New Mexico BlueHMO Preferred (Formerly Lovelace Health Plan administered by BlueCross BlueShield of New Mexico)

http://www.bcbsnm.com/fehb-nmbluehmo (855)235-1039 Statewide

BlueCross BlueShield of New Mexico

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

2016

A Health Maintenance Organization

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details.

Serving: **The State of New Mexico**

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 12 for requirements.

IMPORTANT
- Rates: Back Cover
- Changes for 2016: Page 13
- Summary of benefits: Page 77

Enrollment codes for this plan

Q11: Self Only
Q13: Self plus One
Q12: Self plus Family

Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-079

Important Notice from Lovelace Health Plan About

Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the New Mexico BlueHMO Preferred Health Plan c/o Blue Cross Blue Shield of New Mexico prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY: 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048)

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Introduction

This brochure describes the benefits under our contract (CS 1911) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at (855) 235-1039 statewide or through our website: www.bcbsnm.com. The address forNew Mexico BlueHMO Preferred HealthPlan administrative office is:

New Mexico BlueHMO Preferred
c/o BlueCross BlueShield of New Mexico
4373 Alexander Boulevard N.E.
Albuquerque, NM 87107

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. If you enroll in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2016 unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2016 and changes are summarized on page 13. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means New Mexico BlueHMO preferred c/o Blue Cross Blue Shield of New Mexico.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at (855) 235-1039 statewide and explain the situation.
  - If we do not resolve the issue

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 (unless he/she was disabled and incapable of self support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
    - "Exactly what will you be doing?"
    - "About how long will it take?"
    - "What will happen after surgery?"

- "How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen. These conditions and errors are called "Never Events." When a Never Event occurs neither your FEHB plan nor you will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events, if you use contracted preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum Value Standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, and give you brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment
  - How you can cover your family members
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before, to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and your eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2016 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2015 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Upon divorce**

If you are divorced from a Federal employee, or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's website at http://www.opm.gov/healthcare-insurance/healthcare/plan-information.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc. You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit **www.HealthCare.gov**. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

Questions regarding what protections apply and what protections do not apply to a grandfathered health plan, may be directed to us at (855) 235-1039. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

Questions regarding protections may be directed to us at (855) 235-1039. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General features of our HMO Plan

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. We compensate our participating providers in ways that are intended to emphasize preventive care, promote quality of care, and assure the most appropriate use of medical services. You can discuss with your provider how he is compensated by us. The methods we use to compensate participating providers are:

Discounted fee for service - payment for service is based on an agreed upon discounted amount for the services provided.

Capitation - Physicians, provider groups and physician/hospital organizations are paid a fixed amount at regular intervals for each Member assigned to the physician, provider group or physician/hospital organization, whether or not services are provided. This payment covers the physician and/or, where applicable, hospital or other services covered under the benefit plan. Medical groups and physician/hospital organizations may in turn compensate providers using a variety of methods.

Capitation offers health care providers a predictable income, encourages Physicians to keep people well through preventive care, eliminates the financial incentive to provide services that will not benefit the patient, and reduces paperwork.

Providers paid on a "capitated" basis may participate with us in a risk sharing arrangement. They agree upon a target amount for the cost of certain health care services, and they share all or some of the amount by which actual costs are over target. Provider services are monitored for appropriate utilization, accessibility, quality and Member satisfaction.

We may also work with third parties who administer payments to Participating Providers. Under these arrangements, we pay the third party a fixed monthly amount for these services. Providers are compensated by the third party for services provided to health plan participants from the fixed amount. The compensation varies based on overall utilization.

Salary - Physicians and other providers who are employed to work in our medical facilities are paid a salary. The compensation is based on a dollar amount, decided in advance each year, that is guaranteed regardless of the services provided. Physicians are eligible for any annual bonus based on quality of care, quality of service and appropriate use of Medical Services.

Bonuses and Incentives - Eligible Physicians may receive additional payments based on their performance. To determine who qualifies, we evaluate Physician performance using criteria that may include quality of care, quality of service, accountability and appropriate use of Medical Services.

Per Diem - A specific amount is paid to a hospital per day for all health care received. The payment may vary by type of service and length of stay.

Case Rate - A specific amount is paid for all the care received in the hospital for each standard service category as specified in our contract with the provider (e.g., for a normal maternity delivery).

Your rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Website (www.opm.gov/insurelists) the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence
- Profit status

If you want more information about us, call (855) 235-1039 statewide or write to New Mexico BlueHMO Preferred c/o Blue Cross Blue Shield of New Mexico 4373 Alexander Boulevard N.E., Albuquerque, NM 87107. You may also visit our Website at www.bcbsnm.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is the State of New Mexico.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2016

Do not rely only on these change descriptions; this Section is not an **official** statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- Self plus One enrollment type has been added effective January 1, 2016.
- We have removed the exclusion for services, drugs, or supplies related to sex transformations. See page 57.

Changes to this Plan

- Your share of the non-Postal and Postal premiums will increase for Self Only, Self Plus One, and for Self and Family. See page 79.
- Plan name change from Lovelace Health Plan administered by BlueCross BlueShield of New Mexico to New Mexico BlueHMO Preferred
- There are no benefit changes.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (855) 235-1039 statewide or write to us at New Mexico BlueHMO Preferred c/o BlueCross BlueShield of New Mexico, 4373 Alexander Boulevard N.E., Albuquerque, NM 87107. You may also request replacement cards through our Website: www.bcbsnm.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Website: www.bcbsnm.com.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Website: www.bcbsnm.com.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care**

Your primary care physician can be a general practitioner, family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

New Mexico BlueHMO Preferred c/o Blue Cross Blue Shield of New Mexico offers choice and convenience through our Open Access feature. This means that you do not need a referral from your Primary Care Physician to see some network specialists.

Your first contact for advice and direction should be your primary care physician. Your PCP's role is to coordinate your overall healthcare. Your PCP should still be your contact for routine and preventive care, recommending specialists and coordinating hospitalizations and follow-up care.

