New Mexico Medical Insurance Pool

"When no one else will help, we're there"

EPO Policy

NMMIP Administrator
PO Box 780548
San Antonio, TX 78278
(866) 306-1882
TTY#: 711
www.nmmip.org

Welcome to the New Mexico Medical Insurance Pool ("NMMIP")

This Policy is issued to you by the New Mexico Medical Insurance Pool "NMMIP", which was created by the New Mexico State Legislature in 1987. NMMIP is a non-profit program that offers health care policies to eligible residents of New Mexico who are denied coverage in the private or public markets as well as individuals eligible under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). NMMIP is governed by a board of directors consisting of consumer, industry, medical, and health planning representatives. It is funded through premiums from the Enrollees, assessments to health insurance companies, a federal assistance grant, and a premium tax credit from the state. NMMIP contracts with 90 Degree Benefits for administrative services.

It is very important that you read this Policy! It explains what benefits NMMIP will provide. Following the procedures of this Policy can save you money. If you ever have a question, it is best to call **Customer Service**, and they can assist you in understanding this Policy. If you are not satisfied with this Policy, you may send it back to the NMMIP's Administrator, 90 Degree Benefits, within ten days after you receive it, and your premium will be refunded*.

*Note: An individual contract shall provide for a ten-day period to examine and return the contract and have the premium refunded. If services were received during the ten-day period, and the person returns the contract to receive a refund of the premium paid, he or she must pay for such services.

We appreciate the opportunity to offer you this Policy and hope this health plan serves you well.

Sincerely,

New Mexico Medical Insurance Pool

CORRESPONDENCE MAY BE DIRECTED TO:
New Mexico Medical Insurance Pool
Post Office Box 780548
San Antonio, TX 78278
Telephone number: (866) 306-1882
TTY# 711
Fax number: (210) 239-8449
Web site: http://www.nmmip.org

Be sure to read this booklet carefully and refer to the separate Summary of Benefits and Coverage.

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IMPORTANT ADDRESSES AND PHONE NUMBERS

CUSTOMER SERVICE

NMMIP
Mailing Address: PO Box 780548
San Antonio, TX 78278

Street Address: 11467 Huebner Rd.
Suite 300
San Antonio, TX 78230

Telephone Number: (866) 306-1882
FAX#: (210) 239-8449
TTY#: 711
Website: www.nmmip.org

If you have any questions about your coverage, call the Administrator's Customer Service Department. Representatives are available Monday through Friday from 7 am to 7 pm MT for Quarters 1 and 4, and 7 am to 6 pm MT for Quarters 2 and 3. For your convenience, the toll-free customer service number is printed at the bottom of every page in this document. Customer Service will assist individuals who speak a primary language other than English.

ADMISSION REVIEW AND PRIOR APPROVAL AND APPEALS FOR MEDICAL NECESSITY DENIALS

ACENTRA
Provider Portal
https://NMMIP.Acentra.com
or call (844) 547-4255

(Submission forms can be found on NMMIP website www.nmmip.org)

You may call Acentra at (844) 547-4255 to ensure authorization has been obtained prior to services being rendered, or to ensure out of Network Provider has requested authorization.

Note: In the event Medicare is primary, precertification under this Plan will still be required for services other than home health care, palliative care, and hospice.

INTEGRATED CARE MANAGEMENT

Ensemble Health
(505) 522-4401 (for care management services)
24-hour Triage Number (800) 385-8356

PHARMACY BENEFIT MANAGER

MedImpact Healthcare Services Inc.
Help Desk: 1-(855) 476-7945
www.Medimpact.com

Call the Pharmacy Benefit Manager if you have any questions about Prescription Drug coverage, how to use the Prescription Drug mail order services, or if you need help with locating a Participating Pharmacy.

CLAIMS AND ENROLLMENT APPEALS, AND ALL GRIEVANCES

NMMIP
Mailing Address: PO Box 780548
San Antonio, TX 78278

Street Address: 11467 Huebner Rd.
Suite 300
San Antonio, TX 78230

Telephone Number: (866) 306-1882
FAX#: (210) 239-8449
TTY#: 711
Website: www.nmmip.org

PAYMENT ADDRESS *(premium remittance)*

NMMIP
PO Box 27745
Albuquerque, NM 87125

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1 Your Health Care Policy

This Policy describes the benefits, plan options, and limitations of NMMIP's program. It explains how to file claims (if needed) and how to request reconsideration of a claim or an adjustment of your benefit payment. **You may contact** NMMIP's **Administrator, 90 Degree Benefits, if you need help understanding the Policy.**

If you are not satisfied with this Policy, you may send it back to the NMMIP Administrator within ten days after you receive it, and your premium will be refunded.

Please take time to read this Policy. Then keep it handy for later reference. You may be accustomed to reading about your health care benefits only **after** you have claims for medical and Hospital services. To receive maximum benefits with the NMMIP program, you should read about your benefits *before* treatment. You have benefit choices and decisions. Your participation and cooperation are required for some features. In addition, it can be financially advantageous for you to request care from Hospitals and Physicians who have contracted with the Network. (See "Provider Choices," in *Section 2*.) If you have questions after you read this Policy, contact the NMMIP Administrator.

Not sure what a particular word or medical term means? As you read through this booklet you will see certain words that are capitalized; these are defined terms. See Section 9 "Definitions" toward the back of this booklet for the meanings of the defined terms.

To ensure timely notification regarding this Policy, it is your responsibility to ensure that the Administrator has all your updated contact information. This includes: your telephone number; physical address; mailing address and or any other contact information i.e., email address. This information is utilized by your Administrator to provide updated information; information on your coverage; and/or benefits and protections available to you, including information during a public health emergency and/or natural disaster.

Other Benefit-Related Materials

In addition to this booklet, you should have the following benefit-related documents:

Prescription Drug Plan Brochure - You should have a separately issued Prescription Drug plan brochure and a mail-order claim form from the Pharmacy Benefit Manager. It provides important information about your Prescription Drug benefits.

Provider Directory - The Provider Directory is available on our website at www.nmmip.org you can also obtain Provider information by calling Customer Service at (866) 306-1882; we will assist you with locating a Preferred Provider. Hearing impaired users may call (TTY)# 711.

The Provider Directory is subject to change without notice, and you should always verify the Network status of your Provider before receiving services.

ID Card (Carry at All Times) - Your NMMIP identification (ID) card provides the information needed when you require health care services or Prescription Drugs, or when you are contacting a Customer Service representative. Carry it with you. Have your ID card handy when you call for an appointment and show it to the receptionist when you sign in for an appointment.

Your ID card is part of your coverage. Do not let anyone use your card to receive benefits.
If you want additional cards or need to replace a lost card, contact a Customer Service representative.

Summary of Benefits and Coverage ("SBC") - The Summary of Benefits and Coverage show specific member cost-sharing amounts and coverage limitations of your Policy. If you do not have a Summary of Benefits and Coverage, please contact a Customer Service representative (the phone number is at the bottom of each page of this benefit booklet). You will receive a new Summary of Benefits and Coverage if changes are made to your healthcare plan.

Internet Programs and Services

If you have Internet access, NMMIP has on-line programs and tools to help Enrollees track their claim payments, make good health care choices, and reduce health care costs.

To review these on-line programs, go to www.nmmip.org and create a user ID and password for instant access. If you need help getting onto the Internet site, call Customer Service at (866) 306-1882, Monday through Friday from 7 am to 7 pm MT for Quarters 1 and 4, and 7 am to 6 pm MT for Quarters 2 and 3.

Programs and program rules may change or end without notice as new programs are designed and/or as our Enrollees' needs change. We encourage you to check the on-line features available to you and check back in as frequently as you like. We hope you will find our Web site helpful.

(The remainder of this page is left blank.)

2 How Your Plan Works

To ensure timely notification regarding this Policy, it is your responsibility to ensure that the Administrator has all your updated contact information. This includes: your telephone number; physical address; mailing address and or any other contact information i.e., email address. This information is utilized by your Administrator to provide updated information; information on your coverage; and/or benefits and protections available to you, including information during a public health emergency and/or natural disaster.

Deductible Options Table

The individual Deductible and Out-of-Pocket Maximum for your Plan is indicated on your ID card. The Deductible will apply to all expenses unless otherwise specified in the Schedule of Benefits as shown below. In addition, each calendar year, satisfaction of new Deductible and Out-of-Pocket Limits must be fulfilled. The table below lists the Deductible, Out-of-Pocket Limits, and Copays that apply to your Policy based on the individual Deductible amount selected by you and printed on your ID card.

IMPORTANT NOTE: In most instances, benefits are available for services only when they are received from Network Providers, unless otherwise specified in the Schedule of Benefits. Also, please refer to page 8 for Plan exceptions to this provision.

DEDUCTIBLE OPTIONS TABLE – PARTICIPATING PROVIDERS				
Calendar Year Deductible	**$500 Option**	**$1,000 Option**	**$2,000 Option**	**$5,000 Option**
Coinsurance Percentage Payable by the Enrollee	20%, after Deductible	20%, after Deductible	30%, after Deductible	40%, after Deductible
Calendar Year Maximum Out-of-Pocket Limit The Deductible and Coinsurance amounts and medical and Prescription Drug Copays are included in the calendar year maximum Out-of-Pocket Limit.	$5,000	$5,000	$6,000	$7,350
Inpatient Hospital	20%, after Deductible	20%, after Deductible	30%, after Deductible	40%, after Deductible
Outpatient Surgery	20%, after Deductible	20%, after Deductible	30%, after Deductible	40%, after Deductible

Skilled Nursing Care Calendar Year maximum limit: 100 days	20%, after Deductible	20%, after Deductible	30%, after Deductible	40%, after Deductible
	$500 Option	**$1,000 Option**	**$2,000 Option**	**$5,000 Option**
Emergency Room Visit • Benefits apply to Network or Non-Network Providers • Condition must meet definition of "Emergency" to be covered, • Copay is waived if confined inpatient directly from the visit or observation stay • Facility, professional, and ancillary fees charged for the services received in the emergency room during the Emergency visit are considered under the Copay.	$250 Copay, then 100%, Deductible waived	$300 Copay, then 100%, Deductible waived	$350 Copay, then 100%, Deductible waived	$400 Copay, then 100%, Deductible waived
Urgent Care Services performed in the Urgent Care setting are considered under the Copay. There is one Copay for all services combined during the Urgent Care visit.	$40 Copay, then 100%, Deductible waived	$45 Copay, then 100%, Deductible waived	$50 Copay, then 100%, Deductible waived	$55 Copay, then 100%, Deductible waived
Physician Office Visits • Primary Care (PCP) • Specialist Services performed in the office setting are considered under the office Copay. There is one Copay for all services combined during the same visit.	$20 Copay *or* $40 Copay, then 100%, Deductible waived	$25 Copay *or* $45 Copay, then 100%, Deductible waived	$30 Copay *or* $50 Copay, then 100%, Deductible waived	$35 Copay *or* $55 Copay, then 100%, Deductible waived
Chiropractic Care/Spinal Manipulations Calendar Year maximum limit: 20 visits Visit limit may be waived for treatment received for habilitative or rehabilitative purposes.	$20 Copay, then 100%, Deductible waived	$25 Copay, then 100%, Deductible waived	$30 Copay, then 100%, Deductible waived	$35 Copay, then 100%, Deductible waived
Outpatient Diagnostic Testing Copay applies per Provider / per day Laboratory or X-ray	$20 Copay, then 100%, Deductible waived	$25 Copay, then 100%, Deductible waived	$30 Copay, then 100%, Deductible waived	$35 Copay, then 100%, Deductible waived
CT, MRI, PET scans, and All Other	20%, after Deductible	20%, after Deductible	30%, after Deductible	40%, after Deductible

