notice is given as soon as reasonably possible.

Notice given by or on behalf of the Member to Us or to any authorized agent of the Plan, with information sufficient to identify the Member, shall be deemed notice to Us.

Claim Forms

You may call or write to Us to notify Us of a Claim. Upon receipt of notice from You, we will furnish You, or the Member policyholder for this Policy, the forms needed for filing a proof of loss (a "Claim"). Forms will be furnished within 15 days after We receive notice from You. You may also access our website, www.christushealthplan.org, to obtain a claim form.

Claim Submission

Written Claims must be furnished to Us within 365 days after the date of service. However, in case of a Claim for loss for which We provide any periodic payment contingent upon continuing loss, this Claim may be furnished within 365 days after termination of each period for which We are liable.

Failure to submit a Claim within the time required will not invalidate nor reduce any benefit if it is not reasonably possible to submit a Claim within 365 days, provided:

- it was not reasonably possible to provide proof in that time; and
- the proof is given within one year from the date Proof of Loss was otherwise required. This one year limit will not apply in the absence of legal capacity.

Payment of Claims

Benefits payable under this Policy will be paid immediately upon receipt of a clean Claim, unless the Policy provides for periodic payment. Where the Policy provides for periodic payments, the benefits will accrue and be paid monthly, subject to submission of a clean Claim.

A Claim will be considered a "clean" Claim if it contains all of the information required by Us to process for payment in accordance with the benefits without additional information. For example, a Claim may not be "clean" if it is incomplete, lacks medical record documentation, is suspicious or appears to be fraudulent, or suggests improper medical practice by the Provider.

Claims submitted for services received by a deceased Member will be payable in accordance with the beneficiary designation and the provisions respecting such payments. If no such designation or provision is provided, claims will be payable to the estate of the Member.

Any other claims unpaid at the Member's death may, at Our option, be paid to the beneficiary. All other claims will be payable to the Member or to the Provider, at Our option.

Right to Examine

We shall have the right and opportunity to examine the Member when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law. We will be liable for such expenses.

Out-of-Network Emergency Claims and Payment

If You receive Emergency Services from Non-Participating Providers, You are responsible for submitting the Claim. The Claim must contain an itemized statement of treatment, expenses, and diagnosis.

The itemized Claim or statement must be submitted to Us as soon as possible at the following address:

CHRISTUS Health Plan
Attn: Claims Department
919 Hidden Ridge
Irving, Texas 75038

Fraud and Abuse

Anyone who knowingly submits a false or fraudulent claim for payment of a loss, or engages in deception or misrepresentation to obtain an unauthorized benefit, may be guilty of a crime and subject to civil fines and criminal penalties.

We may terminate Coverage for any type of fraudulent activity by You or the Members covered by this Policy.

Subrogation

This section will apply when another party is, or may be considered liable for a Member's injury, illness or other Condition. This includes insurance carriers who are financially liable; settlements or awards relating to the Member's injury, sickness, or other condition; medical malpractice lawsuits; and other sources of liability other than this Policy.

We are subrogated to all of the rights of the Member against any party liable for the Member's injury or illness; or is or may be liable for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the value of the medical benefits that may have been paid by Us. We may assert this right without consent from the Member.

This right includes, but is not limited to, the Member's rights under uninsured and underinsured motorist coverage; any no-fault insurance; medical payment coverage (auto, homeowners or otherwise); Workers' Compensation coverage; or other insurance, as well as the Member's rights under the Plan to bring an action to clarify his or her rights under that insurance.

We are not obligated in any way to pursue this right independently or on behalf of the Member, but may choose to pursue Our rights to reimbursement at Our sole discretion.

The Member is obligated to cooperate with Us and its agents in order to protect Our subrogation rights. Cooperation with Us means You will:

- provide Us with any relevant information requested;
- sign and deliver such documents as reasonably requested by Us to secure the subrogation Claim;
- obtain Our consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If the Member enters into litigation or settlement negotiations regarding the obligations of other parties, the Member must not prejudice Our subrogation rights. If a Member fails to obtain prior written consent from Us and agrees to a settlement or releases any party from liability for payment of medical expenses, or otherwise fails to cooperate with this provision, including executing any documents required herein, the Member will be required to repay CHP for the value of any benefits that were paid under Us.

If You are in an accident and another person or entity may be legally liable to You, notify the Plan's Subrogation Services immediately at:

CHRISTUS Health Plan
Attn: Member Services Department
919 Hidden Ridge
Irving, Texas 75038

Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof

within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Medicaid

Benefits paid on behalf of a Member will be paid to the New Mexico Human Services Department (HSD) when:

1. HSD has paid or is paying benefits on behalf of the Member under the New Mexico Medicaid program;
2. Payment for the services in question has been made by HSD directly to the Medicaid Provider; and
3. We are notified that the Member receives benefits under the state Medicaid program and that benefits must be paid directly to HSD.

Otherwise, We will pay Providers for Your Covered Services. If You have already paid a Provider for Covered Services, You must seek reimbursement from the Provider. We are required by state law to make payment to Providers directly.

APPEALS AND GRIEVANCE PROCESS

We have a department that takes care of grievances and appeals. If You disagree with a decision of the Plan, You may ask for a review by filing a grievance or appeal.

You may also disagree with Our administrative practices. If You disagree You may file and Administrative Grievance or Complaint. We will never retaliate against a Member in any way for filing a grievance.

Who Can Help You

Member Services can help You. If You have a Concern about a person, a service, the quality of care, or contractual benefits, You can contact the Member Services toll-free at (844)282-3025(TTY Services provided by Relay New Mexico 1-800-659-8331).

Member Services will make every effort to resolve Your Complaint or Concern to Your satisfaction the first time it is brought to our attention. If the Member Services representative is not able to resolve Your Complaint or Concern, You can file a grievance or appeal.

New Mexico law sets forth certain standards for CHP's handling of grievances and appeals, as set forth below.

Definitions (NMAC 13.10.17.7)

An administrative grievance means an oral or written complaint submitted by or on behalf of a Grievant regarding any aspect of a CHP health benefits plan other than a request for health care services, including but not limited to: (1) administrative practices of CHP that affects the availability, delivery, or quality of health care services; (2) claims payment, handling or reimbursement for health care services; and (3) terminations of coverage.

An adverse determination means any of the following:

- any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time), or
- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payments, that is based on a determination of a member's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

An adverse determination grievance means an oral or written complaint submitted by or on behalf of a Grievant regarding an adverse determination.

A certification means a decision by CHP that a health care service requested by a provider or Grievant has been reviewed and, based upon the information available, meets the health care insurer's requirements for coverage and medical necessity, and the requested health care service is therefore approved.

A culturally and linguistically appropriate manner of notice means:

- CHP provides oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claim and appeals (including external review) in any applicable non-English language;
- CHP provides, upon request, a notice in any applicable non-English language;
- CHP includes in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by CHP; and

With respect to an address in any New Mexico county to which a notice is sent, a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county is literate only in the same non-English language, as determined by the department of health and human services (HHS); the counties that meet this ten percent (10%) standard, as determined by HHS, are found at http://cciio.cms.gov/resources/factsheets/clas-data.html and any necessary changes to this list are posted by HHS annually.

Grievant means any of the following:

- A Member, policyholder, subscriber, enrollee, or other individual, or that person's authorized representative or provider, acting on behalf of that person with that person's consent, entitled to receive health care benefits provided by CHP; or
- an individual, or that person's authorized representative, who may be entitled to receive health care benefits provided by CHP.

Health benefits plan means a health plan or a policy, contract, certificate or agreement offered or issued by CHP or its plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of health care services; this includes a traditional fee-for-service health benefits plan.

Health care insurer means a person that has a valid certificate of authority in good standing issued pursuant to the Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan, fraternal benefit society, vision plan, or pre-paid dental plan.

Health care professional means a physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide health care services consistent with New Mexico state law.

Health care services means services, supplies, and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the health benefits plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay.

Hearing officer, independent co-hearing officer or ICO means a health care or other professional licensed to practice medicine or another profession who is willing to assist the Superintendent as a hearing officer in understanding and analyzing medical necessity and coverage issues that arise in external review hearings.

Medical necessity or medically necessary means health care services determined by a provider, in consultation with CHP, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by CHP consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease.

Provider means a duly licensed hospital or other licensed facility, physician, or other health care professional authorized to furnish health care services within the scope of their license.

Rescission of coverage means a cancellation or discontinuance of coverage that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if:

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

Summary of Benefits and Coverage means the written materials required by NMSA 1978 Section 59A-57-4 to be given to the Grievant by CHP.

Termination of coverage means the cancellation or non-renewal of coverage provided by CHP to a Grievant but does not include a voluntary termination by a Grievant or termination of a health benefits plan that does not contain a renewal provision.

Traditional fee-for-service indemnity benefit means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage Grievants to utilize preferred providers, to follow pre-authorization rules, to utilize prescription drug formularies or other cost-saving procedures to obtain prescription drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services.

Uniform standards means all generally accepted practice guidelines, evidence-based practice guidelines or practice guidelines developed by the federal government or national and professional medical societies, boards and associations, and any applicable clinical review criteria, policies, practice guidelines, or protocols developed by CHP consistent with the federal, national, and professional practice guidelines that are used by a health care insurer in determining whether to certify or deny a requested health care service.

Computation of Time (NMAC 13.10.17.8)

Whenever New Mexico law requires that an action be taken within a certain period of time from receipt of a request or document, the request or document shall be deemed to have been received within three (3) working days of the date it was mailed.

General Requirements Regarding Grievance Procedures (NMAC 13.10.17.9)

Written grievance procedures required. CHP establishes and maintains separate written procedures to provide for the presentation, review, and resolution of:

1) adverse determination grievances, including procedures for both standard and expedited review of adverse determination grievances that comply with the requirements of 13.10.17.17 NMAC through 13.10.17.22 NMAC;
2) administrative grievances, including reviewing administrative grievances that comply with the requirements of 13.10.17.33 NMAC through 13.10.17.36 NMAC; and
3) if a grievance contains clearly divisible administrative and adverse decision issues, then CHP shall initiate separate complaints for each issue; with an explanation of the insurer's actions contained in one acknowledgement letter.

Assistance to Grievants. In those instances where a Grievant makes an oral grievance or request for internal review to CHP, or expresses interest in pursuing a written grievance, CHP shall assist Grievant to complete all the forms required to pursue internal review and shall advise Grievant that the managed health care bureau of the Office of Superintendent of Insurance is available for assistance.

Retaliatory action prohibited. No person shall be subject to retaliatory action by CHP for any reason related to a grievance.