Please note: regardless if your PCP or you self refer to a specialist, it is your responsibility to confirm if the specialist is participating with our plan.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Website: www.bcbsnm.com or contact us at (855) 235-1039.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.
- Your primary care physician will create your treatment plan. The physician may have to get an authorization or approval from us beforehand.
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan. Please make sure the specialist is a contracted provider with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist.
- If you have a chronic and disabling condition and lose access to your specialist because we:

-terminate our contract with your specialist for other than cause;

-drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan;

-reduce our service area and you enroll in another FEHB plan;

You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

Hospital care

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (855) 235-1039 statewide. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out;
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need Prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalizations, the pre-service claim approval process only applies to care shown under *Other services.*

- **Inpatient hospital admission**

Precertification is the process by which - prior to your inpatient hospital admission - we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary and follows generally accepted medical practice. You must obtain prior authorization for:

- Transplants
- Inpatient and Outpatient Hospital Services
- MRI, CT, & PET Scans
- Rehabilitative Therapy
- Growth Hormone Therapy (GHT)
- Skilled Nursing Facility Services
- Home Health Services,
- Second Surgical Opinions
- Services provided by a Non-Plan Provider
- Durable Medical Equipment and Prosthetic Devices

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you or your representative, must call us at (800) 325-8334 statewide before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgement of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at (855) 235-1039 statewide. You may also call OPM's Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at (855) 235-1039 statewide. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

Non-network providers or facilities are not covered in a non-emergency situation. If services are rendered without prior approval, you may submit an appeal on services. Please see Section 8 Disputed claims process.

In emergency situations, please go to the closest facility available. When time allows, contact the New Mexico BlueHMO Preferred c/o Blue Cross Blue Shield of New Mexico Prior Authorization Department at (800) 325-8334 statewide.

Please note: If you receive services without Prior Authorization, you will be obligated to pay for the unauthorized services. Will will not pay for unauthorized services.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification or an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care:

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you see your primary care physician, you pay a copayment of $20 per office visit, and when you go to the hospital, you pay $250 per admission after satisfying the $250 annual deductible.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not accumulate toward any deductible.

- The calendar year deductible is $250 per person. For example, for 2 or more, each person will pay a $250 calendar year deductible. The plan deductible is **only** applicable to inpatient and outpatient hospital facility fees.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care.

Example: In our plan, you pay 20% of our allowance for durable medical equipment and 50% of allowance for infertility services.

Your catastrophic protection out-of-pocket maximum

Your catastrophic protection out-of-pocket maximum

After your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $2,500 for Self Only, or $5,000 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $2,500 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Example Scenario: Your plan has a $2,500 Self Only maximum out-of-pocket limit and a $5,000 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $2,500 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of $5,000, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $5,000 for the calendar year before their qualified medical expenses will begin to be covered in full.

However, copayments and coinsurance, if applicable for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Dental Discount benefits
- Eyeglasses or contact lenses
- Expenses for services and supplies that exceed the stated maximum dollar or day limit
- Expenses from utilizing out-of-network providers

Be sure to keep accurate records and receipts of your copayments and coinsurance to ensure the plan's calculation of your out-of-pocket maximum is reflected accurately.

The catastrophici protection out of pocket maximum for pharmacy copayments and coinsurance total $3,500 per person or $7,000 per Self Plus One or family enrollment in any calendar year.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits Overview

This Plan offers only a High Option. The benefit package is described in Section 5. Make sure that you review the benefits that are available under this option in which you are enrolled.

The High Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections.

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Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient surgical department of a hospital.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost - sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office	Adult - $20 per visit to your primary care physician Children - nothing per visit to primary care physician $35 per visit to a specialist
Professional services of physicians • In a skilled nursing facility • Office medical consultation • Second surgical opinion	Adult - $20 per visit to your primary care physician Children - nothing per visit to primary care physician $35 per visit to a specialist
At home	Nothing
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG **Note: You pay nothing for Lab, X-Rays and other diagnostic tests, however a provider or a facility copayment may apply depending on where you receive the service. Refer to the physician's services in this section and facility changes in Section 5(c).**	Nothing
• CT Scans, MRI and PET Scans	$100 per test

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay
Lab, X-ray and other diagnostic tests (cont.)	**High Option**
Sleep Studies performed in an overnight stay without inpatient admission	$100 per test
Sleep Studies performed in an overnight stay with inpatient admission	$100 per admission
Preventive care, adult	**High Option**
Annual routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening - Colonoscopy screening	Nothing
Routine Prostate Specific Antigen (PSA) test	Nothing
Well woman care; including, but not limited to: • Routine Pap test • Human papillomavirus testing for women • Annual counseling for sexually transmitted infections. • Annual counseling and screening for human immunedeficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	Nothing
Routine mammogram	Nothing
Adult routine immunizations, endorsed by the Centers for Disease Control and Prevention (CDC)	Nothing
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicetaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/	
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.*	*All charges*

Benefit Description	You pay
Preventive care, children	**High Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care charges for routine examinations, immunizations and care (up to age 26) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction, which include: - Ear exams through age 21 to determine the need for hearing correction, which include: - Examinations done on the day of immunizations (up to age 26)	Nothing
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicetaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/	
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestastion or first prenatal visit for women at a high risk. • Delivery • Postnatal care	Adult - $20 per visit to your primary care physician Children - nothing per visit to primary care physician $35 per visit to a specialist for the first office visit to confirm pregnancy; no copay for all pre-/post-delivery visits thereafter.
Breastfeeding support, manual breast pump and supplies, and counseling for each birth	Nothing
Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 16 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	

Benefit Description	You pay
Family planning	**High Option**
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit. **You pay nothing for Voluntary sterilization, however a provider or facility copayment may apply depending on where you receive the service. Refer to the physician's services in this section and facility charges in Section 5 (c).**	Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic screening*	*All charges*
Infertility services	**High Option**
Diagnosis of infertility	Adult - $20 per visit to your primary care physician Children - nothing per visit to primary care physician $35 per visit to a specialist
Treatment of infertility, such as: • Artificial insemination • Intravaginal insemination (IVI) • Intracervical insemination (ICI) • Intrauterine insemination (IUI) **Note:** Infertility is the condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35. For women without male partners or exposure to sperm, infertility is the inability to conceive after six cycles of Artificial Insemination or Intrauterine Insemination performed by a qualified specialist using normal quality donor sperm. These 6 cycles (including donor sperm) are not covered by the Plan as a diagnosis of infertility is not established until the cycles have been completed. **Oral fertility drugs are covered under the prescription drug benefit. We do not cover injectible fertility drugs.**	50% per treatment/surgical procedure

