TABLE OF CONTENTS

IMPORTANT PHONE NUMBERS AND ADDRESSES

Customer Service

Call our Customer Service Department. Our toll-free number is **1-855-7MY-NMHC (1-855-769-6642)**. We are available Monday through Friday, 8 a.m. to 5 p.m., Mountain Standard Time. If you need assistance outside normal business hours, you may call the Customer Service telephone number and leave a message. A Customer Service Representative will return your call by 5 p.m. the next business day.

Send all written inquires to:	Physical address (please do not mail payments here):
P.O. Box 36719 Albuquerque, NM 87176	2440 Louisiana Blvd. NE, Suite 601 Albuquerque, NM 87110

New Mexico Health Connections Customer Care Center: **(505) 633-8020** or **1-855-7MY-NMHC (855-769-6642)**.

- Spanish (español): Para obtener asistencia en español, llame al **1-855-769-6642**.
- Navajo (Diné): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-855-769-6642**.
- TTY services provided by A&T – TTY line: **1-800-659-8331**.

OptumRx® Pharmacy Manager

NMHC's formulary is available on our website at **www.mynmhc.org/Formulary.aspx**. If you need help with the formulary or in obtaining Approval, call OptumRx at **1-855-577-6550**. OptumRx is available 24 hours a day, 7 days a week.

Prior Approvals

Call our Customer Service Department. Our toll-free number is **1-855-7MY-NMHC (1-855-769-6642)**. We are available Monday through Friday, 8 a.m. to 5 p.m., Mountain Standard Time.

NMHC Case Management Department

Our toll-free number is **1-844-691-9984**. We are available Monday through Friday, 8 a.m. to 5 p.m., Mountain Standard Time.

Claims Submission

Please mail claim forms and itemized bills to:

Claims Department
New Mexico Health Connections
P.O. Box 3828
Corpus Christi, TX 78463

NurseAdvice℠ New Mexico

If you have a non-life-threatening illness or injury, or if you have questions about symptoms you are having, you may call NurseAdvice New Mexico toll-free at **1-877-725-2552**. Experienced registered nurses are available to speak to you twenty-four (24) hours a day, seven (7) days a week, 365 days a year.

Website

You may also visit our website for more information about your Benefits and services. Our web address is **www.mynmhc.org**.

WELCOME TO NEW MEXICO HEALTH CONNECTIONS

We are excited that you have selected us as your Healthcare Insurer. We believe that all New Mexicans should have access to quality and affordable Healthcare Services. It is our pleasure to provide you with access to excellent healthcare coverage through our statewide network of Providers.

New Mexico Health Connections (NMHC) is a non-profit, consumer-oriented and operated (CO-OP) health plan organized under the Affordable Care Act and the laws of the State of New Mexico. In this document, we will call ourselves New Mexico Health Connections, or the Insurer. When you see the words "we," "us," "our," and "NMHC" in this document, it is referring to New Mexico Health Connections.

NMHC offers insurance coverage to eligible people. The Benefits provided by your employer are described in this document, which we call an Evidence of Coverage (EOC), as well as your Summary(ies) of Benefits and Coverage; Formulary Reference Guide; and Provider Directory. When you see the words "you" and "your," we are referring to people covered under by one of our insurance plans. Anyone receiving healthcare Benefits under your Policy may also be called Members, Enrollees, Covered Persons/Dependents, or Subscribers.

Please be sure to read this Evidence of Coverage carefully and refer to the Summary of Benefits and Coverage for your plan. The Summary of Benefits and Coverage is a short, plain-language Summary of Benefits and Coverage document that shows some specific Covered Benefits this Plan provides, your cost sharing amounts and the Coverage Limitations and Exclusions.

Understanding how this plan works can help you make the best use of your Covered Benefits.

HOW TO USE THIS DOCUMENT

This Evidence of Coverage is a legal document that is designed to help you understand your healthcare Benefits and the Services available to you. This Evidence of Coverage (EOC), Summary(ies) of Benefits and Coverage, Formulary Reference Guide, and Provider Directory will guide you in using your Plan Benefits. They describe how the Plan works, the Services covered by the Plan, and who to contact if you need assistance with the Plan.

We encourage you to read these documents as it is important to understand what your Plan covers, and especially what it does not cover. Many sections of this Evidence of Coverage refer to other sections of the document. Therefore, you may not have all of the information you need by reading just one section or one document.

You are encouraged to keep this document and your Summary of Benefits and Coverage, in addition to any other documents mentioned, as well as attachments or amendments to this Evidence of Coverage that you may receive for your future reference. Your healthcare Providers do not have a copy this document or the Summary of Benefits and Coverage or other Policy documents and are not responsible for knowing your Plan Benefits.

The Plan

Your employer has chosen NMHC to provide you and your covered Dependents coverage under a Preferred Provider Organization (PPO) Plan. A Preferred Provider Organization (PPO) means that the Plan allows you to see any provider you choose, In-Network Providers as well as Out-of-Network Providers. The level of coverage differs depending on which type of Provider you see. In order to ensure you receive the best value from your Plan, it is important to understand these terms, conditions and benefits.

By enrolling in this Plan, you have agreed to follow the rules of the Plan, which are outlined in this document, your Summary of Benefits and Coverage and other documents mentioned earlier. We may change the Benefits described in this document. If that happens, you will be notified in writing of any changes that may affect you or your covered Dependents. Notification will be provided at least sixty (60) days prior to the change(s) going into effect.

No change to your Benefit Plan shall be valid unless approved, with signatures, by an executive officer of New Mexico Health Connections. NMHC will provide you with at least sixty (60) days prior written notice of an amendment, addendum or endorsement to this Evidence of Coverage. No agent has the right to change the terms and conditions of your benefit Plan.

Please contact our Customer Care Center if you need more information about your Plan or if you need copies of the benefit plan documents, such as this Evidence of Coverage or your Summary of Benefits and Coverage.

New Mexico Health Connections Customer Care Center: (505) 633-8020 or 1-855-7MY-NMHC (855-769-6642).

- Spanish (español): Para obtener asistencia en español, llame al 1-855-769-6642.
- Navajo (Diné): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-769-6642.
- TTY services provided by A&T – TTY line: 1-800-659-8331.

You may also visit our website at www.mynmhc.org for additional information about your Benefits and services.

You may visit or write to us about any questions or concerns at the following addresses.

Physical Address:	Mailing Address:
2440 Louisiana Blvd. NE, Suite 601	P.O. Box 36719
Albuquerque, NM 87110	Albuquerque, NM 87176

Interpreter Services

If you need assistance from an interpreter, we have services to assist you. If you would like access to these services, contact the Customer Care Center during business hours at 1-855-7MY-NMHC.

Entire Contract

This Evidence of Coverage, the Summary of Benefits and Coverage, Pediatric Vision Rider, Formulary Reference Guide, Provider Directory, the Enrollment Application and any amendments or endorsements constitute the Entire Contract between NMHC and the Subscriber; and as of the effective date of the Contract, supersede all other agreements between the parties. The Contract Year is the period of time for which the Agreement is in effect. The Evidence of Coverage, Summary of Benefits and Coverage and the Pediatric Vision Rider are provided to you upon enrollment. A hard copy Formulary Reference Guide and hard copy Provider Directory are provided to you upon request. All documents are available electronically on our website).

Amendments
The provisions of the Plan as outlined in this Evidence of Coverage are subject to amendment; including benefit modifications, premium rate changes, or termination in accordance with their provisions or by mutual agreement in writing between NMHC and the Employer Group. By electing coverage and accepting Benefits under this Policy, all Policyholders that are legally capable of contracting, agree to all terms, conditions, and provisions of the Policy. Premium rate changes shall not be effective without sixty (60) days written prior notice to the Policyholder.

Governing Law
This Evidence of Coverage is made and shall be interpreted under the laws of the State of New Mexico and all applicable federal rules and regulations.

ENROLLING IN THE PLAN

Full and Accurate Completion of Enrollment Application

Each Subscriber must accurately complete the Enrollment Application. If information provided on your Enrollment Application changes throughout the year, please contact your employer.

In order for Covered Benefits described to be available to you, you must be enrolled as a Member of this plan. To be eligible to enroll as a Member you must meet the eligibility criteria listed below:

To be eligible to enroll as a Subscriber under this Plan, you must:

- Be an employee of the Employer Group or a participant in a covered group (including part-time employees) who works at least twenty (20) hours per week over a six month period as defined by State Law); and
- Lives or works in the Service Area, as determined by NMHC; and
- Be lawfully present in the United States, if not a citizen or natural of the United States; and
- Continue to meet the criteria noted above throughout the year.

To be eligible and enroll as a Dependent, you must:

- Be the legal spouse of the Subscriber as determined by the Subscriber's employer; or
- Be the domestic partner (same or opposite sex) of the Subscriber, if your employer extends coverage to domestic partners, and must:
    - Share a permanent residence with the Subscriber;
    - Have resided with the Subscriber for at least 1 year (365 days);
    - Be eighteen years of age or older;
    - Be financially interdependent;
    - Not be a blood relative any closer than would prohibit legal marriage.
- Be the natural child, stepchild, adopted child, foster child of the Subscriber or the Subscriber's spouse or domestic partner, or the child for whom the Subscriber or Subscriber's spouse is the legal guardian, legally placed with the Subscriber or Subscriber's spouse for adoption, foster care, or supported pursuant to a court order imposed on the Subscriber as the non-custodial parent (including a qualified medical child support order) provided that the child:
    - Has not yet reached age twenty-six (26) as required by federal law; or
    - Is twenty-six (26) or older and continuously incapable of self-sustaining support because of a mental or a physical disability which existed prior to attaining twenty-six (26) years of age;
        - You must submit proof of the child's Condition and dependence to us within thirty-one (31) days after the date the child ceases to qualify as a Dependent as defined above. We may annually require proof of the continuation of the child's condition and dependence.

PLEASE NOTE: The grandchild of a Subscriber is not eligible for coverage unless the child meets the eligibility criteria for a Dependent.

Enrollment of Dependents Due to Qualified Medical Child Support Order

NMHC will provide coverage to Dependent children of members required to provide medical insurance due to a Qualified Medical Child Support Order in accordance with applicable state or federal laws or regulations. These Dependents are not bound by enrollment season restrictions. The effective date of coverage for these Dependents is the first of the month following receipt of the Order or the effective date of the Order, not to exceed sixty (60) days retroactive coverage. A child will be covered until satisfactory written evidence is provided, indicating that 1) the order has been vacated or terminated; or 2) the child will be enrolled in comparable health coverage through another insurer that will take effect not later than the effective date of disenrollment.

Enrollment and Effective Dates of Coverage Enrollment during an Open Enrollment Period

NMHC permits a qualified small employer to purchase coverage at any point during the year, provided that the small employer meets NMHC's minimum contribution and group participation requirements. NMHC may limit the annual enrollment period to November 15 through December 15, 2016, for qualified small employers who do not meet our minimum contribution and group requirements.

If you are eligible as a Subscriber or Dependent, you may enroll during an Open Enrollment Period. You must submit a complete Enrollment Application and any applicable fees to the Employer Group. If enrolled during an Open Enrollment Period, your effective date of coverage will be the first day of the plan's Contract Year.

Enrollment after an Open Enrollment Period
If you become eligible for coverage as a Subscriber or a Dependent after the plan's Open Enrollment Period, you may enroll within thirty-one (31) days of the day on which you met the eligibility criteria. To enroll, you must submit an Enrollment Application and any applicable fees to the Employer Group. Your effective date of coverage will be the day on which you met the eligibility criteria.

If the Subscriber or Dependent does not enroll within the thirty-one (31) days, your next opportunity to enroll will be during the next Open Enrollment Period.

If you are a Subscriber and want to enroll a newly born child, you must enroll the child within thirty-one (31) days of the child's birth. To enroll a newborn child, submit an Enrollment Application and any fees to the Employer Group.
The effective date of coverage for your newborn child will be the moment of birth.

Please Note: Failure to enroll a newly born child within the thirty-one (31) days will result in denial of benefits for applicable charges incurred for the birth of that child. If you do not enroll a newborn child or pay the applicable Premiums within the thirty-one (31) days after the child's birth, your child will not be covered. Your next opportunity to enroll the child will be during your Employer's next Open Enrollment Period.

If you are a Subscriber, you may enroll an adopted child or child for whom you have been granted legal guardianship or foster care within thirty-one (31) days of the date the child is legally placed with you for adoption or within thirty-one (31) days of the date you are granted legal guardianship. To enroll an adopted child or child for whom you are the legal guardian, you must submit an Enrollment Application, together with any additional fees due, to the Employer Group and submit a copy of the court or agency order granting placement for purposes of adoption to the Plan.

After enrolling, the effective date of coverage for your child will be the date of legal placement of the child for adoption or the date of court ordered legal guardianship. Coverage shall include the necessary care and treatment of medical conditions existing prior to the date of placement. If you do not enroll an adopted child or a child for whom you are legal guardian within thirty-one (31) days of events noted above, your next opportunity to enroll the child will be during the next Open Enrollment Period.

Special Enrollment after Open Enrollment Period
There are special circumstances under which an individual who was eligible to enroll for coverage as a Subscriber, but did not do so, may be eligible to enroll himself and any eligible Dependents outside of the Open Enrollment Period.

1. After the Open Enrollment Period, you may submit an Enrollment Application and any applicable fees, to the Employer Group, for yourself and any eligible Dependent(s) within thirty-one (31) days of the date of the following events:
    a. Marriage: You may enroll your new spouse and eligible stepchildren;
    b. Birth of a dependent newborn child: You may enroll your newborn and spouse (if not already enrolled) at this time. Other eligible dependents not previously enrolled may be enrolled during your Employer Group's next Open Enrollment Period;
    c. Adoption of a dependent child or legal placement of a dependent child for adoption: You may enroll your adopted or foster or other legally placed child and your spouse (if not already enrolled). Other eligible Dependents may be enrolled during your Employer Group's next Open Enrollment period. Coverage shall include the necessary care and treatment of medical conditions existing prior to the date of placement.
    d. Loss of Minimum Essential Coverage such as:
        - Loss of eligibility for coverage (coverage is not COBRA continuation coverage);
        - Loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment;
        - Loss of coverage because one no longer lives in the service area;
        - Loss of coverage because plan no longer offers any benefits to the class of similarly situated individuals;
        - Termination of employer contributions;
        - Exhaustion of COBRA continuation coverage.
    e. Unintentional enrollment or non-enrollment in a Qualified Health Plan (QHP);
    f. Violation by a QHP of a material contract provision; or
    g. New eligibility determination, access to a new QHP through a permanent move.

If enrolled, the effective date of coverage will be the day of the event creating eligibility.

2. If you do not enroll within the thirty-one (31) days of one of these events, the next opportunity for you and any eligible Dependents to enroll will be during the next Open Enrollment Period.

A change in eligibility for Medicaid or the Children's Health Insurance Program (CHIP) qualifies eligible persons for special enrollment. Affected persons have 60 days from the date of this triggering event to select a plan.

Enrollment and Effective Dates of Coverage
When you enroll on the Plan, your effective date of coverage will be the first of the month. If a Subscriber or Dependent experiences a Qualifying Event, the effective date of coverage will be determined by the event.

Full and Accurate Completion of Enrollment Application
Each Subscriber must accurately complete the full Enrollment Application. You must submit a complete Enrollment Application and any applicable fees as directed by your Employer.

Change of Status
Changes in status, such as Dependent status, marital status, place of work, or residence (in and out of Service Area), tobacco use to non-tobacco use, or leaving an Employer Group may affect your Plan coverage. The Plan must know about these changes as soon as they occur. Please contact your Employer Group's personnel or human resources office. Ask that the Employer Group notify the Plan right away. If you change your address, be sure to notify us to assure that you receive Plan notices and mailings.

Hospitalization on the Effective Date of Coverage
If you or a Dependent are in the hospital on the effective date of your coverage, you must notify the Plan of the hospitalization within two (2) days, or as soon as possible thereafter to ensure that appropriate benefits are available.

OTHER INSURANCE COVERAGE

Injuries Caused by Third Parties and Subrogation

This section will apply when another party is, or may be considered liable, for a Member's injury, sickness or other condition. This includes insurance carriers who are financially liable and for whom NMHC has made a payment for Benefits.

The Plan is 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 NMHC. NMHC 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 the Plan. NMHC is not obligated in any way to pursue this right independently or on behalf of the Member, but may choose to pursue its rights to reimbursement at its sole discretion.

The Member is obligated to cooperate with NMHC and its agents in order to protect NMHC's subrogation rights. Cooperation with NMHC means you will:

- Provide NMHC or its agents with any relevant information requested;
- Sign and deliver such documents as reasonably requested to secure the subrogation claim;
- Obtain the consent of NMHC 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 the subrogation rights of NMHC. If a Member fails to obtain prior written consent from NMHC 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 NMHC for the value of any Benefits that were paid by NMHC. NMHC contracts with First Recovery Group, LLC, at the address listed below, to assist NMHC in its subrogation efforts. You or your provider may be contacted by First Recovery Group for information and assistance in investigating potential Third Party or Subrogation claims.

First Recovery Group, LLC
26899 Northwestern Highway, Suite 250
Southfield, MI 48033

Coordination of Benefits (COB)

Coordination of Benefits (COB) refers to Members who have coverage under more than one health insurance plan. A plan may be another group or individual health insurer or it may be another type of insurance, such as Medicaid or Medicare or certain types of automobile insurance. The insurance industry has developed "order of benefit determination rules" that govern the order in which each plan will pay a claim for Benefits. This ensures that plans will apply consistent rules and that the maximum amount will be paid under each applicable plan. The insurer that pays first is called the primary plan. The primary plan must pay Benefits in accordance with its Policy terms without regard to the possibility that another plan may cover some expenses. The insurance company that pays after the primary plan is the secondary plan. The secondary plan may reduce the Benefits it pays so that payments from all plan Benefits do not exceed 100% of the total Allowable Charge. (Note: In some cases, a Plan Member may be covered under three or more plans. In that case, Benefits can be coordinated among all the applicable plans to ensure that the maximum Benefits are paid by each plan).

Benefits under this Plan will pay after payment is made by a Health plan, group or individual automobile insurance Policy; or homeowner's or premises insurance, including medical payments, personal injury protection, or no-fault coverage.

In order to be able to coordinate Benefits with another insurance carrier, we must know what other health insurance coverage you have. This could reduce the out-of-pocket and/or "not covered" amounts for which you are liable. It is in your best interest to provide us with the most current information about other coverage that you and/or your dependents have. When your other health insurance coverage begins or ends, you should notify the Customer Care Center immediately at 1-855-7MY-NMHC (1-855-769-6642).

Members Eligible for Medicaid

NMHC will pay the New Mexico Human Services Department (HSD) directly for medical assistance Benefits paid under the state's Medicaid program for a Member eligible for Medicaid if:

- HSD has paid or is paying Benefits on behalf of the Member;
- HSD has paid or is paying the Medicaid provider;
- HSD has notified NMHC that Benefits must be paid directly to HSD.

Otherwise, the Plan will pay the provider for medical care covered by the policy. If a Plan Member, who is a Medicaid recipient, has already paid an Out-of-Network Provider for emergency care or for care performed outside the Service Area, the Plan will pay the Provider according to state law. The Member must seek reimbursement directly from the provider.

Note: You can keep your NMHC plan if you also have Medicaid coverage.

Members Eligible for Medicare
Each Member entitled to coverage under Medicare must notify this Plan in writing. Generally, your group health plan pays first if **both** of the following are true:

- You're sixty-five (65) or older, have Medicare and are covered by a group health plan through your current employer or the current employer of a spouse of any age; and
- The employer has twenty (20) or more employees and covers any of the same services as Medicare (this means the group health plan pays first on your hospital and medical bills).
- If you have Medicare and your employer has fewer than twenty (20) employees, Medicare generally pays first.

You may contact our Customer Service for answers to questions you may have regarding employer group and Medicare coverage.

RIGHTS AND RESPONSIBILITIES

As a Member of this Plan, you are entitled to certain rights when you access coverage. There are also certain responsibilities that you hold. It is important that you understand these rights and responsibilities.

As a Member of this Plan:

- **You have a right to information about member rights and responsibilities.**
- You have a right to detailed information about your Plan. This may include Covered Benefits and Services that are covered or excluded from the Plan, and all requirements that must be followed for Prior Approval and Utilization Review.
- You have a right to always have available and accessible services for Medically Necessary and covered services; including 24 hours per day, 7 days per week for urgent and emergency care services, and for other Covered Benefits and Services as defined by the Evidence of Coverage or the Summary of Benefits and Coverage.
- You have a right to information about your out-of-pocket expense limitations, and an explanation of your financial responsibility for Covered Services provided to you.
- You have a right to be treated in a manner that respects your privacy and dignity.
- You have a right to participate with your In-Network Providers in making decisions about your healthcare.
- You have a right to receive an explanation of your medical Condition, recommended treatment, risks of the treatment, expected results, and reasonable medical alternatives from your In-Network Provider in a language that you understand, regardless of cost or your benefit coverage.
- You have a right to be informed about your treatment from your In-Network Provider; to request your consent (agreement) to the treatment; to refuse treatment, including medication; and to be told of the possible consequences of refusing such treatment. This right exists even if treatment is not a Covered Benefit or Medically Necessary according to the Plan. The right to consent or agree to treatment may not be possible in a medical emergency where your life and health are in serious danger.
- You have a right to voice Complaints, Grievances, or Appeals with NMHC or its regulatory bodies about NMHC and/or the Coverage that we provide.
- You have a right to make recommendations regarding Plan's Member Rights and Responsibilities policies.
- You have a right to receive assistance in a prompt, courteous and responsible manner.
- You have a right to the confidential handling of all communication and information maintained by NMHC. Your written permission will always be required for the release of medical and financial information, except:
    - When clinical data is needed by healthcare Providers for your care;
    - When NMHC is bound by law to release information;
    - When NMHC prepares and releases data but without identifying Members; and
    - When necessary to support NMHC's programs or operations, including for payment and to evaluate quality and service.
- You have a right to be promptly informed of termination or changes in Covered Benefits and Services or In-Network Providers.
- You have a right to know, upon request, of any financial arrangements or provisions between NMHC and its In-Network Providers, which may restrict referrals or treatment options or limit the Benefits or Services offered to you.
- You have a right to receive an explanation of why a Benefit is denied; the opportunity to Appeal the denial decision; the right to a second level of Appeal with NMHC; and the right to request help from the New Mexico Superintendent of Insurance.
- You have a right to adequate access to healthcare from In-Network Providers near your home or work within the Plan's service area.
- You have a right to receive detailed information about requirements that you must follow for Prior Approval of certain Covered Benefits and Services.
- You have a right to have access to a current list of In-Network Providers in NMHC's network.
- You have a right to an example of the financial responsibility incurred by a Covered Person for Benefits and Services received from an Out-of-Network Provider.