Information About Grievance Procedures (NMAC 13.10.17.10)

For Grievants. CHP shall:

1) include a clear and concise description of all grievance procedures, both internal and external, in boldface type in the enrollment materials, including in member handbooks or evidences of coverage, issued to Grievants;

2) for a person who has been denied coverage, provide him or her with a copy of the grievance procedures;
3) notify Grievants that a representative of the health care insurer and the managed health care bureau of the insurance division are available upon request to assist Grievants with grievance procedures by including such information, and a toll-free telephone number for obtaining such assistance, in the enrollment materials and *Summary of Benefits and Coverage* issued to Grievants;
4) provide a copy of its grievance procedures and all necessary grievance forms at each decision point in the grievance process and immediately upon request, at any time, to a Grievant, Provider or other interested person;
5) provide a detailed written explanation of the appropriate grievance procedure and a copy of the grievance form to a Grievant or Provider when the health care insurer makes either an adverse determination or adverse administrative decision; the written explanation shall describe how the health care insurer reviews and resolves grievances and provide a toll-free telephone number, facsimile number, e-mail address, and mailing address of the health care insurer's consumer assistance office; and
6) provide consumer education brochures and materials developed and approved by the Superintendent, annually or as directed by the Superintendent in consultation with the insurer for distribution;
7) provide notice to enrollees in a culturally and linguistically appropriate manner as defined in Subsection E of 13.10.17.7 NMAC;
8) provide continued coverage for an ongoing course of treatment pending the outcome of an internal appeal;
9) not reduce or terminate an ongoing course of treatment without first notifying the Grievant sufficiently in advance of the reduction or termination to allow the Grievant to appeal and obtain a determination on review of the proposed reduction or termination; and
10) allow individuals in urgent care situations and receiving an ongoing course of treatment to proceed with an expedited external review at the same time as the internal review process.

Confidentiality of a Grievant's Records and Medical Information (NMAC 13.10.17.11)

Confidentiality. CHP, the Superintendent, independent co-hearing officers, and all others who acquire access to identifiable medical records and information of members when reviewing grievances shall treat and maintain such records and information as confidential except as otherwise provided by federal and New Mexico law.

Procedures Required. The Superintendent and CHP shall establish procedures to ensure the confidential treatment and maintenance of identifiable medical records and information of Grievants submitted as part of any grievance.

Record of Grievances (NMAC 13.10.17.12)

Record required. CHP shall maintain a grievance register to record all grievances received and handled during the calendar year. The register shall be maintained in a manner that is reasonably clear and accessible to the Superintendent.

Contents. For each grievance received, the grievance register shall:

1) assign a grievance number;
2) indicate whether the grievance is an adverse determination or administrative grievance, or a combination of both;
3) state the date, and for an expedited review the time, the grievance was received;
4) state the name and address of the Grievant, if different from the Grievant;
5) identify by name and member number the Grievant making the grievance or for whom the grievance was made;
6) indicate whether the Grievant's coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act, the Medicaid program, or a commercial health care insurer;
7) identify the health insurance policy number and the group if the policy is a group policy;
8) identify the individual employee of the health care insurer to whom the grievance was made;
9) describe the grievance;
10) for adverse determination grievances, indicate whether the grievance received expedited or standard review;
11) indicate at what level the grievance was resolved and what the actual outcome was; and
12) state the date the grievance was resolved and the date the Grievant was notified of the outcome.

Annual report. Each year, the Superintendent shall issue a data call for information based on the grievances received and handled by CHP during the prior calendar year. The data call will be based on the information contained in the grievance register.

Retention. CHP shall maintain such records for at least six (6) years.

Submittal. CHP shall submit information regarding all grievances involving quality of care issues to CHP's quality improvement committee and to the Superintendent and shall document the qualifications and background of the continuous quality improvement committee members. Continuous quality improvement is the ongoing and systematic effort to measure, evaluate, and improve CHP's quality.

Examination. CHP shall make such record available for examination upon request and provide such documents free of charge to a Grievant, or state or federal agency officials, subject to any applicable federal or state law regarding disclosure of personally identifiable health information.

Preliminary Determination (NMAC 13.10.17.13)

Upon receipt of a grievance, CHP shall first determine the type of grievance at hand.

1) If the grievance seeks review of an adverse determination of a pre- or post- health care service, it is an adverse determination grievance and CHP shall review the grievance in accordance with its procedures for adverse determination grievances and the requirements of 13.10.17.17 NMAC through 13.10.17.22 NMAC.
2) If the grievance is not based on an adverse determination of a pre- or post- health care service, it is an administrative grievance and CHP shall review the grievance in accordance with its procedures for administrative grievances and the requirements of 13.10.17.33 NMAC through 13.10.17.36 NMAC.

Timeframes for Initial Determinations (NMAC 13.10.17.14)

Expedited decision. CHP shall make its initial certification or adverse determination decision in accordance with the medical exigencies of the case. CHP shall make decisions within twenty-four (24) hours of the written or verbal receipt of the request for an expedited decision whenever:

1) the life or health of a Grievant would be jeopardized;
2) the Grievant's ability to regain maximum function would be jeopardized;
3) the Provider reasonably requests an expedited decision;
4) in the opinion of the physician with knowledge of the Grievant's medical condition, would subject the Grievant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim;
5) the medical exigencies of the case require an expedited decision; or
6) the Grievant's claim involves urgent care.

Standard decision. CHP shall make all other initial utilization management decisions within five (5) working days. CHP may extend the review period for a maximum of ten (10) working days if it:

1) can demonstrate reasonable cause beyond its control for the delay;
2) can demonstrate that the delay will not result in increased medical risk to the Grievant; and
3) provides a written progress report and explanation for the delay to the Grievant and Provider within the original five (5) working day review period.

Initial Determination (NMAC 13.10.17.15)

Coverage. When considering whether to certify a health care service requested by a Provider or Grievant, CHP shall determine whether the requested health care service is covered by the Plan.

Before denying a health care service requested by a Provider or Grievant on grounds of a lack of

coverage, CHP shall determine that there is no provision of the health benefits plan under which the requested health care service could be covered.

If We find that the requested health care service is not covered by the health benefits plan, We will not address the issue of medical necessity.

Medical Necessity. If We find that the requested health care service is covered by the health benefits plan, then when considering whether to certify a health care service requested by a Provider or Grievant, a physician, registered nurse, or other health care professional shall, within the timeframe required by the medical needs of the case, determine whether the requested health care service is medically necessary.

Before We deny a health care service requested by a Provider or Grievant on grounds of a lack of medical necessity, a physician shall give an opinion as to medical necessity, either after consultation with specialists who are experts in the area that is the subject of review, or after application of uniform standards used by the Plan. The physician shall be under the clinical authority of the chief medical officer responsible for health care services provided to Grievant.

Notice of Initial Determinations (NMAC 13.10.17.16)

Certification. We will notify the Grievant and Provider of the certification by written or electronic communication within two (2) working days of the date the health care service was certified, unless earlier notice is required by the medical needs of the case.

24-hour Notice of Adverse Determination. We will notify the Grievant and Provider of an adverse determination by telephone or as required by the medical needs of the case, but in no case later than twenty-four (24) hours after making the adverse determination, unless the Grievant fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or have insurance coverage.

If the Grievant fails to provide such information, he or she will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. Additionally, We will notify You and Your Provider of the adverse determination by written or electronic communication sent within one (1) working day of the telephone notice.

Contents of Notice of Adverse Determination. We will include:

- if the adverse determination is based on a lack of medical necessity, a clear and complete explanation why the requested health care service is not medically necessary (a statement that the health care service is not medically necessary will not be sufficient);
- if the adverse determination is based on a lack of coverage, an identification of all health

benefits plan provisions relied on in making the adverse determination, and a clear and complete explanation why the requested health care service is not covered by any provision of the health benefits plan (a statement that the requested health care service is not covered will not be sufficient);

- the date of service, the health care Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a description of the CHP standard that was used in denying the claim;
- a summary of the discussion which triggered the final determination;
- a statement to the Grievant that he or she may request internal or external review of the health care insurer's adverse determination; and
- a description of the procedures and all necessary forms to the Grievant for requesting internal appeals and external reviews.

Rights Regarding Internal Review of Adverse Determinations (NMAC 13.10.17.17)

Right to Internal Review. Every Grievant who is dissatisfied with an adverse determination has the right to request internal review of the adverse determination by CHP.

Acknowledgement of Request. Upon receipt of a request for internal review of an adverse determination, CHP shall date and time stamp the request and, within one (1) working day from receipt, send the Grievant an acknowledgment that the request has been received. The acknowledgment shall contain the name, address, and direct telephone number of an individual representative of CHP who may be contacted regarding the grievance.

Full and Fair Hearing. To ensure that a Grievant receives a full and fair internal review, CHP will, in addition to allowing the Grievant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process, provide the Grievant, free of charge, with any new or additional evidence, and new or additional rationale, considered, relied upon, or generated by the health care insurer, as soon as possible and sufficiently in advance of the date of the notice of final internal adverse benefit determination to allow the Grievant a reasonable opportunity to respond before the final internal adverse benefit determination is made.

Conflict of Interest. CHP must ensure that all internal claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions in such a way that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

Timeframes for Internal Review of Adverse Determinations (NMAC 13.10.17.18)

Upon receipt of a request for internal review of an adverse determination, We will conduct either a standard or expedited review, as appropriate.

Expedited review. We will complete our internal review as required by the medical needs of the case but in no case later than seventy-two (72) hours from the time the internal review request was received whenever:

- the life or health of a Grievant would be jeopardized;
- the Grievant's ability to regain maximum function would be jeopardized;
- the Provider reasonably requests an expedited decision;
- in the opinion of the doctor with knowledge of the Grievant's medical Condition, would subject the Grievant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim; or
- the medical needs of the case require an expedited decision.

Standard review. We will complete a standard review of both internal reviews as described in 13.10.17.19 NMAC and 13.10.17.20 NMAC within 20 working days of receipt of the request for internal review in all cases in which the request for review is made prior to the service requested, and does not require expedited review, and within 40 working days of receipt of the request in all post-service requests for internal review.

We may extend the review period for a maximum of 10 working days in pre-service cases, and 20 working days for post-service cases if We:

- can show reasonable cause beyond its control for the delay;
- can show that the delay will not result in increased medical risk to the Grievant; and
- provides a written progress report and explanation for the delay to the Grievant and Provider within the original 30 day for pre-service or 60 day for post-service review period;
- if the grievance contains clearly divisible administrative and adverse decision issues, then the Plan shall initiate separate complaints for each decision.

If We fail to comply with the deadline for completion of an internal review, the requested health care service shall be deemed approved unless the Grievant, after being fully informed of his or her rights, agrees in writing to extend the deadline

Failure to comply with deadline. If We fail to comply with the deadline for completion of an internal review, the requested health care service shall be deemed approved unless the Grievant, after being fully informed of his or her rights, has agreed in writing to extend the deadline.

First and Second Internal Review of Adverse Determinations (NMAC 13.10.17.19)

Applicability. This section applies only to health care insurers that offer group health care benefits plans and entities subject to the Health Care Purchasing Act that conduct the first level of the internal appeal, and health care insurers who offer group health care benefits plans that conduct the second level of the internal appeal.