Preadmission Testing Must be received within 10 days of admission	No Charge	No Charge	No Charge	No Charge
Durable Medical Equipment	20%, after Deductible	20%, after Deductible	30%, after Deductible	40%, after Deductible
Acupuncture Calendar Year maximum limit: 20 visits Visit limit may be waived for treatment received for habilitative or rehabilitative purposes.	20%, after Deductible	20%, after Deductible	30%, after Deductible	40%, after Deductible
Ambulance Benefits apply to Network and Non-Network Providers.	20%, after Deductible	20%, after Deductible	30%, after Deductible	40%, after Deductible
Diabetic Testing & Supplies	No Charge	No Charge	No Charge	No Charge
Home Health Care / I.V. Benefits Calendar Year maximum limit: 100 visits Additional visits may be allowable with determination of Medical Necessity	No Charge	No Charge	No Charge	No Charge
Hospice / Palliative Care Inpatient or Outpatient	No Charge	No Charge	No Charge	No Charge
Maternity Care Prenatal Office Visits Delivery and newborn nursery care Newborns are eligible for up to 31 days of coverage if the Administrator is notified of the birth and appropriate premium paid.	No Charge 20%, after Deductible	No Charge 20%, after Deductible	No Charge 30%, after Deductible	No Charge 40%, after Deductible
Pediatric Dental Care Limited to children birth through age 18	No Charge	No Charge	No Charge	No Charge

Pediatric Vision Care Limited to children birth through age 18	No Charge	No Charge	No Charge	No Charge
Mental Health Treatment				
• Non-Intensive Outpatient (Office Visit)	No Charge	No Charge	No Charge	No Charge
• Intensive Outpatient Program	No Charge	No Charge	No Charge	No Charge
• Inpatient	No Charge	No Charge	No Charge	No Charge
• ABA Therapy or Cognitive Rehabilitation	No Charge	No Charge	No Charge	No Charge
Organ Transplant Travel, Food, and Lodging limit per Transplant Benefit Period (including pre-transplant evaluation)	20%, after Deductible $10,000	20%, after Deductible $10,000	30%, after Deductible $10,000	40%, after Deductible $10,000
Outpatient Dialysis Must receive Dialysis at a Designated Dialysis Facility	20%, after Deductible	20%, after Deductible	30%, after Deductible	40%, after Deductible
Outpatient Rehabilitative / Habilitative Therapies (except as otherwise specified) includes, but is not limited to: Occupational, Speech and Physical Therapy. Copay applies per Provider / per day	$20 Copay, then 100%, Deductible waived	$25 Copay, then 100%, Deductible waived	$30 Copay, then 100%, Deductible waived	$35 Copay, then 100%, Deductible waived
Preventive Care Services Includes Preventive Care Services as required under the Affordable Care Act as well as claims billed with a routine or wellness diagnosis.	No Charge	No Charge	No Charge	No Charge
Substance Use/Chemical Dependency Treatment				
• Non-Intensive Outpatient (Office Visit)	No Charge	No Charge	No Charge	No Charge
• Intensive Outpatient Program	No Charge	No Charge	No Charge	No Charge
• Inpatient	No Charge	No Charge	No Charge	No Charge
All Other Covered Services Except Prescription Drugs – see continuation on following page	20%, after Deductible	20%, after Deductible	30%, after Deductible	40%, after Deductible

Note: A limitation based on a maximum number of days, visits, or benefit periods (e.g., 20 days per calendar year), may be reached even if all Covered Charges were applied to the Deductible.

Physician Services (Medical and Behavioral /Mental Health)	$0 per visit consult fee, Deductible waived
Through the use of Teladoc Health, a medical service that uses telephone and videoconferencing technology to provide remote medical care vis mobile devices, the internet, video, and phone, Teladoc Health provides remote medical assistance and is able to use virtual technology to treat many non-emergency conditions.	

	$500 Option	**$1,000 Option**	**$2,000 Option**	**$5,000 Option**
Prescription Drugs Medical Deductible provisions do not apply. In addition, certain contraceptives and preventive medications are covered with no cost-sharing as required under the Affordable Care Act. Special medical foods and certain drugs require Prior Approval or benefits may be denied. In order to receive benefits for Specialty Pharmacy Drugs, you must purchase such drugs from a Specialty Pharmacy that contracts with the Pharmacy Benefit Manager.				
Outpatient Prescription Drugs Retail and Specialty Pharmacies (Up to a 34-day supply or 30-day supply for Specialty Drugs)				
● Generic Drugs	$10 Copay	$10 Copay	$10 Copay	$10 Copay
● Brand-Name Drug with generic equivalent	$35 Copay	$35 Copay	$35 Copay	$35 Copay
● Brand-Name Drugs with no generic equivalent	$70 Copay	$70 Copay	$70 Copay	$70 Copay
● Specialty Drugs	30% up to $400/script	30% up to $400/script	30% up to $400/script	30% up to $400/script
Outpatient Prescription Drugs Performance 90 Pharmacies and Mail Order (Up to a 90-day supply)				
● Generic Drugs	$30 Copay	$30 Copay	$30 Copay	$30 Copay
● Brand-Name Drug with generic equivalent	$105 Copay	$105 Copay	$105 Copay	$105 Copay
● Brand-Name Drugs with no generic equivalent	$210 Copay	$210 Copay	$210 Copay	$210 Copay

A limitation based on a maximum number of days, visits, or benefit periods (e.g., 30 days per calendar year), may be reached even if all Covered Charges were applied to the Deductible.

Insulin Cap. This policy allows a cap on copays and out-of-pocket expenses for insulin or medically necessary alternative at $25 per prescription for a 30-day supply.

Aid in Dying. This policy covers compound medication under the Prescription Drug benefit, as prescribed by your physician. No prior authorization is needed.

Provider Choices

Your choice of health care Provider can make a difference in the amount you pay for Covered Services and the benefits you receive.

Provider Network. You have a choice between selecting a **Participating Provider** (one that contracts directly or indirectly with NMMIP to provide services at a potentially reduced rate) or a **Non-Participating Provider** (one that does not contract with NMMIP. See the Enrollees ID card for the designated Network(s).

The Policy does not cover health care services obtained from a Non-Participating Provider unless one of the exceptions shown below applies:

- In the event you receive Emergency services at a non-participating emergency room, Hospital, trauma center, or Ambulance for a medical Emergency.
- In the event you receive health care services, that are not emergency care, rendered by a nonparticipating provider at a participating facility where:
    - A participating provider is unavailable
    - A non-participating provider renders unforeseen services
    - The covered person has not given specific consent for that nonparticipating provider to render the particular services rendered.
- In the event an Enrollee receives services from a municipal health department.
- In the event the services received are out of the patient's control:
    - An in-network provider mistakenly makes a referral to an out-of-network provider
    - In the event a non-participating provider performs services at a Network facility.

In the event you cannot access Network Providers necessary to treat your specific medical condition within the state of New Mexico, please contact the Plan at Customer Service. The Plan will allow Out-of-Network providers at Reasonable and Customary rates.

No Surprises Act. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills," on a following page, if the charge billed by an Out-of-Network Provider for any covered

service is higher than the maximum allowable charge determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any Provider, at its discretion.

If an out-of-network provider balance bills you for an amount above the reimbursement rate, also called a surprise bill, you may follow the NMMIP Appeal Process.

The amount NMMIP pays for a Covered Service is always based on the Covered Charge for that service. The Covered Charge is always less than or equal to the Provider's billed amount. You may have to pay the difference between the billed amount and the Covered Charge if you receive services from a Non-Participating Provider under one of the exception rules.

Note: Providers can change without notice. It is the Enrollee's responsibility to verify whether a Provider participates in the Network.

When you receive treatment, schedule a surgery or Admission, ask each of your Providers if they are a Participating Provider. A Physician's or other Provider's contract may be separate from the Health Care Facility's contract.

Continuity of Care. In the event you are a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, you shall have the following rights to continuation of care.

The Plan shall notify you in a timely manner, but in no event later than 90 calendar days after termination that the Provider's contractual relationship with the Plan has terminated, and that you have rights to elect continued transitional care from the Provider. If you elect in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when you cease to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1) Is undergoing a course of treatment for a serious and complex condition from a specific Provider,
2) Is undergoing a course of institutional or Inpatient care from a specific Provider,

3) is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,
4) Is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
5) Is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, Plan benefits will be processed as if the termination had not occurred, however, the Provider may be free to pursue you for any amounts above the Plan's benefit amount.

No Surprises Act – Emergency Services and Surprise Bills. For Non-Participating claims subject to the No Surprises Act ("NSA"), your cost-sharing will be the same amount as would be applied if the claim was provided by a Network Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing you for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward In-Network Deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider. Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Participating Provider at a Participating Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and
- Covered Non-Participating Provider air ambulance services.

Deductibles, Coinsurance, Out-of-Pocket Limits, Copays

Policy Deductible

Deductible. The Deductible you chose is indicated on your ID card. You must pay your Deductible amount before NMMIP will begin paying its share of your Covered Charges. Only Covered Charges are applied toward the Deductible. Covered Charges may be less than the billed amount.

You do not have to meet a Deductible for the following services:

- Outpatient Prescription Drugs purchased with your Prescription Drug card
- Diabetic testing and supplies
- Non-intensive outpatient mental health and substance use/chemical dependency visits

- Inpatient stay for mental health and substance use/chemical dependency
- Preventive care services
- Contraceptive coverage
- Behavioral health services

Deductible Family Savings Provision. If three (3) or more qualified family members enroll for NMMIP Policies with the same Deductible, they may receive reduced Deductible limits. An entire family meets an annual Deductible when the total Deductible amount for all family members reaches two times the individual Deductible amount chosen. If an Enrollee's individual Deductible is met, no more charges incurred by that Enrollee may be used to satisfy the Family Deductible.

Change in Deductible Plan. NMMIP Enrollees may change from a lower to a higher Deductible plan at any time upon written notice to the Administrator. The effective date of the change is the next premium due date following the request date.

If you increase your Deductible amount, the new Deductible amount must be met for all services received as of the effective date of the change. This means that if you had met your lower Deductible and then change to a higher Deductible, for services received as of the effective date of the change, you do not receive benefit payments until the increase in Deductible is met.

NMMIP Enrollees can change from a higher to a lower Deductible plan on or before December 1 each year. The effective date will be January 1 the following year. Requests for such changes must be made in writing to the Administrator. If you decrease your Deductible amount, you do not receive a refund for any Deductible amounts applied for services before the change effective date.

Coinsurance and Out-of-Pocket Limit

Coinsurance. For most Covered Services, you pay a percentage of Covered Charges as Coinsurance after the annual Deductible has been met. After the Deductible is satisfied, the Enrollee pays the Coinsurance percentage payable, shown on the *Deductible Options Table*, for Covered Charges until the calendar year Out-of-Pocket Limit is reached.

Out-of-Pocket Limit. The total amount of Deductible, Coinsurance, medical and Prescription Drug Copays you must pay each calendar year is called the Out-of-Pocket Limit. After the limit is met, NMMIP pays 100 percent of your Covered Charges for the rest of the calendar year.

The following are not applied to the Out-of-Pocket Limits or to the Deductible; therefore, they are not eligible for 100 percent payment under this provision:

- Premium payments;

- Any charges over the Covered Charge amount up to the billed amount;
- Amounts over the Plan's Maximum Allowable Charge;
- Charges that are paid by the Policy at 100%;
- Any charges denied due to non-compliance with the Plan's Admission Review/Prior Approval requirements; and
- Non-covered expenses.