You are responsible for learning how your Plan works. You should carefully read and refer to this Evidence of Coverage, your Summary of Benefits and Coverage, and other Plan documents. Contact the Customer Care Center if you have questions or Concerns about your Plan.

As a Member of the Plan, you have the following responsibilities:

- You have a responsibility to provide honest and complete information to NMHC and to your In-Network Providers.
- You have a responsibility to read and understand the information that you receive about your Plan.
- You have a responsibility to know how to properly access coverage and utilize your Plan.
- You have a responsibility to understand your health problems and participate in developing treatment goals that you agree to with your In-Network Providers.

- You have a responsibility to follow plans and instructions for care that you have agreed to with your In-Network Providers.
- You have a responsibility to present your Plan ID card before you receive care.
- You have a responsibility to promptly notify your In-Network Provider if you will be delayed or unable to keep an appointment.
- You have a responsibility to pay your applicable Deductible, Copayment and Coinsurance amounts, including those for missed appointments.
- You have a responsibility to express your opinions, Concerns or Complaints in a constructive way to NMHC or to your In-Network Provider.
- You have a responsibility to inform NMHC of any changes in family size, address, phone number or Membership status within thirty (30) calendar days of the change.
- You have a responsibility to notify NMHC if you have any other insurance coverage.
- You have a responsibility to follow NMHC's Complaints and Appeals process when you are dissatisfied with NMHC or a Providers' actions or decisions.

Consumer Advisory Board

We are a consumer-oriented and operated health plan (CO-OP). You are a critical part of our organization and we value your feedback regarding our services and health plan operations. We have established a Consumer Advisory Board that meets on a quarterly basis to discuss general operations from the perspective of our members and how we might better serve you. As a Member of this Plan, you are eligible to participate on this Board. If you are interested in doing so, contact us at (505) 633-8020.

HOW YOUR PLAN WORKS

Preferred Provider Organization

A Preferred Provider Organization or PPO plan gives you the opportunity to see the providers that you want. Each time you need care, you can choose the Provider and level of coverage that best meets your health and financial needs.

In-Network or Participating Providers

As a PPO Plan Member, you can feel confident knowing that there is a NMHC In-Network Provider close to where you live or work. Our statewide network of physicians, hospitals and other medical service Providers means that you have access to In-Network providers throughout New Mexico. Your Out-of-Pocket costs will be lowest when you see In-Network Providers.

When you or your covered Dependents see an In-Network Provider, we pay that Provider for Covered Benefits or Services that are included in your Plan. You will be responsible for paying some charges such as your Deductible, Copayment, and Coinsurance amounts. These amounts are due at the time that you receive services.

Prior Approval is required for some Covered Benefits and Services such as hospitalizations. If benefits and services require Prior Approval your In-Network Provider must obtain authorization before providing these services to you.

Provider Directory

Our Provider Directory includes a list of physicians, hospitals, pharmacies, and other In-Network Providers that have contracted with us. The Provider network is subject to change as new Providers join our network and other Provider's leave. If a Provider is listed in the directory, it does not guarantee that the Provider is still contracted with NMHC, or that the Provider is accepting new patients.

Before joining our network, In-Network Providers must meet specific criteria through a process called credentialing. We regularly review our Providers' credentials to make sure that they continue to meet these standards.

If you would like to check the status of a Provider, you can access the Online Provider directory on our website at www.mynmhc.org. You can also contact our Customer Care Center to inquire about a Provider. The Customer Care Center can provide you with information about your Provider such as the medical school attended; residency completed and their Board Certification status. You may also contact our Customer Care Center to ask for a copy of our Provider Directory.

Service Area

NMHC's Service Area is the state of New Mexico.

Primary Care Practitioners (PCP)

PCPs are physicians and other qualified providers that manage your healthcare needs. It is our philosophy that a strong relationship with a Primary Care Practitioner will help you and your family navigate your health plan, as well as keep you healthy. PCPs provide services such as annual exams, routine immunizations, age appropriate preventive screening recommendations and treatment for illnesses and injuries.

Please select a PCP if you didn't do so at the time you completed your enrollment application. NMHC does not select a PCP for you. You can browse the provider directory by In-Network Provider name or specialty. To do this, click on the "Find a Provider" button near the top of our homepage (www.mynmhc.org). After you have chosen a PCP, be sure to call his or her office and make sure they are accepting new patients. After you select a PCP, please let us know of your choice. You may do this in one of two ways:

- Call our Customer Service Department. Our toll-free number is 1-855-7MY-NMHC (1-855-769-6642). We are available Monday through Friday, 8 a.m. to 5 p.m., Mountain Standard Time; or
- Log in to our Member & Provider Portal. You will find a link to the portal at the top right corner of our homepage.

Developing a relationship with a Primary Care Practitioner can help you stay well and avoid costly medical expenses in the future. NMHC's network of PCPs includes physicians practicing Family Medicine, Internal Medicine, and Pediatrics, as well as Doctors of Oriental Medicine, Physician Assistants, and Nurse Practitioners. Healthcare providers that are specialists may act as primary care providers for patients with chronic medical conditions, provided the specialists offer all basic health care services that are required of them by NMHC.

Specialty Care Practitioners

A Specialty Care Practitioner or Specialist is a Provider that treats a specific disease, medical Condition, or a specific part of the body. You do not need a referral to see a Specialist.

Some examples of Specialty Care Practitioners include cardiologists, orthopedists, neurologists, and endocrinologists. Doctors of Oriental Medicine may also be considered Specialty Care Practitioners as long as they have met NMHC's requirements for participation in the provider network. No referral is required for services from participating in-network practitioners providing obstetrical and gynecological care.

Medical Emergencies
An Emergency medical condition means healthcare procedures, treatments, or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson, to result in: jeopardy to the person's health, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or disfigurement to the person.

Prior authorization is not required for emergency care.
In addition, appropriate out-of network emergency care shall be provided to a covered person without additional cost; whether out-of-network emergency care is appropriate shall be determined by the standards of Paragraph (4) of Subsection D of 13.10.21.8 NMAC.

For follow-up care (which is no longer considered an Emergency), you or your family Member will need to select an In-Network Provider in order to receive In-Network benefits.

Medically Necessary Care Not Available in Service Area
If a Covered Benefit or Service is Medically Necessary and is not available from an In-Network Provider, we will refer you to an Out-of-Network Provider. Before we refer you to an Out-of-Network Provider, we will ensure that your request is reviewed by a Specialist practicing in the field of medicine that would be familiar with your specific medical Condition. In these situations, NMHC will coordinate the referral. We will pay the Provider at the Usual, Customary and Reasonable rate, or at a rate agreed upon between NMHC and the Out-of-Network Provider.

Receiving Care from an Out-of-Network or Non-Participating Provider
If you choose, you may receive care from an Out-of-Network Provider. If you access the Out-of-Network (OON) benefit on your Plan, generally your Out-of-Pocket costs will be higher.

When receiving care from an Out-of-Network Provider, payment from the Plan will be limited to the Usual, Customary and Reasonable Charges of the Covered Service. You will be responsible for your Deductible and Coinsurance amounts, and for charges that exceed the Usual, Customary and Reasonable rate.

Be sure to review all sections of this Handbook and your Summary of Benefits and Coverage to understand your Out-of-Network coverage.

Certain Out-of-Network services require Prior Approval by the Plan. You are responsible for ensuring that Prior Approval is obtained from New Mexico Health Connections for the requested service or claims may be denied and payment will be your responsibility.

If you receive care from an Out-of-Network Provider, you may be required to pay the charges in full to that Provider at the time of service. To be reimbursed for the charges you have paid on covered services, you will need to submit a Member Reimbursement form including an itemized statement with the diagnosis, the treatment received and an explanation for the services, the charges for the treatment, and the Member's identification information from your Plan ID card.

Itemized bills must be submitted on billing forms or the Provider's letterhead or stationery and must include:
- The name and address of the Physician or other healthcare Provider;
- The full name of the patient receiving treatment or services; and
- The date, type of service, diagnosis, and charge for each service separately.

Canceled checks, balance due statements, cash register receipts or bills you prepare yourself are not acceptable. Please make a copy of all itemized bills for your records before you send them because the bills will not be returned to you. Itemized bills are necessary for your claim to be processed so that all Benefits or Services available under this Plan are provided.

If your itemized bill includes charges for services that were previously submitted to us, clearly identify the new charges that you are submitting for reimbursement. Medical records of the treatment or service may be required. You can get a Member Reimbursement form from our website at www.mynmhc.org or by calling the Customer Care Center at 1-855-7MY-NMHC (1-855-769-6642).

Claims for Benefits or Services rendered by an Out-of-Network Provider must be submitted to NMHC within one year (365 days) from the date of service. If your Out-of-Network Provider does not file a claim for you, you are responsible for filing the claim within the one-year deadline. Claims submitted after the deadline are not eligible for reimbursement. If a claim is returned to you because we need additional information, you must resubmit it, with the information requested, within 90 days of receipt of the request.

Please mail the claim forms and itemized bills to:

Claims Department
New Mexico Health Connections
P.O. Box 3828
Corpus Christi, TX 78463

Once received, reviewed and approved, NMHC will reimburse you for Covered Benefits and Services, less any required Deductibles and Coinsurance or Copayment amounts that you are required to pay as stated in the Summary of Benefits and Coverage. You will be responsible for services not specifically covered by the Plan.

Usual, Customary, and Reasonable Charges
Out-of-Network Providers are allowed to bill any amount they wish for healthcare services. The charges that they bill may be more than your Plan's Usual, Customary, and Reasonable amount. Covered Benefits and Services received from Out-of-Network Providers are covered up to your Plan's Usual, Customary, and Reasonable amount. The Usual, Customary, and Reasonable amount is determined by the median rate paid for similar healthcare services within the surrounding geographic area in which the charges were incurred. The surrounding geographic area may be determined by the type of service and the access to that service in the geographic region.

When an Out-of-Network Provider charges more than the Usual, Customary, and Reasonable amount, the payment to the provider will be based on the lesser of the billed charge or the Usual, Customary, and Reasonable amount for the services rendered. Depending on the type of Benefit or Service received, the Member will be responsible for the Plan Deductible and Coinsurance amounts, and for charges that the Out-of-Network Provider bills above of the Usual, Customary, and Reasonable amount.

Below are billing examples to help members understand cost-sharing responsibilities and related differences between using a Network Provider and a Non-Network Provider. PLEASE NOTE: These are examples only and do not reflect specific costs based on your selected NMHC plan. In these examples, an insurer pays eighty percent (80%) of the Usual, Customary, and Reasonable Charges and the insured (Member) is responsible for covering the remaining twenty percent (20%).

BILLING EXAMPLES
Below you will find three examples:

- Examples one and three are In-Network claim payment and advantages over Out-of-Network.
- Example two is an out of network claim payment and disadvantages of choosing an Out-of-Network provider.

Example 1. In-Network Provider Claim Payment (80% Plan, Deductible is met):	
Provider's billed charge	$10,000
Reasonable and Customary (R&C) charges (maximum amount that can be considered for benefit payment)	$8,000
The Healthcare Plans payment to provider (80% of $8,000)	$6,400
Member coinsurance (20% of $8,000) applied to out-of-pocket limit	-$1,600
Amount over the R&C charges, the consumer is responsible for all cost incurred over the R&C charges these amounts do not apply to your out of pocket limits)	-$0
With coinsurance, the total amount due would be:	**$1,600**
Total amount due without coinsurance:	**$0**

Example 2. Out-of-Network Provider Claim Payment (80% Plan, Deductible is met):	
Provider's billed charge	$10,000
Reasonable and Customary (R&C) charges (maximum amount that can be considered for benefit payment)	$8,000
The Healthcare Plans payment to provider (80% of $8,000)	$6,400
Member coinsurance (20% of $8,000.00) applied to out-of-pocket limit	-$1,600
Amount over the R&C charges, the consumer is responsible for all cost incurred over the R&C charges these amounts do not apply to your out of pocket limits)	$2,000
With coinsurance, the total amount due would be:	**$3,600**
Total amount due without coinsurance:	**$2,000**

Example 3	In-Network Hospital (Plan Pays 90%)	Out-of-Network Hospital (Plan Pays 70%)
Actual hospital charge	$10,500	$10,500
Amount recognized by medical plan:	$6,500 (the discounted rate for health plan)	$8,800 (the Reasonable & Customary charges based on standard charge for that geographic area). Plan does not recognize the $1,700 difference between the actual charge and the R&C.
Medical plan pays:	90% of the discounted rate: $6,500 x 90% = $5,950	70% of the discounted rate: $8,800 x 70% = $6,160
Member pays:	10% of the discounted rate: $6,500 x 10% = $650	30% of R&C charges ($8,800) plus 100% of the amount over R&C ($1,700): $2,640 + $1,700 = $4,340

Claims for Emergency Services Received Outside the United States
If you need Urgent or Emergency care from a Hospital or Physician when you are outside of the United States, claims should be handled the same way as described in the *Receiving Care from an Out-of-Network or Non-Participating Provider* section of this Evidence of Coverage. You will normally be required to pay the Provider at the time services are received and submit the claim to us for reimbursement. You are responsible for confirming that the claim and/or records are appropriately translated and that the monetary exchange rate is clearly identified when submitting the claim for the reimbursement. Medical records of the treatment or service may also be required.

Providers Outside of New Mexico
When your receive care from a provider who is not a NMHC contracted provider you will have coverage at your plan's out-of-network level of benefits. PPO plan benefits vary depending on your coverage selection (please refer to your Schedule of Benefits for more information). When you receive care at the out-of-network level of benefits, you pay a deductible and then coinsurance until you reach your out-of-pocket maximum. Once you reach your out-of-network maximum, you are covered in full up to usual, reasonable and customary charges for all out-of-network covered services for the remainder of the plan year. You may also be responsible for paying any difference between what the plan covers and what the out-of-network provider charges for a service.

We do have contracts with some out-of-state providers. For more information, please call 1-855-7MY-NMHC.

Case Management
NMHC is committed to the delivery of high-quality case management programs to our members. We ensure members with healthcare needs and/or complex conditions have access to needed resources and services to assist them in better understanding and managing their chronic health condition(s). Members are guided into plans of care appropriate to their specific needs and designed to help them regain optimum health.

Members may be identified for case management through a variety of sources that include, but are not limited to:

- Claims or encounter data;
- Hospital admission and/or discharge data;
- Pharmacy data;
- Data collected through the utilization management (Prior Approval) process;
- Data collected from the health information line;
- Member data;
- Physician or provider data; and
- Purchaser supplied data.

Members may also be referred for case management from multiple sources including, but not limited to:

- Health information line;
- Disease Management programs;
- Discharge planners;
- Utilization Management teams;
- Member or caregiver; and
- A Provider/practitioner.

The NMHC Case Management program is available to all NMHC members. While NMHC monitors claims, utilization patterns and other health plan data, referrals into any level of case management are accepted from members, caregivers and providers.

Referral to a case management program can be started by contacting the NMHC Case Management department at 1-844-691-9984.

Disease Management

NMHC is committed to supporting our Members in the management of asthma and diabetes and other chronic diseases.

Asthma and diabetes are chronic diseases that can be controlled with education, medication management, and identification and elimination of triggers in the environment. NMHC's Asthma and Diabetes Management Programs are designed to identify and improve health outcomes for our Members by:

- Identifying members with asthma or diabetes;
- Analyzing risks factors to determine what level of intervention a Member needs;
- Outreaching, educating, and engaging asthmatic and/or diabetic Members and their families in activities to improve their health and develop self-management strategies;
- Facilitating communication, teamwork, coordination and management of necessary healthcare services; and
- Assisting members that may require community resources such as transportation or other assistance.

For more information or to refer yourself to a Disease Management program, contact the Disease Management department at 1-844-691-9984.

Transition of Care

If you are receiving an ongoing course of treatment from an Out-of-Network Provider when you enroll in the Plan, or with an In-Network Provider whose contract ends with NMHC during your treatment, you may be eligible to continue to receive services and they will be covered under the Plan. This is called a Transition of Care. Determinations for Transition of Care are made based on established medical 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, including post-partum care directly related to the delivery. For Members in the third trimester, the transitional period will continue through delivery, including post-partum care related to the delivery.

Treatment Refusal

A Member is allowed to refuse treatment that is recommended by an In-Network Provider. If this happens, the Provider can decide not to continue their relationship with the Member because proper medical care is being disrupted. If the Provider feels there is no alternative care to the treatment that was refused, neither NMHC or the Provider will be held responsible for treating the Condition or for any complications that result from the Member refusing treatment. This is true as long as a Member refuses treatment determined appropriate.

Customer Care Center
Our Customer Care Center staff will work with you to resolve any issues or answer any questions that you may have regarding your Policy. We resolve to answer your questions or concerns as quickly and as satisfactorily as possible.

Our Customer Care Center may assist you with the following:
- Provider information;
- Enrollment information;
- Questions about Covered Benefits and Services;
- Procedures for obtaining care;
- Information about Prior Approvals;
- Status of claim payment;
- Appeals and Complaint procedures.

Online Member Options
Our interactive website is a valuable source of information. You can check your eligibility and claims status, send secure messages to the Customer Care Center, search for an In-Network Provider, and more. Please visit our website at www.mynmhc.org for more information and to log in to the member portal.

Where to Contact Us
If you have a question or concern about your Plan, you can contact the Customer Care Center at 1-855-7MY-NMHC (1-855-769-6642). The Customer Care Center is open Monday through Friday from 8:00 a.m. to 5:00 p.m. Mountain Standard Time. Calls received after hours or on weekends will be directed to a voicemail messaging system that will be available twenty-four (24) hours a day, 365 days a year, and calls will be returned on the next business day.

Language Line
Se habla español. We have translation services available. If you need translation services during a visit to your physician's office, contact the Customer Care Center for assistance.

NurseAdvice New Mexico
If you have a question related to a medical condition, contact our Nurse Advice Line toll-free at 1-877-725-2552. You can speak to a registered nurse twenty-four (24) hours a day, seven (7) days a week.

Using Your ID Card
You have been issued a Plan ID card that should be carried with you at all times. A Provider will require you to show them your ID card when you receive healthcare services. Your ID card lists some of your Plan Benefits and Copayment or Coinsurance amounts. Additional Copayment and Coinsurance amounts, as well as contact information for the Customer Care Center and for OptumRX, our Pharmacy Benefits Manager (PBM). Additional Copayment and Coinsurance amounts can be found in your Summary of Benefits and Coverage. If you lose your ID card, or need additional cards, contact the Customer Care Center.

Do not allow a non-Member to use your Plan ID card. If this happens, you will be responsible for the cost of services provided to that person. Your membership and the membership of any covered Dependents will be terminated. Contact the Customer Care Center immediately if your Plan ID card is lost or stolen.

Identification (ID) Cards are issued by NMHC for identification purposes only. Possession of a Plan ID Card infers no rights to Covered Services and Benefits under your Plan. To be entitled to Services or Benefits, the cardholder must be the Member on whose behalf all applicable Policy premiums have been paid. If any Member allows the use of his/her ID card by a person other than him/herself, all rights of the Member and any dependents on the Policy will be immediately terminated at the discretion of NMHC.

Claims Payment Process
When you receive Covered Services from an In-Network Provider, your Provider will file your claims to us on your behalf. You must present your Plan ID card at the time of service to make sure that your claims are paid in a timely and accurate manner. You are expected to pay your In-Network Provider for Copayments, Deductible and/or Coinsurance amounts as indicated in your Summary of Benefits Coverage and Plan ID card.

You will be responsible for any charges for missed appointments or appointments cancelled without adequate notice to your In-Network Provider. If you believe you are being asked to pay an amount to In-Network Provider that you do not agree with, you may contact the Customer Care Center for assistance. You are not responsible for any amounts owed to your Provider by NMHC.

Affirmation Statement

We make claims payment decisions based on the appropriateness of care, the services that are received, and the eligibility for coverage only. NMHC does not give incentive payments to NMHC's Claims Representatives or make employment decisions based on the denial of member Benefits.

HOW TO GET CARE

This section explains how you can access care through an In-Network Provider and how to make sure that the care you receive is covered under your Plan.

In order for us to provide your Plan Benefits in a timely fashion, you should follow these basic steps:

- Contact your physician or other In-Network Provider when you have a healthcare need;
- Identify yourself as a Member. Have your Plan ID card on hand when making appointments;
- Upon arriving for a scheduled appointment, show your Plan ID card to the receptionist;
- Make sure Prior Approval has been obtained for the services described in the Prior Approval and What the Plan Covers sections of this Evidence of Coverage;
- Notify NMHC of an Emergency admission within forty-eight (48) hours of being admitted to a hospital; and
- Call the Customer Care Center if you have a question, concern or complaint.