Scope of review. Health care insurers that offer group health care benefits plans and entities subject to the Health Care Purchasing Act shall complete the review of the adverse determination within the timeframes established in 13.10.17.18 NMAC.

Coverage. If the initial adverse determination was based on a lack of coverage, the health care insurer shall review the health benefits plan and determine whether there is any provision in the plan under which the requested health care service could be certified.

Medical necessity. If the initial adverse determination was based on a lack of medical necessity, the health care insurer shall render an opinion as to medical necessity, either after consultation with specialists who are experts in the area that is the subject of review, or after application of uniform standards used by the health care insurer.

Decision to reverse. If the health care insurer reverses the initial adverse determination and certifies the requested health care service, the health care insurer shall notify the Grievant and Provider as required by 13.10.17.16 NMAC.

Decision to uphold. If the health care insurer upholds the initial adverse determination to deny the requested health care service, the health care insurer shall notify the Grievant and Provider as required by 13.10.17.16 NMAC and shall ascertain whether the Grievant wishes to pursue the grievance.

1) If the Grievant does not wish to pursue the grievance, the health care insurer shall mail written notification of health care insurer's decision, and confirmation of the Grievant's decision not to pursue the matter further, to the Grievant within three (3) working days of the health care insurer's decision.
2) If the health care insurer is unable to contact the Grievant by telephone within seventy-two (72) hours of making the decision to uphold the determination, the health care insurer shall notify the Grievant by mail of the health care insurer's decision and shall include in the notification a self-addressed stamped response form which asks the Grievant whether he or she wishes to pursue the grievance further and provides a box for checking "yes" and a box for checking "no." If the Grievant does not return the response form within ten (10) working days, the health care insurer shall again contact the Grievant by telephone.

3) If the Grievant responds affirmatively to the telephone inquiry or by response form, the health care insurer will select a medical panel to further review the adverse determination as described in 13.10.17.20 NMAC.
4) If the Grievant does not respond to the health care insurer's telephone inquiries or return the response form, the health care insurer shall select a medical panel to further review the adverse determination when the review is an expedited review.

Extending the timeframe for standard review. If the Grievant does not make an immediate decision to pursue the grievance, or the Grievant has requested additional time to supply supporting documents or information, or postponement pursuant to Subsection G of 13.10.17.20 NMAC, the timeframe described in Subsection B of 13.10.17.18 NMAC shall be extended to include the additional time required by the Grievant.

Internal Panel Review of Adverse Determinations (NMAC 13.10.17.20)

Selection of an internal review panel. In cases of appeal from an adverse determination or from a third party administrator's decision to uphold an adverse determination, We will select an internal review panel to review the adverse determination or the decision to uphold the adverse determination.

Notice of review. Unless the Grievant chooses not to pursue the grievance, We shall notify the Grievant of the date, time, and place of the internal panel review. The notice shall advise the Grievant of the rights specified in Subsection G of 13.10.17.20 NMAC. If We indicate that CHP will have an attorney represent its interests, the notice shall advise the Grievant that an attorney will represent CHP and that the Grievant may wish to obtain legal representation of their own.

Panel membership. We will select one or more representatives of the Plan and one or more health care or other professionals who have not been previously involved in the adverse determination being reviewed to serve on the internal review panel.

At least one of the health care professionals selected will practice in a specialty that would typically manage the case that is the subject of the grievance or be mutually agreed upon by the Grievant and the health care insurer.

Scope of review.

Coverage. The internal review panel will review the health benefits plan and determine whether there is any provision in the plan under which the requested health care service could be certified.

Medical necessity. The internal review panel will render an opinion as to medical necessity, either after consultation with specialists who are experts in the area that is the subject of review, or after application of uniform standards used by the health care insurer.

Information to Grievant. No fewer than 3 working days prior to the internal panel review, We will provide the Grievant copies of:

- the Grievant's pertinent medical records;
- the treating Provider's recommendation;
- the Grievant's health benefits plan;
- our notice of adverse determination;
- uniform standards relevant to the Grievant's medical condition that is used by the internal panel in reviewing the adverse determination;
- questions sent to or reports received from any medical consultants retained by Us; and
- all other evidence or documentation relevant to reviewing the adverse determination.

Request for postponement. We will not unreasonably deny a request for postponement of the internal panel review made by the Grievant. The timeframes for internal panel review shall be extended during the period of any postponement.

Rights of Grievant. A Grievant has the right to:

- attend and participate in the internal panel review;
- present his or her case to the internal panel;
- submit supporting material both before and at the internal panel review;
- ask questions of any representative of the Plan;
- ask questions of any health care professionals on the internal panel;
- be assisted or represented by a person of her choice, including legal representation; and
- hire a specialist to participate in the internal panel review at his or her own expense, but such specialist may not participate in making the decision.

Timeframe for review; attendance. The internal review panel will complete its review of the adverse determination as required by the medical needs of the case. Internal review panel members will be present physically or by video or telephone conferencing to hear the grievance.

Additional Requirements for an Expedited Internal Review of Adverse Determinations (NMAC 13.10.17.21)

In an expedited review, all information required by Subsection D of 13.10.17.20 NMAC shall be transmitted between CHP and the Grievant by the most expeditious method available.

If an expedited review is conducted during a hospital stay or course of treatment, health care services will be continued without cost (except for applicable co-payments and deductibles) to the Grievant until CHP makes a final decision and notifies the Grievant.

We will not conduct an expedited review of an adverse determination made after health care services have been provided to a Grievant.

Notice of Internal Panel Decision (NMAC 13.10.17.22)

Notice required. Within the time period allotted for completion of its internal review, We will notify the Grievant and Provider of the internal review panel's decision by telephone within twenty-four (24) hours of the panel's decision and in writing or by electronic means within one (1) working day of the telephone notice.

Contents of notice. The written notice will contain:

- the names, titles, and qualifying credentials of the persons on the internal review panel;
- a statement of the internal panel's understanding of the nature of the grievance and all pertinent facts;
- a description of the evidence relied on by the internal review panel in reaching its decision;
- a clear and complete explanation of the rationale for the internal review panel's decision;
- the notice will identify every provision of the Grievant's health benefits plan relevant to the issue of coverage in the case under review, and explain why each provision did or did not support the panel's decision regarding coverage of the requested health care service;
- the notice will cite the uniform standards relevant to the Grievant's medical condition and explain whether each supported or did not support the panel's decision regarding the medical necessity of the requested health care service;

    notice of the Grievant's right to request external review by the Superintendent, including the address and telephone number of the managed health care bureau of the insurance division, a description of all procedures and time deadlines necessary to pursue external review, and copies of any forms required to initiate external review; this notice of the Grievant's right to request external review is in addition to the same notice provided to the Grievant in the *Summary of Benefits and Coverage*.

External Review of an Adverse Determination (NMAC 13.10.17.23)

Right to external review. Every Grievant who is dissatisfied with the results of a review by Us, may request an external review by the Superintendent at no cost to the Grievant.

There is no minimum dollar amount of a claim before a Grievant may exercise this right to external review.

Exhaustion of internal appeals process. The Superintendent may require the Grievant to exhaust any grievance procedures adopted by Us

Deemed exhaustion. If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary and the internal appeals process will be deemed exhausted if:

1) We waive the exhaustion requirement;
2) We are considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process; or
3) the Grievant simultaneously requests an expedited internal appeal and an expedited external review.

Exception to exhaustion requirement.

1) Notwithstanding "Exhaustion of internal appeals process" above, the internal claims and appeals process will not be deemed exhausted based on violations by Us that are *de minimus* and do not cause, and are not likely to cause, prejudice or harm to the Grievant. We must demonstrate that the violation was for good cause or due to matters beyond our control. We must also demonstrate the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the Grievant. This exception is not available if the violation is part of a pattern or practice of violations by Us.

2) the Grievant may request a written explanation of the violation from Us. We must provide such explanation within ten (10) days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects a Grievant's request for immediate review under "Exhaustion of internal appeals process" above, on the basis that We met the standards for the exception set forth in Paragraph (1) above, the Grievant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), We will provide the Grievant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Grievant's receipt of such notice.

Filing Requirements for External Review of Adverse Determinations (NMAC 13.10.16.24)

Deadline for Filing Request.

When required by the medical exigencies of the case. If required by the medical exigencies of the case, a Grievant or Provider may telephonically request an expedited review by calling the managed health care bureau at:

(505) 827-4601 or 1-855-427-5674.

In all other cases. To initiate an external review, the Grievant must file a written request for external review with the Superintendent within one hundred twenty (120) calendar days from receipt of the written notice of internal review decision unless extended by the Superintendent for good cause shown.

The cost of the external review will be borne by the health care insurer or health care plan. The request shall be:

- mailed to:

  Office of Superintendent of Insurance
  Attn: Managed Health Care Bureau - External Review Request
  Post Office Box 1689, 1120 Paseo de Peralta
  Santa Fe, New Mexico 87504-1689

- e-mailed to mhcb.grievance@state.nm.us, subject External Review Request;
- faxed to Office of Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, at (505) 827-4734; or
- completed on-line with NMOSI, Office of Superintendent of Insurance Complaint Form available at http://www.osi.state.nm.us

Documents required to be filed by the Grievant. The Grievant shall file the request for external review on the forms provided to the Grievant by the health care insurer or entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act pursuant to Paragraph (5) of Subsection B of 13.10.17.22 NMAC, and shall also file:

1) a copy of the notice of internal review decision;
2) a fully executed release form authorizing the Superintendent to obtain any necessary medical records from the health care insurer or any other relevant Provider; and
3) if the grievance involves an experimental or investigational treatment adverse determination, the Provider's certification and recommendation as described in Subsection B of 13.10.17.28 NMAC.

Other filings. The Grievant may also file any other supporting documents or information the Grievant wishes to submit to the Superintendent for review.

Extending timeframes for external review. If a Grievant wishes to supply supporting documents or information subsequent to the filing of the request for external review, the timeframes for external review shall be extended up to 90 days from the receipt of the complaint form, or until the Grievant submits all supporting documents, whichever occurs first.

Acknowledgement of Request for External Review of Adverse Determination (NMAC 13.10.17.25)

A. Upon receipt of a request for external review, the Superintendent shall immediately send:

1) the Grievant an acknowledgment that the request has been received;
2) the health care insurer a copy of the request for external review.

B. Upon receipt of the copy of the request for external review, the health care insurer shall, within five (5) working days for standard review or the time limit set by the Superintendent for expedited review, provide to the Superintendent and the Grievant by any available expeditious method:

1) the *Summary of Benefits and Coverage*;
2) the complete health benefits plan, which may be in the form of a member handbook/evidence of coverage;
3) all pertinent medical records, internal review decisions and rationales, consulting physician reports, and documents and information submitted by the Grievant and health care insurer;
4) uniform standards relevant to the Grievant's medical condition that were used by the internal panel in reviewing the adverse determination; and
5) any other documents, records, and information relevant to the adverse determination and the internal review decision or intended to be relied on at the external review hearing.