Coinsurance Family Savings Provision. If three (3) or more qualified family members enroll for NMMIP Policies with the same Deductible, they may receive reduced Out-of-Pocket Limits. An entire family meets an annual Out-of-Pocket Limit when the total out-of-pocket amount for all family members reaches two times the individual Out-of-Pocket Limit. **Note**: If an Enrollee's individual Out-of-Pocket Limit is met, no more charges incurred by that Enrollee may be used to satisfy the family out-of-pocket.

Out-of-Pocket Limit Changes - Changing your Deductible plan also affects your Out-of- Pocket Limit provisions. This means that if you had met your lower Out-of-Pocket Limit and then you change to a higher Out-of-Pocket Limit for services received as of the effective date of the change, you do not receive the 100 percent payment until the increase in out- of-pocket is met.

Copay

Copay. Certain services are subject to a Copay; see the *Deductible Options Table* earlier in this Section to determine which services are subject to a Copay. The Copay amount is not used to satisfy the Deductible; it is used to satisfy the Out-of-Pocket Limit.

Copay Changes. Changing your Deductible plan may also affect your Copay amount. If you change your Deductible plan, the amount of the Copay may also change.

Pharmacy Services

Medications ordered by your providers are available to be filled at any pharmacy, with the exception of Hepatitis C medications which must be filled at the Southwest Care pharmacy.

Certain medications may also require prior authorization, and your provider that ordered the medication may be contacted to provide more information. If that occurs, your provider will be instructed on what additional information is needed and how to complete the prior authorization procedure.

Contact MedImpact Healthcare Services Inc. for more information:

Help Desk: 1 (855) 476-7945
www.Medimpact.com

Urgent Medicine- we will fill within 24 hours

Non-Urgent Medicine – if you do not have an urgent need for a prescription drug, we will resolve the request within three business days if your provider:

- Uses the prior authorization request form approved by the New Mexico Office of Superintendent of Insurance;
- Requests an exception from an established step therapy process; or
- Requests to prescribe a drug that we do not usually cover.

Please note: This policy covers behavioral health prescriptions at no cost share to members.

Authorizations for Inpatient Admissions and Specific Clinical Services

Please note: Not all clinical services require a NMMIP authorization in addition to a physician order.

Why We Review.
Our review of an authorization request from your provider will determine if the proposed care involves a covered service, is medically necessary and whether an alternative type of care should be pursued instead of, or before, the requested care. Our decisions concerning medical necessity and care alternatives will be guided by current clinical care standards and will be made by an appropriate medical professional.

To take the best care of you and make sure you are getting care in the best place and at the right time, the Administrator uses a number of programs. All together, these programs are called Utilization Management.

Utilization Management means NMMIP looks at medical records, claims, and Admission Review Approvals/Prior Authorization requests to make sure that the services are Medically Necessary, given in the right setting, and consistent with the condition reported.

- If this management is done before a service is received, it is part of the Prior Authorization process.
- If it is done while a service is still being received, it is part of the concurrent review process.
- If it is done after a service is received, it is called retrospective review.

Utilization Management decisions are based only on appropriateness of care and service. The Administrator does not reward Providers or persons conducting their programs for denying services and does not offer incentives to utilization review decision-makers that would

encourage them to approve fewer services than you need. We want to make sure you get all of the Covered Services you need in the best manner possible.

Please note: Requests for behavioral health care and prescriptions are subject to the same prior and retroactive authorization processes and timelines as requests for medical care and prescriptions.

Prior Authorization

Certain types of care require prior authorization. This means that your provider must ask us to approve the care before you receive it. Your participating provider is responsible for knowing what care requires prior authorization, and the process for obtaining approval in the required timeframe. We will give any provider access to the NMMIP authorization portal and all necessary forms and instructions for making the request. Your provider may access the portal at https://nmmip.acentra.com.

If your provider is unable to utilize the portal listed above, the provider should contact Customer Service at (866) 306-1882 for further options.

The following Inpatient Services require Prior Authorization/Admission Review Approval:

- Inpatient stays when you are admitted as a bed patient in a Hospital, Skilled Nursing Facility, or any other facility licensed for overnight care;
- Obstetric Admission (childbirth), if you stay in the Hospital more than 48 hours after a routine delivery, or if you stay in the Hospital more than 96 hours after a C-section delivery;
- Newborn inpatient stays if the newborn is not discharged with the mother;
- Observation status which lasts longer than 48 hours.

The following Hospital Based or Outpatient Services require Prior Authorization:

1. Air Ambulance for non-emergency transport
2. Biologic Drugs
3. Deviated Septum/Nasal Surgery
4. Durable Medical Equipment
5. EBCT (Electron Beam Tomography)
6. Endoscopic Procedures
7. Epidural/facet injections
8. Home Health Care
9. Hospice Care
10. Hyperbaric Oxygen Therapy
11. Infusions and injectable drugs (unless provided in a physician office setting)

12. Inpatient Rehabilitation
13. Long Term Acute Care (LTAC)
14. MRI/CT/Pet Scan (excludes bone density scans)
15. Outpatient Therapies (combined Physical/Occupational/Speech Therapy) after the first 13 visits
16. Psychiatric Treatment: Intensive Outpatient, Residential, Partial Hospitalization
17. Radiation Treatment
18. Rehabilitation for Chemical Dependency: Outpatient, Residential, Partial Hospitalization
19. Skilled Nursing Facility (SNF)
20. Surgery (unless performed in a physician office setting)
21. Varicose Vein Ligation

Please note as described above that the following Services do not require Prior Authorization: The attending Physician does not have to obtain Prior Approval from NMMIP for surgeries performed in an office setting or for prescribing a Maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Emergency Department Visits that do not result in a hospitalization do not require Prior Authorization.

Prior Authorization Timelines:

Timelines for requesting Prior Authorizations for Hospital Admissions by submitting on the provider portal at https://nmmip.acentra.com:

Type of Inpatient Admission Readmission or Transfer	**When to Obtain Admission Review Approval:**
Non-emergency	**At least 7 days before the patient is admitted.**
Emergency, non-maternity	**Within 24 hours of inpatient Admission.** If the condition makes it impossible to submit on the portal within 24 hours, submit as soon as possible. (No approval is required for emergency room services that do not result in an inpatient Admission).

Observation exceeding 48 hours	**Before the observation hours exceed 48 hours.**
Maternity-related	**Before the mother's stay exceeds 48 hours** for a routine delivery or 96 hours for a C-section delivery.
Extended stay, newborn	**Before the newborn's mother is discharged.**

How the Prior Authorization Procedure Works.

When your Provider submits the portal authorization request through the provider portal, the provider will submit clinical information about your medical condition, the proposed treatment plan, and the estimated length of stay. The Utilization Review staff will evaluate the information and notify the attending Physician and the facility in the portal if benefits for the proposed hospitalization are approved. If the Admission is not approved, you and/or your provider may appeal the decision.

The authorization reconsideration and appeal process are described in this Section on pages 19-21.

Timelines for Requesting Prior Authorization for Non-Inpatient Services

There are many non-inpatient services that also require Prior Authorization such as home health visits, therapies, and various scans as listed above. These Prior Authorizations must also be obtained prior to the service being rendered. Providers may find a list of services which require Prior Authorization on our website here: https://nmmip.acentra.com/providers-nmmip/.

Timeframe for the Provider/Member Receiving Authorizations:

Prior Authorizations:

Urgent Care – if you require urgent medical care or behavioral health care, we will resolve the request within 72 hours of the request if all necessary information required to make a determination is received.

Non- Urgent - we will resolve all other requests within fifteen calendar days of the request if all necessary information required to make a determination is received.

Meeting these time frames depends on our receipt of sufficient information to evaluate the request. Our utilization management staff will answer questions your provider might

have concerning required information or any aspect of the request submission process. If we require additional information to evaluate a request, we will request it from your provider.

Failure to obtain a required approval may result in a denial of benefits.

Failure to obtain Prior Approval may result in the denial of coverage and extra costs out of your pocket if the services are not Medically Necessary. If a Non-Participating Provider recommends an Admission or a service that requires Prior Approval, the Provider is obligated to obtain the prior approval and obtain a Single Case Agreement. If a Nonparticipating Provider fails to obtain a Single Case Agreement (SCA) for services rendered all charges will be your responsibility.

If NMMIP Coverage Ends

Please note- prior authorization is not a guarantee of payment.

Admission Review/Prior Approval Authorization determines only the Medical Necessity of a specific service and/or an Admission and an allowable length of stay. Eligibility and benefits available are based on the date you receive the services. If you lose coverage under this Policy, benefits are not allowed for any service received after coverage ends, even if Prior Approval was obtained from NMMIP.
For this reason, even if your prior authorization is approved in advance of the service, your provider should check the portal again to verify your eligibility before services are rendered at **https://nmmip.acentra.com**

Concurrent Review

Concurrent Review typically occurs during a hospitalization regarding the length of stay during that hospitalization. This review evaluates your ongoing treatment and discharge plans to ensure you are being treated in the most efficient and effective health care setting.

Prior Authorization and Concurrent Review requirements may affect the amounts that NMMIP pays for Inpatient Services, but they do not deny your right to be admitted to any facility and to choose your services. If an Admission or any days are not approved by the Administrator, you may always choose to receive the services and pay the full amount billed by the facility and other health care Providers for the Admission.

Timeline for the Receipt of Concurrent Authorizations:
We will resolve all requests within 72 hours of the request if all necessary information required to make a determination is received.

Retrospective Review

Retrospective (After Care) Review: If you received care without a required prior authorization, NMMIP may in certain very limited circumstances allow your provider to request authorization retrospectively. Upon NMMIP Executive Approval to submit retrospectively, our utilization management team will assist your provider in the submission of a retrospective authorization request. However, we do not routinely authorize care retrospectively. To avoid uncertainty, it is always best to request prior authorization.

Timeline for Receipt of Retrospective Authorizations:

We will review all requests within 30 days of the request and receipt of all relevant information and provide a determination.

Non-Participating Providers and Unauthorized Services

If you visit a non-Participating Provider, and that provider will not submit a prior authorization request, you may submit a prior authorization request on your own behalf, or on behalf of a dependent. You may not utilize a Non-Participating Provider if a Network Provider is available, except in certain circumstances (see page 8).

We may decline payment for unauthorized care.

- If your provider is participating, and you did not agree to receive unauthorized care, your provider cannot bill you for the care.
- If you received unauthorized care from a provider who is not participating, you may be fully responsible for the resulting bills.

Please note: The charges for non-covered and denied services are not applied to any Deductible or Out-of- Pocket Limit.

Authorization requirements may affect the amounts that NMMIP pays for Services, but they do not deny your right to be admitted to any facility and to choose your services. If an Authorization request is not approved by NMMIP, you may always choose to receive the services and pay the full amount billed by the facility and other health care Providers.

Medical Necessity Authorization Denials:

We will inform you and the requesting Provider in writing if we deny an authorization request. This authorization information is available in the provider portal, FAXED to the Provider, and

sent to you via mail. In most cases, your provider will have the medical information necessary to complete the reconsideration if you or your provider disagree with the denial.

Our notice to you will explain why we were unable to approve the request and will provide you with instructions for disputing our decision if you disagree. A summary of the dispute resolution process is described below. You have a right to request information about the guidance we followed to deny your request, even if you do not dispute our decision.

Request for Authorization Reconsideration and Appeals

You have two options for having a Medical Necessity Denial decision reconsidered.

1. A Reconsideration request to NMMIP's Utilization Management Vendor, Acentra.
2. A Formal Appeal request to the NMMIP's Utilization Management Vendor, Acentra.

There are no other appeal options available after the formal appeal request.

1. **Reconsideration Request:**
   In cases involving medical necessity determinations, your provider is given an opportunity to submit additional information related to your case and to speak with our Medical Director or their designee.
   This is considered a reconsideration of our adverse determination.