Medical Office Visits

Physicians and other Providers who you see in an office setting offer both primary 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 qualified Provider. In-Network Providers will arrange for Prior Approval as necessary, as described in the *Prior Approval* section of this Evidence of Coverage.

If you need a same day appointment or have an Urgent Illness, call your Provider's office to make an appointment. If your Provider is unable to see you, you may be able to see another physician or other practitioner in that office.

When you arrive for your appointment, show your Plan I.D. card to the receptionist. If a particular benefit requires a Co-Payment, you must pay it before receiving services. If you are unable to keep an appointment, cancel as soon as possible.

After Hours

After normal work hours, you can call the Nurse Advice Line twenty-four (24) hours a day, seven (7) days a week at 1-877-725-2552. Registered nurses can help you determine the kind of care that is most appropriate for you.

Urgent Care

Urgent Care is for a situation that is not life threatening but requires medical care quickly, or after a Primary Care Practitioner's normal business hours. Urgent Care conditions are unexpected and arise due to illness or injury.

Some examples of Urgent Care situations are a rising fever even after taking medication, 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 medicine is not helping.

If you need assistance finding the nearest In-Network Urgent Care facility, please contact the Customer Care Center, or refer to the Provider Directory. You can find a listing of Urgent Care centers on our website: www.mynmhc.org/find_a_doctor.aspx.

You may want to call your Primary Care Practitioner for an appointment before seeking care from another provider. If the Primary Care Practitioner is not available and your Condition persists, you can call the Nurse Advice Line at 1-877-725-2552. 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.

Emergency Services

Emergency Medical Conditions require quick action. An Emergency Medical Condition refers to the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson, to result in: jeopardy to the person's health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part; or disfigurement to the person.

Examples of emergencies are severe bleeding, severe abdominal pain, a spinal cord or back injury, chest pain, a heart attack, a stroke, poisoning, a gunshot wound, a severe eye injury, or the sudden inability to breathe. There are many other acute conditions that NMHC considers an Emergency.

If you seek emergency care for an illness or injury that you believe requires immediate medical attention, the services will be covered by your Plan. Prior Approval is not needed for Emergency care. If your emergency results in you being admitted to the

hospital, concurrent or retrospective Prior Approval will be required for the hospital Admission. You are responsible for contacting us to authorize your hospital stay once your emergency medical Condition has been stabilized.

We will consider the following when determining whether a situation truly required emergency care:

- Would a reasonable person believe that the situation required immediate medical care and could not wait until the next working day or next available appointment with a PCP?
- What time of day was the care provided?
- What were the presenting symptoms?
- Are there any circumstances that prevented you from seeking emergency care from a Provider under established Plan guidelines?

You may have questions about acute illness other than an Emergency Medical Condition. You should contact your physician or other Provider before going to the emergency room, if possible. If your physician is not available, you should contact our Nurse Advice Line toll-free at 1-877-725-2552. You can speak to a registered nurse twenty-four (24) hours a day, seven (7) days a week.

What to Do in an Emergency

If you have an emergency, go to the nearest emergency room. Emergency Rooms are open twenty-four (24) hours a day, seven (7) days a week. If necessary, dial 911 for help. If you are able, tell the emergency room staff that you are a Plan Member and show them your ID Card. They can then contact us for you. In situations where you are unable to immediately notify NMHC, contact us as soon as you are able. We will provide direction and Prior Approval as needed.

Emergency Services at an Out-of-Network Provider or Facility

Emergency care should be obtained from the nearest available Provider or Facility, even if that Provider or Facility is not contracted with us. Emergency Services obtained from Out-of-Network Providers will be covered at your plans benefit level as if you had visited an In-Network Provider. Non-emergency services, such as follow-up care from a prior emergency require Prior Approval from NMHC. If you do not receive Prior Approval, NMHC may not pay for the services. If you are admitted to an Out-of-Network Facility, contact NMHC for Prior Approval. If you are not able to contact us, a family member or caregiver should contact us.

Some services NOT covered as Emergency Care from an Out-of-Network Provider include, but are not limited to:

- Elective or non-emergency care, including follow-up Care;
- Supplies, medications, and Durable Medical Equipment provided outside of the Service Area, except in an emergency or for an urgent illness, unless the need for care could not have been foreseen before leaving the Service Area;
- Care received after it is medically feasible to return to the Service Area.

If you are receiving Emergency care from an Out-of-Network Provider or Facility, you can transfer to an In-Network Facility or Provider to continue your care if it is safe for you to do so. Contact your In-Network Provider to help make arrangements for a transfer.

Ambulance Service

If you need an ambulance, call 911 or your local ambulance service. Your Plan covers ambulance services for emergency services. Non-Emergent ambulance transport requires Prior Approval. If ambulance services were used in a non-emergent situation and Prior Approval was not obtained from NMHC, you will be responsible for the charges.

PRIOR APPROVAL

Some services require NMHC's approval before care is received. The first step in the Prior Approval process is to confirm whether a treatment or service is a covered benefit under the Plan. If the service is not a covered benefit, the Prior Approval process cannot change this. You can confirm whether a treatment or service is covered by the Plan by reviewing this Evidence of Coverage and your Summary of Benefits and Coverage, or by contacting the Customer Care Center. Our Customer Care Center can answer questions that you or your provider may have regarding this process.

For covered Benefits and services that require approval, our Medical Management team will review your case and help determine whether the procedure, treatment or service being requested is Medically Necessary. Without Prior Approval, the services may not be covered.

Receiving Prior Approval for a service does not guarantee that the service will be paid for. For instance, if the number of services received exceeds the number of services approved in the Prior Approval or the Plan limits, services may not be covered. To ensure that the necessary Prior Approval is in place, contact the Customer Care Center before receiving services.

Who Obtains Approval from NMHC?

When an In-Network Provider recommends care that requires Prior Approval, the Provider should contact us for approval. The Provider must submit information about your condition so we can review and determine whether the requested service is covered by the Plan, and if so, that it is Medically Necessary. We may need to talk to the Provider about the request.

Providers Outside of New Mexico

When your receive care from a provider who is not a NMHC contracted provider you will have coverage at your plans out-of-network level of benefits. PPO plan benefits vary depending on your coverage selection (please refer to your Schedule of Benefits for more information). When you receive care at the out-of-network level of benefits, you pay a deductible and then coinsurance until you reach your out-of-pocket maximum. Once you reach your out-of-network maximum, you are covered in full up to Usual, Reasonable and Customary charges for all out-of-network covered services for the remainder of the plan year. You may also be responsible for paying any difference between what the plan covers and what the out-of-network provider charges for a service.

We do have contracts with some out of state providers. For more information, please call 1-855-7MY-NMHC.

To ensure that Prior Approval is in place, call the Customer Care Center before your scheduled service. Our Customer Care Center representatives can tell you which services require Prior Approval.

Failure to obtain Prior Approval may cause a delay of service or denial of claims.

How Does the Process Work?

NMHC requires Prior Approval for non-emergent hospital admissions and certain outpatient services. When we receive a request for Prior Approval, our Medical Management Department reviews the request using nationally recognized guidelines. These guidelines used by NMHC and practicing healthcare Providers are consistent with sound clinical principles. If guidelines do not exist for a certain service or treatment, resource tools based on clinical evidence are used.

Examples of services that require Prior Approval are:

- Non-emergent inpatient hospital admissions;
- Advanced imaging procedures, such as MRI, CT Scan, or PET Scans;
- Durable Medical Equipment (DME) and External Prosthetic Appliances (EPA);
- Surgical Procedures;
- Specialty Treatments or Supplies and
- Out-of-Network Services

Prior Approval Coverage Decisions

If we are not able to approve your Prior Approval request for clinical reasons, your case will be referred to a Medical Director before we notify you and your Provider of a disapproval. The Medical Director will consider your case and may speak with your Provider for more information. You and your Provider will be notified in writing if the request for Prior Approval cannot be approved based on the information we received, or if the Plan does not cover the service. If you disagree with the decision, you may appeal the decision through our formal Appeals Process, or have your Provider contact us to provide additional information.

When Does Prior Approval Review Occur?
Three types of Approval Review can occur:

- Prior Approval occurs when we receive a request before you receive care. Standard/Non-urgent service decisions are made within seventy-two (72) hours of receiving the request for approval for Prescription Drugs and within five (5) business days for all other Standard/Non-urgent service decisions. We will send notice of the coverage decision to you and your Provider in writing.
- Concurrent review occurs when we receive a request for approval while you are receiving care, for example, in a hospital, skilled nursing facility or rehabilitation facility. Decisions are made within twenty-four (24) hours of receipt of the review request. We will send notice of the coverage decision to you and your Provider in writing.
- Retrospective review occurs when we receive a request for approval after you have received care. Decisions related to these services are made within thirty (30) days of receiving all of the necessary information.

Prior Approval for Immediately Needed (Expedited) Care
If you have a medical Condition or situation that requires a Prior Approval decision to be made right away, we will perform an expedited review. For urgent or emergent situations, pre-service or concurrent review and determinations will be made within twenty-four (24) hours of receiving the request.

WHAT IS COVERED BY THE PLAN?

Your Plan covers Medically Necessary healthcare services. Some services require Prior Approval. Please refer to the *Prior Approval* section in this Evidence of Coverage or contact the Customer Care Center for questions regarding Prior Approval. Some services may also have limitations. Refer to your Summary of Benefits and Coverage for dollar, visit, and/or Provider limitations.

As a member of NMHC, you are required to pay your Copayment, Coinsurance, and Deductible amounts.

All services in this section are covered by the Plan. Please refer to other sections of this Evidence of Coverage for information about other covered Benefits, for example, emergency and urgent care. Please also refer to your Summary of Benefits and Coverage or call the Customer Care Center for more information.

Acupuncture
Acupuncture must be provided by a licensed Provider unless covered services are unavailable in your area and a prior approval is received to see an out-of-network provider. Services must be appropriate for the treatment of a Condition that is covered by the Plan. Coverage is limited to twenty (20) visits per Calendar Year. Acupuncture services that are habilitative or rehabilitative require prior approval and are not subject to the visit limitation. Please refer to your Summary of Benefits and Coverage for your Cost Sharing (Deductible, Coinsurance, Copayment) amount.

Allergy Treatment
The Plan covers Benefits for direct skin (percutaneous and intradermal), patch allergy tests, and radioallergosorbent testing. Includes testing and sera. **Prior Approval** is required.

Alpha-fetoprotein IV Screening Test
The Plan will cover an 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 (16^{th}) and twentieth (20^{th}) week of pregnancy.

Ambulance Services
Ambulance transport is covered when it is necessary for an emergency. The Plan will review the ambulance and medical records to determine medicall necessity. The use of an ambulance for non-emergent services requires **Prior Approval** from NMHC. If services were not Medically Necessary, or not approved by NMHC, you will be responsible for the charges.

Autism Spectrum Disorder
The Plan covers the diagnosis and treatment of Autism Spectrum Disorder for members up to age nineteen or for members up to age twenty-two years if they are enrolled in high school. Coverage includes well-baby and well-child screenings for the diagnosis; treatment by means of speech, occupational, and physical therapy; and applied behavioral analysis. Coverage is limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan. A treatment plan developed by your provider must contain diagnosis, proposed treatment by types, the frequency and duration of treatment, anticipated outcomes stated as goals, the frequency with which the treatment plan will be updated, and the signature of the treating physician.

Care that is received under the Individuals with Disabilities Education Improvement Act of 2004 is not covered by this Plan. Special education and services that are the responsibility of the state and local school boards are not covered by this Plan. Speech, occupational and physical therapy, and applied behavioral analysis therapy require **Prior Approval** by NMHC.

Bariatric Surgery
Bariatric Surgery means surgery that modifies the gastrointestinal tract with the purpose of decreasing calorie consumption and therefore decreasing weight. Before pursuing bariatric surgery, a complete nutritional, behavioral and medical evaluation must be done. Indications include a Body Mass Index (BMI) of 35kg/m2 or greater with other serious illnesses such as diabetes, high blood pressure or obstructive sleep apnea. **Prior Approval** is required and services must be performed at an In-network facility that is designated by NMHC.

Behavioral and Mental Health Services
Services for the treatment of behavioral/mental health are covered by the Plan on an outpatient basis for treatment, outpatient testing and assessment. Inpatient and partial hospitalization for psychiatric care are covered when Medically Necessary for the acute stabilization of a mental illness.

Providers or facilities offering Behavioral and Mental Health treatment must be qualified to treat mental illness. Some services require **Prior Approval** by NMHC.

Please refer to your Summary of Benefits and Coverage for level of Covered Services.

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 for which no standard cancer treatment exists or more effective standard cancer 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 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: (a) One of the federal National Institutes of Health; (b) A federal National Institute of Health Cooperative Group or center; (c) The United States Food and Drug Administration in the form of an investigational new drug application; (d) The United States Department of Defense; (e) The United States Department of Veteran Affairs; or (f) 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 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 (a) 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; (b) Agree to accept reimbursement as payment in full from NMHC and that is not more than the level of reimbursement applicable to other similar services provided by the In-Network Providers within our provider network; (c) 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; and 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.

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 of Insurance and 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 of Insurance.

For the purposes of this specific Covered Benefit and Service, the term "Routine Patient Care Cost" means:

- A medical service or treatment that is a benefit under the Plan that would be covered if the patient were receiving standard cancer treatment; or
- 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:

- The cost of an investigational drug, device, or procedure;
- The cost of a non-healthcare service that the patient is required to receive as a result of participation in the clinical trial;
- Costs associated with managing the research that is associated with the clinical trial;
- Costs that would not be covered by the patient's if non-investigational treatments were provided; or
- Costs paid or not charged for by the clinical trial Providers.

Childhood Immunizations
This Plan provides coverage for childhood immunizations, as well as coverage for Medically Necessary booster doses of all immunizing agents used in child immunizations, in accordance with the current schedule of immunizations recommended by the American Academy of Pediatrics.

Chiropractic Care
Chiropractic Care must be provided by a licensed Provider unless covered services are unavailable in your area and prior approval is received to see an out-of-network provider. Services must be appropriate for the treatment of a condition that is covered by the Plan. Coverage is limited to twenty (20) visits per Calendar Year. Chiropractic services that are habilitative or rehabilitative require prior approval and are not subject to the visit limitation. Please refer to your Summary of Benefits and Coverage for your Cost-Sharing (Deductible, Coinsurance, Copayment) amount.

Circumcision of Newborn Males
The Plan will cover circumcision of newborn males whether the child is natural or adopted or in a "placement for adoption" status.

Colorectal Cancer Screening
The Plan will provide coverage for colorectal screenings to determine the presence of precancerous or cancerous conditions and other health problems.

Compression Garments
The Plan covers gradient or graduated compression garments as Medically Necessary when prescribed by a contracted physician for the treatment of a medical Condition. Such Conditions may be lymphedema, varicose veins, deep vein thrombosis or venous ulcers. The garments must be obtained from A qualified Provider. Garments that are/or can be obtained over the counter, or without a prescription are not covered. Replacement of a covered garment is limited to once every six (6) months.

Consumable Medical Supplies
Consumable medical supplies are only covered during hospitalization, an office visit, or an approved home health visit. The Plan does not cover these supplies when used at other times by the Member or Member's family.

Consumable medical supplies are supplies that:
- Are usually disposable;
- Cannot be used repeatedly by more than one person;
- Are normally used for a medical purpose;
- Are generally useful only to a person who is ill or injured;
- Are ordered or prescribed by a licensed and qualified Provider.

Coverage for Individuals Participating in Approved Clinical Trials
Members are eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either (1) the referring healthcare professional is A qualified provider and has concluded that the member's participation in such trial would be appropriate; or (2) the member provides medical and scientific information establishing that the member's participation in such a trial would be appropriate.

NMHC may not deny an eligible member's participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. NMHC may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial. NMHC may not discriminate against the individual on the basis of the individual's participation in the trial.

Craniomandibular Joint (CMJ) and Temporomandibular Joint (TMJ) Dysfunction Conditions
The Plan provides coverage for surgical and non-surgical treatment of temporomandibular joint disorders and craniomandibular disorders, subject to the same conditions, limitations, and prior review procedures that apply to treatment of any other joint. The Plan does not cover orthodontic treatment and appliances, crowns, bridges, and dentures used for treatment of these disorders unless the disorder is caused by trauma.

Dental Services
This Plan will cover the following Medically Necessary dental services, when **Prior Approval** is obtained:
- An accidental injury from an outside force to sound, natural teeth, the jawbones or surrounding tissues. A sound tooth is a tooth that does not have significant decay or prior trauma such as a filling, cap or crown. Any services required after the initial treatment must be accident in order to be covered (unless treatment must be delayed due to dental necessity as determined by NMHC).
- For coverage of accidental injury of the teeth, the member should receive initial treatment within ninety (90) days of the accident and completion of treatment within one hundred eighty (180) days. Subsequent covered treatment can be extended to twelve (12) months from the accident date if it is determined to be medically necessary to occur within this time period. Coverage for services will not be extended beyond twelve (12) months from the accident date.

- Treatment of tumors and cysts that require pathological examination of the jaws, cheeks, lips, tongue, or the roof and floor of the mouth.
- Hospitalization and general anesthesia for dental services provided in a hospital or ambulatory surgical center when Medically Necessary or:
    - The Member exhibits a physical, intellectual or medically compromising condition 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;
    - Local anesthesia is ineffective for the Member due to an acute infection, anatomic variation or allergy;
    - The Member is a Covered dependent child age nineteen (19) or younger who is 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;
    - The Member has extensive oral, facial, or dental trauma for which treatment under local anesthesia would be ineffective or compromised; or
    - Other dental procedures for which hospitalization or general anesthesia in a hospital or ambulatory surgical center is Medically Necessary.

Copayments, Coinsurance, and Deductible amounts listed in your Summary of Benefits and Coverage will apply. Routine dental care is not covered by your Plan.

Diabetes Supplies and Treatment
The Plan covers Diabetic Supplies and Treatment when used to treat insulin dependent diabetes, non-insulin dependent diabetes, or high blood glucose levels induced by pregnancy subject to Plan cost-sharing amounts. Examples of treatment and supplies include:
- Blood glucose monitors, including those for the legally blind;
- Test strips;
- Visual reading urine and ketone 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, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; Podiatric appliances require Prior Approval to determine medical necessity;
- Physician visits and post-diagnosis follow-up care;
- Syringes.

When prescribed or diagnosed by a healthcare practitioner, all individuals with diabetes shall be entitled to diabetes self-management training provided by a certified, registered, or licensed healthcare profession with recent education in diabetes management, limited to:
- Medically Necessary visits upon diagnosis of diabetes;
- Visits following a physician diagnosis that represents a significant change in the patient's symptoms or conditional that warrants changes in the patient's self-management;
- Visits for re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and
- Medical nutrition therapy related to diabetes management.

When new or improved equipment, appliances, and prescription drugs for the treatment of diabetes, insulin or supplies for the treatment of diabetes are approved by the food and drug administration, NMHC shall maintain an adequate formulary to provide these resources to individuals with diabetes; and cover equipment, appliances, insulin or supplies within the limits of a Member's plan.

Contact the Customer Care Center for questions regarding these requirements.

Diagnostic Services
Laboratory, x-ray, and other diagnostic tests are covered when Medically Necessary. Some services require **Prior Approval** by NMHC.

Dialysis Services

The plan covers acute and chronic dialysis services including renal dialysis (hemodialysis) and continuous ambulatory peritoneal dialysis (CAPD) by approved dialysis providers.

Durable Medical Equipment (DME)
DME is covered when it is **Prior Approved** by NMHC.

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

Some exclusions and limitations to DME coverage:
- Coverage is for medically appropriate equipment only, and does not include special features, upgrades or equipment accessories unless Medically Necessary;
- The Plan covers the rental or purchase of Medically Necessary DME, including repair and adjustment of DME. We will not cover repairs that exceed the purchase price. 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 is be at the discretion NMHC;
- NMHC follows guidelines established by Medicare for the lifetime of DME. Equipment is expected to last at least five (5) years;
- Replacement due to loss, theft, misuse, abuse, or destruction is not covered. The Plan does 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, or new and improved equipment becoming available. The Plan does not cover duplicate or extra DME for the purpose of member comfort, convenience, or travel.

Enteral Nutrition Products
The Plan covers enteral nutrition products and related DME and supplies required to deliver the Medically Necessary enteral nutrition. The enteral nutrition must be prescribed by a physician; administered via tube feeding; and must be the primary source of nutrition for the member. The Plan does not cover oral nutrition products even when prescribed or administered by a physician.

Foods obtained from a grocery store or internet provider will not be covered as Special Medical Foods.

External Prosthetic Appliance (EPA)
The Plan covers EPA that is necessary to accomplish ordinary activities of daily living. EPA requires **Prior Approval** by NMHC. 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 following exclusions and limitations apply to EPA coverage:
- The Plan covers EPA for K1-3 ambulators. EPA for Level 0 or Level 4 ambulators are not covered;
- This Plan covers replacement of EPA if it is needed due to normal body growth or for changes due to illness or injury;
- The Plan follows Medicare guidelines to determine the lifetime of EPA;
- The Plan covers 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 it is Medically Necessary as determined by NMHC;
- Repair or replacement of EPA is not covered if due to loss, theft, or destruction;
- The Plan does not cover duplicate or extra EPA for Member convenience or comfort.