C. If the health care insurer fails to comply with the requirements of Subsection B of this section, the Superintendent may reverse the adverse determination.

D. The Superintendent may waive the requirements of this section if necessitated by the medical exigencies of the case.

Timeframes for External Review of Adverse Determinations (NMAC 13.10.17.26)

The Superintendent will conduct either a standard or expedited external review of the adverse determination, as required by the medical needs of the case.

Expedited review.

1. The Superintendent shall complete an external review as required by the medical needs of the case but in no case later than seventy-two (72) hours of receipt of the external review request whenever:

    - the life or health of a Grievant would be jeopardized; or
    - the Grievant's ability to regain maximum function would be jeopardized.

2. If the Superintendent's initial decision is made orally, written notice of the decision must be provided within 48 hours of the oral notification.

Standard review. The Superintendent shall conduct a standard review in all cases not requiring expedited review. Insurance division staff shall complete the initial review within ten (10) working days from receipt of the request for external review and the information required of the Grievant and health care insurer in Subsection B of 13.10.17.24 and Subsection B of 13.10.17.25 NMAC respectively. If a hearing is held in accordance with 13.10.17.30 NMAC, the Superintendent shall complete the external review within forty-five (45) working days from receipt of the complete request for external review in compliance with 13.10.17.24 NMAC. The Superintendent may extend the external review period for up to an additional ten (10) working days when the Superintendent has been unable to schedule the hearing within the required timeframe and the delay will not result in increased medical risk to the Grievant.

Criteria for Initial External Review of Adverse Determination by Insurance Division Staff (NMAC 13.10.17.27)

Upon receipt of the request for external review, insurance division staff shall review the request to determine whether:

- the Grievant has provided the documents required by Subsection B of 13.10.17.24 NMAC;
- the individual is or was a Grievant of the health care insurer at the time the health care service was requested or provided;
- the Grievant has exhausted the health care insurer's internal review procedure and any applicable grievance review procedure of an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act; and
- the health care service that is the subject of the grievance reasonably appears to be a covered benefit under the health benefits plan.

Additional Criteria for Initial External Review of Experimental or Investigational Treatment Adverse Determinations by Insurance Division Staff (NMAC 13.10.17.28)

If the request is for external review of an experimental or investigational treatment adverse determination, insurance division staff shall also consider whether:

coverage; the recommended or requested health care service:

1. reasonably appears to be a covered benefit under the Grievant's health benefit plan except for the health care insurer's determination that the health care service is experimental or investigational for a particular medical Condition; and
2. is not clearly listed as an excluded benefit under the Grievant's health benefit plan; and

medical necessity; the Grievant's treating Provider has certified that:

1. standard health care services have not been effective in improving the Grievant's condition; or
2. standard health care services are not medically appropriate for the Grievant; or
3. there is no standard health care service covered by the health care insurer that is as beneficial or more beneficial than the health care service:
    a. recommended by the Grievant's treating Provider that the treating Provider certifies in writing is likely to be more beneficial to the Grievant, in the treating Provider's opinion, than standard health care services; or
    b. requested by the Grievant regarding which the Grievant's treating Provider, who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the Grievant's Condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service requested by the Grievant is likely to be more beneficial to the Grievant than available standard health care services.

Initial External Review of Adverse Determination by Insurance Division Staff (NMAC 13.10.17.29)

Request incomplete. If the request for external review is incomplete, insurance division staff shall immediately notify the Grievant and require the Grievant to submit the information required by Subsection B of 13.10.17.25 NMAC within a specified period of time.

Request does not meet criteria. If the request for external review does not meet the criteria prescribed by 13.10.17.27 and, if applicable, 13.10.17.28 NMAC, insurance division staff shall so inform the Superintendent. The Superintendent shall notify the Grievant and the health care insurer that the request does not meet the criteria for external review and is thereby denied, and that the Grievant has the right to request a hearing in the manner provided by NMSA 1978 Sections 59A-4-15 and 59A-4-18 within thirty-three (33) days from the date the notice was mailed.

Request meets criteria. If the request for external review is complete and meets the criteria prescribed by 13.10.17.27 and, if applicable, 13.10.17.28 NMAC, insurance division staff shall so inform the Superintendent. The Superintendent shall notify the Grievant and the health care insurer that the request meets the criteria for external review and that an informal hearing pursuant to NMSA 1978 Section 59A-4-18 and 13.10.17.30 NMAC has been set to determine whether, as a result of the health care insurer's adverse determination, the Grievant was deprived of medically necessary covered services. Prior to the hearing, insurance division staff shall attempt to informally resolve the grievance in accordance with NMSA 1978 Section 12-8-10.

Notice of hearing. The notice of hearing shall be mailed no later than eight (8) working days prior to the hearing date. The notice shall state the date, time, and place of the hearing and the matters to be considered and shall advise the Grievant and the health care insurer of the rights specified in Subsection G of 13.10.17.30 NMAC. The Superintendent shall not unreasonably deny a request for postponement of the hearing made by the Grievant or the health care insurer.

Hearing Procedures for External Review of Adverse Determinations (NMAC 13.10.17.30)

Conduct of hearing. The Superintendent may designate a hearing officer who shall be an attorney licensed to practice in New Mexico. The hearing may be conducted by telephone conference call, video conferencing, or other appropriate technology at the insurance division’s expense.

Co-hearing officers. The Superintendent may designate two (2) independent co-hearing officers who shall be licensed health care professionals and who shall maintain independence and impartiality in the process. If the Superintendent designates two (2) independent co-hearing officers, at least one of them shall practice in a specialty that would typically manage the case that is the subject of the grievance.

Powers. The Superintendent or attorney hearing officer shall regulate the proceedings and perform all acts and take all measures necessary or proper for the efficient conduct of the hearing. The Superintendent or attorney hearing officer may:

1) require the production of additional records, documents, and writings relevant to the subject of the grievance;
2) exclude any irrelevant, immaterial, or unduly repetitious evidence; and
3) if the Grievant or health care insurer fails to appear, proceed with the hearing or adjourn the proceedings to a future date, giving notice of the adjournment to the absent party.

Staff participation. Staff may attend the hearing, ask questions, and otherwise solicit evidence from the parties, but shall not be present during deliberations among the Superintendent or his designated hearing officer and any independent co-hearing officers.

Testimony. Testimony at the hearing shall be taken under oath. The Superintendent or hearing officers may call and examine the Grievant, the health care insurer, and other witnesses.

Hearing recorded. The hearing shall be stenographically recorded at the insurance division's expense.

Rights of parties. Both the Grievant and the health care insurer have the right to:

1) attend the hearing; the health care insurer shall designate a person to attend on its behalf and the Grievant may designate a person to attend on Grievant's behalf if the Grievant chooses not to attend personally;
2) be assisted or represented by an attorney or other person;
3) call, examine and cross-examine witnesses; and
4) submit to the ICO, prior to the scheduled hearing, in writing, additional information that the ICO must consider when conducting the internal review hearing and require that the information be submitted to the health care insurer and the MHCB staff.

Stipulation. The Grievant and the health care insurer shall each stipulate on the record that the hearing officers shall be released from civil liability for all communications, findings, opinions, and conclusions made in the course and scope of the external review.

Independent Co-Hearing Officers (ICOs) (NMAC 13.10.17.31)

Identification of ICOs. The Superintendent shall provide for maintenance of a list of licensed professionals qualified to serve as independent co-hearing officers. The Superintendent shall select appropriate professional societies, organizations, or associations to identify licensed health care and other professionals who are willing to serve as independent co-hearing officers in external reviews who maintain independence and impartiality of the process.

Disclosure of interests. Prior to accepting designation as an ICO, each potential ICO shall provide to the Superintendent a list identifying all health care insurers and Providers with whom the potential ICO maintains any health care related or other professional business arrangements and briefly describe the nature of each arrangement. Each potential ICO shall disclose to the Superintendent any other potential conflict of interest that may arise in hearing a particular case, including any personal or professional relationship to the Grievant or to the health care insurer or Providers involved in a particular external review.

Compensation of hearing officers and ICOs.

Compensation schedule. The Superintendent shall consult with appropriate professional societies, organizations, or associations in New Mexico to determine reasonable compensation for health care and other professionals who are appointed as ICOs for external grievance reviews and shall annually publish a schedule of ICO compensation in a bulletin.

Statement of ICO compensation. Upon completion of an external review, the attorney and co-hearing officers shall each complete a statement of ICO compensation form prescribed by the Superintendent detailing the amount of time spent participating in the external review and submit it to the Superintendent for approval. The Superintendent shall send the approved statement of ICO compensation to the Grievant's health care insurer.

Direct payment to ICOs. Within thirty (30) days of receipt of the statement of ICO compensation, the Grievant's health care insurer shall remit the approved compensation directly to the ICO.

No compensation with early settlement. If the parties provide written notice of a settlement up to three (3) working days prior to the date set for external review hearing, compensation will be unavailable to the hearing officers or ICOs.

The hearing officer and ICOs must maintain written records for a period of three (3) years and make them available upon request to the state.

Superintendent's Decision on External Review of Adverse Determination (NMAC 13.10.17.32)

Deliberation. At the close of the hearing, the hearing officers shall review and consider the entire record and prepare findings of fact, conclusions of law, and a recommended decision. Any hearing officer may submit a supplementary or dissenting opinion to the recommended decision.

Order. Within the time period allotted for external review, the Superintendent shall issue an appropriate order. If the order requires action on the part of the health care insurer, the order shall specify the timeframe for compliance.

1) The order shall be binding on the Grievant and the health care insurer and shall state that the Grievant and the health care insurer have the right to judicial review pursuant to NMSA 1978 Section 59A-4-20 and that state and federal law may provide other remedies.
2) Neither the Grievant nor the health care insurer may file a subsequent request for external review of the same adverse determination that was the subject of the Superintendent's order.

Internal Review of Administrative Grievances (NMAC 13.10.17.33)

Request for internal review of grievance. Any person dissatisfied with a decision, action or inaction of a health care insurer, including termination of coverage, has the right to request internal review of an administrative grievance orally or in writing.

Acknowledgement of grievance. Within 3 working days after receipt of an administrative grievance, the health care insurer shall send the Grievant a written acknowledgment that it has received the grievance. The notice will contain the name, address, and direct telephone number of a representative of the plan who may be contacted regarding the grievance.

Initial review. We will promptly review the grievance. The initial review shall:

1) be conducted by Our representative authorized to take corrective action on the administrative grievance; and
2) allow the Grievant to present any information pertinent to the grievance.