   A reconsideration is typically based on submission of additional information or a peer-to-peer discussion.

   This option is available only for initial pre-service or concurrent review determinations that are requested within 30 days of the initial non-certification.

   The peer-to-peer discussion shall be timely, preferably within one business day or at the convenience of the ordering provider not to exceed 30 days from the date of the initial adverse determination.

   A peer to peer is not required; you may file an appeal without first requesting a peer to peer.

   Providers may submit a request for reconsideration/peer-to-peer discussion through the provider portal at: https://nmmip.acentra.com/

2. **Formal Internal Appeals Process:**

If the reconsideration process does not reverse the denial determination, or the reconsideration process was not initiated, your provider may initiate the formal internal appeals process. This process must be initiated within 90 days of the original utilization review denial. If requested, an expedited review will be accepted for participants meeting expedited appeal requirements and completed no later than seventy-two (72) hours following the initiation of the appeal process and receipt of all information necessary to complete the appeal review.

During this process, the case will be referred to a physician who:

- Was not involved in the completion of the initial utilization review denial;
- Is board-certified/licensed in the same or similar specialty that typically manages the medical condition, procedure, or treatment in question; and
- Has no conflict of interest regarding the case under review.

The Clinical Peer Reviewer will consider all information submitted by the member, provider, or authorized representative, including any new or additional evidence not available during the initial review. All internal appeal decisions will be issued in writing to the requesting physician and copied to the member.

Written notifications will contain:

- The specific reason(s) for the determination, referencing applicable plan provisions, guidelines, or criteria;
- The date(s) of service being denied;
- The date of the notice;
- A statement of Acentra Health's authority and responsibility to perform the review.

The appeal review may result in a decision to uphold, modify, or reverse the original determination.

Appeals Timeframes

- Expedited Appeals – Completed within 72 hours of the request receipt by Acentra Health and receipt of all information necessary to complete the appeal review.
- Standard Appeals – Completed within 30 calendar days of the request receipt by Acentra Health and receipt of all information necessary to complete the appeal review.

Administrative Authorization Denials:

NMMIP may administratively deny services such as when the requested service is not a covered benefit or when the requesting Provider is Non-Participating where there are Participating

Providers available. In these circumstances the denial letter will identify the reason for the administrative denial and if there is an alternative option.

CARE MANAGEMENT

Care Management is a program whereby a care manager monitors the patient and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The care manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- Personal support to the patient;
- Contracting the family to offer assistance and support;
- Monitoring Hospital or Skilled Nursing Facility; and
- Assistance obtaining any necessary equipment and services.

Care management occurs when providing targeted outpatient care and services are vital to prevent the worsening of acute and chronic conditions and/or Emergency Department visits or hospitalizations.

The care manager will coordinate and implement the Care Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. You, your family and your primary Physician should all agree to the treatment plan.

It is important to know what resources are available so you can make the best decisions regarding your health and wellness. Our Care Services Coordinators will get to know you and your healthcare needs, so we can help you navigate the complicated healthcare system. We work to connect you with medical providers, home health care services, or other resources in your community. You can expect to be contacted regularly, either by telephone, text message, or video visit.

NMMIP offers targeted programs to optimize good health outcomes. All of these programs are a part of your benefits package and are provided at no cost to you.

Below are the Tools of Care:

- **Health Questionnaire.** You have the opportunity to complete a health questionnaire which helps identify any non-medical barriers to care that could negatively impact your health.

- **Transition of Care.** If you end up in the hospital, we will reach out to you to make sure you have what you need when you're ready to come home. We'll also continue to follow up with you for 30 days after you leave the hospital.
- **Remote Monitoring.** Part of your benefit includes access to remote monitoring of vital signs which allows your Care Services Coordinator to help you identify trends which may indicate a need to see your doctor. Depending on your needs, you'll receive a tablet device, a blood pressure cuff, pulse oximeter, scale or glucometer (including lancets and strips). These readings can instantly be available to your care team to help you manage your health in real time.
- **24 Hour Nurse Triage Line.** Have a question for a nurse? Not feeling well? You can call our Nurse Help line after hours or on the weekend and holidays at (800) 385 - 8356 to get your questions answered.
- **Clinical Support at Home** (specific coverage areas). Your care management team is available to come to your home or do a video visit to help provide support to you if you aren't sure whether you should go to urgent care.
- **Virtual Visits.** Need to see a doctor, but can't get in for a couple of weeks? Allow us to help you connect with a doctor via telephone or video to get your needs met quickly.

All of these support services are available to you as a member of NMMIP with no out-of-pocket cost. We believe that by working together to meet your healthcare needs, we can help reduce the need for emergency care and hospitalizations. Our goal is to keep you at home where you want to be.

Alternative Benefits/Extra Contractual Benefits

In specific circumstances, alternative treatment plans for specific patients will be implemented that cover additional benefits. These alternative treatment plans must meet the following criteria:

- The treatment must be medically indicated and necessary for the condition being treated
- The treatment must not be experimental and investigational
- The treatment must be Cost-Effective to both the member and the plan.
- The treatment must be provided as an alternative to an otherwise Covered Charge under the plan.

The Plan shall have the right to waive the normal provisions of the Plan when it is reasonable to expect a Cost-Effective result without sacrificing the quality of patient care. Alternate treatment will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that Enrollee or any other Enrollee.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

For more information, visit www.ensemblehealth.com, e-mail info@ensemblehealth.com, or call (800) 385 -8356 or 505-552-4401.

MEMBER GRIEVANCES

A member or an authorized member's representative may file a grievance which is a complaint or dissatisfaction about a service, process, provider, or administrative decision or outcome. This is a separate process from an appeal, which is a formal process of contesting a decision on coverage or payment.

Grievances will be acknowledged with confirmation of receipt and expected timelines.

Grievances will be reviewed by appropriate personnel who are not directly involved in the original issue. Documentation and subject matter expertise will be considered.

Final determinations will include rationale for the decisions, and notification of case outcome. The final determination will also be communicated to the member.

Grievance Escalation Process

The escalation process for a grievance review is as follows:

1. The first level of review is to NMMIP's Administrator, 90 Degree Benefits;
2. If the member is dissatisfied with the outcome, the second level of review is also to NMMIP's Administrator, 90 Degree Benefits where additional information can be provided;
3. If the member is still dissatisfied with the outcome of the second level of review, the final level of review to the NMMIP Executive Office

To ensure timely notification regarding the grievance, it is the member's responsibility to ensure that the Administrator has all updated contact information, and the member has "opted in" to receiving this information by mail or email.

The member's updated contact information includes: telephone number; physical address; mailing address and/or any other contact information, i.e. email address. This information is utilized by the Administrator to provide updated information available to the member.

Health Care Fraud Information

Health care and insurance fraud result in cost increases for health care plans. You can help. Always:

- Be wary of offers to waive Copayments, Deductibles, or Coinsurance. These costs are passed on to you eventually.
- Be wary of mobile health testing labs. Ask what your health care insurance will be charged for the tests.
- Review the bills from your Providers and the Explanation of Benefits (EOB) form you receive from the Administrator after a claim has been paid or denied. Verify that all services billed to the Administrator were received. If there are any discrepancies, call a Customer Service representative.
- Be very cautious about giving information about your health care insurance over the phone.

If you suspect fraud, contact Customer Service at (866) 306-1882.

3 Covered Services

This section describes the services and supplies covered by this Policy, subject to the limitations and exclusions in *Sections 2 and 4*. All payments are based on Covered Charges as determined by the Administrator. Reminder: It is to your financial advantage to receive care from Participating Providers.

Medical Necessity. The Administrator determines what is Medically Necessary based on what is:

- Medically appropriate, considering your age and health, for the symptoms and diagnosis or treatment of your medical condition, illness, or injury;
- In accordance with standards of sound medical practice;
- Not primarily for you, your family's, or your Provider's convenience; and
- The most appropriate supply or level of service that can safely be provided to you. When applied to hospitalization, this also means that you require inpatient acute care due to the nature of the services rendered or of your condition, and you cannot receive safe or adequate care as an outpatient.

Note: The decision as to whether a service is Medically Necessary is based on generally accepted medical or surgical standards. Medical Necessity or Medically Necessary means health care services determined by a Provider, in consultation with the health care insurer, to be appropriate or necessary; according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or applicable clinical protocols or practice guidelines developed by the health care insurer consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease.

Because a Provider prescribes, orders, recommends, or approves a service does not make it Medically Necessary or make it a Covered Service, even if it is not specifically listed as an exclusion. If you disagree with a decision made by the Administrator, see *Section 6* for information on appeals.

Acupuncture Services

Acupuncture is covered when administered by a licensed Provider acting within the scope of licensure and when necessary for the treatment of a medical condition. Benefits are limited to **20 visits per calendar year**, unless for rehabilitative or habilitative purposes. Reimbursement is limited to the Covered Charge for the Acupuncture treatment itself and associated office visits.

Acupuncture benefits include, but are not limited to, Acupuncture used as an anesthetic during a covered surgical procedure or in the treatment of severe pain and administered by a Physician or a licensed acupuncturist. Cost-sharing for Acupuncture is limited to that of Primary Care.

Exclusions. This Policy does not cover herbs, homeopathic preparations, nutritional supplements, massage therapy (unless Medically Necessary and performed by an M.D., Physical Therapist, or Occupational Therapist), or Rolfing.

Ambulance Services

This Policy covers Ambulance services in an Emergency (e.g., cardiac arrest, stroke). When you cannot be safely transported by any other means in a non-emergency situation, this Policy also covers Medically Necessary Ambulance transportation to a Hospital with appropriate facilities capable of treating your medical condition, or from one Hospital to another. All Ambulance services are subject to pre and/or post service Medical Necessity review. Prior Approval is required for Air Ambulance in a non-medical Emergency including Hospital to Hospital transfers. When using an Air Ambulance in a non-Emergency situation, the Policy reserves the right to select the Air Ambulance Provider. If you do not use the Air Ambulance the Policy selects in a non-Emergency situation, no coverage will be provided.

Air Ambulance. Air Ambulance is covered only when terrain, distance, or your physical condition requires the use of Air Ambulance services, or for high-risk Maternity and newborn transport to tertiary care facilities. Prior Approval is required for Air Ambulance in a non-medical emergency. Air Ambulance coverage is based on Medical Necessity.

Exclusions. This Policy **does not cover**:

- Commercial transport, private aviation, or air taxi;
- Services not specifically listed as covered, such as private automobile, public transportation, or wheelchair Ambulance; or
- Services ordered only because other transportation was not available or for your convenience.

Autism Spectrum Disorder

This Policy covers the diagnosis and treatment for Autism Spectrum Disorder is covered regardless of age in accordance with state mandated benefits as follows:

- Diagnosis for the presence of Autism Spectrum Disorder when performed during a Well-Child or well-baby screening
- Diagnosis of autism; and

- Treatment through speech therapy, occupational therapy, physical therapy and Applied Behavioral Analysis (ABA) to develop, maintain, restore and maximize the functioning of the individual, which may include services that are habilitative or rehabilitative.

  Autism Spectrum Disorder Services must be provided by Practitioners/Providers who are certified, registered or licensed to provide these services.

  Treatment must be prescribed by the member's treating Physician in accordance with a treatment plan. The treatment plan must be maintained by the prescribing Physician and submitted with the claim for services. The treatment plan will be reviewed to ensure the services are Medically Necessary. If services are received but are not part of the treatment plan, benefits for services may be denied.

  Services are subject to usual member cost-sharing features such as Deductible, Coinsurance, Copayments, and Out-of-Pocket Limits based on place of treatment and type of service. All services are subject to General Limitations and Exclusions except where explicitly mentioned as being an exception. This benefit is subject to the other general provisions of the Policy, including but not limited to: coordination of benefits, restrictions on health care services, including review of Medical Necessity, care management, and other managed care provisions.