New Mexico Family, Infant, and Toddler (FIT) Program
For covered children under age three who are also eligible for services under the New Mexico Department of Health's (DOH) Family, Infant and Toddler (FIT) program, as defined in 7.30.8, NMAC, your NMHC Plan will reimburse the DOH for certain Medically Necessary early intervention services that are provided as part of an individualized family service plan under the FIT program by personnel who are licensed and certified for the DOH's FIT program. The maximum reimbursement under the NMHC Plan is limited to $3,500 per year.

However, amounts paid to DOH for such services are not included in any annual or lifetime benefit maximums under this Plan. Claims for services payable to the DOH under this provision will be honored only if submitted to NMHC by the New Mexico DOH.

Family Planning Services
Family Planning Services are covered by the Plan. Some covered services include contraceptive counseling and contraceptive drugs or devices approved by the Food and Drug Administration (FDA). Many FDA approved contraception methods are covered at no cost to you. NMHC must cover, without-cost sharing, at least one form of contraception in each of the methods (currently 18) that the Food and Drug Administration has identified for women in its current Birth Control Guide. This coverage must also include the clinical services, including patient education and counseling, needed for provision of the contraceptive method.

Growth Hormone Therapy
Growth Hormone Therapy may be covered if an endocrinologist provides medical records that support the request for the Growth Hormone Therapy. Therapy must be for a medical diagnosis covered by the Plan. This Plan does not cover growth hormone treatment for children with idiopathic short stature.

Habilitative Services
Healthcare 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. Services require Prior Approval after ten (10) visits.

Hearing Aids for Dependent Children
The Plan covers hearing aids and the evaluation for the fitting of Hearing Aids only for Dependent children up to age eighteen (18), or up to age twenty-one (21) if still attending high school.

NMHC will cover one hearing aid per hearing impaired ear every thirty-six (36) months for dependent children under eighteen (18) years old (or under twenty-one [21] years of age if still attending high school). Refer to your Summary of Benefits and Coverage for your Cost-Sharing (Deductible, Coinsurance, Copayment) amount.

Covered services include fitting and dispensing fees, and ear molds, as necessary to maintain optimal fit of the hearing aids. Services must be provided by an audiologist, hearing aid dispenser, or physician.

Hearing Care
Hearing exams are covered when they are used to diagnose and treat ear injuries or diseases of the ear. Routine hearing screenings from a Primary Care Practitioner are covered for Members up to age eighteen (18).

Home Health Care Services
Home Health Care services are covered for a member that is confined to the home, and that requires Skilled Care and is unable to receive medical care on an Ambulatory outpatient basis. Home Health Care services must be provided on the written order of a licensed physician, provided such order is renewed at least every sixty (60) days. Services must be delivered by a licensed and qualified Provider. Home Health visits are limited to one hundred (100) four (4) hour visits per Member, per year.

Home health services include:
- Visits from professional nurses including but not limited to registered nurses, licensed professional nurses, and other
- In-Network 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 approved home health visit;
- Covered Drugs prescribed by a qualified Provider for the duration of Home Health Services; and
- Laboratory services.

Physical, occupational, respiratory, and speech therapy provided in the home will be covered when Prior Approval is obtained from NMHC. These are limited to services provided on the written order of a Physician.

Home Health Care Services/Home Intravenous Services and Supplies Exclusions
This Plan does not cover:
- Private duty nursing is not Covered.

- Custodial Care needs that can be performed by non-licensed medical personnel to meet the normal activities of daily living do not qualify for Home Health Care Services and are not Covered. Examples of Custodial Care that are not Covered include, but are not limited to, bathing, feeding, preparing meals, or performing housekeeping tasks.

Hospice Care Services
Services must be provided by an approved Hospice program during a Hospice benefit period and will not be Covered to the extent that they duplicate other Covered Services available to you. Benefits that are provided for by a Hospice or other facility require approval by your Practitioner/Provider and our Prior Approval.

The Hospice benefit period is defined as follows:
- Beginning on the date your Practitioner/Provider certifies that you are terminally ill with a life expectancy of six months or less.
- Ending six months after it began, or upon, your death.
- You must be a Covered Member throughout your Hospice benefit period.
- Outpatient Hospice Care benefit has a lifetime limit of 100 visits.
- In-patient Hospice Care benefit has a lifetime limit of 14 days.

The following services are Covered:
- Inpatient Hospice care
- Practitioner/Provider visits by Certified Hospice Practitioner/Providers
- Home Health Care Services by approved home health care personnel
- Physical therapy
- Medical supplies
- Prescription Drugs and Medication for the pain and discomfort specifically related to the terminal illness

Exclusions
This Plan does not cover:
- Food, housing, or delivered meals
- Homemaker and housekeeping services
- Comfort items
- Private duty nursing
- Supportive services provided to the family of a Terminally Ill Patient when the members benefit has ended.
- Respite care defined as care that provides relief for the care-giver.)

Where there is not a certified Hospice program available, regular Home Health Care Services benefits will apply.

Illness and Injury
The Plan will cover Primary care and Specialist services for the diagnosis and treatment of an illness or injury.

Implanted Medical Devices
Implanted medical devices must receive **Prior Approval** from NMHC. They must be ordered by a qualified 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. The Plan will also cover the cost for repairs or maintenance of covered appliances.

Infertility Treatment
The Plan will cover the diagnosis and treatment of a physical condition causing infertility, with limitations. Please refer to the Exclusions section of the Evidence of Coverage for more information regarding exclusions. Infertility services are covered only when provided by an In-Network, Participating Provider. Please refer to the *Exclusions* section of this Evidence of Coverage for services that are not covered. Benefits related to infertility are limited to testing, diagnosis, and corrective procedures.

Inpatient Acute-Care Hospital Services
Inpatient hospital services require **Prior Approval** from NMHC. Services include the treatment and evaluation of conditions for which outpatient care would not be appropriate.

Inpatient Long-Term Acute Care Hospital Services

Long Term Acute Care hospitals provide longer-term inpatient care that cannot be treated at a facility with a lower level of care. Such services may include pulmonary care, advanced wound care, and critical care. Stays at a Long-Term Acute Care (LTAC) hospital require **Prior Approval** from NMHC.

Inpatient Rehabilitation Hospital Services
Inpatient services at an acute rehabilitation facility are covered by the Plan. Services require **Prior Approval** from NMHC and must be rendered by a licensed and qualified Provider.

Internal Prosthetics
Internal prosthetics and/or medical appliances are covered when ordered by a Physician and require **Prior Approval** from NMHC.

Jaw or Facial Surgery
Surgery must be for the correction of a significant functional disorder. Skeletal deformities must be the result of an accidental injury, a congenital or developmental defect, or disease of the jaw and/or facial bones. Dental procedures, orthodontic braces, and surgery to improve appearance or other services determined to not be Medically Necessary are not covered under the Plan.

Maternity Care
Your Plan covers maternity services, including pre and postnatal care. Care received during the postpartum period for a normal delivery, spontaneous abortion (miscarriage), and complications of pregnancy are also covered by the Plan. Coverage for the mother is for at least forty-eight (48) hours of inpatient care following a vaginal delivery and at least ninety-six (96) hours following a Cesarean section. A decision to reduce the period of inpatient care for the mother or the newborn child must be made by the attending physician, and in consultation with the mother.

If a decision is made to reduce the hospital stay to less than forty-eight (48) hours for a vaginal delivery, or less than ninety-six (96) hours for a Cesarean section, the Plan provides coverage for at least three (3) home care visits. If the attending physician or home care provider and the mother agree that fewer visits are sufficient, the number of visits can be reduced. Home care may include parental education, assistance and training in breast and bottle-feeding, and the administration of any appropriate clinical tests. Home Births are not covered by your Plan. Refer to the *Exclusions* section of this Evidence of Coverage for more information.

Maternity Transport
The Plan covers ground and/or air transport to the nearest available and licensed Healthcare Facility for medically high-risk pregnant women with an impending delivery of a potentially viable infant. The Plan also covers transport to the nearest available tertiary care facility when it is necessary to protect the life of the infant.

Morbid Obesity Treatment
Morbid Obesity is defined as a condition of weighing one hundred (100) pounds over a person's ideal body weight. The Plan covers surgical treatment for morbid obesity if it is Medically Necessary and if defined medical criteria are met. Criteria varies dependent upon the type of surgery. NMHC utilizes Interqual and Hayes Technology Manual for this criteria. Services require Prior Approval from NMHC. One new surgical procedure per Member, per lifetime is covered by the Plan. Treatment for the maintenance of, or Medically Necessary reversal of a previously obtained surgical procedure may be covered with Prior Approval from NMHC.

Newborn and Adopted Children Coverage
Newly born and adopted children of a Member are covered from the moment of birth or adoption if the newborn or adopted child is enrolled on the Plan within thirty-one (31) days of the birth or placement for adoption. Please refer to the *Enrolling in the Plan* section of this Evidence of Coverage for more information.

The Plan covers injury or sickness in 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 Evaluation
The Plan covers dietary evaluations and counseling for the medical management of a disease, including obesity. Services must be obtained from a licensed and qualified provider or a registered dietician. Refer to the *Exclusions* section of this Evidence of Coverage for more information.

Orally Administered Anti-Cancer Medications

This Plan provides coverage for orally administered anti-cancer medication used to slow or kill the growth of cancerous cells. Coverage of these medications are subject to the same Prior Approval requirements as intravenously administered injected cancer medications covered by the Plan. Orally administered medications cannot cost more than intravenously injected equivalent and intravenously injected medications cannot cost more than orally administered medications.

Organ Transplant Services
The Plan covers human organ, tissue transplant services when **Prior Approval** is obtain from NMHC, and services are received from recognized Centers of Excellence facilities within the United States.

The recipient of an organ transplant must be a Member at the time of services. Benefits are not available when the Member is a donor. Benefits are not available if the recipient is not a Member. The term recipient is defined to include a Member receiving approved 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 Evidence of Coverage.

Definition of Transplant Services
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/stem cell, heart, heart/lung, liver and pancreas.

Prior Approval
Transplant services require **Prior Approval** from NMHC. Prior Approval is based on an evaluation conducted by a Plan-approved transplant facility and on the relevant evidence-based medical guidelines.

A member may seek approval 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 approved, payment will be made to only one facility for the actual transplant event.

Organ Procurement Costs
The Plan covers 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 organ 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 NMHC.

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 Prior-Approved organ/tissue transplant from a Plan approved Provider. Transplant Travel requires **Prior Approval** from NMHC.

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, domestic partner, a family member, a legal guardian, or any person not related to the Member but actively involved in the Member's care.

The following are specific travel expenses travel expenses 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 covers inpatient immunosuppressive drugs for organ transplants. Outpatient immunosuppressive Prescription Drugs may be covered. Please refer to your Summary of Benefits and Coverage and Prescription Drug Formulary for information regarding your Outpatient Prescription Drug Benefits.

Outpatient Hospital or Ambulatory Surgical Procedures
Your Plan covers outpatient hospital and/or ambulatory surgical procedures including operating, recovery and other treatment rooms, physician and surgeon services, laboratory and pathology services, pre-surgical testing, anesthesia and medical supplies. Services must be prescribed by your Primary Care Practitioner or attending healthcare 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, and must be practicing under authority of the Healthcare Insurer, the medical group, an independent practice association or other authority as applicable by New Mexico law. **Prior Approval** is required.

Outpatient Prescription Drugs
NMHC offers a formulary or preferred drug list for all benefit plans. The NMHC pharmacy benefit is provided and managed by OptumRx, one of the industry's largest and most experienced Pharmacy Benefit Managers (PBM) with retail locations all over the United States and a mail-order service.

Pharmacy & Therapeutics Committee
The NMHC formulary and the policies and procedures regarding managing the formulary are reviewed and approved by the OptumRx Pharmacy & Therapeutics (P&T) Committee on NMHC's behalf. The P&T Committee is comprised of actively practicing physicians, actively practicing pharmacists and other licensed healthcare professionals. P&T Committee members exercise their professional judgment in making determinations based on clinical and scientific evidence and analyses. The P&T Committee reviews the formulary and policies annually, and updates occur as information from the Food and Drug Administration (FDA), Centers for Medicare & Medicaid Services (CMS), or when sound clinical evidence becomes available.

In its evaluation, review, guidance and clinical recommendations, the P&T Committee shall:
- Make recommendations on the therapeutic placement and appropriate prescribing guidelines for prescription drug products, and as appropriate, medical device products, intended for use in an ambulatory care setting;
- Provide ongoing review and monitoring of the safety, effectiveness and quality of care of products contained within the formulary and in NMHC's clinical programs;
- Initiate and/or review recommended Drug Utilization Review and Drug Use Evaluation programs;
- As necessary, review, advise and approve utilization management guidelines, including prior approval, step therapies and quantity limits;
- Advise NMHC on suitable educational programs (e.g., for healthcare provider networks, Plan Participants, and pharmacy providers); and
- Make recommendations for the implementation of effective product utilization control procedures.

In addition to making clinical recommendations to the formulary, the P&T Committee shall provide information to medical, healthcare and related pharmacy benefit professionals on matters pertaining to the clinical management of prescription drug and medical device usage by:

- Establishing policies and procedures to educate and inform healthcare professionals about products, product usage, and the P&T Committee's clinical recommendations;
- Overseeing quality improvement programs that employ product use evaluation;
- Providing recommendations for implementation of generic substitution and therapeutic interchange programs based upon clinical and medical analysis and assessment; and
- Evaluating, analyzing and reviewing protocols for the use of and access to non-Formulary products.

Additional responsibilities may be established and delegated to the P&T Committee, as determined by the Chief Medical Officer.

NMHC Formulary
The P&T Committee maintains the formulary for outpatient medications, which may be prescribed by an NMHC provider without Prior Approval. The NMHC formulary is a closed formulary, meaning that not all drugs are covered by the plan. NMHC providers are required to use formulary medications whenever medically appropriate.

Specialty medications may be received from Briova. Briova is OptumRx's preferred Specialty Pharmacy and only provides mail service for specialty medications. For non-specialty medications, mail order services are provided by OptumRx Home Delivery. Briova Specialty Pharmacy provides clinical support services to members who require use of these medications and

provides home delivery service. Specialty medications may also be filled at certain retail pharmacies, when appropriate. Specialty medications, typically, require prior approval from NMHC.

Pharmacists will not fill prescriptions for NMHC members for non-formulary drugs unless an approval has been received fromOptumRx. Limits and quotas on drugs are set as needed by the P&T committee based on best medical evidence and communicated to providers through regular provider updates such as newsletters or other communications.

NMHC's formulary is available on our website at www.mynmhc.org/Formulary.aspx. If you need assistance with the formulary or in obtaining Approval, call OptumRx at 1-855- 577-6550. Formulary exceptions (requests for drugs not on our formulary) are processed by OptumRX based on medical necessity.

Covered medications include:

- Up to a thirty (30)-day supply of drugs requiring a prescription under state or federal law;
- Up to a ninety (90)-day supply of drugs when purchasing through the mail order program or retail pharmacy requiring a prescription under state or federal law;
- Generic drug coverage at no cost for Hypertension, Depression, Bipolar Disorder, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Hypercholesterolemia, Diabetes, Congestive Heart Failure, and Asthma;
- Specialty Medications when NMHC clinical criteria guidelines are met.

The prescription drug Benefits for NMHC members are listed on the member ID card. For member convenience, we also offer a mail-order prescription service for ongoing maintenance medications.

Prescription Synchronization

NMHC allows its members to fill or refill a prescription for less than a 30-day supply and applies a pro-rated copay/coinsurance for the fill/refill when determined by the prescriber or pharmacist to be:

- In the best interest of the member
- The member requests or agrees to receive less than a 30-day supply of medication
- The reduced fill is made for the purpose of synchronizing the member's drug fills

NMHC will pay a full pharmacy dispensing fee for partially-filled prescription medications pursuant to prescription synchronization services.

Exclusions, including but not limited to:

- Non-prescription drugs (unless specifically listed on the formulary);
- Compounded medications filled by a non-credentialed pharmacy;
- Bulk chemicals used in compounds
- Compounding kits
- Drugs purchased at a pharmacy that are not in the NMHC Pharmacy Network (unless as emergency);
- Early refills, based upon the directions supplied by your provider. Vacation fills are handled on a case-by-case basis and are generally limited to two vacation fills per rolling calendar year;
- Infertility drugs;
- Drugs used to treat sexual dysfunction;
- Drugs or drug combinations not approved by the Food and Drug Administration (FDA);
- Medications excluded by regulation as described by the Centers for Medicare & Medicaid Services (CMS);
- Personal care items;
- Drugs used for Cosmetic purposes;
- Appetite suppressants/weight control drugs,, dietary supplements, prescription vitamins (other than prenatal);
- Experimental/investigational/unproven drugs.

Formulary Changes

In-Network practitioners may request the addition of a product to the formulary by submitting a request along with any supporting information to the NMHC Medical Management Team. The request will be presented at the subsequent Pharmacy & Therapeutics Committee for review and consideration. The P&T Committee decision will be provided to the requesting practitioner within fifteen (15) days following the P&T Committee meeting.

Formulary Exceptions, Prior Approvals, and Appeals

All requests for approval of formulary exceptions should be sent to OptumRx by the prescribing physician. In most cases, the review and approval/denial of formulary exceptions will be executed as expeditiously as possible, but generally will not take longer than 3 business days for a non-urgent request. Our procedures include an expedited process for exigent (immediate) circumstances that requires a health plan to make its coverage determination within no more than 24 hours after it receives the

request and that requires a health plan to provide the drug for the duration of the exigency However, requests for coverage of a non-formulary drug will be made within twenty-four (24) hours of receiving an expedited request or seventy-two (72) hours of receipt of a non-expedited request. NMHC provides coverage for the non-formulary drug during a prior approval review period. Otherwise, NMHC does not reimburse members for non-formulary drugs.

Prospective review procedures and guidelines for formulary exceptions are developed and updated by and in conjunction with the NMHC P&T Committee and other specialist providers who have agreed to work with NMHC and OptumRx to provide expert guidance. In the event that a request for a coverage determination cannot be approved with the available clinical information, the prescriber and the member are notified telephonically and in writing of the coverage determination. The written notification to the provider and the member will contain the rationale for the determination and a description of the appeal process. Additionally, the drug use by NMHC members is reviewed to determine if use is appropriate, safe, and meets current medication therapy standards.

The prescribed drug will be considered for coverage under the pharmacy benefit program when the following criteria are met:

- A formulary alternative is not appropriate for this patient (e.g., patient has a contraindication or intolerance to the formulary alternative, etc.);
- The medication is being prescribed for an FDA approved indication OR the patient has a diagnosis which is considered medically acceptable in the approved compendia* or a peer-reviewed medical journal; and
- The patient does not have any contraindications or significant safety concerns with using the prescribed drug.

A lifetime approval will be granted for patients who meet the above criteria. If the patient does not meet the above criteria, the prescribed use is considered experimental/investigational for conditions not listed in this section of the Evidence of Coverage.

*The approved compendia includes:

- American Hospital Formulary Service (AHFS) Compendium;
- Thomson Reuters (Healthcare) Micromedex/DrugDex (not Drug Points) Compendium;
- Elsevier Gold Standard's Clinical Pharmacology Compendium;
- National Comprehensive Cancer Network Drugs and Biologics Compendium,

Generic Substitutions

A generic drug is a chemically and pharmaceutically equivalent (equal) version of a brand-name drug whose patent has expired. A generic drug meets the same FDA standard for bio-equivalency that brand-name drugs must meet. However, a generic drug is usually less costly. Your pharmacist will substitute a generic drug for you automatically when one is available, even if your provider writes a prescription for the brand drug. If the generic drug does not meet your needs, your provider can start a pharmacy exception. You may then receive the brand drug, depending on the drug's clinical criteria and if NMHC approves the exception.

Therapeutic Interchange

Many drugs work the same way and have the same Benefits. Therapeutic interchange is the practice of substituting one drug for another (a therapeutic alternative) when both drugs have the same therapeutic effects. This substituted drug is called the therapeutic alternative. When you get your prescription filled, your pharmacist will tell you if a therapeutic alternative has been made for you. The pharmacist can do this only with your provider's approval.

Step Therapy

Step therapy is the practice of treating a patient first with the least costly drug. If that drug does not work for the patient, the provider will prescribe higher-cost drugs or therapies, if medically necessary. Step therapy applies only to certain drugs. NMHC has criteria for step therapy that helps to decrease the practice of prescribing the most costly drug when a less costly drug may work just as well. OptumRx, our pharmacy benefit manager, will need information from your provider if there is a medical reason that you cannot complete all of the "steps" in the process before moving to the more costly drug.

Online Tools

NMHC Members and Providers are encouraged to use online tools available at www.optumrx.com/mycatamaranrx.com. Some actions a member or provider may perform online include:

- Determine copay or coinsurance amount for a medication;
- Initiate the exception process;
- Order a refill for an existing, unexpired mail order prescription;
- Locate In-Network pharmacies;
- Determine potential drug interactions or side effects;
- Look for generic substitutes.

Physician Office Visits
Services received in a physician's office may include treatment of an injury or illness, and even some minor surgical procedures. These services may be provided by a Primary Care Practitioner or a Specialist.

Podiatry
Foot care, orthopedic shoes, arch supports, foot orthotics, and shoe lifts and wedges. However, foot care, including all routine services such as the treatment of flat foot conditions, supportive devices, accommodative orthotics, orthopedic shoes unless jointed to braces, partial dislocations, bunions except capsular or bone surgery, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet and the trimming of corns, calluses, or toenails are not covered by the Plan unless Medically Necessary due to diabetes or other significant peripheral neuropathies for the treatment of a medical Conditions such as diabetes.