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**High Option**
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*
Allergy care	**High Option**
• Testing and treatment • Allergy injections	Adult - $20 per visit to your primary care physician Children - nothing per visit to primary care physician $35 per visit to a specialist
Allergy serum	Nothing
Not covered: • *Provocative food testing and Sublingual allergy desensitization* • *Self-Administered allergy injections*	*All charges*
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 38. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	Nothing

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	**High Option**
Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder	Adult - $20 per visit to your primary care physician Children - nothing per visit to primary care physician
Cancer Clinical Trials	**High Option**
Coverage shall be provided for Medically Necessary covered routine patient care costs at a New Mexico facility, incurred as a result of the Member's participation in a cancer clinical trial if: 1) The clinical trial is undertaken for the purposes of the prevention, early detection or treatment of cancer for which standard cancer treatment exists; 2) The clinical trial is not designed exclusively to test toxicity or disease pathophysiology, and it has a therapeutic intent; 3) 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; 4) The clinical trial is being provided as part of a study 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; 5) 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; 6) 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; and (b) agree to accept reimbursement as payment in full from New Mexico BlueHMO Preferred c/o Blue Cross Blue Shield of New Mexico and that are not more than the level of reimbursement applicable to other similar services provided by the health care Providers within Blue Cross Blue Shield's network.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.

Cancer Clinical Trials - continued on next page

Benefit Description	You pay
Cancer Clinical Trials (cont.)	**High Option**
7) There is no non-investigational treatment equivalent to the clinical trial; and For the purposes of this specific Covered Benefit and Service, the following terms have the following meaning: • "Routine Patient Care Cost" - means (1) A medical service or treatment that is a benefit under the Plan that would be covered if the patient were receiving standard cancer treatment; or (2) adrug provided to a patient during a cancer clinical trial if the drug has been approved by the United States Food and Drug Administration, whether or not that organization has approved the drug for use in treating the patient's particular Condition, but only to the extent that the drug is not paid for by the manufacturer, distributor or Provider of the drug. Routine Patient Care Cost does not include (1) the cost of an investigational drug, device or procedure; (2) the cost of a non-health care service that the patient is required to receive as a result of participation in the cancer clinical trial; (3) costs that would not be covered by the patient's if non-investigational treatments were provided; or (4) costs paid or not charged for by the cancer clinical trial Providers.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
Physical and occupational therapies	**High Option**
• Qualified Physical Therapists • Occupational Therapists • Cardiac and pulmonary rehabilitation programs Note: This benefit does include rehabilitative and habilitative services. We only cover therapy when a provider: • orders the care	$35 per office visit Nothing per visit during covered inpatient admission
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	**High Option**
Unlimited outpatient visits per condition Note: This benefit does include rehabilitative and habilitative services.	$35 per office visit Nothing per visit during covered inpatient admission.

Benefit Description	You pay
Hearing services (testing, treatment, and supplies)	**High Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist. • Fitting and dispensing services including ear molds as necessary to maintain optimal fit, provided by an audiologist, a hearing aid dispenser or licensed physician; • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Coverage for one hearing aid per hearing-impaired ear. We limit coverage to a maximum benefit limit of $2,200 every 36 months. Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, Children.* Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	Adult - $20 per visit to your primary care physician Children - nothing per visit to primary care physician $35 per visit to a specialist
Not covered • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
• One complete routine eye exam, including eye refractions (to determine the need for vision correction) is covered once every calendar year through participating providers. • One pair of eyeglasses and/or contact lenses (including fitting services) is covered once every calendar year limited to a $150 maximum Plan payment. Just find a Davis Vision doctor at bcbsnm.com or call (800) 350-1377. Note: See Preventive care, children for eye exams for children	$5 per visit to a Davis Vision network provider All charges above the maximum plan payment amount shown for eyeglasses and/or contact lenses.
Medically necessary service - disease or injury to the eye • After cataract surgery, the first pair eyeglasses and/or contact lenses is covered by the Plan. • Contact lenses for the medically necessary treatment of keratoconus are covered.	Adult - $20 per visit to your primary care physician Children - nothing per visit to primary care physician $35 per visit to a specialist
Not covered: • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*

Benefit Description	You pay
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	Adult - $20 per visit to your primary care physician Children - nothing per visit to primary care physician $35 per visit to a specialist
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet, bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	**High Option**
External prosthetic appliances are covered subject to Prior Authorization. Coverage includes but is not limited to the following: • Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • External hearing aids, see hearing services on page 30. • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical and anesthesia services. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	20% of allowable charges.
Not covered: • *Orthopedic shoes, arch supports, foot orthotics, shoe lifts and wedges are not covered unless they are medically necessary for the treatment of diabetes.* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	**High Option**
• *Prosthetic replacements due to wear and tear, loss, theft or destruction* • *Biomechanical devices* • *Penile prosthetics* • *Prosthetic replacements provided less than (5) years after the last one we covered*	*All charges*
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment of durable medical equipment prescribed by your Plan physician, and received by a vendor approved by the Plan. • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs (limited to the lowest cost alternative to satisfy medical necessity) • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors and blood glucose monitors for the legally blind • Insulin pumps and infusion devices • Respirators Note: Your PCP will prescribe and arrange for a participating health care provider to rent or sell you the durable medical equipment. We will not cover equipment received from a non-participating health care provider unless your PCP has received our prior authorization.	Oxygen - Nothing All other DME - 20% of allowable charges.
Not covered: • *Hygienic or self-help items or equipment, or items or equipment that are primarily for comfort or convenience, such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment;* • *Environmental control equipment, such as air purifiers, humidifiers, and electrostatic machines;* • *Institutional equipment such as air fluidized beds and diathermy machines;* • *Consumable medical supplies including, but not limited to, bandages and other disposable supplies, skin preparations, test strips, ostomy supplies, surgical leggings, elastic stockings and wigs.*	*All charges*