Exclusions for autism spectrum disorders. This Policy **does not cover:**

- Any experimental, long-term, or maintenance treatments not required under state law;
- Medically unnecessary or non-habilitative services under any circumstance;
- Respite services or care;
- Sensory integration therapy (SIT) or auditory integration therapy (AIT);
- Music therapy, vision therapy, or touch or massage therapy (unless Medically Necessary and performed by an M.D., Physical Therapist, or Occupational Therapist);
- Floor time;
- Facilitated communication;
- Elimination diets, nutritional supplements, intravenous immune globulin infusion, secretin infusion;
- Chelation therapy; or
- Hippotherapy, animal therapy, or art therapy.

Blood Services

This Policy covers the processing, transporting, handling, and administration of blood. **Note:** This Policy covers blood storage fees only when the blood is to be used for an already scheduled surgical procedure and only if the donor has specifically indicated that you, the policyholder, are to receive the donated blood. (This includes situations in which you are donating blood to

be used in your own scheduled procedure.) Blood storage costs for any other purpose will not be covered. This Policy does not cover blood replaced by or for the patient through donor credit.

Chemical Dependency

If you are admitted because of an Emergency, prior authorization for the initial hospitalization will be automatically approved when notification is made.

NMMIP does not require any prior authorization for ED services at any ED facility or prior authorization from contracted urgent care facilities for the following substance use disorder services
(1) acute or immediately necessary care;
(2) acute episodes of substance use disorder conditions;
NMMIP will automatically approve prior authorization requests for initial in-network inpatient or outpatient substance use treatment services. Additional services after the initial approval will undergo the standard prior authorization process.
Prior authorization will be determined in consultation with the enrollee's substance use disorder services provider for:
(1) continuation of services in chronic or stable conditions; or
(2) additional services.
NMMIP does not limit coverage for substance use disorder services up to the point of relief of presenting signs and symptoms or to short-term care or acute treatment.
The duration of coverage for an enrollee with a substance use disorder shall be based on the substance use disorder needs of the insured rather than on arbitrary time limits.

Services for individuals with co-occurring chemical dependency and mental health are covered.

This Policy covers the following inpatient and outpatient care (including intensive outpatient programs and partial hospitalization), for the evaluation, diagnosis, and/or treatment of Chemical Dependency, which includes both Alcoholism and Drug Abuse:

- Therapeutic individual and group psychotherapy rendered by psychiatrists, psychologists, licensed family therapists, and Other Mental Health/Chemical Dependency Providers (as defined in Section 9: Definitions);
- Inpatient visits and other Professional Provider services received on a day during which Hospital benefits were provided;
- Medical management of prescription medication;
- Intake evaluations and psychological testing;
- Family counseling, or counseling with family members to assist in the patient's diagnosis and treatment; and

- Other therapeutic services, as appropriate and prior-approved by the Administrator.

Chiropractic Services

Chiropractic care including the manipulation of body joints and the spine are covered when administered by a licensed Provider acting within the scope of licensure, and when necessary for the treatment of a medical condition. Benefits are limited to **20 visits per calendar year**, unless for rehabilitative or habilitative purposes. Reimbursement is limited to the Covered Charge for the chiropractic treatment itself and associated office visit. Chiropractic physician shall not impose a copayment or coinsurance on those chiropractic physician services that exceeds the copayment or coinsurance imposed for primary care services.

Covid-19 Services

This Plan covers the following at no cost-sharing in the testing and delivery of health care services for Covid-19 (including testing/screening for pneumonia and influenza, treatment for pneumonia when due to or a result of Covid-19 infection, and treatment for influenza when a co-infection with Covid-19) or any disease or condition which is the cause of, or subject of, a public health emergency is presumptively unreasonable and is prohibited.

Dental-Related/TMJ Services and Oral Surgery

The following services are the only dental services and oral surgery procedures covered under this Policy. When alternative procedures or devices are available, benefits are based upon the most Cost-Effective, medically appropriate procedure or device available.

Dental and Facial Accidents. Benefits for Covered Services for the treatment of accidental injuries to the jaw, mouth, face, or Sound Natural Teeth are generally subject to the same limitations, exclusions, and Enrollee cost-sharing provisions that would apply to similar services when not dental-related (e.g., x-rays, Medical Supplies, surgical procedures).

Facility Charges and General Anesthesia for Dental-Related Services. This Policy covers inpatient or outpatient Hospital expenses (including Ambulatory Surgical Facilities and Hospital and Physician charges for administration of general anesthesia for non-covered, Medically Necessary Dental-Related Services) if the patient requires hospitalization for one of the following reasons:

- Insureds exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results;
- Local anesthesia is ineffective because of acute infection, anatomic variation, or allergy to local anesthesia;

- insured children or adolescents who are extremely uncooperative, fearful, anxious or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity;
- Because oral-facial or dental trauma is so extensive, local anesthesia would be ineffective;
- There is a Medically Necessary dental procedure (not excluded by any General Limitation or Exclusion listed in the benefit booklet such as for work-related, or Cosmetic services, etc.) that requires the patient to undergo general anesthesia or be hospitalized.

Note: Unless listed as a covered procedure in this section, the Dentist's services for the procedure will not be covered.

Oral Surgery. Covered Services include surgeon's charges for the following oral surgical procedures only:

- Removal of fully or partially bony impacted teeth;
- External or intraoral cutting and draining of cellulitis (not including treatment of dental-related abscesses);
- Incision of accessory sinuses, salivary glands, or ducts;
- Medically Necessary orthognathic surgery;
- Lingual frenectomy;
- Removal or biopsy of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of mouth when pathological examination is required; and
- Removal of exostoses (bony growths) on the jaws and hard palate, provided the procedure is not done in preparation of the mouth for dentures.
- The correction of non-dental physiological conditions such as, but not limited to, cleft palate repair that has resulted in a severe functional impairment.
- Removal of infected teeth in preparation for an organ transplant, joint replacement surgery or radiation therapy of the head and neck.

Note: Prior Approval is required for orthognathic surgery that requires inpatient Admission.

Pediatric Dental Services. This policy covers children up to the age of 19 for the following:

- Cleanings, fluoride, diagnostic exams and X-rays twice per calendar year;
- Full mouth or panoramic x-rays, once per 60 months;
- Sealants once per 60 months;
- Space maintainers;
- Fillings;
- Crowns;
- Root canals;
- Extractions; and
- Orthodontic appliances and treatment that are Medically Necessary to treat a cleft palate or lip.

Dental Services for Transplant Candidates. This Policy will cover the essential dental services determined to be Medically Necessary for the general management of the transplant recipient's health prior to transplant.

TMJ/CMJ Services. This Policy covers standard diagnostic, therapeutic, surgical, and non-surgical treatments of Temporomandibular Joint (TMJ) or craniomandibular joint (CMJ) disorders or accidental injuries. Treatment may include orthodontic Appliances and treatment, crowns, bridges, or dentures **only if** required because of an Accidental Injury to Sound Natural Teeth involving the TMJ or CMJ.

Exclusions. This Policy **does not cover** oral or dental procedures not specifically listed as covered such as, but not limited to:

- Non-standard services (diagnostic, therapeutic, or surgical);
- Removal of tori;
- Vestibuloplasty (surgical modification following periodontal treatment);
- Dental services that may be related to, or required as the result of, a medical condition or procedure (e.g., Chemotherapy or Radiation Therapy) except as specifically stated under transplant benefits;
- Procedures involving orthodontic care (except as specifically stated), the teeth, dental implants, periodontal disease or condition, or preparing the mouth for dentures;
- Procedures to correct anomalies relating to teeth or structures supporting the teeth or for Cosmetic procedures when the surgery does not correct a bodily malfunction;
- Duplicate or "spare" Appliances;
- Personalized restorations, Cosmetic replacement of serviceable restorations, or materials (such as precious metals) that are more expensive than necessary to restore damaged teeth;
- Artificial devices and/or bone grafts for denture wear;
- Surgeon's or Dentist's charges for the non-covered Dental-Related Services;
- Hospitalization or general anesthesia for the patient's or Provider's convenience; or
- Any service related to a dental procedure that is not Medically Necessary or that is excluded under this Policy for reasons other than being dental-related, even if hospitalization and/or general anesthesia is Medically Necessary for the procedure being received (e.g., Cosmetic procedures, experimental procedures, services received after coverage termination, work-related injuries, etc.).

Developmental Delay

Services and supplies related to occupational therapy, physical therapy, speech therapy or other medical charges in association with treatment for developmental delays or learning disorders. Benefits for specific services will be subject to any applicable maximums as indicated in the Schedule of Benefits.

Diabetic Services

Diabetes Self-Management. This Policy covers diabetes self-management training and education prescribed by a health care Provider. A diabetes patient education program is a planned program of instruction that is:

- Provided by a health professional diabetes educator who is certified by the National Certification Board as a Certified Diabetes Educator (C.D.E); and

- Designed to teach patients with diabetes and their families to:

- Understand the relationship between diabetes control and complications;
- Perform diabetic management skills to achieve adequate diabetes control; and
- Avoid frequent Hospital confinements and complications.

Covered Services are limited to:

- Medically Necessary visits upon the diagnosis of diabetes;
- Visits following a Physician diagnosis that represents a significant change in your symptoms or condition that warrants changes in your self-management;
- Visits when reeducation or refresher training is prescribed by a health care Provider; and
- Medical nutrition therapy related to diabetes management.
- Telephonic visits with a Certified Diabetes Educator (CDE).
- Glucagon-like peptide-1 (GLP-1) medications for Type 2 Diabetes with a pharmacy prior authorization.

Diabetic Supplies and Equipment. This provision of the Policy covers the following supplies and equipment for diabetic Enrollees and individuals with elevated blood glucose levels due to pregnancy (for supplies, this Policy covers up to a **month's supply** purchased during any given month):

- Insulin pump supplies;
- Injection aids, including those adaptable to meet the needs of the legally blind;
- Insulin pumps;
- Blood glucose monitors, including those for the legally blind; and
- Medically Necessary podiatric Appliances for prevention and treatment of foot complications associated with diabetes; including durable medical equipment for the treatment of active diabetic foot ulcers, including topical oxygen and including therapeutic molded or depth- inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices, and shoe modifications.

All members with diabetes are eligible to receive the following diabetic testing supplies at no cost-sharing (no charge): diabetic pump supplies, glucose meter, test strips, control solution, lancets and lancing devices. On a regularly scheduled basis the program will automatically ship the necessary supplies to your home. Contact the Administrator about this program or see our Web Site **www.nmmip.org**.

Dialysis Services

Dialysis. This Policy covers the following services when received from a Designated Dialysis Facility or in your home:

- Renal dialysis (hemodialysis);
- Continual ambulatory peritoneal dialysis (CAPD);

- Home dialysis;
- Apheresis and plasmapheresis; and
- The cost of equipment rentals and supplies for home dialysis.

A Designated Dialysis Facility is an appropriately licensed facility in the state in which the service is received specializing in dialysis and is participating in the Network or is a Provider facility participating with NMMIP. **This Policy also covers dialysis from a Non-Participating Provider under specific limited circumstances such as when you are on vacation and/or out of the services area or when there are no contracted Providers within the service area.**

If dialysis is based on End Stage Renal disease, you may also qualify for Medicare. You should learn all you can about your options for Medicare coverage based on End Stage Renal Disease. Care managers will answer your initial questions about Medicare, but you must contact Medicare for complete details.