Preventive Care Services
Age and gender specific preventive care and periodic health exams are covered by the Plan. Some examples of preventive care services are adult and child immunizations; annual physicals for men, women and children, educational materials or consultations from providers to promote a healthy lifestyle, glaucoma (periodic) eye tests for all persons up to age thirty-five (35) years, hearing screenings (for Members up to age nineteen [19] and under) limited, laboratory tests listed as an A or B recommendation by the U.S. Preventive Services Task Force, colorectal cancer screenings, radiological (periodic) tests, vision screenings performed by a Primary Care Practitioner for Members up to age nineteen [19], and well-baby and well-child care including immunizations.

Although the A or B recommendations by the U.S. Preventive Services Task Force are covered at no charge for Preventive Care services , you may be charged office visit cost-sharing for other services provided during your visit. NMHC may not impose cost-sharing with respect to anesthesia services performed in connection with a preventive colonoscopy if the attending provider determines that anesthesia would be medically appropriate for a member.

A member's attending provider may determine whether a sex-specific recommended preventive service that is required to be covered without cost sharing, under the Affordable Care Act and its implementing regulations, is medically appropriate for a particular individual. For example, providing a mammogram or Pap smear for a transgender man who has residual breast tissue or an intact cervix (and the individual otherwise satisfies the criteria in the relevant recommendation or guideline as well as all other applicable coverage requirements), NMHC provides coverage for the recommended preventive service, without cost sharing, regardless of sex assigned at birth, gender identity, or gender of the individual otherwise recorded by NMHC.

For a complete list of Preventive Care services, please visit the U.S. Preventive Services Task Force website at www.uspreventiveservicestaskforce.org.

Reconstructive Surgery
This Plan will cover Medically Necessary reconstructive surgery when needed for the correction of a functional disorder resulting from accidental injury or from a congenital defects or disease. Services require Prior Approval, and an improvement in physiologic function must be reasonably expected.

Routine Physical Exams
Routine physical exams are covered one (1) time per year.

Second Opinions
Second Opinions are covered according to your Plan Benefits.

Short-Term Rehabilitation Therapy
Short-Term Rehabilitation Therapy may include physical, speech, occupational, cardiac, and pulmonary therapy. These therapies are covered when NMHC has determined that they are expected to result in significant improvement of a Member's physical condition within two (2) months of beginning therapy. 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. Services require **Prior Approval** after ten (10) visits.

Skilled Nursing
Inpatient services at a skilled nursing facility must be Prior Approved and furnished by a licensed and qualified Provider. Covered Services are limited to sixty (60) days/visits per year as stated in the Summary of Benefits and Coverage and may 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 Treatment
Quitting smoking isn't easy, but we are here to help. If you want to quit smoking, call the state's Quit Line at 1-800-QUITNOW (1-800-784-8669). The Quit Line:

- Is open from 6 a.m. to 10 p.m., 7 days a week;
- Provides services in Spanish and English, with translation available for other languages;
- Provides services for youth and adults;
- Is free of charge; and
- Is staffed by cessation specialists trained in serving diverse populations.

Callers are offered:

- A self-paced guide to walk through the steps of quitting;
- Comprehensive information on methods to promote quitting success;
- An individualized quit plan;
- Free Quit Kits to help participants stay on track with their quit plan between calls; and
- Unlimited telephone support, including optional follow-up calls from help line specialists.

The Plan also covers with no charge:

- Screening for tobacco use; and,
- For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
    - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
    - All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

Please talk to your Primary Care Practitioner about your desire to quit smoking.

Special Medical Foods for Genetic Inborn Errors of Metabolism
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;
- Specifically processed or formulated to be distinct in one or more nutrients that is present in natural foods;
- Formulated to be consumed or administered internally; and
- Essential for optimal growth, health and metabolic homeostasis.

Special medical foods must be obtained from a qualified Vendor or Provider and must be prescribed by a physician for the treatment of an inborn error of metabolism.

The Plan will cover enteral nutrition products and related DME and supplies required to deliver the Medically Necessary enteral nutrition. The enteral nutrition must be prescribed by a physician and administered via tube feeding, and must be the primary source of nutrition for the member. The Plan does not cover oral nutrition products even when prescribed or administered by a physician.

Substance Abuse Services
Your Plan covers alcohol and substance abuse treatment. Covered services may include alcohol and drug abuse detoxification; partial hospitalization; and rehabilitation services. Except in a life-threatening emergency, alcohol and substance abuse admissions must be **Prior Approved** by NMHC.

Vision Care
Eye exams are covered to diagnose and treat eye injuries or disease. The Plan will pay for contact lenses when Medically Necessary for the treatment of keratoconus (adults and children). The Plan will also pay for the first pair of contact lenses after Medically Necessary cataract surgery.

Pediatric Vision Care. Vision screenings are covered for Members through the end of the month in which the child turns nineteen (19). Please refer to Exhibit A at the end of this Agreement for benefit coverage and details.

Well-Child Care

Well-Child and well-baby medical care, including immunizations are covered by the Plan. These preventive care services are covered at no charge; however, if other services are received during an office visit in which well-child or well-baby care is administered, cost-sharing may apply.

Women's Healthcare

Some covered services related to women's healthcare include, but are not limited to:

- 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 mammogram biennially to persons age forty (40) up to fifty (50), and one mammogram annually to persons age fifty (50) and over;
- Cytologic Screenings (Pap tests) for women ages eighteen (18) and older for determining the presence of precancerous or cancerous Conditions and other health problems, or where clinical conditions warrant, non-routine Pap testing in females under the age of 18;
- Screening and vaccine for Human papillomavirus (HPV). An HPV screening is allowed once every three (3) years for women age thirty (30) and older. The HPV vaccine is available for girls age nine (9) to fourteen (14) 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;
- Services related to the diagnosis, treatment, and appropriate management of osteoporosis when Medically Necessary;
- Breast and Ovarian cancer genetic testing and genetic counseling based on family history;
- Screening for gestational diabetes;
- Counseling for HIV and 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 Dependents age thirteen (13) or older; and
- Termination of pregnancy.

SERVICES YOUR PLAN DOES NOT COVER (EXCLUSIONS)

Services that are not described in the *What Is Covered by the Plan?* section may not be covered by this Plan. If services are Medically Necessary and you are unsure of Plan coverage, contact the Customer Care Center at 1-855-7MY-NMHC.

Services and Benefits excluded from coverage under this Plan are listed below.

Amniocentesis, ultrasound, or any other procedures requested solely to determine the gender of a fetus, unless Medically Necessary to determine the existence of a gender-linked genetic disorder, are not covered by the Plan.

Any treatments, procedures, services, equipment, drugs, drug usage, devices or supplies that NMHC Medical Director determines are not Medically Necessary unless Prior Approval is obtained from NMHC are not covered.

Artificial aids, including but not limited to hearing aids and devices or computers to assist in communication or speech, except as required by law are not covered by the Plan.

Assistance in the activities of daily living, such as eating, bathing, and dressing are not covered by the Plan.

Autopsies and/or transportation costs for deceased Members are not covered by the Plan.

Benefits and services not specified in the *What Is Covered by the Plan?* section of this Evidence of Coverage or in your Summary of Benefits and Coverage are not covered by the Plan.

Care related to complications for a non-covered surgery in general, are not covered by the Plan.

Certain Services related to the treatment of mental illness and substance abuse conditions are not covered by the Plan. These excluded services include, but are not limited to, the following:

- Any court-ordered treatment or therapy, or any treatment or therapy ordered as a Condition of parole, probation or custody or visitation evaluations unless Medically Necessary and covered under the *What Is Covered by the Plan?* section of this Evidence of Coverage;
- Treatment of organic mental disorders associated with permanent dysfunction of the brain; developmental disorders, including but not limited to, developmental reading disorders, developmental delay and articulation disorder;
- Treatment, therapies, counseling, programs, or activities of an educational nature;
- Treatment, therapies, counseling, programs, and activities for borderline intellectual functioning;
- Treatment, therapies, counseling, programs, and activities for occupational problems or vocational or religious counseling;
- Treatment, therapies, counseling, programs, and activities related consciousness raising;
- Intelligence Quotient (IQ) testing;
- Residential treatment center (RTC), Group Home, Treatment Foster Care (TFC), Day Treatment, Multisystemic Therapy (MST), Family Stabilization (FST), and Comprehensive Community Support Services (CCSS);
- Services that are considered experimental and/or are not generally accepted by the medical community or proven to be safe and effective;
- Therapeutic schools and programs, including but not limited to wilderness and other experimental programs; and
- Psychological testing on children requested by or for a school system, unless Medically Necessary.

Charges that exceed Usual, Customary, and unreasonable Charges are not covered by the Plan.

Complementary and alternative (CAM) treatments, including but not limited to aromatherapy, massage therapy, and hypnotherapy are not covered by the Plan.

Conditions for which state or local law mandates treatment in a public facility, or court-ordered services are not covered by the Plan. These are not covered unless they are ordered by the treating physician and approved by the Plan.

Cosmetics and health and beauty aids are not covered by the Plan.

Cosmetic therapy, drugs/medications or procedures for the purpose of changing appearance are not covered by the Plan. Examples of these services are:

- Surgical excision or reformation of sagging skin on any part of the body including, but not limited to, eyelids, face, neck, abdomen, arms, lips, or buttocks, unless medically necessary;
- Services for the enlargement, reduction, implantation or change in appearance of a part of the body(for instance the breast, face, lips, jaw, chin, nose, ears, or genitals);

SERVICES YOUR PLAN DOES NOT COVER (EXCLUSIONS), CONTINUED

- Hair transplantation;
- Chemical or laser face peels or abrasions of the skin;
- Removal of hair by electrolysis or other methods including lasers; and
- Any other surgical or non-surgical procedures which are primarily for the purpose of altering appearance and not performed for the purpose of correcting functional disorders resulting from accidental injury or from congenital defects or disease.

Custodial, domiciliary, or respite care is not covered by the Plan.

Dental Care: Dental x-rays, routine dental care including exams, repairs, orthodontics, periodontics, casts, splints, and services for dental malocclusion are not covered by the Plan, except as otherwise described in the *What Is Covered by the Plan?* section of this Evidence of Coverage regarding Dental Services and Craniomandibular Joint (CMJ) and Temporomandibular Joint (TMJ) Dysfunction Conditions. In the case of CMJ and TMJ Dysfunction Conditions, the Plan does not cover orthodontic treatment and appliances, crowns, bridges and dentures used for treatment of these disorders unless the disorder is caused by trauma. For coverage of accidental injury the patient must receive initial treatment within ninety (90) days of the accident and completion of treatment within one hundred eighty (180) days. Subsequent covered treatment can be extended to twelve (12) months from the accident date if it is determined to be medically necessary to occur within this time period. Coverage for services will not be extended beyond twelve (12) months from the accident date.

Diapers and incontinence supplies are not covered by the Plan.

Dietary supplements and nutritional formulae taken by mouth or feeding tubes are not covered by the Plan, except as otherwise described in the *What Is Covered by the Plan?* section of this Evidence of Coverage (Enteral Nutrition Products).

Equipment that serves the comfort or convenience of the Member or the person caring for the Member is not covered by the Plan.

Infertility services are excluded from coverage including, but not limited to:

- In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and variations of these procedures;
- Surrogacy services, including the medical care of the surrogate mother, and the medical care of the surrogate mother's newborn child, unless and until that child becomes an eligible Dependent of the Subscriber as provided in the *Enrolling in the Plan* section of this Evidence of Coverage;
- Reversal of sterilization;
- Any costs associated with the collection, preparation or storage of sperm for artificial insemination, including donor fees, donor egg or sperm retrieval; and
- Infertility injectable and suppository medications are not covered by the Plan.

Fees for television, telephone, newborn infant photographs, and other such articles are not covered by the Plan.

Foot care including all routine services such as the treatment of flat foot conditions, supportive devices, accommodative orthotics, orthopedic shoes unless jointed to braces, partial dislocations, bunions except capsular or bone surgery, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet, and the trimming of corns, calluses, or toenails are not covered by the Plan unless Medically Necessary for the treatment of a medical conditions such as diabetes.

Hearing aids, ear molds, or fitting of hearing aids or ear molds for adults is not covered by the Plan.

Home births are not covered by the Plan. Home births, including but not limited to deliveries and services provided by a lay-midwife, are not covered by the Plan.

Home Health Care Services does not cover Private duty nursing and Custodial Care needs that can be performed by non-licensed medical personnel to meet the normal activities of daily living. Examples of Custodial Care that are not Covered include, but are not limited to, bathing, feeding, preparing meals, or performing housekeeping tasks.

Homemaker services and non-skilled nursing care are not covered by the Plan.

Infant or baby food, formula, or breast milk or other regular grocery products that can be processed for oral feedings are not covered by the Plan.

SERVICES YOUR PLAN DOES NOT COVER (EXCLUSIONS), CONTINUED

Injuries sustained in the course of committing a criminal act are not covered by the Plan.

Medical and hospital care and related costs for the infant child of a Dependent, unless the infant child is otherwise eligible for coverage under the Plan, are not covered by the Plan.

Medical, surgical, or other healthcare procedures and treatments that are experimental, unproven, ineffective or investigational treatment as determined by the Medical Director and in accordance with peer-reviewed published medical and scientific literature and the practice of the national medical community are not covered by the Plan. See Cancer Clinical Trials in this Evidence of Coverage for exceptions to this exclusion.

This exclusion is for:

- Any procedures or treatments which are not recognized as conforming to accepted medical practice;
- Any procedures or treatments in which the scientific assessment of the technique, or its application for a particular Condition, has not been completed or its effectiveness has not been established;
- Any procedures or treatments for which the required approval of a governmental agency has not been granted at the time the services are given;
- Cancer chemotherapy or other types of therapy that are subject to ongoing phase I, II or III clinical trials, except when the chemotherapy is prescribed under medical research protocol and submitted to regional and national databases; and
- Therapy administered under experimental protocols.

Membership costs or fees associated with health clubs and weight loss clinics, physical conditioning programs, exercise programs or equipment, personal trainers, software designed to promote good health and activity, and the use of club swimming pools for therapy are not covered by the Plan.

Modifications or installations to building and related structures and vehicles are not covered by the Plan. Some examples are stairway lifts, ceiling-mounted lifts, and wheelchair lifts.

Non-emergency care when traveling outside the United States of America is not covered by the Plan.

Non-medical ancillary services such as vocational or educational rehabilitation, behavioral training, sleep therapy, job counseling, psychological counseling and training, or educational therapy for learning disabilities or mental impairment are not covered by the Plan.

Non-medical, non-approved expenses for personal services or comfort items are not covered by the Plan. Examples of these services are charges for legal counsel, hotel accommodations, meals, telephone charges and reimbursement for lost wages.

Non-Prescription formulas for food allergies or food intolerances are not covered by the Plan.

Nursing home care, except for those services with Prior Approved by the Plan and is provided in a skilled nursing facility, is not covered by the Plan.

Penile implants are not covered by the Plan.

Personal or comfort items such as personal care kits provided at a hospital, are not covered by the Plan.

Private hospital rooms and/or private duty nursing, unless determined to be Medically Necessary by NMHC Medical Director, are not covered by the Plan.

Replacement of Durable Medical Equipment due to loss, theft, misuse, abuse, destruction, warranty expiration, new/improved equipment availability, or sale of the equipment is not covered by the Plan.

Routine refractions, eyeglasses, corrective lenses, other eye appliances, and eye exercises are not covered by the Plan.

Routine physical exams, checkups, medications, evaluations (including functional capacity evaluations), immunizations, inoculations and/or Biologicals required for reasons other than health are not covered by the Plan. Examples of such services are physical exams that may be required for licensing, employment, marriage, insurance, operation of a vehicle or equipment, and travel purposes.

SERVICES YOUR PLAN DOES NOT COVER (EXCLUSIONS), CONTINUED

Services and/or supplies received prior to and after dates of coverage under the Plan are not covered by the Plan.

Services for which other coverage is required to provide or reimburse; including but not limited to Workers' Compensation, automobile insurance or similar coverage; is not covered by the Plan.

Services from a Provider that are not within his or her scope of practice are not covered by the Plan.

Services and/or supplies received from an Out-of-Network Provider for which a Prior Approval was not obtained and are not for urgent/emergent care, are not covered by the Plan.

Services not generally recognized as Medically Necessary, such as:

- HCG (Human Chorionic Gonadotrophin) injections to increase ovulation;
- Hair analysis;
- Reversal of voluntary sterilization are not covered by the Plan.

Services not primarily medical in nature, or supplies or equipment that are primarily and customarily used for a non-medical purpose as determined by the Plan Medical Director, are not covered by the Plan.

Services that are primarily for rest, domiciliary or convalescent care, are not covered by the Plan.

Surgical treatments for the correction of a refractive error, including radial keratotomy and laser vision correction; or the fitting of eyeglasses are not covered by the Plan.

Travel, lodging, and other related expenses, except as defined in this Evidence of Coverage, are not covered by the Plan.

Treatment for sexual dysfunction, including but not limited to medications, counseling and clinics, is not covered by the Plan.

Treatment of an immediate family member, or engagement in self-treatment absent an emergency or a short term situation involving a minor problem in which a qualified physician is not available, is not covered by the Plan.

Treatment or services provided in connection with, or to comply with, police detention, court orders or other similar arrangements are not covered by the Plan.

Treatment which results from an injury or illness that arises out of, or as the result of employment for wage or profit, regardless of whether such treatment is covered by any Workers' Compensation or other similar coverage or if covered, whether such treatment is found compensable thereunder, is not covered by the Plan.

If you are uncertain about a treatment or service and whether or not it is excluded, contact the Customer Care Center before the treatment or service is provided. Services Benefits that are not described in this Evidence of Coverage and/or the Summary of Benefits and Coverage are not covered by the Plan.

MEMBER COST-SHARING REQUIREMENTS

Cost-sharing amounts include deductibles, coinsurance, copayments and any other expense required of a Member. Cost-sharing amounts listed in your Summary of Benefits and Coverage. Your cost-sharing amounts will vary depending on the type of service you receive.

Copayments

A Copayment, or Copay, is a fixed dollar amount that you must pay each time you obtain a particular Covered Service. After you pay your Copay, NMHC pays the rest of the charges. Your Summary of Benefits and Coverage contains your Plan's Copayment amounts, if any.

Coinsurance

Coinsurance is a percentage of charges that is paid partially by NMHC and partially by the Member. Coinsurance amounts continue to be the responsibility of the member after the Plan Deductible has been met. Your Summary of Benefits and Coverage contains your Coinsurance amounts, if any.

Coinsurance is due after services have been provided and the claim has been processed. Coinsurance is calculated based on the total amount of the claim paid. It is your responsibility to pay your Provider the Coinsurance amount and keep receipts as your proof of payment.

Annual Deductibles

Your Annual Deductible is the amount that you are required to pay for certain services before Benefits are paid by NMHC. Your Annual Deductible runs on a Calendar Year, meaning the Annual Deductible period begins on January 1, your Plan's effective date, and resets on your Plan's renewal date, December 31. Separate deductibles apply for In-Network and Out-of-Network services. Not all services are subject to your Deductible. Please refer to your Summary of Benefits and Coverage for your Deductible amount. Services that have a Copayment do not apply to your Deductible.

Individual Deductible Amount

If you have single coverage, you must meet your individual Deductible for certain services. Once the Deductible has been met, the Plan will pay Benefits for your Covered Services.

Family Deductible

If you have family coverage (or coverage for two [2] or more people), your Plan has a Family Deductible that must be met before we will pay for some Covered Services. The Family Deductible is two (2) times the Plan's individual Deductible. Each covered person's individual Deductible amount applies to the Family Deductible until the Family Deductible has been met. For example, if the Per-Person Deductible is $500, then up to $500 per Member can be applied to the Family Deductible.

Annual Out-of-Pocket Maximums

Your Plan has an Annual Out-of-Pocket Maximum to protect you from the high cost of a catastrophic illness. Having an Out-of-Pocket Maximum means that you will not pay more than a specified amount each year in Deductible, Copayment, and Coinsurance charges. Your Annual Out-of-Pocket Maximum runs on a Calendar Year, meaning the Annual Out-of-Pocket Maximum period begins on January 1, your Plan's effective date, and resets on your Plan's renewal date, December 31. Refer to your Summary of Benefits and Coverage for your Plan's Out-of-Pocket Maximum amount.

Some expenses, such as charges above Usual, Customary, and Reasonable amounts, do not apply to your Out-of-Pocket Maximum.

Once the In-Network Out-of-Pocket Maximum has been met, we will pay one hundred percent (100%) of the Allowable Charges for Covered Services received from In-Network Providers. Plan benefit maximums will still apply.

Individual Maximum

If you have single or couple coverage, each Member enrolled under your Policy has his or her own Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum has been met for a person, we will pay one hundred percent (100%) of charges up to the Allowable amount or the Usual, Customary and Reasonable amount for the Covered Service for that person. As stated above, some charges do not apply to the Out-of-Pocket Maximum.

Family Maximum

If you have family coverage (coverage for two [2] or more people), your Plan has a Family Out-of-Pocket Maximum. The entire family out-of-pocket maximum must be met before benefits will be paid at one hundred percent (100%). If one (family) Member meets the Individual Out-of-Pocket maximum amount before the Family has met the Family out-of-pocket maximum, benefits will be paid at one hundred percent (100%) for that (family) member who has met the individual out of pocket

maximum. The Annual Out-of-pocket Maximum does not include non-covered charges including charges incurred after the benefit maximum has been reached.

To find out what your specific Out-of-Pocket Maximum amount is, please refer to your Summary of Benefits and Coverage. If you want to know how much of your Out-of-Pocket Maximum has been met, contact the Customer Care Center.