Initial Internal Review of Administrative Grievance (NMAC 13.10.17.34)

We will mail a written decision to the Grievant within 15 working days of getting the administrative grievance. The 15 working day period may be extended when there is a delay in getting documents or records necessary for the review of the administrative grievance, provided that the health care insurer notifies the Grievant in writing of the need and reasons for the extension and the expected date of resolution, or by mutual written agreement of the health care insurer and the Grievant. The written decision shall contain:

- the name, title, and qualifications of the person leading the initial review;
- a statement of the reviewer's understanding of the nature of the grievance and all pertinent facts;
- a clear and complete account of the basis for the reviewer's decision;
- identification of the health benefits plan provisions relied upon in reaching the decision;
- reference to evidence or documents considered by the reviewer in making the decision;
- a statement that the initial decision will be binding unless the Grievant submits a request for reconsideration within 20 working days of receipt of the initial decision; and
- a description of the procedures and deadlines for requesting reconsideration of the initial decision, including any necessary forms.

Reconsideration of Internal Review of Administrative Grievance (NMAC 13.10.17.35)

Committee. Upon receipt of a request for reconsideration, We will appoint a reconsideration committee consisting of one or more employees of CHP who have not participated in the initial decision. We may include one or more employees other than the Grievant to participate on the reconsideration committee.

Hearing. The reconsideration committee shall schedule and hold a hearing within 15 working days after getting a request. The hearing will be held during regular business hours at a location reasonably accessible to the Grievant. We will give the Grievant the chance to talk with the committee, at Our expense, by conference call, video conferencing, or other appropriate technology. We will not unreasonably deny a request for postponement of the hearing made by the Grievant.

Notice. We will notify the Grievant in writing of the hearing date, time and place at least 10 working days in advance. The notice will advise the Grievant of the rights specified in the "Rights of Grievant" section below. If We will have an attorney represent Our interests, the notice will advise the Grievant that the Grievant may wish to obtain legal representation of his or her own.

Information to Grievant. No fewer than 3 working days prior to the hearing, We will provide to the Grievant all documents and information that the committee will rely on in reviewing the case.

Rights of Grievant. The Grievant has the right to:

- attend the reconsideration committee hearing;
- present their case to the reconsideration committee;
- submit supporting material both before and at the reconsideration committee hearing;
- ask questions of any person of the health care insurer; and
- be assisted or represented by a person of their choice.

Decision of Reconsideration Committee (NMAC 13.10.17.36)

We will mail a written decision to the Grievant within 7 working days after the reconsideration committee hearing. The written decision will include:

- the names, titles, and qualifications of the persons on the reconsideration committee;
- the reconsideration committee's statement of the issues involved in the administrative grievance;
- a clear and complete explanation of the rationale for the reconsideration committee's decision;
- the health benefits plan provision relied on in reaching the decision;
- references to the evidence or documents relied on in reaching the decision;

- a statement that the initial decision will be binding unless the Grievant submits a request for external review by the Superintendent within 20 working days of receipt of the reconsideration decision; and
- a description of the procedures and deadlines for asking for external review by the Superintendent, including any necessary forms; the notice shall contain the toll-free telephone number and address of the Superintendent's office.

External Review of Administrative Grievances (NMAC 13.10.17.37)

Right to external review. Every Grievant who is dissatisfied with the results of the internal review of an administrative decision shall have the right to request external review by the Superintendent.

Exhaustion of remedies. The Superintendent may require the Grievant to exhaust any grievance procedures adopted by the health care insurer or the entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act, as appropriate, before accepting a grievance for external review.

Deemed exhaustion. If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary and the internal appeals process will be deemed exhausted if:

1. the health care insurer waives the exhaustion requirement;
2. the health care insurer is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process; or
3. the Grievant simultaneously requests an expedited internal appeal and an expedited internal appeal and an expedited external review.

Exception to exhaustion requirement.

1. Notwithstanding Subsection B of this section, the internal claims and appeals process will not be deemed exhausted based on violations by the health care insurer that are de minimus and do not cause, and are not likely to cause, prejudice or harm to the Grievant, so long as the health care insurer demonstrates that the violation was for good cause or due to matters beyond the control of the health care insurer, and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the Grievant. This exception is not available if the violation is part of a pattern or practice of violations by the health care insurer.
2. The Grievant may request a written explanation of the violation from the health care insurer, and the health care insurer must provide such explanation within ten (10) days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects the Grievant's request for immediate review under Subsection B of this section on the basis that the health care insurer met the standards for the exception under Paragraph (1) of Subsection D of this section, the Grievant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external

reviewer or court rejects the claim for immediate review (not to exceed ten (10) days), the health care insurer shall provide the Grievant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Grievant receipt of such notice.

Filing Requirements for External Review of Administrative Grievance (NMAC 13.10.17.38)

Deadline for filing request. To initiate an external review, a Grievant must file a written request for external review with the Superintendent within twenty (20) working days from receipt of the written notice of reconsideration decision. The request shall either be:

1. mailed to the Office of Superintendent of Insurance, Attn: Managed Health Care Bureau – External Review Request, New Mexico Office of Superintendent of Insurance, Post Office Box 1689, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1689;
2. e-mailed to mhcb.grievance@state.nm.us, subject External Review Request;
3. faxed to the Office of Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, (505) 827-4734; or
4. completed on-line with NMOSI, Office of Superintendent of Insurance Complaint Form available at http://www.osi.state.nm.us.

Documents required to be filed by the Grievant. The Grievant shall file the request for external review on the forms provided to the Grievant by the health care insurer pursuant to Subsection G of 13.10.17.36 NMAC.

Other filings. The Grievant may also file any other supporting documents or information the Grievant wishes to submit to the Superintendent for review.

Extending timeframes for external review. If a Grievant wishes to supply supporting documents or information subsequent to the filing of the request for external review, the timeframes for external review shall be extended up to 90 days from the receipt of the complaint form, or until the Grievant submits all supporting documents, whichever occurs first.

Acknowledgement of Request for External Review of Administrative Grievance (NMAC 13.10.17.39)

Upon receipt of a request for external review, the Superintendent shall immediately send the:

1) Grievant an acknowledgment that the request has been received;
2) health care insurer a copy of the request for external review.

Upon receipt of the copy of the request for external review, the health care insurer shall provide to the Superintendent and the Grievant by any available expeditious method within five (5) working days all necessary documents and information considered in arriving at the administrative grievance decision.

Review of Administrative Grievance by Superintendent (NMAC 13.10.17.40)

The Superintendent shall review the documents submitted by the health care insurer and the Grievant, and may conduct an investigation or inquiry or consult with the Grievant, as appropriate. The Superintendent shall issue a written decision on the administrative grievance within twenty (20) working days of receipt of the complete request for external review in compliance with 13.10.17.38 NMAC.

PAYMENT OF PREMIUM

Payment of Premium

You, as the Member, are responsible for the timely prepayment of all Premiums. The first premium is due with the enrollment application. Subsequent premiums are due on the first day of month for the coverage provided during that month Premium period means monthly. All premiums are payable to Us.

You must pay the required premium to Us as it becomes due. If We do not receive Your premium on time, or within the Grace Period We will terminate coverage in accordance with the TERMINATION OF COVERAGE section of this Policy. We will not be financially responsible for any services rendered after that date.

Grace Period

A grace period of 30 days will be granted for the payment of each premium due after the initial premium. During the grace period, coverage shall continue in force. If payment is not received within the 30 day grace period, coverage will be terminated as of the last day of the month before the grace period began.

> Example: April payment is due April 1. If payment is not received by April 30, coverage is terminated retroactive to the last day of March.

Members Eligible to Receive Advance Premium Tax Credits

A grace period of 90 days will be granted for Qualified Individuals who have paid at least one month's worth of premiums, and are receiving Advance Payments of the Federal Premium Tax Credit. If is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, even if Advance Premium Tax Credits are received. We will continue to pay all appropriate claims for Covered Services provided to the Member during the first month of the grace period, and will pend claims for Covered Services provided to the Member in the second and third month of the grace period. We will notify the Exchange of the nonpayment of premiums, the Member, as well as Providers of the possibility of denied claims when the Member is in the second and third month of the grace period. We will continue to collect Advance Premium Tax Credits on behalf of the Member from the Department of the Treasury, and will return the Advance Premium Tax Credits on behalf of the Member for the second and third month of the grace period if the Member exhausts their grace period as described above.

> Example: April payment is due April 1. If payment is not received by June 30, coverage is terminated retroactive to the last day of March.

Changes in Premium Payments

We reserve the right to change the Premium Payment amount for the Covered Benefits upon at least 60 days' advance notice in writing.

Additionally, certain actions by the Member may result in a rate change with less than sixty (60) days' prior notice, including but not limited to:

1) A change of residence;
2) The addition of a Dependent due to marriage, birth, or adoption;

3) A request to change benefits that is approved by the Underwriting department; or
4) Termination of a Dependent on a family policy.

Recovery of Excess Benefit Overpayments

We shall have the right to recover any overpayments that it has made. Recovery may be sought from one or more of the following: any person to, for, or with respect to whom such services were provided or such payments were made; any insurance company; any health care plan or other organization. The right of recovery belongs to the Plan alone. It is used at the Plan's sole discretion. If We notify You (or Your legal representative if You are a minor or legally incompetent) that We are pursuing the recovery of these benefits, We ask that You cooperate with Us to secure these recovery rights.

GENERAL PROVISIONS

Amendments

Your Policy may be changed at any time. We will give You sixty (60) days' notice prior to any change. You will receive an amendment to Your Policy showing any change.

Assignment

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

Availability of Provider Services

We do not guarantee that a Hospital, Health Care Facility, Physician, or other Provider will be available in the Provider Network.

Circumstances Beyond Our Control

If a disaster occurs, We will make a good faith effort to help Members get Covered Services, and We will remain responsible for payment for Covered Services; however, We will not be liable for damages resulting from delays, or failures due to a lack of facilities or personnel that are beyond Our control. Examples of disasters are earthquakes, epidemics, war, and riots.

Clerical Error

A clerical error in record keeping will not void coverage otherwise validly in force, nor will it continue coverage otherwise validly terminated. Upon discovery of the error an equitable adjustment of premium shall be made.

Computation of Time

Whenever the New Mexico regulation requires that an action be taken within a certain period of time from receipt of a request or document, the request or document shall be deemed to have been received within 3 working days of the date it was mailed.

Conformity with State Statutes

Any provision which, on its Effective Date, is in conflict with the statutes of the state in which the Member resides, is hereby amended to conform to the minimum requirements of such statutes.

Disclaimer of Liability

The Plan has no control over the diagnosis, treatment, care, or other service provided to a Member by any facility or Provider, whether a Participating or Non-Participating Provider. The Plan is not liable for loss or injury caused by any health care Provider by reason of negligence or otherwise.

Entire Contract

This Policy and Evidence of Coverage, together with the *Summary of Benefits and Coverage* and *Formulary*; the Application; and any supplements; amendments; endorsements or riders collectively constitute the Entire Contract between Us and the Member. No change in this Policy is valid unless it is in writing and is approved by one of Our executive officers. You will be notified of any such changes. No agent may change this Evidence of Coverage or waive any of its provisions.