Emergency Care

Emergency Care is covered:

- 24 hours per day, 7 days per week, when those services are needed immediately to prevent jeopardy to the enrollee's health.
- For a health care procedure, treatment or service, excluding ambulance transportation service, which procedure, treatment or service is delivered to you after the sudden onset of what reasonably appears to be a medical or behavioral health condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention, regardless of eventual diagnosis, could be expected by a reasonable layperson to result in jeopardy to a person's physical or mental health or to the health or safety of a fetus or pregnant person, serious impairment of bodily function, serious dysfunction of a bodily organ or part or disfigurement to a person; or
- For trauma services and all other emergency services until the member is medically stable, does not require critical care, and can be safely transferred to an in-network facility, if required, based on the judgment of the attending physician.

Equipment, Orthotics, Appliances, Supplies, and Prosthetics

Durable Medical Equipment and Appliances.

This Policy covers Durable Medical Equipment which is equipment that is Medically Necessary for treatment of an illness or Accidental Injury or to prevent further deterioration. This equipment is designed for repeated use and used to treat a medical condition or illness, and includes items such as but not limited to:

- Orthopedic appliances;
- Replacement of items when required because of wear (and the item cannot be repaired) or because of a change in your condition; or if equipment is no longer

functioning, is outside the warranty period and the defect is unable to be repaired; or repair of item not due to misuse;

- Oxygen and oxygen equipment, wheelchairs (including batteries), hospital beds, crutches, and other necessary Durable Medical Equipment;
- Lens implants for aphakic patients (those with no lens in the eye) and soft lenses or sclera shells (white supporting tissue of eyeball);
- Either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) when necessary to replace lenses absent at birth or lost through cataract or other intraocular surgery or ocular injury, to treat conditions related to genetic inborn errors of metabolism, or prescribed by a Physician as the only treatment available for keratoconus (Duplicate glasses/lenses are not covered. Replacement is covered only if a Physician or Optometrist recommends a change in prescription due to a change in your medical condition.);
- Cardiac pacemakers;
- Blood pressure monitors, limited to one (1) per calendar year;
- The rental of (or at the option of the Administrator, the purchase of) Durable Medical Equipment, including repairs to purchased equipment, when prescribed by a covered health care Provider and required for therapeutic use; and
- Sales tax, shipping and handling costs associated with the rental or purchase of Durable Medical equipment.

Hearing Aids. This Policy covers the following items if prescribed by a Physician and received from a Physician, qualified audiologist, or hearing aid dealer:

- The hearing aid unit and its acquisition costs;
- Ear mold, necessary cords, tubing, and connectors;
- Standard package of batteries; and
- Earphone or oscillator.

This Policy **does not cover**:

- Spare hearing aids;
- Hearing aids that do not meet FDA or FTC requirement; or
- Eyeglass-type hearing aids, to the extent the charge for such hearing aid exceeds the covered hearing aid expense for one basic behind-the-ear type model.

Cochlear implantation of a hearing device (such as an electromagnetic bone conductor) for the profoundly hearing impaired, including the cost of the device and training to use the device, may be covered.

Medical Supplies. For the following Medical Supplies, this Policy covers up to a **month's supply** purchased during any given month:

- Colostomy bags, catheters;
- Gastrostomy tubes;

- Hollister supplies;
- Tracheostomy kits, masks;
- Lamb's wool or sheepskin pads;
- Ace bandages, elastic supports when billed by a Physician or other Provider during a covered office visit; and
- Slings.

Orthotics and Prosthetic Devices. This Policy covers:

- Functional orthotics only for patients having a locomotive problem or gait difficulty resulting from mechanical problems of the foot, ankle, or leg. (A functional orthotic is used to control the function of the joints.);
- Surgically implanted prosthetics or devices, including penile implants required as a result of illness or injury;
- Externally attached prostheses to replace a limb or other body part lost after Accidental Injury or surgical removal; their fitting, adjustment, repairs, and replacement;
- Replacement of prosthetics only when required because of wear (and the item cannot be repaired) or because of a change in your condition;
- Breast prosthetics when required as the result of a mastectomy;
- Mastectomy brassieres; and
- Support hose when prescribed by a Physician.

Coverage is equivalent to Medicare. Coverage is for the most appropriate device as determined to be medically necessary by the treating Provider. Coverage of prosthetics may be subject to authorization.

Exclusions. This Policy **does not cover**, regardless of therapeutic value, items such as, but not limited to:

- Air conditioners, biofeedback equipment, humidifiers, purifiers, self-help devices, or whirlpools;
- Items that are primarily non-medical in nature such as Jacuzzi units, hot tubs, exercise equipment, heating pads, hot water bottles, or diapers;
- Non-standard or deluxe equipment when standard equipment is available and adequate;
- External prosthetics that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing;
- Comfort items such as bed boards, beds or mattresses of any kind, bathtub lifts, overbed tables, or telephone arms;
- Repair costs that exceed the rental price of another unit for the estimated period of need, or repair or rental costs that exceed the purchase price of a new unit;
- Dental Appliances (See "Dental-Related/TMJ Services and Oral Surgery" for exceptions);
- Accommodative orthotics (deal with structural abnormalities of the foot, accommodate such abnormalities, and provide comfort, but do not alter function);

- Orthopedic shoes, unless joined to braces; (Diabetic Enrollees and Enrollees with diagnosed severe neuropathy may be eligible to receive benefits for these items. Call the Administrator for details. Also see "Diabetic Services.");
- Equipment or supplies not ordered by a health care Provider, including items used for comfort, convenience, or personal hygiene;
- Duplicate items; repairs to duplicate items; or the replacement of items because of loss, theft, or destruction;
- Voice synthesizers or other communication devices;
- Eyeglasses or contact lenses or the costs related to prescribing or fitting of glasses or contact lenses, unless listed as covered; sunglasses, special tints, and other extra features for eyeglasses or contact lenses;
- Syringes or needles for self-administering drugs; (Coverage for insulin needles and syringes and other diabetic supplies are covered as described under "Diabetic Services."); or
- Items that can be purchased over-the-counter (unless listed as covered under "Medical Supplies"), including, but not limited to, dressings for bed sores or burns, gauze, and bandages.

Family Planning/Infertility/Contraceptive Services

Family Planning

Covered family planning services include FDA approved (if applicable) devices and other procedures such as:

- Health education.
- Tubal ligation; sterilization implant; copper intrauterine device; intrauterine device with progestin; implantable rod; contraceptive shot or injection; combined oral contraceptives; extended or continuous use oral contraceptives; progestin-only oral contraceptives; patch; vaginal ring; diaphragm with spermicide; sponge with spermicide; cervical cap with spermicide; male and female condoms; spermicide alone; vasectomy; ulipristal acetate; levonorgestrel Emergency contraception; and any additional method categories of contraception approved by the FDA.
- Pregnancy testing and counseling.

For these following covered family planning services, no Coinsurance, Deductible, Copayment, or benefit maximums will apply when received from an HMO-Participating Provider.

- Clinical contraceptive services such as consultations, examinations, procedures (including for immediate (pre-discharge) post-partum long acting reversible contraception, or follow-up care for trouble you may have from using a birth control method that a family planning Provider gave you) and medical services provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

- Male and female surgical sterilization procedures (other than hysterectomy), including tubal ligations.

Contraception Coverage. You are entitled to receive certain covered contraception services and supplies without cost sharing and without prior approval. This means that you do not have to make a co-payment, coinsurance, satisfy a deductible or pay out-of-pocket for any part of contraception benefits listed if you receive them from an in-network provider.

You may be required to pay a copay, coinsurance, and/or deductible if you receive a contraception service or supply from an out-of-network provider if the same service or supply is available in-network. You may also owe cost sharing if you receive a brand-name contraceptive when at least one generic or therapeutic equivalent is available.

- **Long-Acting Reversible Contraceptives (LARCs).** Coverage with no cost-sharing also applies to IUD insertion and removal, including surgical removal, and to any related medical examination when services are obtained from an in-network provider. Coverage of LARCs with no cost-sharing also includes (pre-discharge) post-partum clinical services.
- **Oral Contraceptives.** You are entitled to receive a six-month supply of contraceptives, if prescribed and self-administered, when dispensed at one time by your pharmacy. To receive this benefit, your provider must specifically prescribe the six-month supply. If you need to change your contraceptive method before the six-month supply runs out, you may do so without cost-sharing. You will not owe cost sharing for any related contraceptive counseling or side-effects management.

  Your plan may exclude or apply cost sharing to a name-brand contraceptive if a generic or therapeutic equivalent is available within the same category of contraception. Ask your provider about a possible equivalent. If your provider determines a brand-name contraceptive is medically necessary, your provider may ask for coverage of that contraceptive without cost-sharing. If we deny the request, you or your provider can submit an appeal to contest the denial.

- **Vasectomies and Male Condoms**. This plan covers vasectomies and male condoms. No prescription or cost sharing is required for coverage of male condoms. (Please see the section below on Coverage for Contraception Where a Prescription Is Not Required for instructions on reimbursement for condoms.)

- **Sexually Transmitted Infections.** This plan covers, and no cost-sharing applies to, contraception methods that are prescribed for the prevention of sexually transmitted infections.

- **Coverage for Contraception Where a Prescription is Not Required.** This plan covers contraception with no-cost sharing even when a prescription is not required. Contraceptive methods such as condoms or Plan B may fall into this

category. For purchases of covered contraceptives, you may submit a request for reimbursement as follows.

Receipt must be submitted within 90 days of the date of purchase of the contraceptive method. Receipt must include item name and amount, your name, address, plan ID number, along with reimbursement request form located at www.nmmip.org. Receipt must be mailed to Plan Administrator at P.O. Box 780548, San Antonio, TX 78278.

- **Prescription Drugs**. Benefits mandated through the PPACA legislation to include Preventive Care medications, and contraceptives that are listed as recommended by Health Reform Law A and B recommendations as determined by the United Sates Preventive Services Task Force (USPSTF).

Infertility-Related Services. This Policy covers the following infertility-related treatments (note that the following procedures only secondarily also treat infertility):

- Infertility testing to diagnose cause of infertility;
- Surgical and medical to repair or correct the condition causing infertility;
- Diagnostic lab and x-ray;
- Therapeutic and infertility drugs; or
- Infertility treatments and related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilizations.

The above services are the only infertility-related treatments that will be considered for benefit payment.

Exclusions. This Policy **does not cover**:

- Sterilization reversal for males or females;
- Gamete Intrafallopian Transfer (GIFT) or Zygote Intrafallopian Transfer (ZIFT) or other similar procedures;
- Cost of donor sperm; and
- Artificial conception or insemination, including fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such as in-vivo or in-vitro ("test tube") fertilization, and embryo transfer; drugs for induced ovulation; or other artificial methods of conception.
- Sexual Dysfunction. Services related to male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause, including prescriptions drugs, sex counseling, penile prosthetic implants (except as otherwise specified), and all other procedures and equipment developed for or used in the treatment of impotency, however expenses which are incurred in order to diagnose the condition will be covered.

Gender Affirming Care

This Policy covers care for enrollees with a clinical diagnosis of Gender Dysphoria. Covered services include the following:

- Behavioral health services;
- Hormone therapy services, limited to Gonadotropin-Releasing Hormone Therapy (GnRH) and Gender-Affirming Hormone Therapy;
- Genital surgeries ;
- Breast/chest surgeries;
- Facial and neck surgeries;
- Pre- and post-operative services;
- Pre-surgical permanent hair removal/electrolysis to treat surgical sites; and
- Outpatient physical therapy.