Benefit Maximums
Some services have a benefit maximum, which is the maximum amount of Benefits that the Plan will pay for that type of service over the course of the Calendar Year or the member's lifetime. Please refer to your Summary of Benefits and Coverage to see which services may have a benefit maximum. The Plan will not pay any additional Benefits for that service once the benefit maximum has been reached for that Member.

GRIEVANCES (COMPLAINTS) AND APPEAL PROCEDURES

Summary of Health Insurance Grievance Procedures

This is a summary of the process you must follow when you request a review of a decision by your insurer. You will be provided with detailed information and complaint forms by your insurer at each step. In addition, you can review the complete New Mexico regulations that control the process under the Legal tab on the Office of Superintendent of Insurance (OSI) website, located at www.osi.state.nm.us. You may also request a copy from your insurer at: 2440 Louisiana Blvd NE, Suite 601, Albuquerque, NM 87110 or from OSI by calling 1-505 827-4601 or toll free at 1-855-427-5674.

What types of decisions can be reviewed?

You may request a review of two different types of decisions:

Adverse determination: You may request a review if your insurer has denied pre-authorization (certification) for a proposed procedure, has denied full or partial payment for a procedure you have already received, or is denying or reducing further payment for an ongoing procedure that you are already receiving and that has been previously covered. (The insurer must notify you *before* terminating or reducing coverage for an ongoing course of treatment, and must continue to cover the treatment during the appeal process.) This type of denial may also include a refusal to cover a service for which benefits might otherwise be provided because the service is determined to be experimental, investigational, or not medically necessary or appropriate. It may also include a denial by the insurer of a participant's or beneficiary's eligibility to participate in a plan. These types of denials are collectively called **"adverse determinations."**

Administrative decision: You may also request a review if you object to how the insurer handles other matters, such as its administrative practices that affect the availability, delivery, or quality of health care services; claims payment, handling or reimbursement for health care services; or if your coverage has been terminated.

Review of an Adverse Determination

How does pre-authorization for a health care service work?

When your insurer receives a request to pre-authorize (certify) payment for a healthcare service (service) or a request to reimburse your healthcare provider (provider) for a service that you have already had, it follows a two-step process.

Coverage: First, the insurer determines whether the requested service is covered under the terms of your health benefits plan (policy). For example, if your policy excludes payment for adult hearing aids, then your insurer will not agree to pay for you to have them even if you have a clear need for them.

Medical necessity: Next, if the insurer finds that the requested service is covered by the policy, the insurer determines, in consultation with a physician, whether a requested service is medically necessary. The consulting physician determines medical necessity either after consultation with specialists who are experts in the area or after application of uniform standards used by the insurer. For example, if you have a crippling hand injury that could be corrected by plastic surgery and you are also requesting that your insurer pay for cosmetic plastic surgery to give you a more attractive nose, the insurer might certify the first request to repair your hand and deny the second, because it is not medically necessary.

Depending on terms of your policy, your insurer might also deny certification if the service you are requesting is outside the scope of your policy. For example, if your policy does not pay for experimental procedures, and the service you are requesting is classified as experimental, the insurer may deny certification. Your insurer might also deny certification if a procedure that your provider has requested is not recognized as a standard treatment for the condition being treated.

IMPORTANT: If your insurer determines that it will not certify your request for services, you may still go forward with the treatment or procedure. **However,** you will be responsible for paying the provider yourself for the services.

How long does initial certification take?

Standard decision: The insurer must make an initial decision within 5 working days. However, the insurer may extend the review period for a maximum of 10 calendar 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 you; and **(3)** provides a written progress report and explanation for the delay to you and your provider within the original 5 working day review period.

What if I need services in a hurry?

Urgent care situation: An **urgent care situation** is a situation in which a decision from the insurer is needed quickly because: **(1)** delay would jeopardize your life or health; **(2)** delay would jeopardize your ability to regain maximum function; **(3)** your provider **reasonably** requests an expedited decision; **(4)** the physician with knowledge of your medical condition, believes that delay would subject you to severe pain that cannot be adequately managed without the requested care or treatment; or **(5)** the medical demands of your case require an expedited decision.

If you are facing an urgent care situation **or** your insurer has notified you that payment for an ongoing course of treatment that you are already receiving is being reduced or discontinued, you or your provider may request an expedited review and the insurer

must either certify or deny the initial request quickly. The insurer must make its initial decision in accordance with the medical demands of the case, but within 24 hours of the written or verbal receipt of the request for an **expedited** decision.

If you are dissatisfied with the insurer's initial expedited decision in an urgent care situation, you may then request an **expedited review** of the insurer's decision by both the insurer and an external reviewer called an Independent Review Organization (IRO). When an **expedited** review is requested, the insurer must review its prior decision and respond to your request within 72 hours. If you request that an IRO also perform an expedited review simultaneously with the insurer's review, the IRO must also provide its expedited decision within 72 hours of receiving the necessary release of information and related records. If you are still dissatisfied after the IRO completes its review, you may request that the Superintendent review your request. This review will be completed within 72 hours after your request is complete. The internal review, the IRO review, and the review by the Superintendent are described in greater detail in the following sections.

IMPORTANT: If you are facing an emergency, you should seek medical care immediately and then notify your insurer as soon as possible. The insurer will guide you through the claims process once the emergency has passed.

When will I be notified that my initial request has been either certified or denied?

If the initial request is approved, the insurer must notify you and your provider within 2 working days after the decision, unless an urgent matter requires a quicker notice. If the insurer denies certification, the insurer must notify you and the provider within 24 hours after the decision.

If my initial request is denied, how can I appeal this decision?

If your initial request for services is denied or you are dissatisfied with the way your insurer handles an administrative matter, you will receive a detailed written description of the grievance procedures from your insurer as well as forms and detailed instructions for requesting a review. **You must submit the request for review in writing, but assistance is available.** The insurer provides representatives who have been trained to assist you with the process of requesting a review. This person can help you to complete the necessary forms and with gathering information that you need to submit your request. For assistance, contact the insurer's consumer assistance office as follows:

Telephone: (855)-769-6642
Address: P.O. Box 36719, Albuquerque, NM 87176
FAX #: 1-866-231-1344
Email: info@mynmhc.org

You may also contact the Managed Health Care Bureau (MHCB) at OSI for assistance with preparing the written request for a review at:
Telephone: 1-(505) 827-4601 or toll free at 1-(855) 427-5674
Address:

Office of Superintendent of Insurance - MHCB
P.O. Box 1689, 1120 Paseo de Peralta
Santa Fe, NM 87504-1689
FAX #: (505) 827-4734, Attn: MHCB
E-mail: mhcb.grievance@state.nm.us

Who can request a review?

A review may be requested by you as the patient, your provider, or someone that you select to act on your behalf. The patient may be the actual subscriber or a dependent who receives coverage through the subscriber. The person requesting the review is called the **"grievant."**

Appealing an adverse determination – first level review

If you are dissatisfied with the initial decision by your insurer, you have the right to request that the insurer's decision be reviewed by its medical director. The medical director may make a decision based on the terms of your policy, may choose to contact a specialist or the provider who has requested the service on your behalf, or may rely on the insurer's standards or generally recognized standards.

How much time do I have to decide whether to request a review?

You must notify the insurer that you wish to request an internal review within **180 days** after the date you are notified that the initial request has been denied.

What do I need to provide? What else can I provide?

If you request that the insurer review its decision, the insurer will provide you with a list of the documents you need to provide and will provide to you all of your records and other information the medical director will consider when reviewing your case. You may also provide additional information that you would like to have the medical director consider, such as a statement or recommendation from your doctor, a written statement from you, or published clinical studies that support your request.

How long does a first level internal review take?
Expedited review. If a review request involves an urgent care situation, your insurer must complete an expedited internal review as required by the medical demands of the case, but in no case later than 72 hours from the time the internal review request was received.

Standard review. Your insurer must complete both the medical director's review and (if you then request it) the insurer's internal panel review within 30 days after receipt of your request for review. The medical director's review generally takes only a few days.

The medical director denied my request - now what?
If you remain dissatisfied after the medical director's review, you may either request a review by a panel that is selected by the insurer or you may skip this step and ask that your request be reviewed by an IRO that is appointed by the Superintendent.

- If you ask to have your request reviewed by the insurer's panel, then you have the right to appear before the panel in person or by telephone or have someone, (including your attorney), appear with you or on your behalf. You may submit information that you want the panel to consider, and ask questions of the panel members. Your medical provider may also address the panel or send a written statement.
- If you decide to skip the panel review, you will have the opportunity to submit your information for review by the IRO, but you will not be able to appear in person or by telephone. OSI can assist you in getting your information to the IRO.

IMPORTANT: If you are covered under the NM State Healthcare Purchasing Act, you may NOT skip the panel review.

How long do I have to make my decision?
If you wish to have your request reviewed by the insurer's panel, you must inform the insurer within **5 days** after you receive the medical director's decision. If you wish to skip the insurer's panel review and have your matter go directly to the IRO, you must inform OSI of your decision within **120 days** after you receive the medical director's decision.

What happens during a panel review?
If you request that the insurer provide a panel to review its decision, the insurer will schedule a hearing with a group of medical and other professionals to review the request. If your request was denied because the insurer felt the requested services were not medically necessary, were experimental or were investigational, then the panel will include at least one specialist with specific training or experience with the requested services.

The insurer will contact you with information about the panel's hearing date so that you may arrange to attend in person or by telephone, or arrange to have someone attend with you or on your behalf. You may review all of the information that the insurer will provide to the panel and submit additional information that you want the panel to consider. If you attend the hearing in person or by telephone, you may ask questions of the panel members. Your medical provider may also attend and address the panel or send a written statement.

The insurer's internal panel must complete its review within 30 days following your original request for an internal review. You will be notified within 2 days after the panel decision. If you fail to provide records or other information that the insurer needs to complete the review, you will be given an opportunity to provide the missing items, *but the review process may take much longer and you will be forced to wait for a decision.*
Hint: If you need extra time to prepare for the panel's review, then you may request that the panel be delayed for a maximum of 30 days.

If I choose to have my request reviewed by the insurer's panel, can I still request the IRO review?
Yes. If your request has been reviewed by the insurer's panel and you are still dissatisfied with the decision, you will have **120 days** to decide whether you want to have the request reviewed by an IRO.

What's an IRO and what does it do?
An IRO is a certified organization appointed by OSI to review requests that have been denied by an insurer. The IRO employs various medical and other professionals from around the country to perform reviews. Once OSI selects and appoints an IRO, the IRO will assign one or more professionals who have specific credentials that qualify them to understand and evaluate the issues that are particular to a request. Depending on the type of issue, the IRO may assign a single reviewer to consider your request, or it may assign a panel of reviewers. The IRO must assign reviewers who have no prior knowledge of the case and who have

no close association with the insurer or with you. The reviewer will consider all of the information that is provided by the insurer and by you. (OSI can assist you in getting your information to the IRO.) In making a decision, the reviewer may also rely on other published materials, such as clinical studies.

The IRO will report the final decision to you, your provider, your insurer, and to OSI. Your insurer must comply with the decision of the IRO. If the IRO finds that the requested services should be provided, then the insurer must provide them.

The IRO's fees are billed directly to the insurer – there is no charge to you for this service.

How long does an IRO review take?
The IRO must complete the review and report back within 20 days after it receives the information necessary for the review. (However, if the IRO has been asked to provide an expedited review regarding an urgent care matter, the IRO must report back within 72 hours after receiving all of the information it needs to review the matter.)

Review by the Superintendent of Insurance
If you remain dissatisfied after the IRO's review, you may still be able to have the matter reviewed by the Superintendent. You may submit your request directly to OSI, and if your case meets certain requirements, a hearing will be scheduled. You will then have the right to submit additional information to support your request and you may choose to attend the hearing and speak. You may also ask other persons to testify at the hearing. The Superintendent may appoint independent co-hearing officers to hear the matter and to provide a recommendation.

The co-hearing officers will provide a recommendation to the Superintendent within 20 days after the hearing is complete. The Superintendent will then issue a final order.

There is no charge to you for a review by the Superintendent of Insurance and any fees for the hearing officers are billed directly to the insurer. However, if you arrange to be represented by an attorney or your witnesses require a fee, you will need to pay those fees.

Review of an Administrative Decision
How long do I have to decide if I want to appeal and how do I start the process?
If you are dissatisfied with an initial administrative decision made by your insurer, you have a right to request an internal review within **180 days** after the date you are notified of the decision. The insurer will notify you within 3 days after receiving your request for a review and will review the matter promptly. You may submit relevant information to be considered by the reviewer.

How long does an internal review of an Administrative Decision take?
The insurer will mail a decision to you within 15 days after receiving your request for a review of an administrative decision. If the insurer is unable to obtain information it needs to perform the review, the insurer may extend the time period for review to a total of 25 days.

Can I appeal the decision from the internal reviewer?
Yes. You have **20 days** to request that the insurer form a committee to reconsider its administrative decision.

What does the reconsideration committee do? How long does it take?
When the insurer receives your request, it will appoint two or more members to form a committee to review the administrative decision. The committee members must be representatives of the company who were not involved in either the initial decision or the internal review. The committee will meet to review the decision within 15 days after the insurer receives your request. You will be notified at least 3 days prior to the committee meeting so that you may provide information, and/or attend the hearing in person or by telephone.

If you are unable to prepare for the committee hearing within the time set by the insurer, you may request that the committee hearing be postponed for up to 30 days.

The reconsideration committee will mail its decision to you within 7 days after the hearing.

How can I request an external review?
If you are dissatisfied with the reconsideration committee's decision, you may ask the Superintendent to review the matter within **20 days** after you receive the written decision from the insurer. You may submit the request to OSI using forms that are provided by your insurer. Forms are also available on the OSI website located at www.osi.state.nm.us. You may also call OSI to request the forms at (505) 827-4601 or toll free at 1-(855)-427-5674.

How does the external review work?
Upon receipt of your request, the Superintendent will request that both you and the insurer submit information for consideration. The insurer has 5 days to provide its information to the Superintendent, with a copy to you. If your matter qualifies for external review, you may also submit additional information including documents and reports for review by the Superintendent. The Superintendent will review all of the information received from both you and the insurer and issue a final decision within 45 days. If you need extra time to gather information, you may request an extension of up to 90 days. Any extension will cause the review process and decision to take more time.

General Information
Confidentiality
Any person who comes into contact with your personal health care records during the grievance process must protect your records in compliance with state and federal patient confidentiality laws and regulations. In fact, the provider and insurer cannot release your records, even to OSI, until you have signed a release.

Special needs and cultural and linguistic diversity
Information about the grievance procedures will be provided in accessible means or in a different language upon request in accordance with applicable state and federal laws and regulations.

Reporting requirements
Insurers are required to provide an annual report to the Superintendent with details about the number of grievances it received, how many were resolved and at what stage in the process they were resolved. You may review the results of the annual reports on the OSI website.

The preceding summary has been provided by the Office of Superintendent of Insurance. This is not legal advice, and you may have other legal rights that are not discussed in these procedures.

TERMINATION FROM THE PLAN

Termination for Cause

The Plan may terminate this Policy upon written notice to the Subscriber. We may terminate the Subscriber or Dependent's coverage for cause if:

1. The Plan discovers that information was intentionally omitted, misrepresented, or was materially false or fraudulent in the Enrollment Application; in which case, we may render coverage to be null and void retroactive to the effective date of coverage;
2. A member allows a person that is not a member of the Plan to use the Plan issued ID card to falsely obtain Services and Supplies;
3. An attempt is made to obtain Services or Supplies by means of false or fraudulent information, acts, or omissions;
4. A Member's behavior, in the opinion of the Plan, is disruptive, unruly, abusive or uncooperative to the extent that the Plan is seriously impaired in the ability to provide coverage to that Member or any Member; or
5. The life or well-being of any Plan employee,
6. An In-Network Provider or another Member is threatened by a Member.

In no event will we terminate coverage due to health status, the need for healthcare services, race, gender, age, sexual orientation or utilization of Services and Supplies. If you feel that coverage has been unjustly terminated, you can file an Appeal with the Plan or Appeal the decision to the Superintendent of Insurance. The address and toll-free number for the Superintendent of Insurance is provided below.

Office of Superintendent of Insurance
Attn: Superintendent
P.O. Box 1689
Santa Fe, NM 87504-1689
1-855-427-5674

We shall not terminate coverage for a member that is receiving treatment for a life threatening condition or for failure to follow a prescribed course of treatment.

Termination by Reason of Ineligibility

When you are no longer eligible as defined in the *Enrolling on the Plan* section, your coverage under this Plan will end. If you fail to meet the eligibility criteria, your coverage will end at midnight of the last day of the month in which you were no longer eligible. The Plan has no obligation to cover Services and Supplies once your Plan has terminated. Your Employer Group will notify us if and when you no longer meet eligibility criteria.

Termination of the Policy

The Plan may terminate your coverage for reasons such as:

- Non-payment of health insurance Premiums;
- Fraud or intentional misrepresentation of a material fact made by the Subscriber;
- The Subscriber moves out of the Plan's service area; or
- The Plan exits from the New Mexico marketplace.

In the event of termination, appropriate written notice must be provided by the Plan in advance, as indicated in the timeframes noted throughout this section of this Evidence of Coverage.

Misrepresentation of Information

If the Plan determines that information was inaccurate or intentionally omitted from an application for coverage, there will be serious consequences. The Plan can 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 enforcement form, enrollment process or in seeking benefits under the Plan. Rescinding coverage means that coverage will be cancelled and deemed null and void retroactively to the effective date of the policy. The Member must pay for any services or other benefits that have been provided by the Plan.

Before a rescission is effective, the Plan will provide the Member with at least 30 calendar days prior notice that coverage is being rescinded. During this thirty (30)-day notice period, Members are advised to seek alternative healthcare 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.

Termination by Termination of the Employer Group Policy
This Policy may be terminated for certain reasons including the failure of the Employer Group to pay Premiums owed to us, fraud or intentional misrepresentation of a material fact, violation of contribution or participation requirements and upon appropriate Notice given by the Plan or the Employer Group.

Additional Reasons for Termination under New Mexico Law
If there is no longer any member in connection with the Plan who lives, resides or works in the Plan's service area and/or where the Plan is authorized to do business and in the case of Small Employer Groups, as defined by New Mexico Law, limit the employers that may apply for the coverage to those with eligible individuals who live, work, or reside in the service area for the network plan. If membership through one or more bona fide association ceases, but without regard to any health status related factor related to a covered individual.

Effective Date of Termination
Coverage under this Policy may end at different times during the month. Reasons for termination may include, but are not limited to termination for cause; loss of eligibility due to termination of employment; and loss of eligibility due to a change in dependent status. Please be sure to contact the Plan for specific information about termination effective dates.

Notice of Termination to Members
If this Policy is terminated for cause, we will send a Notice of Cancellation to Subscriber no less than thirty (30) days prior to the effective date of termination. The notice will be dated; state the reasons for termination; state the reasons for which you cannot be terminated, including, but not limited to health status, age or gender; state the effective date of termination; state your right to file an Appeal with the Plan or with the Superintendent of Insurance if you feel you have been wrongly dis-enrolled; provide information about your ability to enroll in a conversion plan; and any other matters required by law, including premium refund, if applicable and information related to reinstatement of a Policy.

Continuation of Group Coverage under COBRA
Under the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, a qualified employer must give its employees and dependents the right to continue their group healthcare benefits. A person who would otherwise lose coverage as a result of a qualifying event is generally entitled to continue the same benefit coverage that was in effect the day before the date of the qualifying event. Coverage may be continued under COBRA only if the required Premiums are paid when due and will be subject to future Plan changes.

IMPORTANT NOTICE: COBRA BENEFITS WILL ONLY BE ADMINISTERED ACCORDING TO THE TERMS OF THE CONTRACT SIGNED WITH THE QUALIFIED EMPLOYER AND NEW MEXICO HEALTH CONNECTIONS. THE PLAN IS NOT THE DETERMINING AUTHORITY OF COBRA ELIGIBILITY AND WILL NOT BE OBLIGATED TO ADMINISTER OR FURNISH, ANY COBRA BENEFITS AFTER THE CONTRACT HAS TERMINATED.

A COBRA qualifying event is any of the following:
- Termination of the Subscriber's employment (other than for gross misconduct) or reduction of hours worked so as to render the Subscriber ineligible for coverage;
- Death of the Subscriber;
- Divorce or legal separation of the Subscriber from his or her spouse;
- Loss of coverage due to the Subscriber becoming entitled to Medicare;
- A Dependent child ceasing to qualify as an eligible Dependent under the Plan; or
- If the Plan provides coverage for retired Subscribers and eligible Dependents, a qualifying event will also mean a substantial loss of that retiree coverage due to the employer filing for Chapter 11 Bankruptcy. (The substantial loss can occur within 1 year [365 days] before or after the filing for Chapter 11 Bankruptcy.)

When there is a divorce or legal separation or a child ceases to qualify as an eligible Dependent, the Subscriber or eligible Dependent is responsible for notifying the employer within sixty (60) days after the date of the qualifying event. If the employer is not so notified, the person will not be given the opportunity to continue coverage.

After notification of his or her COBRA rights, the Subscriber or eligible Dependent has a limited amount of time to elect continuation. Continued healthcare coverage is not automatic.

Continuation of coverage under COBRA must be elected within sixty (60) days of the later of the following:
- The date of the Subscriber or eligible Dependent loses coverage as a result of the qualifying event; or
- The date of the Subscriber or eligible Dependent is notified by the employer of the right to continued coverage.

Failure of your employer group or the employer group's representative to provide the member with appropriate election information will not obligate the Plan to provide continuation coverage. Notice of the right to continue coverage to your spouse will be deemed notice to any Dependent child residing with you or your spouse.