Benefit Description	You pay
Home health services	**High Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	Nothing
Not covered • *Nursing care requested by, or for the convenience of, the patient or the patient's family.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.* • *Services primarily for rest, domiciliary or convalescent care.*	*All charges*
Chiropractic	**High Option**
• Chiropractic care is limited to 20 visits in a calendar year.	$35 per office visit
Alternative treatments	**High Option**
Acupuncture – is limited to authorized referrals for the treatment of chronic musculoskeletal or neurogenic pain. The benefit is limited to 20 visits every calendar year.	Adult - $20 per visit to your primary care physician Children - nothing per visit to primary care physician $35 per visit to a specialist
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Massage services*	*All charges*
Special medical foods	**High Option**
Special medical foods are covered for the treatment of inborn errors of metabolism that involve amino acids, carbohydrate and fat metabolism, for which medically standard methods of diagnosis, treatment, and monitoring exist. A genetic inborn error of metabolism is a rare, inherited, disorder that is present at birth, results in death if untreated and requires special medical foods. The foods must be authorized by New Mexico BlueHMO Preferred c/o BlueCross BlueShield of New Mexico. Special medical foods include nutritional substances in any form that are: • Formulated to be consumed or administered internally • Specifically processed or formulated to be distinct in one or more nutrients present in natural foods	Nothing

Special medical foods - continued on next page

Benefit Description	You pay
Special medical foods (cont.)	**High Option**
• Intended for the medical and nutritional management or patients with limited capacity to metabolize ordinary food • Essential to optimize growth, health and metabolic homeostasis Must be obtained from New Mexico BlueHMO Preferred c/o Blue Cross Blue Shield's Participating Vendor/Provider	Nothing
Not covered: *Foods obtained from a grocery store or internet provider*	*All charges*
Educational classes and programs	**High Option**
Coverage is provided for: • Tobacco cessation programs, including individual/group telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for up to four counseling sessions for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
• Diabetes self management • Childhood obesity education	$10 per office visit Nothing
Coverage for other educational classes and programs is limited to: • Nutrition • Care giving; Families coping with chronic illness • Parenting Children with Attention Deficit Hyperactivity disorder • It's up to You to Bring it Down: A class for people managing hypertension • Breast Health Program • Disease Management Programs	Cost varies by class and/or program. Call our customer service department at (855) 235-1039 statewide for details.

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost - sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Insertion of internal prosthetic devices . See 5(a) – *Orthopedic and prosthetic devices* for device coverage information .	Nothing
• Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing
Surgical treatment of morbid obesity (Bariatric Surgery) • A condition in which an individual weighs 200% of his or her normal weight according to current underwriting standards; eligible members must be age 18 or over	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
• The patient must first meet the medical guidelines of New Mexico BlueHMO Preferred c/o BlueCross and BlueShield of New Mexico AND also meet the guidelines established by the Bariatric surgical facility where the surgery would be performed. These guidelines may include physical and psychological testing. If the patient does not meet the guidelines of the Bariatric surgical facility, the facility may elect not to proceed with the surgery. • Generally, patients must be at least 100 pounds over their ideal weight, and have a body mass index (BMI) exceeding 40. • Patients with a BMI over 35, accompanied by another clinically serious condition (e.g., diabetes, hypertension, etc) may also be considered for this procedure.	Nothing
Not covered: • *Surgeries related to sex transformation* • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedemas - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All charges*

Benefit Description	You pay
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, with the prior approval of Plan Medical Director, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • TMJ treatment and services (non-dental); and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	**High Option**
These **solid organ transplants** are covered. These Solid organ transplants are subject to medical necessity and experimental/ investigational review by the Plan. See Other services under *You need Prior Plan approval for certain services* on page 15. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung; single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	Nothing
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for:	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
• AL Amyloidosis •Multiple myeloma (de novo and treated) •Recurrent germ cell tumors (including testicular cancer)	Nothing
These **blood or marrow stem cell transplants** limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered statisfied if the patient meets the staging description. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency disease (e.g., Wiskott-Aldrich syndrome)	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle Cell Anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	Nothing
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphomas with recurrence (relapsed) - Aggressive non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e.,, myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	Nothing
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated Center of Excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Myeloproliferative disorder (MDDs) - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MSDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast Cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphomas/small lymphocytic lymphoma (CLL/SLL) - Early state (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	Nothing
National Transplant Program (NTP) -	See Centers of Excellence page 56.
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*

Benefit Description	You pay
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- In this section a calendar year deductible applies to **inpatient and outpatient surgical hospital facility fees**. The calendar year deductible is: $250 per person. For example, for 2 or more, each person will pay a $250 calendar deductible. After the deductible has been satisfied, co-pay still applies.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost - sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$250 per admission after $250 annual plan deductible is satisfied.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen	Nothing
• Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	Nothing
Sleep Studies performed in an overnight stay without inpatient admission Sleep Studies performed in an overnight stay with inpatient admission	$100 per test $100 per admission
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High Option**
• *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma , if not donated or replaced • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$100 per facility use after $250 annual plan deductible is satisfied.
Preventive Care Outpatient Hospital Facility	Nothing
Not covered: Blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Covered for up to 60 days per calendar year when full-time skilled nursing care is necessary, and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. • Skilled and general nursing services • Physician visits • Physiotherapy • X-rays • Administration of drugs, medications and fluids	Nothing
Not covered: • *Personal comfort items; such as television and telephone* • *Custodial care* • *Rest cures, domiciliary or convalescent care*	*All charges*

Benefit Description	You pay
Hospice care	**High Option**
Hospice care for a patient who, as certified by the Plan doctor, is in the terminal stages of illness and who has a life expectancy of six months or less. Hospice care services include: • Inpatient care • Outpatient care • Physician services • Psychologist, social worker or family counselor services for individual or family counseling	Nothing
Not covered: • *Independent nursing* • *Homemaker services, including services and supplies that are primarily to aid you or your dependent in daily living* • *Services of a person who is a member of your family who normally resides in your house* • *Services or supplies not listed in the Hospice Care Program* • *Services for curative or life-prolonging procedures* • *Bereavement counseling* • *Services for respite care* • *Nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals*	*All charges*
Ambulance	**High Option**
Local professional ambulance service when medically appropriate • Ground Ambulance • Air Ambulance	$50 per ground ambulance trip $100 per air ambulance trip

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Be sure to read section 5(h), *Special features* for *Travel benefit/services overseas.*

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergency Services Both In and Out of our service area

In the event of an emergency, get help immediately. Go the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a referral from your PCP for emergency services, but you do need to call your PCP as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your PCP will coordinate it and handle the necessary authorizations for care or hospitalization. Participating providers are on call twenty-four (24) hours a day, seven (7) days a week, to assist you when you need Emergency Services.

If you receive emergency services outside the service area, you must notify us as soon as reasonably possible. We may arrange to have you transferred to a participating provider for continuing or follow-up care if it is determined to be medically safe to do so.