Coverage limitations include the following:

- Enrollees must have a clinical diagnosis of Gender Dysphoria.
- Service must be medically necessary.
- Any co-existing physical and behavioral health conditions do not interfere with diagnostic clarity or capacity to consent, and associated risks and benefits have been discussed.
- The Enrollee has given informed consent for the service.
- If the Enrollee is under 18 years of age, Enrollee's parent(s) or legal guardian has given informed consent for the service.
- GnRH therapy is a covered service for an Enrollee who has reached Tanner Stage 2.
- Gender-Affirming Hormone Therapy is a covered service for an Enrollee who:
    - Has been informed of the possible reproductive effects of hormone therapy, including the potential loss of fertility, and the available options to preserve fertility,
    - Has reached Tanner Stage 2, and
    - If under 18 years of age, demonstrates the emotional and cognitive maturity required to understand the potential impacts of the treatment.
- Prior to beginning Gender-Affirming Hormone Therapy, a licensed health care professional who has competencies in the assessment of transgender and gender diverse people must determine that any behavioral health conditions that could negatively impact the outcome of treatment have been assessed and the risks and benefits have been discussed with the member.

- For the first 12 months of Gender-Affirming Hormone Therapy, an Enrollee must receive medical assessments at a frequency determined to be clinically appropriate by the prescribing provider.
- Surgical procedures are limited to an Enrollee 18 years of age or older who:
    - Has completed 6 continuous months of hormone therapy (does not apply for mastectomy surgeries), unless hormone therapy is not clinically indicated or is inconsistent with the client's desires, goals, or expressions of individual gender identity; and
    - Understands the potential effect of the Gender-Affirming Surgery on fertility.
- Mammoplasty is covered when an Enrollee has completed 12 continuous months of hormone therapy, unless hormone therapy is not clinically indicated or is inconsistent with the patient's desires, goals, or expressions of gender identity.
- Requests for surgery for Enrollees under 18 years of age will be reviewed and considered based on medical circumstances and clinical appropriateness of the request.

Exclusions. This Policy **does not cover**:

- Reversal of covered surgical procedures; or
- Any items or services excluded from coverage as listed in the Policy.

Genetic Inborn Errors of Metabolism

This Policy covers Medically Necessary expenses related to the treatment of Genetic Inborn Errors of Metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist. (as defined in *Section 9:* Definitions).

Covered Services include medical assessment, including clinical services, chemical analysis, Medical Supplies, Prescription Drugs, corrective lenses for conditions related to the genetic Inborn Error of Metabolism, nutritional management, and prior approved Special Medical Foods (as defined) that are used to treat and to compensate for the metabolic abnormality of Enrollees with genetic inborn errors of metabolism in order to maintain their adequate nutritional status. In order to be covered, services cannot be excluded under any other provision of this booklet and are paid according to the provisions of the Policy that apply to that particular type of service (e.g., Special Medical Foods are covered under "Prescription Drugs and Other Items," medical assessments under "Physician Visits/Medical Care," and corrective lenses under "Equipment, Orthotics, Appliances, Supplies, and Prosthetics").

To be covered, the Enrollee must be receiving medical treatment provided by licensed health care professionals, including Physicians, dieticians, and nutritionists, who have specific training in managing patients diagnosed with genetic inborn errors of metabolism.

Habilitative Services

Habilitative Treatment. Treatment programs that are necessary to: 1) develop, 2) maintain, and 3) restore to the maximum extent practicable the functioning of an individual. All three conditions must be met in order to be considered habilitative.

Home Health Care/Home I.V. Services

Conditions and Limitations of Coverage. If home healthcare is proven to be Medically Necessary, home health care and home I.V. services are covered. Benefits are limited to 100 visits per calendar year. (Additional visits may be approved with a determination of Medical Necessity.) A visit is one period of home health service of up to four hours. Services must be provided under the direction of a Physician and nursing management must be through a home health care agency approved by the Administrator.

Such services may include collection of specimens to be submitted to an approved laboratory facility for analysis.

Covered Services. The following services are covered, subject to the conditions and limitations above, when provided by an approved home health care agency during a covered visit in your home:

- Skilled Nursing Care provided on an intermittent basis by a Registered Nurse or Licensed Practical Nurse;
- Physical, Occupational, Respiratory, or Speech Therapy provided by licensed or certified therapists;
- Intravenous medications and other Prescription Drugs ordinarily not available through a retail pharmacy if **Prior Approval** is received from the Administrator (If drugs are not provided by the home health care agency, see "Prescription Drugs and Other Items.");
- Parenteral and Enteral Nutritional Products that can only be legally dispensed by the written prescription of a Physician and are labeled as such on the packages (If not provided by the home health care agency, see "Prescription Drugs and Other Items.");
- Medical Supplies; or
- Services of a home health aide under the supervision of a Registered Nurse and in conjunction with Skilled Nursing Care.

Exclusions. This Policy **does not cover**:

- Care provided primarily for you or your family's convenience;

- Homemaking services or care that consists mostly of bathing, feeding, exercising, preparing meals for, moving, giving medications to, or acting as a sitter for the patient (See the "Custodial Care" exclusion in *Section 4*.);
- Services provided by a nurse who ordinarily resides in your home or is a member of your immediate family; or
- Non-prescription Enteral Nutritional Products.

Hospice Care

This Policy covers Hospice services for a terminally ill Enrollee received during a Hospice Benefit Period when provided by a Hospice program approved by the Administrator.

Note: Prior Approval is required for inpatient Hospice Care.

Covered Services. The following services are covered, subject to the conditions and limitations above, under the Hospice Care benefit:

- Palliative Care;
- inpatient Hospice Care and Hospice home visits by a Physician;
- Skilled Nursing Care by a Registered Nurse or Licensed Practical Nurse;
- Physical, Occupational Therapy, Speech Therapy provided by licensed Providers;
- Medical Supplies (If supplies are not provided by the Hospice agency, see "Equipment, Supplies, and Prosthetics.");
- Drugs and medications for the Terminally Ill Patient (If drugs are not provided by the Hospice agency, see "Prescription Drugs and Other Items.");
- Medical social services provided by a qualified individual with a degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training, and experience (Such services must be recommended by a Physician to help the Enrollee or their family deal with a specified medical condition.);
- Services of a home health aide under the supervision of a Registered Nurse and in conjunction with Skilled Nursing Care;
- Nutritional guidance and support, such as intravenous feeding and hyperalimentation;
- Respite care for a period not to exceed five (5) continuous days for every 60 days of Hospice Care and no more than two (2) respite care periods during the Hospice Benefit Period. (Respite care provides a brief break from total care-giving by the family); and
- Bereavement family counseling.

Exclusions. This Policy **does not cover**:

- Food, housing, delivered meals or non- medical transportation;
- Volunteer services;
- Homemaker and housekeeping services, comfort items;
- Private duty nursing;

- Supportive services provided to the family of a Terminally Ill Patient when the patient is not an Enrollee of this Policy; or care or services received after the Enrollee's coverage terminates.
- Care or services received after the Enrollee's coverage terminates.

The following services are not Hospice care benefits but may be covered elsewhere under this Policy: acute inpatient Hospital care for curative services, Durable Medical Equipment, Physician visits unrelated to Hospice care, and Ambulance services.

Hospital/Other Facility Services

Acute Inpatient Services. Inpatient means you have been admitted by a health care practitioner/provider to a hospital for the purpose of receiving hospital services.

Eligible inpatient hospital services are acute care services provided when you are a registered bed patient and there is a room and board charge. Admissions are considered inpatient based on medical necessity, regardless of the length of time spent in the hospital.

Inpatient hospital benefits include:

• acute medical detoxification

• medical and surgical care provided by physicians, surgeons, other practitioners and nursing care

• facility fees for other services when medically necessary such as special diets or parenteral nutrition, pharmaceuticals and other medications, anesthesia and oxygen services, radiation therapy, inhalation therapy and administration of whole blood and blood components.

Exclusions Acute medical detoxification in a residential treatment center is not covered. Rehabilitation is not covered as a part of acute medical detoxification.

For acute care received during a covered Hospital Admission, this Policy covers semiprivate room or Special Care Unit (e.g., ICU, CCU) expenses and other Medically Necessary services provided by the facility. (If you have a private room for any reason other than isolation, covered room expenses are limited to the average semiprivate room rate, whether or not a semiprivate room is available.) **Note:** Prior Approval is required for all non-emergency inpatient Admissions.

If you are admitted because of an Emergency the Administrator must be called within 24 hours of Admission or as soon as reasonably possible or benefits for covered facility services may be denied.

Outpatient/Emergency Room Services. This Policy covers Medically Necessary outpatient, observation, and other treatment room services.

Emergency Room. If services are received in an emergency room or other trauma center, the condition must meet the definition of an "Emergency" in order to be covered.

Hyperbaric Oxygen Therapy

Hyperbaric Oxygen Therapy is a covered benefit only if the therapy is proposed for a condition recognized as one of the accepted indications as defined by the Hyperbaric Oxygen Therapy Committee of The Undersea and Hyperbaric Medical Society (UHMS), or as medically necessary Hyperbaric Oxygen Therapy is **Excluded** for any other condition. Hyperbaric Oxygen Therapy requires **Prior Authorization** and services must be provided by your In-network Practitioner/Provider in order to be Covered.

Hypnotherapy Services

Benefits for Medically Necessary hypnotherapy are available when provided by a Provider trained in the use of hypnosis when used for anesthesia.

Lab, X-Ray, Other Diagnostic Services

This policy covers Diagnostic Services, including preadmission testing, that are related to an illness or injury. Covered Services include:

- X-ray and radiology services, ultrasound, and imaging studies; MRI, CT/PET;
- Clinical laboratory and pathology tests;
- EKG, EEG, and other electronic diagnostic medical procedures;
- Audiometric (hearing) and vision tests required for the diagnosis and/or treatment of Accidental Injury or an illness or for prescribing an appropriate hearing aid for a known hearing loss;
- Direct skin (percutaneous and intradermal) and patch allergy tests; radio-allergosorbent testing (RAST);
- Testing and treatment for glaucoma;
- An annual routine, low-dose mammogram screening and Pap test in accordance with national medical standards;
- Biomarker testing for diagnostic, treatment, management and monitoring; and
- Sleep Disorders. Medically Necessary services and supplies rendered by covered Providers for the treatment for sleep disorders, including sleep studies, if medically appropriate.
- Prior Approval is not required for gynecological and/or obstetrical ultrasounds.

Prior Approval is required for certain MRI, CT and PET Scans (excludes bone density scans).

Preadmission Testing. This Policy covers 100 percent of the Covered Charge for

Hospital outpatient preadmission testing that is received within 10 days before the start of a related inpatient stay. This benefit is not subject to Deductible, Coinsurance, or Out-of-Pocket Limit provisions.

Mastectomy Services

This Policy covers Medically Necessary hospitalization related to a covered mastectomy (including at least 48 hours of inpatient care following a mastectomy and 24 hours following a lymph node dissection).

This Policy also covers Cosmetic breast surgery for a mastectomy related to breast cancer. Benefits are limited to:

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

This Policy covers prophylactic mastectomies even though a current cancer diagnosis does not exist. Risk-reducing surgery will be considered the same as any other illness when there is an increased risk of breast cancer, when documented family history exists of breast or ovarian cancer, or when genetic testing demonstrates the existence of the cancer risk.

This Policy does not cover subsequent procedures to correct unsatisfactory Cosmetic results attained during the initial breast/nipple surgery or tattooing.

Mental Health Services

Services related to rehabilitation of Alcoholism or other chemical dependency are not covered under this “Mental Health” provision; see “Chemical Dependency” for benefits.

Services for individuals with co-occurring mental health and chemical dependency are covered.

Medical Necessity. In order to be covered, treatment must be Medically Necessary and not experimental or investigational. Therapy must be required for the treatment of a distinct Mental Disorder as defined by the latest version of the Diagnostic and Statistical Manual published by the American Psychiatric Association; and

- Reasonably expected to result in significant and sustained improvement in your condition and daily functioning;
- Consistent with your symptoms, functional impairments, and diagnoses;
- In keeping with generally accepted national and local standards of care; and

- Provided to you at the least restrictive level of care.