The Subscriber or eligible Dependent may be required to pay a Premium to continue coverage. If the Subscriber or eligible Dependent elects to continue coverage, the Subscriber or eligible Dependent will have forty-five (45) days from the date of election to pay the initial Premium due. All subsequent Premiums will be due on a monthly basis.

There is a thirty (30)-day grace period to pay Premiums. If the Premium is not paid before the expiration of the grace period, COBRA continuation benefits will end.

If elected, the maximum period of continued coverage for a qualifying event involving termination of employment or reduced working hours is eighteen (18) months from the date of the qualifying event. However, if a second qualifying event occurs (such as a divorce or death of the Subscriber) within this eighteen (18) month period, the period of coverage for any affected Dependent may be extended to up to thirty-six (36) months from the date of the initial (first) qualifying event.

If a qualified beneficiary is totally disabled under the Social Security Act on the date of the qualifying event, or at any time during the first sixty (60) days of continued coverage, the eighteen (18)-month period may be extended to up to twenty-nine (29) months. If there are non-disabled families Members of this qualified beneficiary who have elected COBRA continuation coverage, they are also entitled to this additional eleven (11) months of coverage. In order for this additional eleven (11) months of coverage to be effective, the Subscriber or eligible Dependent must provide the employer with a copy of the Social Security Administration's determination of total disability within sixty (60) days of receiving such notice. The notice must also be provided to the employer within the initial 18 months of COBRA continuation coverage.

If a covered Subscriber has a qualifying event (termination of employment or reduction in hours worked) and he/she had become entitled to Medicare before the date of this qualifying event, then:

- The Subscriber may continue the group health coverage for up to eighteen (18) months from the date of termination or reduction in hours worked, and
- Any other qualified beneficiary (the spouse and/or children) will be entitled to the greater of (i) thirty-six (36) months from the date the Subscriber first became entitled to Medicare, or (ii) eighteen (18) months from the covered Subscriber's termination or reduction in hours.

The maximum period of continued benefits for a qualifying event involving retired Subscribers of employers under Chapter 11 Bankruptcy and their Dependents will be:

- The date of death of the retired Subscriber; or
- For a surviving spouse or eligible Dependent, thirty-six (36) months after the date of death of the retired employee.

For all other qualifying events, the maximum period is thirty-six (36) months, except as provided below.

If the employer provides continuation options in addition to COBRA, the Subscriber or eligible Dependent may elect one of them in lieu of COBRA, but the Subscriber or eligible Dependent may not have both. The election of another continuation option is a waiver of COBRA.

However, if the Plan provides for continuation of existing coverage for a certain period of time after any qualifying event, the Subscriber may receive a COBRA election form when the existing coverage actually ends. The Subscriber or eligible Dependent may elect COBRA continuation coverage for the balance of the applicable eighteen (18)-, twenty-nine (29)-, or thirty-six (36)-month period.

Other events will cause COBRA continuation coverage to end sooner. This will occur on the earliest of any of the following:

- The date the employer ceases to provide any group health plan to any employee;
- The date the Subscriber or eligible Dependent fails to timely pay any required Premium;
- The first day after the date of election on which the qualified beneficiary first becomes covered under any other group health plan which does not contain any exclusions or limitations with respect to any pre-existing Condition for such person; or the date such exclusion or limitation no longer applies to the Subscriber or Dependent;
- The first day after the date of election on which the qualified beneficiary first becomes entitled to Medicare(except for a Chapter 11 Bankruptcy qualifying event); or
- With respect to a qualified beneficiary whose coverage is being extended for the additional eleven (11) months due to a disability as described above, coverage will terminate on the first day of the month that is more than thirty (30) days after the date in which the disabled individual is no longer disabled for Social Security purposes.

Continuation of Group Coverage Under New Mexico State Law
If enrollment through the Employer Group is no longer available due to termination of employment and your Employer Group does not offer COBRA, you still may continue coverage with the Employer Group for a period of six (6) months, after which you may convert to individual conversion coverage. Coverage may be continued under this section only if the required Premiums are paid when due, and is subject to all future Plan changes.

Conversion to Non-Group (Individual) Coverage
If you do not elect COBRA or State continuation coverage, fail to properly elect COBRA or State continuation coverage, are ineligible to elect COBRA continuation coverage, or had COBRA or State continuation coverage for the maximum coverage period has expired, you may apply to NMHC for conversion to nongroup (individual) coverage. You must continue to reside in the Service Area in order to be eligible for non-group (individual) coverage. Coverage may be continued under Conversion only if the required Premiums are paid when due and will be subject to future Plan changes.

Loss of Subscriber Eligibility
If you, as the Subscriber, are no longer eligible for coverage under this Policy for any reason other than the reasons stated in the "Termination for Cause" or "Termination of Policy" provisions of this section, you may apply for conversion to non-group (individual) coverage. You must apply and pay the applicable Premium within thirty-one (31) days of the loss of Employer Group coverage. At the time of conversion to non-group (individual) coverage, you may also apply for non-group (individual) coverage for Dependents who were Members at the time of your loss of eligibility. If your application and all non-group fees, including all fees for the period since the termination of Employer Group coverage, are submitted within thirty-one (31) days of the loss of Employer Group coverage your non-group (individual) coverage will be effective as of the date of such termination.

Loss of Subscriber Eligibility includes:

- **Conversion upon Death or Divorce of Subscriber**. If you are a Dependent who has lost eligibility for coverage under this Policy due to the death or divorce, annulment or dissolution of marriage or legal separation of the Subscriber, you may apply for conversion to non-group (individual) coverage.
- **Conversion upon Meeting Age Limitation**. If you are a Dependent who has lost eligibility for coverage under this Policy due to your attainment of an age limitation identified in the Policy, you may apply for conversion to non-group (individual) coverage.
- **Conversion after Expiration of COBRA Continuation Coverage**. A Member whose COBRA continuation coverage has expired after the maximum coverage period may apply for conversion to non-group (individual) coverage. However, no conversion will be provided if the qualified beneficiary does not actually maintain COBRA coverage to the expiration date. The benefits, terms and conditions of the non-group (individual) coverage, including Premiums, Co-Payment/Co-Insurance amounts and deductibles, if any, shall be in accordance with the rules of the Plan in effect at the time of conversion and will not necessarily be identical to benefits provided under this Policy.
- **Conversion after Expiration of Continuation Coverage under New Mexico Law**. A Member, whose continuing coverage under New Mexico law has expired after the maximum coverage period, may apply for conversion to non-group (individual) coverage. The benefits, terms and conditions of the non-group (individual) coverage, including Premiums, Co-Payment/Co-Insurance amounts and deductibles, if any, shall be in accordance with the rules of the Plan in effect at the time of conversion and will not necessarily be identical to the benefits provided under this Policy.

Continuation of Coverage under FMLA
If the Employer Group is subject to the requirements of FMLA (Family and Medical Leave Act of 1993, as amended), the Subscriber shall have coverage under this Policy during a leave of absence if the Subscriber is an eligible employee under the terms of the FMLA and the leave of absence qualifies as a leave of absence under FMLA. The Subscriber shall pay to the Employer Group the portion of the Premium, if any that the Subscriber would have paid had the Subscriber not taken leave and the Employer Group shall pay the Plan the Premium for the Subscriber as if the Subscriber had not taken leave.

ERISA PROVISIONS

Plan Modification, Amendment, and Termination

The Employer Group as Plan Sponsor has the right, at any time, to change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other Plan term or condition, and to terminate the whole Plan or any part of it. The procedure by which the eligibility of classes of employees may be changed or terminated, or by which part or the whole Plan may be terminated, is contained in the employer's plan document, which is available for inspection and copying from the Plan Administrator designated by the employer. No consent of any Member is required to terminate, modify, amend, or change the Plan. For purposes of ERISA, the Employer Group is the Plan Administrator of this Plan.

Statement of Rights

As a person covered under this Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974. This law called ERISA, provides that all people covered by the Plan are entitled to:

- Examine, without charge, all Plan documents, including insurance policies, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information by writing to the Plan Administrator and asking for them. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report if the Plan covers one hundred (100) or more people. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

In addition to creating rights for persons covered by the Plan, ERISA imposes duties upon the people who are responsible for the operation of the benefit portion of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and in the interest of the other people covered by the Plan and beneficiaries.

The law provides that no one may fire you or otherwise discriminate against you in any way to prevent you from getting a benefit or exercising your rights under ERISA. The law provides that if your claim for a benefit is denied in whole or in part, you will receive a written notice, explaining why your claim was denied. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request copies of documents from the Plan and do not receive them within thirty (30) days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the documents and pay up to $110 a day until you receive them, unless they were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that the people who operate the Plan misuse the Plan's money or if you are discriminated against for asserting your rights, you may ask the U.S. Department of Labor for help, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If your suit is successful, the court may order the person you have sued to pay costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

If you have any questions about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory). If you have any questions about your Plan, you should see your Plan Administrator.

OTHER POLICY PROVISIONS

Age Limits

If the Policy contains an age limit or a date after which coverage provided by the Plan will not be effective, and if such date falls within a period for which premium is accepted by NMHC or if NMHC accepts a premium after such date, the Policy will remain in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured the coverage provided by the Policy would not have become effective or would have ceased prior to the acceptance of such premium or premiums, then the liability of the Policy shall be limited to the refund, upon request, of all premiums paid for the period not covered by the Policy.

Assignment of Benefits

NMHC specifically reserves the right to pay the Subscriber directly and to refuse to honor an assignment of Benefits in any circumstances. If a medical provider or another party receives written or verbal permission from a Member to receive payment for Covered Benefits and Services directly from NMHC, NMHC is not bound to honor the agreement and may make payment to the Member. No person may execute any power of attorney to interfere with NMHC's right to pay the Subscriber or Plan Member instead of another entity.

Circumstances Beyond NMHC's Control

If faced with a disaster such as an earthquake, war, or riot, we will make a good faith effort to help Members get Covered Services, and we will remain responsible for payment of Covered Services. NMHC will not be liable for damages resulting from delays in service, or failure due to a lack of facilities or personnel.

Claim Forms and Proof of Loss

A written receipt, claim form or proof of loss must be furnished to NMHC in accordance with the claim procedures specified in this Evidence of Coverage. Electronic submission of proof of loss is as acceptable as submission on paper. All submissions must be made to NMHC within one year (365 days) of the occurrence or start date of the loss on which claim is based. If notice is not provided during that time, the claim will not be invalidated, denied or reduced if it is shown that written notice was given as soon as reasonably possible. When a request for a claim form or the notice of a claim is provided to NMHC, we will provide the claimant or policyholder the claim forms that we require for filing. If the claimant does not receive these claim forms within fifteen (15) days after NMHC receives notice of claim or the request for a claim form, the claimant will be considered to meet the proof of loss requirement of the Plan. Foreign claims must be translated in U.S. currency prior to being submitted to NMHC for payment.

Disclaimer of Liability

NMHC has no control over the diagnosis, treatment, care, or other service provided to a Member by any facility or Provider, whether the Provider is an In-Network or Out-of-Network Provider. NMHC is not liable for loss or injury caused by any healthcare Provider by reason of negligence or otherwise.

Evaluating New Technology for Inclusion as a Covered Benefit

The Plan excludes coverage of healthcare services that are considered to be experimental or investigational in nature or the use of technology that is for an off-label use. NMHC has a process to evaluate health services and new technology that might be considered experimental or investigational. If NMHC determines the procedure or service to be experimental or investigational, the service will not be covered by this Plan. If you agree to receive these services, you may be responsible for the charges.

The NMHC Medical Director will verify whether or not there is support for a particular healthcare service and will make the coverage determination. This support will generally be in the form of prospective, randomized, controlled clinical trials that support the safety and effectiveness of the healthcare service in question.

In addition, the new technology must be as beneficial as any established alternative and the outcomes must be attainable outside of investigational settings. If the Medical Director is unable to locate support, he/she may consult with an outside vendor that NMHC uses to help us evaluate new technologies.

Extension of Benefits

The Plan will provide a reasonable period for the extension of benefits in the event a Member becomes totally disabled on the date the group contract is discontinued. This extension of benefits period will be at least twelve (12) months.

Freedom of Choice of Hospital or Practitioner

Within the area and coverage limits of the Policy, an insured person has the right to exercise full freedom of choice in the selection of a hospital, practitioner of the healing arts, optometrist, psychologist, podiatrist, physician assistant, certified nurse-midwife, registered lay midwife, registered nurse in expanded practice, or independent social worker as defined in the *Glossary*

of this Evidence of Coverage. Treatment of an illness or injury within the provider's scope of practice shall not be restricted under any new health insurance contract or healthcare Policy. A person insured under a health insurance Policy providing coverage for payment of Benefits for the treatment or cure or correction of any physical or mental condition shall be deemed to have complied with the requirements of the Policy by submission of a proof of loss, or upon submitting written proof supported by the certificate of the provider or independent social worker.

Fraud and Abuse
Our Fraud and Abuse Program works to investigate and prevent all forms of suspicious activity related to health insurance fraud and/or abuse.

Definitions of Fraud and Abuse
Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or another person. It includes any act that constitutes fraud under applicable federal or state law.

Abuse is when a person is involved in practices that are inconsistent with sound, fiscal business or medical practices. These practices may result in an unnecessary cost to a health plan or in reimbursement for services that are not Medically Necessary or that do not meet professionally recognized standards for healthcare.

Reporting Potential Fraud, Abuse, or Suspicious Activity
If you think that insurance fraud, abuse, or other suspicious activity has occurred, may be occurring, or is going to occur, please report it immediately. You can report this activity by:

- Calling the Fraud & Abuse Telephone Hotline at 1-855- 882-3903 or (505) 492-2056, extension 156;
- Faxing the information to the Fraud & Abuse Department at 1-866-231-1344; or
- Mailing the information to:
  New Mexico Health Connections
  Attn: Fraud and Abuse Department
  P.O. Box 36719
  Albuquerque, NM 87176

If you report suspicious or fraudulent activity, be sure to include as much detail as possible with your report so we can investigate the issue. Reports can be made anonymously. All reports are treated as confidential and will be investigated. We may refer the activity to law enforcement or to the appropriate regulatory body. Members or Providers that are found to be engaging in suspicious activity, fraud or abuse are subject to removal from the Plan and recovery of any overpayments.

Legal Action
No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished, in accordance with the requirements of this Policy. 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.

Member Incentives
NMHC may offer incentives as part of our health promotion efforts. Incentives can help motivate members to change negative health behaviors and to maintain positive health behaviors. It is our focus to encourage members to obtain the recommended age and gender appropriate preventive services. Our preventive care guidelines are based on the United States Preventive Services Task Force guidelines.

Payment of Claims
Claims submitted by a Member 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 insured. 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 the option of NMHC.

Physical Examination
NMHC has the right to arrange for, at its own expense, the examination of any person for whom claim is pending as often as it may reasonably require. This includes an autopsy in the case of death, where it is not forbidden by law.

Recovery of Excess Benefit Overpayments
An "excess benefit" overpayment is a service or benefit not required by this Policy, but that has been paid by NMHC. We have the right to recover any overpayments that we make. If the excess benefit is a service, recovery shall be based upon the usual rate for that service. If the excess benefit is a payment, recovery shall be based on the payment 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 healthcare plan or other organization.

The right of recovery belongs to NMHC alone. It is used at NMHC'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.

Reinstatement
NMHC may reinstate this Policy after it has been terminated. This may be done without the execution of a new application, the issuance of a new ID Card, or any notice to the Subscriber other than the unqualified acceptance of an additional payment from the Subscriber.

Renewability
Coverage shall be renewed at the option of the Subscriber unless:

- The individual has failed to pay premiums or contributions in accordance with the terms of the Policy, or NMHC has not received timely premium payments; or
- The individual has performed an act or practice that constitutes fraud, or has made an intentional misrepresentation of a material fact under the terms of coverage;
- The individual no longer lives or works in the Plan's service area; or
- The individual is no longer a member of the group or association to which coverage was offered.

The Rights of Custodial Parents
When a child has coverage under a non-custodial parent, or a parent that does not have primary custody of the child, NMHC will provide information to the custodial parent, as necessary, for the child to obtain Benefits; permit the custodial parent or the provider to submit claims for covered services without the approval of the noncustodial parent; and 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
NMHC acknowledges 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 NMHC 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

Reimbursement of Claims to Member
To be reimbursed for the charges you have paid, you will need to submit a Member Reimbursement form including an itemized statement with the diagnosis, the treatment received and an explanation for the services, the charges for the treatment, and the patient's identification information from your Plan ID card.

Itemized bills must be submitted on billing forms or the Provider's letterhead or stationery and must include:

- The name and address of the Physician or other healthcare Provider;
- The full name of the patient receiving treatment or services; and
- The date, type of service, diagnosis, and charge for each service separately.

Canceled checks, balance due statements, cash register receipts or bills you prepare yourself are not acceptable. Please make a copy of all itemized bills for your records before you send them because the bills will not be returned to you. Itemized bills are necessary for your claim to be processed so that all Benefits available under this Policy are provided.

If your itemized bill includes charges for services that were previously submitted to us, clearly identify the new charges that you are submitting for reimbursement. Medical records of the treatment or service may be required. You can get a Member Reimbursement form from our website at www.mynmhc.org or by calling the Customer Care Center at 1-855-7MY-NMHC (1-855-769-6642).

Claims for services rendered by an Out-of-Network Provider must be submitted to NMHC within one year (365 days) from the date of service. If your Out-of-Network Provider does not file a claim for you, you are responsible for filing the claim within the one-year deadline. Claims submitted after the deadline are not eligible for benefit payment or reimbursement. If a claim is returned to you because we need additional information, you must resubmit it, with the information requested, within ninety (90) days of receipt of the request. Please mail the claim forms and itemized bills to:

Claims Department
New Mexico Health Connections
P.O. Box 3828
Corpus Christi, TX 78463

Once received, reviewed, and approved, NMHC will reimburse you for Covered Services, less any required Deductibles and Coinsurance or Copayment amounts that you are required to pay as stated in the Summary of Benefits and Coverage. You will be responsible for charges not specifically covered by NMHC within forty-five (45) business days.

Time Limit on Certain Defenses
As of the date of issue of this policy, no misstatements, except willful or fraudulent misstatements, made by the Subscriber 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 the policy).

In the event a misstatement in an application is made that is not fraudulent or willful, NMHC 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 had such misstatement not been made.

NOTICE OF PRIVACY PRACTICES (HIPAA)

NMHC is committed to maintaining and protecting your privacy. We are required to protect the privacy of your individually identifiable health information, genetic information and other personal information and to send you this Notice about our policies, safeguards and practices. When we use or disclose your Protected Health Information (PHI), we are bound by the terms of this Notice.

How We Protect Your Privacy

We will not disclose your Protected Health Information (PHI) without your authorization unless it is necessary to provide your health Benefits, administer your benefit Plan, support Plan programs or services, or as required or permitted by law. If we need to disclose your PHI, we will follow the policies described in this Notice to protect your privacy.

NMHC protects your PHI by following processes and procedures for accessing, labeling and storing confidential records. Access to our facilities is limited only to authorized personnel. Internal access to your PHI is restricted to Plan employees who need the information to conduct Plan business. We train our employees on policies and procedures designed to protect you and your privacy. Our Privacy Officer monitors the policies and procedures and ensures that they are being followed.

How We Use and Disclose Your Confidential Information

We will not use your PHI or disclose it to others without your authorization, except for the following purposes:

- **Treatment**. We may disclose your PHI to your healthcare Provider for Plan coordination, or management of your healthcare and related services;
- **Payment**. We may use and disclose your PHI to obtain payment of Premiums for your coverage and to determine and fulfill our responsibility to provide your Plan Benefits. However, we are prohibited from using or disclosing genetic information to make any coverage determinations, such as eligibility or rate setting. We may also disclose your PHI to another health plan or a healthcare Provider for its payment activities;
- **Healthcare Operations**. We may use and disclose your PHI for our healthcare operations. We may also disclose your PHI to another health plan or a Provider who has a relationship with you, so that it can conduct quality assessment and improvement activities;
- **Appointment Reminders and Treatment Alternatives.** We may use and disclose your PHI for appointment reminders or send you information about treatment alternatives or other health-related Benefits and services. You will have an opportunity to opt out of future communications;
- **Disclosure to Plan Vendors and Accreditation Organizations**. We may disclose your PHI to companies with whom we contract if they need the information to perform the services they provide to us. We may also disclose your PHI to accreditation organizations such as the National Committee for Quality Assurance (NCQA) when the NCQA auditors collect Health Employer Data and Information Set (HEDIS®) data for quality measurement purposes. When we enter into these types of arrangements, we obtain a written agreement to protect your PHI;
- **Public Health Activities**. We may use and disclose your PHI for public health activities authorized by law, such as preventing or controlling disease, reporting child or adult abuse or neglect to government authorities. PHI information to close friends or family members who are involved in or help pay for your care. We may also advise your family members or close friends about your condition or location (such as that you are in the hospital);
- **Health Oversight Activities**. We may disclose your PHI to a government agency that is legally responsible for oversight of the healthcare system or for ensuring compliance with the rules of government benefit programs, such as Medicare or Medicaid, or other regulatory programs that need health information to determine compliance;
- **For Research**. We may disclose your PHI for research purposes, subject to strict legal restrictions;
- **To Comply with the Law**. We may use and disclose your PHI as required by law;
- **Judicial and Administrative Proceedings**. We may disclose your PHI in response to a court or administrative order and, under certain circumstances, a subpoena, warrant, discovery request or other lawful process;
- **Law Enforcement Officials**. We may disclose your PHI to the police or other law enforcement officials, as required by law in compliance with a court order, warrant or other process or request authorized by law to report a crime or as otherwise permitted by law;
- **Health or Safety**. We may disclose your PHI to prevent or lessen a serious and imminent threat to your health or safety or the health and safety of the general public or other person;
- **Government Functions**. Under certain circumstances, we may disclose your PHI to various departments of the government such as the U.S. military or the U.S. Department of State;
- **Workers' Compensation**. We may disclose your PHI when necessary to comply with Workers' Compensation laws. State law may further limit the permissible ways we use or disclose your PHI. If an applicable state law imposes stricter restrictions, we will comply with that state law.