Emergency services are defined as the medical, psychiatric, surgical, hospital and related health care services and testing, including ambulance service, which are required to treat a sudden unexpected onset of a bodily injury or a serious illness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital on the UB92 claim form or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

Continuing or follow-up treatment, whether in or out of the service area, is not covered unless it is provided or arranged for by your PCP or upon Prior Authorization of our Medical Director.

Benefit Description	You pay
Emergency within our service area	**High Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the emergency room copay if you are admitted to the hospital.	$20 per office visit $40 per visit. $100 per visit.
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	**High Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the emergency copay if you are admitted to the hospital.	$20 per office visit $40 per visit. $100 per visit.
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.*	*All charges*
Ambulance	**High Option**
Local professional ambulance services when medically appropriate. Air ambulance is covered when medically necessary. • Ground Ambulance • Air Ambulance Note: See 5(c) for non-emergency service.	$50 per ground ambulance trip $100 per air ambulance trip

Section 5(e). Mental health and substance abuse benefits

Important things you should keep in mind about these benefits:

- Some benefits require a preauthorization.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plan on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay
Professional Services	**High Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Adult - $20 per visit Children - nothing per visit

Professional Services - continued on next page

Benefit Description	You pay
Professional Services (cont.)	**High Option**
• Applied Behavior Analysis (ABA) for the treatment of autism	Adult - $20 per visit Children - nothing per visit
Diagnostics test	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner. • Outpatient diagnostic test provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing
Inpatient hospital or other covered facility	**High Option**
• Inpatient and partial hospitalization services • Substance Abuse Rehabilitation is covered when provided in an inpatient setting. • Residential Treatment Center (RTC) services for the treatment of behavioral disorders and substance abuse.	$250 per admission after $250 annual plan deductible is satisfied.
Outpatient hospital or other covered facility	**High Option**
• Individual Family or Marital Therapy • Intensive Outpatient (IOP) • Group Therapy	Adult - $20 per visit Children - nothing per visit
Not covered	**High Option**
Services that are not part of a preauthorized approved treatment plan.	*All charges.*

Preauthorization

All behavioral health and substance abuse services, other than the outpatient services listed above, do not require a referral, but do require preauthorization (certification) which is obtained from us by the provider of the services.

Behavioral health outpatient services do not require a referral or pre-certification (authorization) from us. You can obtain assistance with determining which providers in your area might be best qualified to provide you with the behavioral health or substance abuse treatment services you need by calling us and speaking to a behavioral health Care Coordinator.

Limitation

We will limit your benefits if they are not medically necessary.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- After your copayments or coinsurance for prescribed drugs and medications total $3,500 per Self Only or $7,000 per Self Plus One or Self and Family, in any calendar year, you do not have to pay any more for prescribed drugs and medications.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at a Plan network pharmacy, or by mail through the Plan's mail-order pharmacy for a maintenance medication,
- **We use a formulary.** A formulary is a listing of approved drug products. The drugs and medications included have been approved in accordance with parameters established by us. This list is subject to periodic review and is amended as required.

If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a preferred name brand drug from a formulary list. This list of preferred name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call (855) 235-1039 statewide.

- **These are the dispensing limitations.** Your copayment for preferred generic retail prescription drugs that are on the formulary is $5. Your copayment for preferred name brand retail prescription drugs that are on the formulary but do not have a preferred generic equivalent is $35. Your copayment for preferred name brand drugs that are on the formulary but do have a generic equivalent OR for drugs that are not on the formulary is $60. Your co-insurance for preferred specialty medications will be 50% of medication cost. The minimum you will pay per speciality prescription will be $50 but not to exceed $250. The catastrophic protection out-of-pocket maximum is up to $3,500 per person or $7000 per family in any calender year. Each prescription order or refill is limited to a consecutive thirty (30) day supply at a retail participating pharmacy, unless limited by the drug manufacturer's packaging.

Members called to active military duty in a time of national or other emergency who need to obtain a greater-than-normal supply of prescribed medications should call our Customer Care Center at (855) 235-1039 statewide.

- **Maintenance medications** prescribed by Plan doctors may also be obtained through our mail order program. Your copayment for preferred generic mail order prescription drugs that are on the formulary is $10. Your copayment for preferred name brand mail order prescription drugs that are on the formulary but do not have a generic equivalent is $70. Your copayment for preferred name brand drugs that are on the formulary but do have a generic equivalent OR for drugs that are not on the formulary is $120. Each prescription order or refill is limited to a consecutive ninety (90) day supply at a mail order participating pharmacy, unless limited by the manufacturer's packaging.
- **A generic equivalent** will be dispensed if it is available, When a member or provider insists on obtaining a preferred name brand drug that has a generic equivalent, the prescription is available to the member at the $60 copayment level (i.e., the third tier).

- **Why use generic drugs?** Generic drugs offer a safe and economical way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A preferred generic prescription costs you - and us - less than a name brand prescription.
- **Prior Authorization:** As part of the Prior Authorization process, the Plan uses a "Step Therapy" program. This program requires that before a member may receive Prior Authorization, he/she must first attempt the use of a lesser-priced alternative medication. This helps the member and the attending physician to determine if an intermediate "step" or course of drug treatment might be just as effective. If using a step therapy medication is not effective for the member, or if it is documented that the member has previously attempted the use of one or more Step Therapy alternative medications, his or her physician may then apply to the New Mexico BlueHMO Preferred c/o Blue Cross Blue Shield of New Mexico Pharacy Exception Center for a Prior Authorization exception. Examples of Step Therapy drugs are: Cozaar, Hyzaar, Estratest, Diovan, Lotrel, Coreg, Oxytrol, Neurontin, Singulair and Soriatane.
- **When you do have to file a claim.** Please refer to Section 7 Filing a claim for covered services.
- Member must meet New Mexico BlueHMO Preferred c/o Blue Cross Blue Shield of New Mexico Prior Authorization process to obtain certain drugs, including but not limited to Actos, Amaryl, Arava, Celebrex, Detrol, Aciphex, Nexium and Prevacid.