Execution of a Contract – Application for Coverage

The parties acknowledge and agree that Your signature or execution of the Application shall be deemed to be Your acceptance of the contract, including this Policy. All statements, in the absence of fraud, made by any applicant (You and/or Your Dependents) shall be deemed representations and not warranties. No such statements shall void Coverage or reduce benefits unless contained in a written Application.

Federal and State Health Care Reform

This Policy shall comply with all applicable state and federal laws, rules and regulations. Upon the compliance date of any change in law, or the promulgation of any final rule or regulation which directly affects Our obligations under this Policy, this Policy will be deemed automatically amended such that We shall remain in compliance with the obligations imposed by such law, rule or regulation.

Fraud

We are required to cooperate with government, regulatory and law enforcement agencies in reporting suspicious activity. This includes both Provider and Member activity.

Practitioner/Provider Activity

If You suspect that a Practitioner, pharmacy, Hospital, facility or other Health Care Professional has done any of the items listed below, please call the Practitioner or Provider and ask for an explanation, as there may be an error.

- Charged for services that You did not receive

- Billed more than one time for the same service
- Billed for one type of service, but gave You another service (such as charging for one type of equipment but delivering another less expensive type)
- Misrepresented information to You (such as changing Your diagnosis or changing the dates that You were seen in the office)

If You are unable to resolve the issue with the Provider, or if You suspect any other suspicious activity, please contact Our Member Services.

Member Activity

Anyone who knowingly presents a false or fraudulent claim for payment of a loss, or benefit or knowingly presents false information for services is guilty of a crime and may be subject to civil fines and criminal penalties. We may terminate enrollment for any Member for any type of fraudulent activity. Some examples of fraudulent activity are:

- Falsifying enrollment information
- Allowing someone else to use Your ID Card
- Forging or selling prescriptions
- Misrepresenting a medical condition in order to receive Covered benefits to which You would not normally be entitled

Misrepresentation of Information

If, in the first two (2) years from the effective date of Your and/or Your Dependents Coverage, We determine that You intentionally omitted information from Your Application and/or You provided fraudulent or false information, the Coverage for You and/or Your Dependent shall be null and void from the effective date. In the case of fraud, no time limits shall apply and You will be required to pay for all benefits that We have provided.

If the age of the Member has been misstated all amounts payable under this Policy shall be adjusted to reflect the premium that would have been paid for the correct age.

Misstatements

If the Plan determines that information was inaccurate or intentionally omitted from an application for coverage, there may be serious consequences. The Plan will rescind a Member's coverage if he or she commits an action; practice or omission that constitutes fraud or makes an intentional misrepresentation of a material fact in connection with the enrollment application, enrollment process or in seeking benefits under the Plan. Rescinding coverage means that coverage will be cancelled and deemed null and void retroactively to Your Effective Date of the policy.

Before a rescission is effective, the Plan will provide the Member with at least sixty (60) calendar days prior notice that coverage is being rescinded. During this 60-day notice period, Members are advised to seek alternative health care coverage or explore their rights to contest the rescission, as appropriate. This notice requirement does not mean that the Member's coverage will not be voided on a retroactive basis.

Governing Law

The Policy is issued in the State of New Mexico and shall be interpreted under the laws of the State of New Mexico and applicable federal rules and regulation.

Hospitalization on the Effective Date of Coverage

If You are confined in a Hospital on the Effective Date of Your coverage, You must notify the Plan of the hospitalization within two (2) days; or as soon as reasonably possible thereafter.

Identification Cards

We issue Identification (ID) Cards to You for identification purposes only. Possession of Our ID Card confers no rights to services or other benefits under this Policy. To be entitled to such services or benefits, the holder of the ID Card must, in fact, be a Member on whose behalf all applicable Contract charges have actually been paid. If You or any family member permits the use of Your ID Card by any other person, all Your rights and those of other members of Your family pursuant to this Policy may be immediately terminated at Our discretion. Any person receiving services or other benefits to which he or she is not then entitled pursuant to the provisions of this Policy shall be charged therefore at the rates generally charged in the area for medical, Hospital and other Health Care Services.

Independent Contractors

Participating Providers are not employees, representatives or agents of the Plan. They are independent contractors. The Plan is not liable or responsible for their actions or failure to act. You are encouraged to contact Member Services if You are not satisfied with Your care.

Legal Actions

No legal action shall be brought to recover on this Plan by the Group or Member prior to the expiration of sixty (60) days after written proof of loss has been furnished, in accordance with the requirements of state law. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Time Limit on Certain Defenses

The applicant must fully and accurately complete the enrollment application on behalf of him/herself and any eligible dependents that he or she wishes to enroll in the Plan. As of the date of issue of this Policy, no misstatements, except willful or fraudulent misstatements, made by the applicant in the application for this policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in this Policy). In the event of a misstatement in an application is made that is not fraudulent or willful, the issue of the Policy may prospectively rate and collect from the insured the premium that would have been charged to the insured at the time the Policy was issued has such misstatement not been made.

Notice

If We are required or permitted by this Policy to give any Notice to the Member, it shall be given appropriately if it is in writing and delivered personally or deposited in the United States mail with postage prepaid and addressed to the Member at the address of record on file at Our principal office. You are solely responsible for ensuring the accuracy of Your address of record on file with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules, and interpretations for the purposes of promoting the orderly and efficient administration of the Policy.

Reinstatements

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if We or Our agent requires an application for reinstatement and issues a condition receipt for the premium tendered, the Policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the thirtieth (30^{th}) day following the date of such conditional receipt unless the insurance company has previously notified the insured in writing of its disapproval of such application.

Right to Examine

We, at Our own expense, shall have the right and opportunity to examine You when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Waiver by Agents

No agent or other person, except an officer of CHP, has the authority to waive any conditions or restrictions of this Policy, to extend the time for making payment, or to bind CHP, by making promise or representation or by giving or receiving any information. No such waiver, extension, promise, or representation shall be valid or effective unless evidenced by an Endorsement or amendment in writing to this Policy or a Letter of Agreement signed by a CHP officer.

Workers' Compensation Insurance

This Policy is not in lieu of and does not affect any requirement for Coverage by the New Mexico Workers Compensation Act. However, an employee of a professional or business corporation may affirmatively elect not to accept the provisions of the New Mexico Workers Compensation Act if they are an executive officer of that professional or business corporation and owns ten percent (10%) or more of the outstanding stock of the professional business corporation.

For purposes of the New Mexico Workers Compensation Act, an executive officer means the chairman of the board, president, vice-president, secretary or treasurer of a professional or business corporation.

In the event that an employee chooses to opt out of workers compensation coverage, and meets the criteria stated above, CHP will provide 24-hour health care Coverage to those employees, subject to the eligibility requirements for Coverage with CHP. In addition to meeting all of CHP's eligibility requirements, documentation indicating that the aforementioned criteria have been met will be required in order for Coverage with CHP to become effective.

DEFINITIONS

Unless specifically defined elsewhere, wherever used in this Policy, the following terms have the meanings given below:

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

Acupuncture means the use of needles inserted into and removed from the body and the use of other devices, modalities and procedures at specific locations on the body for the prevention, cure or correction of any disease, Illness, injury, pain or other Condition by controlling and regulating the flow and balance of energy and functioning of the person to restore and maintain health.

Advance Payments of the Federal Premium Tax Credit (APFPTC) means payment of the tax credits as specified in section 36B of the US Code (as added by section 1401 of PPACA) and which are provided on an advance basis to an eligible individual enrolled in an individual QHP through an Exchange in accordance with sections 1402 and 1412 of PPACA.

Administrative Grievance means an oral or written complaint submitted by or on behalf of a Grievant regarding any aspect of a health benefits plan other than a request for health care services, including but not limited to:

- administrative practices of the health care insurer that affects the availability, delivery, or quality of health care services;
- claims payment, handling or reimbursement for health care services; and
- termination of coverage.

Adverse Determination means any of the following: any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time), a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payments, that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Adverse Determination Grievance means an oral or written complaint submitted by or on behalf of a Grievant regarding an adverse determination.

Alcoholism means alcohol dependence or alcohol abuse meeting the criteria as stated in the Diagnostic and Statistical Manual IV for these disorders.

Allowable Charge is the amount that We have determined to be the maximum amount payable for a Covered Service. For Covered Services provided by Non-Participating Providers, the amount payable will be based upon Our out-of-network fee schedule. For out-of-network Emergency Services, the Allowable Charge is based upon the greater of 1.) the median amount negotiated with Participating Providers for similar Emergency Services; 2) the amount for the Emergency Services calculated using the same method generally used to determine payments for out-of-network services; or (3) the amount that would be paid under Medicare for the Emergency Services.

Ambulance is a vehicle which is licensed solely as an Ambulance by the local regulatory body to provide Emergency transportation to a Hospital or transportation from one Hospital to another Health Care Facility for those individuals who are unable to travel to receive medical care by any other means or the Hospital cannot provide the needed care. Air Ambulance charges are payable only for transportation from the site of an Emergency to the nearest Hospital that is equipped to treat the Condition instead of local Ambulance service.

Ambulatory Services are health care services delivered at a Provider's office, clinic, medical center, or Ambulatory Surgical Facility in which the patient's stay is not longer than 24 hours.

Ambulatory Surgical Facility means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide Ambulatory Services.

Annual Out-of-pocket Maximum means a specified dollar amount of Covered Services received in a Calendar Year that is the most the Member will pay (Cost Sharing responsibility) for that Calendar Year.

Application means the forms, including required medical underwriting questionnaires, if any, that each Subscriber is required to complete when enrolling for Our Coverage.

Autism Spectrum Disorder is a Condition that meets the diagnostic criteria for the pervasive developmental disorders published in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision, also known as DSM-IV-TR, published by the American Psychiatric Association, including autistic disorder; Asperger's disorder; pervasive development disorder not otherwise specified; Rett's disorder; and childhood disintegrative disorder.

Bariatric Surgery means surgery that modifies the gastrointestinal tract with the purpose of decreasing calorie consumption and therefore decreasing weight.

Behavioral Disorder is a disability characterized by displayed behaviors of sufficient duration, frequency, and intensity over a long period of time which significantly deviates from socially acceptable norms for a person's age and situation.

Biofeedback means therapy that provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition.

Biologicals are medical compounds that are prepared from living organisms and/or their products.

Calendar Year is the period of time beginning January 1 and ending December 31 of any given year. The initial Calendar Year period is from a Member's Effective Date of coverage and ends on December 31, which may be less than 12 months.

Certification means a decision by a health plan that a health care service requested by a Provider or Grievant has been reviewed and, based upon the information available, meets the health care insurer's requirements for coverage and medical necessity, and the requested health care service is therefore approved.

Certified Nurse Midwife (Registered lay midwife) is any person who is licensed by the board of nursing as a Registered Nurse and who is licensed by the New Mexico Department of Health as a Certified Nurse Midwife.