Uses and Disclosures with Your Written Authorization
We will not use or disclose your PHI for any purpose other than the purposes described in this Notice without your written authorization. The written authorization to use or disclose health information shall remain valid, which in no event shall be for more than twenty-four (24) months. You can revoke the authorization at any time.

Your Individual Privacy Rights
- **Right to Request Additional Restrictions.** You may request restrictions on our use and disclosure of your PHI for the treatment, payment and healthcare operations purposes explained in this Notice. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction.
- **Right to Receive Confidential Communications.** You may ask to receive communications of your PHI from us by alternative means of communication or at alternative locations, if you believe that communication through normal business practices could endanger you. While we will consider reasonable requests carefully, we are not required to agree to all requests. Your request must specify how or where you wish to be contacted.
- **Right to Inspect and Copy your PHI.** You may ask to inspect or to obtain a copy of your PHI that is included in certain records we maintain. Under limited circumstances, we may deny you access to a portion of your records. If you request copies, we may charge you copying and mailing costs consistent with applicable law. If your information is stored electronically and you request an electronic copy, we will provide it to you in a readable electronic form and format.
- **Right to Amend your Records.** You have the right to ask us to amend your PHI that is contained in our records. If we determine that the record is inaccurate, and the law permits us to amend it, we will correct it. If your physician or another practitioner or person created the information that you want to change, you should ask that person to amend the information.
- **Right to Receive an Accounting of Disclosures.** Upon request, you may obtain an accounting of disclosures we have made of your PHI, except for disclosures made for treatment, payment or healthcare operations, disclosures made earlier than six years before the date of your request, and certain other disclosures that are exempt by law. If you request an accounting more than once during any 12-month period, we may charge you a reasonable fee for each accounting statement after the first one.
- **Right to Receive Paper Copy of this Notice.** You may contact Customer Care at the number on your Plan ID card to obtain a paper copy of this Notice.

If you wish to make any of the requests listed above under *Your Individual Privacy Rights*, you must notify NMHC in writing.

For More Information or Complaints
If you want more information about your privacy rights, do not understand your privacy rights, are concerned that NMHC has violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact our Privacy Officer. If we discover a breach involving your unsecured PHI, we will notify you of the breach by letter or other method permitted by law. You may also file written complaints with the Secretary of U.S. Department of Health and Human Services (www.hhs.gov/ocr/privacy). Please contact our Privacy Officer to obtain the correct address for the Secretary. We will not take any action against you if you file a complaint with the Secretary or us.

Privacy Officer
You may contact our Privacy Officer at:

New Mexico Health Connections
P.O. Box 36719
Albuquerque, NM 87176
(505) 633-8020

We may change the terms of this Notice at any time. If we change this Notice, we may make the new Notice terms effective for any PHI that we maintain, including any information we created or received before we issue the new Notice.

PROTECTING YOUR CONFIDENTIALITY (GRAHAM, LEACH, BLILEY ACT)

We are committed to keeping your personal and sensitive information confidential. In order to do so, we follow state and federal laws regarding confidentiality. We have safeguards in place to protect the privacy and security of your personal information. You can trust us to collect and maintain the information we need to administer your Plan in a way that protects your privacy. Below are answers to some common questions about our confidentiality policies.

What Types of Information Do We Receive?

We receive information that we need to administer your Plan. This may include information from Members who apply for coverage; submit a claim; and information from medical Providers.

How Do We Protect Your Oral, Written, and Electronic Personal Information?

Employees and/or organizations that act on our behalf are required to keep your personal information confidential. Here is a list of things that we do to help ensure our policies are followed:

- Our Compliance Department monitors our confidentiality policies, and educates our employees on this topic;
- If possible, we provide only aggregate information that doesn't identify a person. If we need to share individually identifiable information, we have policies that protect confidentiality;
- Our employees may not disclose information to other employees unless it is needed to conduct Plan business;
- We require a written agreement from companies and/or organizations that receive confidential information from us. These partners agree that they will use any individually identifiable information only to administer the benefit plan in accordance with applicable laws;
- We may require your written authorization before we disclose your confidential information. For example, if we receive a request from a research organization or from an attorney, we would require an authorization to be signed before we release any information. Requests for confidential information for a minor, or for an adult who is unable to exercise rational judgment or give informed consent, require authorization from the Member's parent or legal guardian;
- We protect the confidentiality of former Members just as we do for current Members;

We have taken the following steps to make sure our facilities protect your confidential information:

- Facility access is limited to authorized personnel only;
- We maintain procedures for accessing, labeling and storing confidential records, including electronic records.

What Types of Information Do We Disclose and to Whom?

We will not release confidential information unless it is necessary to administer the plan, or to support NMHC programs or services. We may disclose information relating to claims and the processing of claims to:

- Providers, Plan Sponsors, and insurers that provide reinsurance;
- Plan affiliated companies, such as contracted entities providing medical services for Members;
- Regulatory agencies such as the Office of the Superintendent of Insurance (OSI); and Centers for Medicare & Medicaid Services (CMS); and accreditation organizations such as the National Committee for Quality Assurance;
- Courts or attorneys who serve us with a subpoena;
- New insurers or claims administrators who assume responsibility for administering the benefit plan;
- Companies that assist us in recovering overpayments;
- Companies that pay claims or perform Utilization Review services for us;
- Companies that assist us in recovering Benefits that were paid for claims incurred as a result of third-party negligence; and
- Companies not affiliated with NMHC that perform other types of services for us.

How Can Members Access Their Confidential Information?

All Members have a right to review their medical records. If you wish to review yours, you can submit a written request to your physician or healthcare Provider. We strive to make sure that the information we keep is accurate and complete. If a Member finds an error and wishes to correct it, he or she can contact the Provider who created the record.

Notice of Confidentiality of Domestic Abuse Information

There is a State confidentiality law that protects Member's confidential information if they have been involved in domestic abuse. In processing your application for insurance or a claim for insurance Benefits, we may receive confidential domestic abuse information from sources other than you. If this happens, we are prohibited from using it or any other confidential abuse information, or your status as a victim of domestic abuse as a basis for denying, refusing to insure, renew or reissue, cancel, or otherwise terminate your healthcare coverage. We are also prohibited from restricting or excluding coverage, or charging a higher premium for health coverage based on domestic abuse information.

As a health plan Member, you have the right to access and correct all confidential domestic abuse information that we may have about you. A full or more comprehensive notice and explanation of confidential domestic abuse information practices, as

required by law, will be provided to you upon your request. If you are or have been a victim of domestic abuse, you have the right to inform us of your wish to be designated as a protected person. As a protected person, confidential information including your address and telephone number will remain confidential, and will be disclosed and transferred only in accordance with state and federal laws.

If you wish to be designated as a protected person, please contact NMHC at (505) 633-8020 or 1-855-7MY-NMHC (1-855-769-6642).

GLOSSARY

When used in this Evidence of Coverage, the following terms are defined as follows:

An **Administrative Grievance or Complaint** 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 healthcare services, including but not limited to:

1. Administrative practices of the Healthcare Insurer that affects the availability, delivery, or quality of healthcare services;
2. Claims payment, handling or reimbursement for healthcare services; and
3. Terminations 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.

Agreement refers to the Health Insurance Contract and its Attachments. The Agreement is a contract between NMHC and the Subscriber for the provision of healthcare coverage.

An **Allowable Charge** is the amount NMHC will use to calculate payment to an In-Network Provider for a Covered Service. In-Network Providers are not allowed to bill more than the Allowable Charge.

Ambulatory Services are healthcare services delivered at a physician's office, clinic, medical center or outpatient facility in which the patient's stay does is no longer than 24 hours.

The **Annual Deductible** is the amount a Member must pay for Covered Services before health Benefits are paid by NMHC. It is also referred to as a "Deductible."

The **Annual Out-of-Pocket Maximum** is the highest dollar amount a Member will pay in Deductible, Coinsurance and Copayment amounts for Covered Services. Plan maximums, exclusions and limitations of this Plan will apply. It is also referred to as the "Out-of-Pocket Maximum."

An **Appeal of Adverse Determination** is something you do if you disagree with our decision to deny a request for coverage of healthcare services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we do not pay for a drug, item, or service you think you should be able to receive.

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.

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

A **Calendar Year** is the period of time beginning January 1 and ending December 31 of any given year.

Certification means a decision by a Healthcare Insurer that a healthcare service requested by a provider or grievant has been reviewed and, based upon the information available, meets the Healthcare Insurer's requirements for coverage and medical necessity, and the requested healthcare service is therefore approved.

A **Certified Nurse 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.

A **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.

Coinsurance is the percentage of allowable charges that you must pay for Covered Services after the Deductible has been met. The Coinsurance will be applied to the total allowable charges for the service. Refer to your Summary of Benefits and Coverage to see what your Coinsurance amounts are.

The **Consumer Operated and Oriented Plan (CO-OP)** program was created by the Affordable Care Act (ACA). The CO-OP program is designed to help create non-profit, member controlled, health insurance plans that offer ACA compliant policies in the individual and small business markets.

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

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

Continuous Quality Improvement is the effort to measure, evaluate, and improve a managed healthcare plan's processes. The purpose of the effort is to continually improve the quality of healthcare services provided to Plan Members.

The **Contract Year** is the period of time for which the Agreement is in effect.

A **Copayment** is a dollar amount that is the Member's share of the fee for Covered Services, as described in the Summary of Benefits and Coverage or Rider, if applicable, which is payable at time of service.

Covered Benefit or **Covered Services are** general terms we use to refer to all of the healthcare services and supplies that are covered by the Policy.

A **Covered Person** is a person that is entitled to receive healthcare Benefits provided by a health benefit plan.

Culturally and Linguistically Appropriate Manner of notice means a notice that meets the following requirements:

- The Healthcare Insurer must provide 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 claims and appeals (including external review) in any applicable non-English language;
- The Healthcare Insurer must provide, upon request, a notice in any applicable non-English language;
- The Healthcare Insurer must include 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 the Healthcare Insurer; and
- For purposes of this definition, 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.

A **Cytological Screening** is a pelvic exam for female patients. The exam includes a Papanicolauo test (Pap smear) or liquid based cervical cytopathology and a human papillomavirus (HPV) test, whether or not symptoms are present.

The **Deductible** is the amount a Member must pay for Covered Services before health Benefits are paid by NMHC. It is also referred to as an "Annual Deductible."

A **Dependent** is the spouse, domestic partner or natural, stepchild, adopted, or foster child of a Subscriber of the Plan.

A **Doctor of Oriental Medicine (DOM)** is one that is licensed and approved to practice acupuncture and oriental medicine.

An **Emergency Medical Condition** is one in which a prudent layperson with an average knowledge of health and medicine would believe that symptoms require immediate medical attention to help prevent the loss of life, the loss of a limb, or the loss of function of a limb. Symptoms may be due to an illness, injury, severe pain, or a medical Condition that is quickly getting worse.

Emergency Care or **Emergency Services** are covered services that are furnished by a Provider who is qualified to provide emergency services. The services are needed to evaluate or stabilize an Emergency Medical Condition.

An **Enrollee** is a Covered Person who receives healthcare Benefits under this Policy.

Essential Benefits refers to coverage for ambulatory patient services, emergency services, hospitalizations, maternity and newborn services, services for Behavioral Health 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. NMHC is not allowed to set lifetime limits to these types of Benefits as regulated by the Patient Protection and Affordable Care Act.

Evidence of Coverage (EOC) Handbook refers to this document, along with any riders or other optional coverage selected; which explains your coverage, what we must do, your rights, and what you have to do as a member of the Plan.

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:

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

The **FDA** is the United States Food and Drug Administration.

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

A **Grievance** is a type of complaint you make about the Plan or one of our providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

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 healthcare Benefits provided by the healthcare plan;
- An individual, or that person's authorized representative, who may be entitled to receive healthcare Benefits provided by the healthcare plan;
- Medicaid recipients enrolled in a Healthcare Insurer's Medicaid plan; or
- Individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase healthcare Benefits pursuant to the New Mexico Healthcare Purchasing Act.

Habilitative Services Healthcare 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 Healthcare Insurer or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of healthcare services; this includes a traditional fee-for-service health Benefits plan.

A **Healthcare Facility** is a place that provides healthcare services. This may include a hospital or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing center, a home health agency, a diagnostic, laboratory or imaging center, and a rehabilitation or other therapeutic health setting.

The **Healthcare Insurer** is the insurance provider. The insurance provider must have a valid certificate of authority in good standing under the Insurance Code.

A **Healthcare Professional** is a person that is licensed or otherwise authorized under state law to deliver medical services within the scope of his/her license.

Healthcare Services include services, supplies, procedures for 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 services or developmental delay.

Hearing Officer, Independent Co-Hearing Officer, or ICO means a healthcare 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.

An **Independent Quality Review Organization** is one that is appointed to review a Plan's practices. The organization performs external quality audits of the managed healthcare plan and reports its findings to NMHC and to the OSI. The review helps NMHC improve and enhance their operations and improve their quality of healthcare.

An **Independent Social Worker** means a person licensed as an independent social worker by the board of social work examiners, pursuant to the Social Work Practice Act.

An **In-Network Provider** is the term we use for physicians, other healthcare professionals, hospitals, and other healthcare facilities that are licensed or certified to provide healthcare services. We call them "In-Network Providers" when they have an agreement with NMHC to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of the Plan. NMHC pays network providers based on the agreements we have with the providers or if the providers agree to provide you with Plan-covered services.

Managed Care is a system or technique used by third party payors or their agents to affect access to, and control payment for Healthcare services. Managed care techniques most often include: (1) prior, concurrent and retrospective review of the medical necessity and appropriateness of services or site of services; (2) contracts with selected healthcare Providers; (3) financial incentives or disincentives for Covered Persons to use specific Providers, services, prescription drugs or service sites; (4) controlled access to and coordination of services by a case manager; and/or (5) payor efforts to identify treatment alternatives and modify benefit restrictions for high cost patient care.

A **Managed Care Health Plan (MHCP)** is a Policy, contract, certificate, or agreement offered or issued by a Healthcare Insurer, Provider service network, or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of Healthcare services. A MHCP either requires a Covered person to use healthcare Providers that are managed, owned, under contract with or employed by the Healthcare Insurer, Provider service network, or plan administrator. A MHCP does not include a traditional fee-for-service indemnity health benefit plan or a health benefit plan that covers only short-term travel, accident-only, limited benefit, an indemnity, PPO dental or non-profit dental benefit plan, student health plan, or specified disease policies.

A **Medical Director** is a physician of NMHC that serves to manage the provision of healthcare services to Plan Members.

Medicaid is a grant to a state for medical assistance programs.

Medical Necessity or Medically Necessary means healthcare services determined by a provider, in consultation with the Healthcare Insurer, 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 the Healthcare Insurer 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.

Medicare is the Federal health insurance program for people sixty-five (65) years of age or older; some disabled people under age sixty-five (65); and people with End-Stage Renal Disease.

A **Member** is any Subscriber or Dependent who elects the Plan coverage and for whom the required Premium has been received by NMHC. A Member must meet all the enrollment and eligibility requirements as defined.

Morbid Obesity is defined as a condition of weighing one hundred (100) pounds over a person's ideal body weight.

New Technology is technology that must be approved by the appropriate government regulatory bodies, and for which scientific evidence must permit conclusions about the effect of the technology on health outcomes. The technology must improve the net health outcomes. The technology must be as beneficial as any established alternatives. The improvement must be attainable outside of the setting in which investigation of the technology occurs.

A **Non-Participating Provider** is a physician, facility or ancillary Provider that is not contracted with NMHC and has not agreed to a pre-determined reimbursement schedule for the services that they provide.

A **Non-Specialist** or **Primary Care Practitioner (PCP)** is a doctor that provides general medical services. Primary Care Practitioners are able to take care of basic services such as behavioral health, preventive care, chronic disease, OB/GYN care, orthopedic, and dermatology services.

An **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.

OSI refers to the Office of the Superintendent of Insurance.

Other In-Network Healthcare Facility is any facility, other than an In-Network medical hospital; which is operated by or has an agreement with NMHC to provide services to our Members.

An **Out-of-Network Provider** is a physician or other practitioner or facility that is not contracted with NMHC to provide services to Members of the Plan for a pre-determined cost.

In-Network Provider is the term we use for a physician, other healthcare professionals, hospitals, and other healthcare facilities that are licensed or certified to provide healthcare services. We call them "In-Network Providers" when they have an agreement with NMHC to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of the Plan. NMHC pays network providers based on the agreements we have with the providers or if the providers agree to provide you with plan-covered services.

A **Physician** is a licensed doctor of medicine and/or surgery or Practitioner of the Healing Arts.

A **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 in the State of New Mexico to practice medicine under the supervision of a licensed physician.

The **Plan** is the health insurance plan available from NMHC and selected by the Subscriber to provide Covered Benefits and Services to the Subscriber and eligible dependents.

A **Plan Year** is the time frame from your effective date to your renewal date, and to each renewal date thereafter, specifically January 1 through December 31.

A **Policy** is a contract (generally a standard form contract) between the insurer and the Subscriber, known as the policyholder, which determines the claims that the insurer is legally required to pay.

Policyholder is the Subscriber to whom the Policy is issued.

The **Preferred Drug List** is a listing of approved drug products. These drugs and medications have been approved in accordance with parameters established by NMHC. The list is subject to periodic review and is amended as required.

The **Premium** is the sum of money paid to NMHC by the Subscriber for the receipt of services and Benefits associated with the Plan.

Prescription Drugs are drugs for which sale or legal dispensing requires the order of a physician.

A **Primary Care Practitioner (PCP)** is the physician or other person you see first for most health problems. A PCP coordinates, supervises, provides, and maintains the continuity of care.

Primary Care Services are services provided by a PCP or primary provider of healthcare services.

Prior Approval is approval from NMHC in advance for certain services or drugs that may or may not be on our formulary. Some services and medications are only covered if your doctor or other network provider receives Prior Approval from NMHC.

A **Prospective Enrollee** is an individual eligible for enrollment; or a person who has expressed interest in purchasing coverage and is eligible for coverage through NMHC.

A **Provider** or **Practitioner** is a licensed hospital, physician or other healthcare provider that is authorized to render health services within the scope of their license.

The **Provider Network** means the physicians, pharmacies, facilities and other healthcare providers and practitioners that have contracted with NMHC.

A **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.

A **Registered Lay Midwife** is any person who practices lay midwifery and is registered as a lay midwife by the New Mexico Department of Health.

A **Rider** is an addition that is made to the Policy that refers to Benefits not noted in the Summary of Benefits and Coverage. It is a part of the Policy and subject to the same general conditions of the regular Policy. It is not a separate Policy. It contains information regarding Benefits in addition to those in the Summary of Benefits and Coverage. Lastly, it is paid for by an addition to the basic premium.

A **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.

The **Service Area** is the state of New Mexico.

Skilled Nursing Care refers to services ordered by a physician that require the skills of professional personnel such as a registered nurse or licensed practical nurse. 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 nursing care.

A **Specialist** is a physician that is certified to provide services for a specific type of medicine.

A **Subscriber** is a person to whom a Policy is issued. A Subscriber must meet the established eligibility requirements and is entitled to enroll in the Plan on his or her own behalf, and not as the dependent of another person.

The **Summary of Benefits and Coverage** is a document that describes Plan Benefits such as Copayments, Coinsurance and Deductible amounts. The Summary of Benefits and Coverage is a supplement to this Evidence of Coverage.

The **Termination Date** is midnight of the date on which a Member's coverage ends.

Termination of Coverage means the cancellation or non-renewal of coverage provided by a Healthcare 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.

A **Tertiary Care Facility** is a hospital 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. Patients of these facilities need high-risk perinatal care and intensive intrapartum care.

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 the Healthcare Insurer consistent with the federal, national, and professional practice guidelines that are used by a Healthcare Insurer in determining whether to certify or deny a requested healthcare service.

Urgent Care is care for a condition that is not an emergency; but is an unforeseen medical illness, injury, or condition that requires immediate care when NMHC's network of providers is unavailable or inaccessible.

An **Urgent Illness** is a non-life-threatening illness that requires prompt medical attention. Some examples of urgent situations are sprains, strains, vomiting, cramps, diarrhea, bumps, bruises, cold, fever, small lacerations, and minor burns.

Usual, Customary, and Reasonable Charges is the amount NMHC will pay for care given to a Member by an Out-of-Network Provider. Usual, Customary, and Reasonable rates means that healthcare services, medical supplies and payment rates for healthcare services provided by a healthcare practitioner are at or near the median rate paid for similar healthcare services within a surrounding geographic area where the charges were incurred. The surrounding geographic area may be determined by the type of service and access to that service in the geographic area.

Utilization Review or **Utilization Management** is the process of reviewing and managing a Member's medical Conditions so the Member receives the right care, by the right Provider, at the right time. This process maximizes Plan Benefits and ensures quality healthcare.

A **Women's Healthcare Provider** is certified healthcare provider that specializes in women's health.

Workers' Compensation Policy or Plan refers to the workers' compensation plan of the fifty (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.