Benefit Description	You pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin, glucose test strips, and other prescription diabetic supplies • Disposable needles and syringes for the administration of covered medications • Oral fertility medications • Intravenous fluids and medication for home use, implantable drugs, and some injectable drugs are covered under Medical and Surgical Benefits. • Drugs to treat sexual dysfunction are limited to 8 doses per month. (Prior authorization is required by the Plan) • Oral agent for controlling blood sugar • Growth Hormones (Prior Authorization is required by the Plan)	**Retail Pharmacy** Tier 1 - $5 per preferred generic formulary drug Tier 2 - $35 per preferred name brand formulary drug with no generic equivalent Tier 3 - $60 per preferred name brand formulary drug with generic equivalent OR per non-preferred formulary drug Tier 4 - 50% of medication cost for preferred specialty medications. For each specialty prescription, you will pay 50% of the cost. The minimum you will pay per prescription will be $50 but not to exceed $250. (Mail Order not available) **Mail Order (Maintenance medications only)** Tier 1 - $10 per preferred generic formulary drug Tier 2 - $70 per preferred name brand formulary drug with no generic equivalent Tier 3 - $120 per preferred name brand formulary drug with generic equivalent OR per non-preferred formulary drug Tier 4 - Specialty medication not available for Mail Order Note: If there is no preferred generic equivalent available, you will still have to pay the preferred brand name copay.

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
Oral prescription medications for the treatment of cancer.	Nothing
Women's contraceptive drugs and devices The "morning after pill" is considered a preventive service under contraceptives, with no cost to the member if prescribed by a physician and purchased at a network pharmacy. The "morning after pill" should be addressed under the pharmacy benefit as an over-the counter (OTC) emergency contraceptive drug. Note: Over-the-counter contraceptives drugs and devices approved by the FDA require a written prescription by an approved provider.	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Injectable Fertility drugs (see Infertility benefit under Medical and Surgical benefits for limited coverage)* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins (except for prenatal vitamins), nutrients and food supplements even if a physician prescribes or administers them. ACA requires that Vitamin D is to be overed for adults 65 and older.* • *Nonprescription medicines, over the counter drugs* • *Medical supplies such as dressings and antiseptics* • *Diet pills or appetite suppressants (except when used in the treatment of morbid obesity)* • *Replacement of drugs due to loss or theft* • *Prescriptions more than one year from the original date of issue.* *Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit and require written prescription by an approved provider. See page 34.*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental Vision Insurance Program (FEDVIP) Dental Plan, your FEHB plan will be First/Primary Payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Desription	You Pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	$35 per specialist office visit
Dental benefit	**High Option**
We have no other dental benefits.	

Section 5(h). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then we may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
24 hour nurse line	Blue Care Connection - The 24/7 NurseLine is a phone-based general health information and triage service available 24 hours a day, 365 days a year through McKesson Health Solutions.
Healthy Living (Gift Card Incentive Program)	We know that maintaining a healthy lifestyle can sometimes be challenging. **Healthy Living** is a new incentive program designed to help people become engaged in their own healthcare. As you complete an annual physical including biometric screening and Health Assessment you will earn a $50 gift card to over 300 retail, restaurant, travel and entertainment vendors.
	• Blue365 - BCBSNM is committed to supporting our clients' and members' wellness objectives. With our expanded member discount program, Blue365, members will be able to receive exclusive health and wellness deals from national and local retailers to stay healthy and happy. Benefits include saving money on health care products and services that are most often not covered by benefit plans such as gym memberships, vision exams and services, hearing aids, and diet-related services. • Well OnTarget - Our Well onTarget℠ wellness portal is a fun and engaging portal that tracks participant success and is artfully integrated with a proprietary coaching platform when coaching services are provided. The portal is the platform in which science and coaching services (telephonic, online or self-directed) integrate to create a meaningful and unique experience for the participant. The wellness portal is the gateway to an interactive health assessment, self-directed programs, and preference-based dedicated health coaching. The site also offers a full range of interactive health management tools including a food and exercise diary and a personal health record. The portal also leverages social networking for participants and allows them to have full access to a wealth of resources for learning and accountability.

Blue365 & Well On Target Programs for Better Health	• Lifestyle Management - BCBSNM offers a Lifestyle Management Program to our employer groups as part of the wellness program within Blue Care Connection®. Health coaching occurs telephonically for our smoking cessation, weight management, and metabolic syndrome/leading indicators programs and either telephonically or via email engagement with a dedicated health coach, or independently online through the self-directed model for our stress management, nutrition, and physical activity programs. • Tobacco Cessation - BCBSNM Tobacco cessation program uses multiple approaches to help smokers achieve their goal of living a tobacco-free life. The tobacco cessation program provides personal coaching, online tools, an audio library, and discounts to wellness-related products and services. • TruHearing customers save on average $890 per hearing aid compared to national retail prices. Each purchase comes with a 45-day money-back guarantee, a three-year warranty and 48 free batteries per hearing aid. Plus, get personal advice when you visit one of TruHearing's professional hearing care providers near you. Contact them today at 800-687-4617.
Services for deaf and hearing impaired	Deaf and Speech Disabled Assistance - Deaf, hard-of-hearing, and speech disabled callers may use the New Mexico Relay Network. Dialing 711 connects the call to the state transfer relay service for TTY and voice calls. Translation Assistance - If you need help communicating with Blue Cross Blue Shield of New Mexico, we offer Spanish bilingual interpreters for members who call Customer Service. If you need multi-lingual services, call the Customer Service phone number on the back of your ID card.
Pregnancies	**Special Beginnings** - related expenses have become the largest component of health care costs today. To maintain costs and to assist female members in achieving healthy pregnancy outcomes, BCBSNM offers the Special Beginnings program, our obstetrical wellness program. Starting with program referral and continuing through the first six weeks of the infant's life, our goal is to achieve healthier families through proactive pre- and post-natal health education. In addition, BCBSNM provides high-risk pregnancy case management services.
Centers of Excellence ofr Transplant Services	Facility Must Be in Transplant Network - Benefits for Covered Services will be approved only when the transplant is performed at a Facility that contracts with BCBSNM, another Blue Cross Blue Shield (BCBS) Plan, or the national BCBS Transplant network, for the transplant being provided. Your BCBSNM case manager will assist your Provider with information on the exclusive network of contracted facilities and required approvals. Call New Mexico BlueHMO Preverred c/o Blue Cross Blue Shield of New Mexico Health Services for information on these New Mexico BlueHMO Preverred c/o Blue Cross Blue Shield of New Mexico Transplant programs.
Travel benefit/services overseas	The New Mexico BlueHMO Preferred c/o Blue Cross Blue Shield of New Mexico offer Out-of-Area Coverage to members when they live, work or travel outside of the HMO service area. The Out-of-Area Coverage Program consists of two components: Urgent Care and Guest Membership. The **Urgent Care** component enables members to receive care for an unexpected illness or injury when they are outside of the HMO service area. Members will have access to a national network ``of over 278,000 physicians, 485,000 specialists and 5,700 hospitals that contract with a Blue Cross and Blue Shield Plan. Outside of the United States, members have access to participating doctors and hospitals in over 195 countries. Members do not have to file a claim form or pay up-front for health care services, except for out-of-pocket expenses such as copayments.