Certified Nurse Practitioner is a Registered Nurse endorsed by the Board of Nursing for the expanded practice as a Certified Nurse Practitioner. A Certified Nurse Practitioner's name and pertinent information is entered on the list of Certified Nurse Practitioners maintained by the New Mexico Board of Nursing.

CHP means CHRISTUS Health Plan.

Clinical Trial means a course of treatment provided to a Member for the purpose of prevention or reoccurrence, early detection of treatment of cancer that is being provided in New Mexico.

Codependency means a popular term referring to all the effects that people who are dependent on alcohol or other substances have on those around them, including the attempts of those people to affect the dependent person.

Coinsurance is part of the payment that a Member must pay toward Health Care Services also known as Cost Sharing. It means the amount of Covered charges calculated as a percentage, after any Copayment and Deductive have been paid, that a Member must pay directly to the Practitioner/Provider in connection with Covered Health Care Services.

Complaint or **Concern** is made when a Member calls the Customer Care Center to express dissatisfaction with coverage or benefits.

Condition is a group of related diagnoses dealing with the same organ, system, or disease process.

Copayment is part of the contribution that Members make toward the cost of their health Care Services also known as Cost Sharing. It means the fixed amount that the Member must pay directly to the Practitioner/Provider in connection with Covered Health Care Services. The fixed amount may vary by the type of Covered Health Care Service provided.

Cosmetic Surgery means surgery that is performed primarily to improve appearance and self-esteem, which may include reshaping normal structures of the body.

Cost Sharing means any contribution Members make towards the cost of their Covered Health Care Services as defined in their policy. This includes Deductibles, Coinsurance and Copayments.

Coverage/Covered/Covered Person means benefits extended under this Policy, subject to the terms, conditions, Limitations, and Exclusions of this Policy. Covered Person means the person covered.

Covered Benefit or **Covered Service(s)** means a benefit or service incurred by or on behalf of a Member for those services or supplies which are:

- Administered or ordered by a Physician or other qualified Provider;
- Medically Necessary to the diagnosis and treatment of an Injury or Illness;
- Not excluded by any provision of the Policy; and
- Incurred while the Member's insurance is in force under the Policy.

A Covered Service is deemed to be incurred on the date such service or supply which gave rise to the expense or charge was rendered or obtained.

Craniomandibular means the joint where the jaw attaches to the skull. Also refer to Temporomandibular Joint (TMJ).

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

Custom-fitted Orthotics means an Orthosis which is individually made for a specific patient starting with the basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, bars, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending, or making other modifications to substantially prefabricated item.

Deductible is part of the contribution that Members make toward the cost of their health care, also known as Cost Sharing. It means that amount the Member is required to pay each Calendar Year, directly to the Practitioner/Provider in connection with Covered Health Care Services before CHP begins to pay Covered Benefits. The Deductible may not apply to all Health Care Services.

Diagnostic Service means procedures ordered by a Practitioner/Provider to determine a definite condition or disease or review the medical status of an existing condition or disease.

Division means the New Mexico division of insurance.

Durable Medical Equipment means equipment or supplies prescribed by a Practitioner/Provider that is Medically Necessary for the treatment of an Illness or Accidental Injury, or to prevent the Member's further deterioration. This equipment is designed for repeated use, generally is not useful in the absence of Illness or Accidental Injury, and includes items such as oxygen equipment, wheelchairs, Hospital beds, crutches, and other medical equipment.

Effective Date is 12:01 a.m. of the date on which the Member's coverage begins.

Emergency Care or **Emergency Services** are Covered Services that are furnished by a Provider or Practitioner who is qualified to provide Emergency services. The services are needed to evaluate or stabilize an Emergency Medical Condition. Services are available 24-hours per day, 7 days per week.

Emergency Medical Condition is a severe Injury or the sudden onset of a medical Condition. The Injury or medical Condition must be one which manifests itself by acute symptoms that in the absence of immediate medical attention a prudent layperson with an average knowledge of health and medicines would expect that: (a) such person's life or health would be in serious jeopardy; (b) bodily functions would be seriously impaired; (c) a bodily organ or part would be seriously damaged; or (e) or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another Hospital for delivery or that a transfer may pose a threat to the health or safety of the woman or the unborn child.

Essential Health Benefits are determined by HHS under PPACA and are subject to change, but currently include the following general categories of service: Ambulatory Services; Emergency Services; hospitalizations; maternity and newborn services; services for Behavioral Disorders, Mental Illness disorders or Substance Abuse Conditions; Prescription Drugs; rehabilitative and

Habilitative Services and devices; lab services; preventive and wellness services; services related to chronic disease management; and pediatric services, including oral and vision care.

Evidence of Coverage means a clear and conspicuous written statement of covered services.

Exchange means the New Mexico Health Insurance Exchange.

Excluded Services means Health Care Services that are not Covered Services and that We will not pay for.

Experimental, Investigational or **Unproven** means any treatment, procedure, facility, equipment, drug, device, or supply that is not accepted as standard medical practice in the state where services are provided. In addition, if a federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is Experimental. To be considered standard medical practice and not Experimental or Investigational, treatment must meet all five of the following criteria:

1) A technology must have final approval from the appropriate regulatory government bodies;
2) The scientific evidence as published in evidence-based, peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes;
3) The technology must improve the net health outcome;
4) The technology must be as beneficial as any established alternatives; and
5) The improvement must be attainable outside the Investigational settings.

FDA means the United States food and drug administration.

Federal Cost-Sharing Reductions means reductions in cost sharing provided under federal law for an eligible individual, such as for an individual enrolled in a Silver level plan in the Exchange or for an individual who is an American Indian/Native Alaskan enrolled in a QHP in the Exchange.

Follow-up Care is the contact with, or re-examination of a patient at prescribed intervals following diagnosis or during a course of treatment.

Formulary is a listing of covered drug products selected by Us in consultation with a team of health care Providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. You may obtain Your *Formulary* by calling the telephone number on Your ID card.

Genetic Inborn Errors of Metabolism (IEM) means a rare, inherited disorder that is present at birth and results in death or mental retardation if untreated and requires consumption of special medical foods.

Grievance means a written complaint submitted by or on behalf of an enrollee regarding any aspect of the Member's health care services, including but not limited to the:

1) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
2) Administrative practices of the health care insurer that affect the availability, delivery or quality of health care services;
3) Claims payment, handling or reimbursement for health care services; or
4) Matters pertaining to the contractual relationship between an enrollee or Subscriber and a health care insurer.

Grievant means any of the following:

- a policyholder, subscriber, enrollee, or other individual, or that person's authorized representative or Provider, acting on behalf of that person with that person's consent, entitled to receive health care benefits provided by the health care plan;
- an individual, or that person's authorized representative, who may be entitled to receive health care benefits provided by the health care plan;
- Medicaid recipients enrolled in a health care insurer's Medicaid plan; or
- individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act.

Habilitative Services means health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include Physical and Occupational Therapy, speech-language pathology, and other services for people with disabilities in a variety of Inpatient and/or outpatient settings.

Health Benefits Plan means a health plan or a policy, contract, certificate or agreement offered or issued by a health care insurer or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of health care services; this includes a traditional fee-for-service health benefits plan.

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

Health Care Insurer means a person that has a valid certificate of authority in good standing under the Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan or prepaid dental plan.

Health Care Professional means a physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide health care services consistent with state law.

Health Care Services means, to the extent offered by the Plan, services, supplies, and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the health benefits plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay;.

Health Maintenance Organization means any person who undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles.

Hearing Officer, Independent Co-Hearing Officer or ICO means a health care or other professional licensed to practice medicine or another profession who is willing to assist the Superintendent as a hearing officer in understanding and analyzing medical necessity and coverage issues that arise in external review hearings.

HHS means the United States Department of Health and Human Services.

Home Health Agency means an agency or organization that:

- Specializes in giving nursing care or therapeutic services in the home;
- Is licensed to provide such care or services by the appropriate licensing agency where services are performed or is certified as a Home Health Agency under Title XVlll of the Social Security Act of 1965, as amended;
- Is operating within the scope of its license of certification; and
- Maintains a complete medical record for each patient.

Home Health Agency does not mean any other similar service or agency which does not meet this definition, even if the service or agency meets some of the above requirements or provides some or all of the services which may be provided by a Home Health Agency.

Hospice Care Program means an organization duly licensed to provide Hospice Care Program Services. An approved Hospice must be licensed when required, Medicare-certified as a Hospice, or accredited by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) as a Hospice.

Hospice Care Program Services means a centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while

maintaining dignity and a quality of life. Hospice Care Program Services is available in the home, in a Skilled Nursing Facility, or in a special hospice care unit.

Hospital is an institution licensed, accredited or certified by the State providing Health Care Services under the care of a Physician which:

1) Provides 24-hour nursing service by licensed Registered Nurses (R.N.);
2) Mainly provides diagnostic and therapeutic care under the supervision of Physicians while Hospital Confined; and
3) Maintains permanent surgical facilities or has an arrangement with another surgical facility supervised by a staff of one or more Physicians.

Hospital also includes certain tax-supported institutions, which may not be required to maintain surgical facilities. Hospital does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

Illness means a sickness or disease, including all related Conditions and occurrences, requiring Health Care Services.

In-network means care received from a Participating Provider.

Injury is bodily injury due to an accident which results solely, directly and independently of disease, bodily infirmity, or any other causes.

Inpatient means You are a registered bed patient and are treated as such in a Hospital.

Licensed Practical Nurse (LPN) means an individual who has received specialized nursing training and practical nursing experience and is duly licensed to perform nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such service.

Maternity means Coverage for prenatal, intrapartum, perinatal or postpartum care.

Managed Care means a system or technique(s) generally used by third party payers or their agents to affect access to and control payment for health care services. Managed care techniques most often include one or more of the following:

- Prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services;
- Contracts with selected health care providers;
- Financial incentives or disincentives for enrollees to use specific providers, services, or service sites;
- Controlled access to and coordination of services by a case manager; and

- Payer efforts to identify treatment alternatives and modify benefit restrictions for high cost patient care.

Medicaid means Title XIX and/or Title XXI of the Social Security Act and all amendments thereto.

Medical Director is a Physician who serves to manage the provision of Health Care Services to Our Members.

Medically Necessary means a treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of an Illness or Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- Is Experimental, Investigational or Unproven or for research purposes;
- Is provided solely for educational purposes or the convenience of the patient, the patient's family, Physician, Hospital, or any other Provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- Could have been omitted without adversely affecting the patient's Condition or the quality of medical care;
- Does not apply to cancer chemotherapy or other types of therapy that are subjects of on-going phase IV clinical trials;
- Involves treatment of or the use of a medical device, drug, or substance not formally approved by the U.S. Food and Drug Administration (FDA); or
- Involves a service, supply, or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual.

We may require You or Your Provider to furnish peer-reviewed, evidence-based scientific literature that demonstrates that the service is required for the health of the Member.

Medicare means Title XVIII of the Social Security Act and all amendments thereto.

Member is an individual:

- who meets each of the enrollment and eligibility requirements described in this Policy;
- who has been properly enrolled in coverage with Us; and
- for whom We have received any required Premium for the enrolled coverage.

Mental Illness/Disorder is any Condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV, or current edition), and/or Mental Disorders Section of the International Classification of Disease.

Non-Participating Provider means a Provider that does not participate in Our provider network.

Nutritional Support means the administration of solid, powder or liquid preparations provided either orally or by enteral tube feedings. It is Covered only when enteral tube feedings are required.
Obstetrician/Gynecologist (OB/GYN) is a Physician that is board eligible or certified by the American Board of Obstetricians and Gynecologists, or by the American College of Osteopathic Obstetricians and Gynecologists.

Occupational Therapy means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function and improve a Member's functional ability to perform activities of daily living.

Orthotic Appliances/Devices/Orthosis means an individualized rigid or semi-rigid supportive device constructed and fitted by a licensed orthopedic technician which supports or eliminates motion of a weak or diseased body part.

Out-of-Network Services means Health Care Services Obtained from a Non-Participating Provider.

Outpatient Hospital is a place to receive Covered Services while not an Inpatient. Services considered Outpatient include, but are not limited to, services in an Emergency room regardless of whether You are subsequently admitted as an Inpatient in a Hospital.

Participating Provider is a Physician, Provider, Hospital or Health Care Facility that has an agreement with Us to accept Our rates and payments as payment in full when providing Health Care Services to Members.

PPACA means the federal Patient Protection and Affordable Care Act.

Physical Therapy is therapy for the preservation, enhancement, or restoration of movement and physical function impaired or threatened by Illness or Injury that utilizes therapeutic exercise, physical modalities (as massage and electrotherapy), assistive devices, and patient education and training.

Physician is one of the following:

- A doctor of medicine, surgery, or osteopathy;
- A doctor of podiatry or a doctor of chiropractic;
- A practitioner of the healing arts; or

- Any other licensed Provider who is required to be recognized as a Physician by state law and acts within the scope of his/her license to treat an Illness or Injury.

Physician Assistant is a person who has graduated from a nationally-recognized physician assistant or assistant surgeon program; or who is currently certified by the national commission of Physician Assistants. A Physician Assistant must be licensed to practice medicine under the supervision of a licensed Physician in the state in which they practice.

Plan means the health benefit plan established by CHRISTUS Health Plan and selected by the Member to provide Health Care Services to Members, as it exists on the Effective Date of this Policy or as subsequently amended as provided herein.

Prior Authorization means a decision by a Health Care Insurer that a Health Care Service requested by a Practitioner/Provider or Covered Person has been reviewed and, based upon the information available, meets the Health Care Insurer's requirements for Coverage and Medical Necessity, and the requested Health Care Service is therefore approved.

Prescription Drugs are drugs for which sale or legal dispensing requires the order of a Provider with legal authority to prescribe drugs.

Primary Care Provider or **Primary Care Provider, or Doctor of Oriental Medicine** or **PCP** is the Physician or other Provider You see first for most health problems. Your PCP makes sure You get the care You need to keep You healthy. Your PCP also may talk with other Physicians and Providers about Your care and refer You to them. PCPs include, but are not limited to family practice Physicians; general practitioners; internists; pediatricians; Obstetricians and/or Gynecologists (OB/GYNs). Your PCP is responsible for providing Your Primary Care Services. These include annual examinations; routine immunizations; and treatment of non-emergency acute illnesses and injuries. This includes well-child care according to the American Academy of Pediatrics.

Primary Care Services are services provided by a PCP or primary Provider of Health Care Services.

Prospective Enrollee means a person who has expressed an interest in becoming a Member but has not yet purchased a plan.

Provider means a duly licensed Hospital, Physician, or other practitioner of the healing arts that is authorized to render Health Care Services within the scope of their license.

Provider Network means a list of the Providers that are Participating Providers.

Qualified Health Plan or **QHP** means health care coverage that has been determined to meet the requirements in state and federal law for coverage to be offered through the Exchange.

Qualified Individual means, with respect to the Exchange, an individual who has been determined eligible to enroll through the Exchange in a Qualified Health Plan in the individual or small group Exchange market.

Qualified Medical Child Support Order is an order from a State or Federal government agency or court. It requires a person to provide health insurance coverage for specific dependents.

Rescission of Coverage means a cancellation or discontinuance of coverage that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if:

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

Registered Nurse is an individual who has received specialized nursing training, is authorized to use the designation of (R.N.) and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

Rehabilitation means care for restoration (including by education or training) of a Member's prior ability to function at a level of maximum therapeutic benefit. This type of care must be acute Rehabilitation, sub-acute Rehabilitation, or intensive day Rehabilitation, and it includes Rehabilitation Therapy and pain management programs. An Inpatient Hospitalization will be deemed to be for Rehabilitation at the time the Member has been medically stabilized and begins to receive Rehabilitation Therapy or treatment under a pain management program.

Rehabilitation Therapy means Physical Therapy, Occupational Therapy, Speech Therapy, or Respiratory Therapy.

Residential Treatment Center means a non-acute level facility that is credentialed and provides overnight lodging that is monitored by medical personnel, has a structured treatment program, and has staff available 24 hours a day.

Respiratory Therapy means a medically supervised, individualized, physical conditioning program designed and adapted to promote and improve the lung and breathing health and well being of a Member and would include simple breathing exercises and advice on posture and the use of supplementary devices that aid in removing mucus from the airways and improve the strength of the lungs. Respiratory therapists train You in bronchial hygiene, proper use of inhalers, and proper breathing.

Screening Mammography is a radiologic examination designed to detect breast cancer at an early stage in a person that has no symptoms. The exam includes an x-ray of the breast using equipment

specific for mammography. The x-ray has an average radiation exposure delivery of less than one radiation mid-breast. It includes two views for each breast, as well as the professional interpretation of the film. It does not include diagnostic mammography.

Second Opinions provide an opportunity or requirement to obtain a clinical evaluation by a Provider other than the one originally making a recommendation for a proposed health service to assess the Medical Necessity and appropriateness of the initial proposed health service.

Service Area is the State of New Mexico.

Skilled Nursing Care refers to services ordered by a Physician which require the clinical skills and professional personnel of a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Skilled Care is provided directly by or under the supervision of such personnel to a patient who needs those services twenty-four (24) hours a day, along with other treatment, for recovery from illness or injury. Skilled Care does not include Custodial Care.

Skilled Nursing Facility means a place that:

1) Is legally operated as a Skilled Nursing Facility;
2) Primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Care under the supervision of a Physician;
3) Provides continuous 24 hour a day nursing service by or under the supervision of a Licensed Practical Nurse;
4) Maintains a daily medical record on each patient; and
5) Provides Rehabilitation services, such as Physical, Occupational and Speech therapy, and may provide other multidisciplinary services, such as Respiratory Therapy, dietician/nutrition services, and medical social work.

Skilled Nursing Facility does not include any facility that is primarily a rest home, a facility for the care of the aged, or for treatment of drug abuse, Mental Disorder, tuberculosis, or for intermediate, custodial or educational care.

Specialist is a Physician who provides Covered Services for a specific disease or part of the body. Examples include internists who care for diseases of internal organs in adults; oncologists who care for patients with cancer; cardiologists who care for patients with heart Conditions; and orthopedists who care for patients with certain bone, joint, or muscle Conditions and psychiatrists care for Members with Behavioral Disorders or Mental Illness/Disorders.

Speech Therapy is the treatment and exercises for treating voice and speech and swallowing disorders due to diagnosed Illness or Injury provided by a qualified Provider.

Subluxation means misalignment, demonstrable by x-rays or Chiropractic examination, which produces pain and is correctible by manual manipulation

Subscriber means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the managed health care plan, or in the case of an individual contract, the person in whose name the contract is issued.

Substance Abuse means alcohol, drug, or chemical abuse, overuse, or dependency.

Summary of Benefits and Coverage means the written materials required by NMSA 1978 Section 59A-57-4 to be given to the Grievant by the health care insurer or group contract holder.

Superintendent means the New Mexico Superintendent of Insurance.

Termination Date is 11:59 pm on the last day of the month for which premiums were paid and the date that the Member's coverage ends.

Termination of Coverage means the cancellation or non-renewal of coverage provided by a health care insurer to a Grievant but does not include a voluntary termination by a Grievant or termination of a health benefits plan that does not contain a renewal provision;

Tertiary Care Facility is a Hospital unit that provides specialized care for high-risk patients. The facility provides and coordinates transport, communication, education and data analysis systems for the geographic area that it serves.

Traditional Fee-for-Service Indemnity Benefit means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage Grievant to utilize preferred providers, to follow pre-authorization rules, to utilize prescription drug formularies or other cost-saving procedures to obtain Prescription Drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services;

Treatment Plan is something that includes all elements necessary for Us to pay claims appropriately, including but not limited to (1) the diagnosis; (2) the proposed treatment by types; (3) the frequency and duration of treatment; (4) the anticipated outcomes states as goals; (5) the frequency with which the treatment plan will be updated; and (6) the signature of the treating Physician.

Uniform Standards means all generally accepted practice guidelines, evidence-based practice guidelines or practice guidelines developed by the federal government or national and professional medical societies, boards and associations, and any applicable clinical review criteria, policies, practice guidelines, or protocols developed by the health care insurer consistent with the federal,

national, and professional practice guidelines that are used by a health care insurer in determining whether to certify or deny a requested health care service.

Urgent Care means Medically Necessary health care services provided in emergencies or after a Primary Care Provider's normal business hours for unforeseen Conditions due to Illness or Injury that are not life-threatening but require prompt medical attention.

Urgent Illness is a non-life-threatening illness that requires prompt medical attention. Some examples of urgent situations are sprains; a rising fever despite having taken medication; new ear pain; an asthma attack where medications are not helping; an animal bite; an object in the eye or eye infection; a cut that may need stitches; a child with severe vomiting or diarrhea; a possible broken bone; shortness of breath; a sore throat; flu symptoms; a urinary tract infection; or a migraine headache where medicines are not relieving the pain.

Utilization Review or **Utilization Management** is the process of reviewing and managing a Member's medical Conditions so that the Member receives the right care, by the right Provider, at the right time. This process maximizes benefits and ensures quality health care.

Workers' Compensation refers to the workers' compensation plan of any of the 50 United States, the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands; as well as the systems provided under the Federal Employees' Compensation Act and the Longshoreman's and Harbor Workers' Compensation Act; and any other federal, state, county, or municipal workers' compensation; occupational disease or other employer liability laws; or other legislation of similar purpose or intent.

We, **Our**, **Us**, and **CHRISTUS** refers to CHRISTUS Health Plan.

You, **Your**, and **Yours** refers to the Member.