	The **Away from Home Care Program (where available)** component is a courtesy enrollment for members or their eligible dependents that are located in the service area of another participating Blue Cross HMO. Guest Membership provides members with the same HMO benefits they receive at home. Enrollment in this program is only available to members who will be living outside of the HMO service area for at least 90 consecutive days. This is ideal for employees on extended work assignments, children away at school, split families or dependents that live away from the employee's household. Travel benefit/services overseas For travel outside of the service area, benefits are only available in the case of emergencies. For questions regarding the program, please call (855) 235-1039 Statewide or at our web site at www.BCBSNM.com or a member traveling outside of the country in need of emergency services can also call our Provider Locator at (800) 810-2583 (Blue).

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines.

At New Mexico BlueHMO Preferred c/o Blue Cross Blue Shield of New Mexico, our mission is to provide high-quality health coverage to our community. For those who are not eligible to participate in the Federal Employees Health Benefit Plan, we offer a selection of individual products. The Individual portfolio provides medical coverage for New Mexico residents under 65 - adults, children, families, self-employed, those between jobs, students or retirees not yet eligible for Medicare. Individual Plan options allow you to design the plan and premium that best suits you. In addition, individual plans for dental and vision are available. Contact us at (855) 235-1039 Statewide or at our Web site at www.BCBSNM.com to request an enrollment packet or more information about our outstanding individual plans. Individual coverage can also be obtained through the New Mexico Marketplace or Exchange (NMHIX) by calling (855) 99-NMHIX or visiting the Web site at: www.bewellnm.com.

BenefitSource Dental Option Visit the BenefitSource website: www.benefitsource.org for a complete plan description.

Option 1: Sandia Plan BenefitSource Sandia Dental Plan is the most economic dental plan option. Members enjoy guaranteed low, pre-set fees on almost all types of dental work. Savings from 20% to 60% are available for most basic and major dental services. Plan discounts are designed to encourage proper dental care by promoting early detection and regular dental health maintenance. Members must use Sandia Plan participating providers to obtain discounts.

Membership Fee: Employee $6.00/month $63/year	Employee + one $10.50/month $118 / year	Employee + family $15.50/month $172/year

No deductibles or claim forms; No annual limit on the amount of benefits provided; No waiting periods for benefits to begin; Orthodontia benefits covered; No prior authorization requirements; No pre-enrollment exams. It is easy to enroll, simply complete the Enrollment/Authorization form and send it with the correct payment to BenefitSource in the self-addressed envelope.

Option 2: Elite Plan This is a comprehensive indemnity dental plan. When obtaining services from our PPO participating dental offices, members have no deductibles and enjoy significant out of pocket savings on most dental fees. If members choose to use non-PPO participating dental offices, there is still excellent coverage with no deductibles for diagnostic and preventive services (class I) and a low $50 deductible for all other services.

Plan Premiums: Employee $27.35 month	Employee + one $52.86 /month	Employee + family $88.86/month

Freedom to see any licensed dentist; Over 1,600 PPO dental providers throughout New Mexico; No in-network deductibles; 6 month waiting period for major services; $1,200 annual maximum per person.

Option 3: PPO Dental Option This is a comprehensive dental indemnity plan with the freedom of choice to see any licensed dentist. When using a participating PPO dental plan provider, members have lower out of pocket costs and no balance billing for dental services.

$50 annual deductible per person, maximum of $150 per family per calendar year. $1,000 annual maximum per person. No waiting period for preventive and basic dental services (Class I and Class II). 12 month waiting period for major services (Class III), from date of enrollment.

Benefits include: 100% coverage for Class I diagnostic/preventive; 50% coverage for Class II basic services; 50% coverage for Class III major services.

Plan Premiums: Employee $32.88/ month	Employee + one $68.24/month	Employee + family $117.18/month

This plan is underwritten by Companion Life and administered by Total Dental Administrators.

Section 6. General exclusions – services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For more information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials and this plan does not cover these costs.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at (855) 235-1039 Statewide or at our web site at www.bcbsnm.com.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the physician or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services.

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to: Please refer to your ID card for the address to mail claims.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive the claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may appeal directly to Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.bcbsnm.com.

Please follow this Federal Employees Health Benefit Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our contract relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing to New Mexico Blue HMO Preferred c/o Blue Cross Blue Shield of New Mexico 4373 Alexander Boulevard N.E., Albuquerque, New Mexico, 87107 or by calling (855) 235-1039 statewide.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: New Mexico BlueHMO Preferred c/o BlueCross BlueShield of New Mexico, 4373 Alexander Boulevard N.E, Albuquerque, NM 87107; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or

b) Write to you and maintain our denial or

c) Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to have OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claims.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

4 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (855) 235-1039 statewide. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibilty issues. For example, we do not determine whether you or a dependent is covered under the plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at www.NAIC.org.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

- **TRICARE AND CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgement, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on www.BENEFEDS.comor by phone 1-877-888-3337 (TTY 1-877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as the patient's routine care.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age

- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-877-633-4227), (TTY: 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We, Blue Cross Blue Shield of New Mexico, offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription durg coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY: 1-800-325-0778).

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213, (TTY: 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage.

It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges.

We do not waive any costs if the Original Medicare Plan is your primary carrier.

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B
Deductible	$250 per person	$250 per person
Out of Pocket Maximum	$2,500 for Self Only/$5,000 Self Plus One and Self and Family	$2,500 for Self Only/$5,000 Self Plus One and Self and Family
Primary Care Physician	$20 copay - Adult $0 copay - Children	$20 copay - Adult $0 copay - Children
Specialist	$35 copay	$35 copay
Inpatient Hospital	Initial $250 Deductible plus $250 copay per person	Initial $250 Deductible plus $250 copay per person
Outpatient Surgery - Hospital	Initial $250 Deductible plus $100 copay per person	Initial $250 Deductible plus $100 copay per person
RX	Tier 1 Generic - $5 Tier 2 Preferred Name Brand - $35 Tier 3 Non-Preferred Name Brand - $60 Tier 4 Specialty (30 day supply) - 50% of medication cost for preferred specialty medications. For each specialty prescription, you will pay 50% of the cost. The minimum you will pay per prescription will be $50 but not to exceed $250 (Mail order not available)	Tier 1 Generic- $5 Tier 2 Preferred Name Brand - $35 Tier 3 Non-Preferred Name Brand - $60 Tier 4 Specialty (30 day supply) - 50% of medication cost for preferred specialty medications. For each speciality prescription, you will pay 50% of the cost. The minimum you will pay per prescription will be $50 but not to exceed $250 (Mail order not available)
Mail order (90 day supply)	2x retail copay	2x retail copay

You can find more information about how our plan coordinates benefits with Medicare by calling us at (855) 235-1039 statewide.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you have Medicare Part A and B, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048) or at www.medicare.gov.

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. In this case, we will coordinate benefits between FEHB and our Medicare Advantage plan. When both plans have the same type of coverage and benefit, you will have no out of pocket expenses.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), However, we will not coordinate any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical Trials Cost Categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care cost - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care cost- costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

Coinsurance is the percentage of our allowance you must pay for your care. You may also be responsible for additional amounts. See page 19.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 19.

Cost-sharing

Cost-sharing is the general term used to refer your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Custodial care is care you receive when you need help performing activities of daily living-such as walking, grooming, bathing, dressing, getting in and out of bed, toileting, eating, preparing foods, or taking medications that can usually be self-administered. Custodial care that lasts 90 days or more is sometimes known as Long Term Care. We do not cover Custodial Care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 19.

Experimental or investigational service

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Medical Director to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations; or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal.
- the subject of review or approval by an Institutional Review Board for the proposed use;

- the subject of an ongoing clinical trial that meets the definition of Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or
- not demonstrated, through existing peer-reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Health care professional A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity Medically necessary covered Services and Supplies are those covered Services and Supplies that are determined by our Medical Director to be:

- No more than required to meet your basic health needs; and
- consistent with the diagnosis of the condition for which they are required; and
- consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; and
- required for purposes other than the comfort and convenience of the patient or his Physician; and
- rendered in the least intensive setting that is appropriate for the delivery of healthcare; and
- of demonstrated medical value.

Post-Service Claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Reimbursement A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Us/We Us and We refer to New Mexico BlueHMO Preferred c/o Blue Cross Blue Shield of New Mexico.

You You refers to the enrollee and each covered family member.

Urgent care claims A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have on of the following impacts;

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum functions; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgement of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our New Mexico BlueHMO Preferred c/o Blue Cross Blue Shield of New Mexico Customer Service Department at (855) 235-1039 statewide. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no Government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,550 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **nonmedical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee, you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?	Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Empolyees Dental and Vision Insurance Program – *FEDVIP*

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.** FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.
Dental Insurance	All dental plans provide a comprehensive range of services, including: • Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures. • Class D (Orthodontic) services with up to a12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**
Vision Insurance	All vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
Additional Information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision . These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll?	You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY: 1-877- 889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection	The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY: 1-800-843-3557) or visit www.ltcfeds.com.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for the New Mexico BlueHMO Preferred - 2016

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions , limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the $250 per person calendar year deductible.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Adult - $20 per visit to your primary care physician; Children - nothing per visit to primary care physician; $35 per visit to a specialist	23
Services provided by a hospital:		
• **Inpatient**	$250 per person per admission copay* (After satisfying the annual deductible of $250 per person)	43
• **Outpatient**	$100 per person per visit* (After satisfying the annual deductible of $250 per person)	43
Emergency benefits:		
• **In-area**	Adult - $20 per primary care office visit, Children - nothing per primary care office visit; $35 per specialist office visit; $40 per urgent care visit; $100 per hospital emergency care visit	46
• **Out-of-area**	Adult - $20 per primary care office visit, Children - nothing per primary care office visit; $35 per specialist office visit; $40 per urgent care visit; $100 per hospital emergency care visit	46
Mental health and substance abuse treatment:	Regular cost share	48
Prescription drugs:		
• Retail pharmacy	Tier 1 - $5 per preferred generic; Tier 2 -$35 per preferred name brand; Tier 3 -$60 per preferred name brand non-formulary; Tier 4 - 50% of medication cost for preferred speciality medications. The minimum you will pay per speciality prescription will be $50 but not to exceed $250 per person.	50

High Option Benefits	You pay	Page
• Mail order	Tier 1 - $10 per preferred generic formulary; Tier 2 - $70 per preferred name brand formulary; Tier 3 -$120 per preferred name brand non-formulary. Note: If there is no preferred generic equivalent available, you will still have to pay the preferred name brand copay. **Mail order not available for specialty medications.**	50
Dental care (Accidental dental injury only)	$35 per office visit	53
Vision care:	$5 per visit to a Davis Vision network provider One pair of eyeglasses and/or contact lenses (including fitting services) is covered once every calendar year limited to a $150 maximum plan payment.	30
Special features:	Flexible benefits option; 24 hour nurse line; services for deaf and hearing impaired; discounted services for Acupuncture, Chiropractic Care, Massage Therapy, Eye Care, Pregnancies, Centers of Excellence and Travel benefit/services overseas.	54
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $2,500 per person or $5,000 per Self Plus One or Self and family enrollment in any calendar year. This copayment and coinsurance maximum does not include prescription drugs. Nothing after your copayment and coinsurance for prescription drugs total $3,500 per person or $7,000 per Self Plus One or Self and family in any calendar year.	20
Healthy Living (Gift Card Incentive Program)	We know that maintaining a healthy lifestyle can sometime be challenging. **Healthy Living** is an incentive program designed to help people become engaged in their own healthcare. As you complete an on-line Health Assessment you will earn a $50 gift card redeemable at National Retailers, such as Walgreens, Whole Foods Markets, and Dick's Sporting Goods.	54

2016 Rate Information for - New Mexico BlueHMO Preferred

For 2016 health premium information, please see: http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.