Covered Services.

NMMIP does not require any prior authorization for ED services for the following mental health services:
(1) acute or immediately necessary care;

(2) acute episodes of chronic mental health conditions;
NMMIP does not require prior authorization for any of the following services by contracted urgent care facilities:
(1) acute or immediately necessary care;
(2) acute episodes of chronic mental health conditions;

Prior Approval is required for all inpatient mental health services except for the initial inpatient admission for **emergent mental health services through the ED**. This admission will be automatically approved through the prior authorization process. (Outpatient benefits are not available for services received while you are inpatient. Inpatient benefits are not available for services received on an outpatient basis.)

Prior authorization will be determined in consultation with the insured's mental health provider for:
(1) continuation of services in chronic or stable conditions; or
(2) additional services.
NMMIP does not limit coverage for mental health services up to the point of relief of presenting signs and symptoms or to short-term care or acute treatment.
The duration of coverage for an insured with a mental health disorder shall be based on the mental health disorder needs of the enrollee rather than on arbitrary time limits.

The mental health benefit of this policy covers Medically Necessary short-term inpatient and outpatient care, evaluation, diagnosis, crisis intervention, and/or treatment of acute Mental Illness or other mental condition not related to Alcoholism or other Chemical Dependency. This Policy covers inpatient Physician services received on a day during which Hospital benefits were provided.

Changes in level and duration of care shall be determined by your provider in consultation with the Administrator and based on your needs; and may include placement into a facility that provides detoxification services, a hospital, an inpatient rehabilitation treatment facility or an outpatient treatment program.

The Administrator may facilitate communication between the insured's behavioral health and primary care providers to ensure coordination of care to prevent any conflict of care that could be harmful.

The administrator will protect the confidentiality of an insured receiving behavioral health treatment.

Covered Services include:

- Therapeutic individual and group psychotherapy rendered by psychiatrists, psychologists, licensed family therapists, and other Providers (as defined in Section 9: Definitions);
- Medical management of Prescription Drugs;
- Intake evaluations and psychological testing;
- Inpatient family counseling, or counseling with family members to assist in the patient's diagnosis and treatment; and
- Other therapeutic services, as appropriate.

Exclusions. This Policy **does not cover**:

- Services provided or billed by a school, halfway house, or their staff members;
- Psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education;
- Court-ordered or police-ordered services, or services rendered as a condition of parole or probation, unless the services would otherwise be covered;
- Biofeedback or hypnotherapy;
- Religious counseling; marital counseling;
- The cost of any damages to a treatment facility;

- Custodial Care (See the "Custodial Care" exclusion in *Section 4*.);
- Confinement for the purpose of environmental change; or
- Treatment for learning disabilities or behavioral problems.

Morbid Obesity Services

Morbid obesity means the state of being either 35 kilograms/m2 or greater.

The Policy covers care, services, treatment and supplies for **Morbid Obesity** including surgical intervention, when Medically Necessary, the same as any other illness or sickness. The following criteria must be met prior to surgery:

- Prior Approval by the Administrator;
- Behavioral health assessment;
- Determination of Medical Necessity to treat the medical condition; and
- Completion of a six (6) month course in Integrated Care Management.

To facilitate a healthy recovery, care managers support the patient for the twelve (12) month post-surgery period.

Exclusions. This Policy does not cover fees for club/gym memberships or membership fees of any kind or type; costs associated with enrolling/attendance in an exercise program; appetite suppressants, nutritional supplements or food products unless specifically stated elsewhere; and equipment used for exercise including but not limited

to treadmills, elliptical machines, weight machines, pools or hot tubs of any type, or services related to panniculectomy / abdominoplasty or similar surgical procedures.

Note: Prior Approval is required for all surgical procedures.

Newborn Care

Newborn Care will be covered for the initial Hospital confinement following birth as described below:

Benefits will be available for the newborn child of a mother who is currently enrolled under the Plan, from the moment of birth, for well or sick newborn care. (This will include coverage for birth-related injury or sickness and the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.)

- For infants born on the first of the month, this coverage will end on the last day of the month of birth, and for infants born on any other day, coverage will end on the last day of the month following the month of birth.
- Benefits under this provision include services and supplies furnished by the Hospital and Physicians. Inpatient Physician care for the newborn includes, but is not limited to, Physician visits and the circumcision of male infants. Additionally, when necessary to protect the life of the infant, coverage will include transportation, including air ambulance services, to the nearest tertiary facility equipped to render Medically Necessary services.

Coverage Requirements and Timelines:

Please note, the newborn will not be eligible for enrollment in NMMIP if any other coverage is available. For eligible newborns, the child must be enrolled by the first of the month following the month of birth for deliveries that occur on the first of the month, or by the first of the second month following the birth month for deliveries that occur on any other date. Furthermore, NMMIP does not coordinate benefits for newborn care with other insurers.

If there are no coverage options available for the newborn, the newborn may be enrolled in NMMIP but the enrollment process must prove all other options were accessed timely and were denied. The first month's premium must be included with the application.

Admission review approval is required if your eligible newborn stays in the Hospital longer than the mother for non-routine medical or Surgical Services. You must call for approval before the mother is discharged from the Hospital.

NOTE: To obtain coverage options for your newborn please contact Customer Service at (866) 306-1882.

Nutritional Counseling and Supplements

Covered under Hospice: Nutritional guidance and support, such as intravenous feedings and hyperalimentation.

Covered under Home Health Care/IV services: Intravenous medications and other Prescription Drugs not available through a retail pharmacy if Prior Approval is received

Covered under Preventive Care Services: Health education and counseling if recommended by your Physician, including obesity screening and counseling.

Covered under General Limitations and Exclusions: This Policy does not cover vitamins, dietary/nutritional supplements, special foods, formulas, mother's milk or diets UNLESS 1) A prescription is required for the product; or 2) it meets the definition of Special Medical Foods that are used to treat and compensate for the metabolic abnormality of Enrollees with genetic inborn errors of metabolism in order to maintain their adequate nutritional status.

Not Covered under Home Care/IV: Non-prescription Enteral Nutritional Products.

Not Covered under Morbid Obesity: Fees for club/gym membership or membership fees of any types; costs associated with enrolling/attendance in an exercise program; appetite suppressants, nutritional supplements or food products unless specifically stated elsewhere, and equipment used for exercise.

Observation Services

Observation Services are Covered: Observation services are defined as outpatient services furnished by a hospital and practitioner/provider on the hospital's premises. These services may include the use of a bed and periodic monitoring by a hospital's nursing staff, which are reasonable and necessary to:

- Evaluate an outpatient's condition
- Determine the need for a possible admission to the hospital
- When rapid improvement of the patient's condition is anticipated or occurs

Orthotics and Prosthetics

This plan provides coverage for initial and secondary prosthetic devices and custom orthotics in a non-discriminatory manner, and without restriction based on predetermined utilization limits, at the same level and cost-sharing as the coverage provided for medical and surgical benefits.

Prosthetic and custom orthotic devices are considered habilitative and rehabilitative essential health benefits and are not subject to separate financial requirements or utilization restrictions. Coverage includes:

- Clinical care
- All supplies, materials, and devices determined by the physician to be medically necessary and most appropriate to maximize upper and lower limb function, maintain

activities of daily living or essential job-related activities, and meet the medical needs for physical activities.

- All services, including design, fabrication, and repair
- Replacement when applicable after meeting clinical criteria.

Utilization management decisions related to coverage for prosthetic or custom orthotic devices will be applied in a non-discriminatory manner using the most recent version of evidence-based treatment and fit criteria as recognized by relevant clinical specialists or their organizations.

Prosthetic and custom orthotic benefits will not be denied for an individual with limb loss or absence that would otherwise be covered for a non-disabled person who is seeking medical or surgical intervention to restore or maintain the ability to perform the same daily functions and physical activity.

However, coverage for prosthetic devices and custom orthotics will not be provided when required solely for comfort or convenience.

Outpatient Medical Services

Outpatient Medical Services that covers outpatient medical services, which are services provided in a hospital, outpatient facility, practitioner/provider's office or other appropriately licensed facility. These services do not require admission to any facility but may charge a facility fee. These services include reasonable hospital services provided on an ambulatory (outpatient) basis, and those preventive, medically necessary diagnostic and treatment procedures that are prescribed by a practitioner/provider.

Covered services must be provided by a contracted provider and some services require prior authorization. These include, but are not limited to:

- Chemotherapy and radiation therapy treatment or control of disease.
- Dialysis
- Diagnostic Services – refer to the diagnostic services section
- Acute Medical Detoxification – medically necessary services for substance use detoxification
- Medical drugs (medications obtained through the medical benefit). Medical drugs are defined as medications administered in the office of facility that require a health care professional to administer. These medications include, but are not limited to oral, injectable, infused, or inhaled drugs. Office administered applies to all outpatient settings including, but not limited to, physician's offices, emergency rooms, urgent care center, and outpatient surgery facilities
- Observation following outpatient services
- Sleep disorder studies, in home or outpatient facility

- Surgery
- Therapeutic and support care services, supplies, appliances, and therapies
- Wound care
- Facilities fees

Exclusions

- Electronic mail (e-mail) by a practitioner/provider for which the practitioner/provider charges
- Get acquainted visits without physical assessment or diagnostic or therapeutic intervention

Pharmacist Services

Pursuant to a board-approved protocol approved by the New Mexico Medical Board, an in-network pharmacist may order, test, screen, treat, and provide preventive services for Flu, Strep Throat, SARS, UTIs, HIV for prep only, and an illness subject to an active Public Health Emergency.

Physician Visits/Medical Care

Participating (contracted) Practitioners/Provider Services

Participating practitioner/provider services are covered, which are services that are reasonably required to maintain good health, including primary care services. Participating practitioner/provider services include, but are not limited to, periodic examinations and office visits by:

- A licensed practitioner/provider, including physician assistants and nurse practitioners
- Specialist services provided by other health care professionals who are licensed to practice, are certified, and practicing as authorized by applicable law or authority
- A medical group
- An independent practice association
- Other authority authorized by applicable state law
- Participating Provider services include, but are not limited to, health care services and supplies as described below:
- Office visits provided by a qualified participating practitioner/provider, including primary care providers.
- Outpatient surgery and inpatient surgery including necessary anesthesia services. Anesthesia may include hypnotherapy.
- Second medical opinions.

This section describes benefits for medical visits to a health care Provider for evaluating your condition and planning a course of treatment. This Policy covers Medically Necessary care provided by a Physician or other Professional Provider for an illness or Accidental Injury.

Office, Urgent Care, and Emergency Room Visits. Covered Services include office, Urgent Care Facility, and emergency room visits, consultations (including second or third surgical opinions), and examinations when not related to Hospice Care or payable as part of a surgical procedure. This Policy also covers other services and supplies received during the visit, such as allergy injections, therapeutic injections, casting, and sutures**.**

Inpatient Medical Visits. With the exception of Dental-Related Services (see "Dental-Related/TMJ Services and Oral Surgery"), this Policy covers the following services when received on a covered inpatient Hospital day:

- Visits for a condition requiring only medical care, unless related to Hospice Care (See "Hospice Care.");
- Consultations (including second opinions)
- If surgery is performed, inpatient visits by a Provider who is not the surgeon and who provides medical care not related to the surgery (For the surgeon's services, see "Surgery and Related Services" or "Transplant Services."); and
- Medical care requiring two or more Physicians at the same time because of multiple illnesses.

Non-contracted providers: As described in Section 2, NMMIP also covers claims from non-contracted physicians under the No Surprises Act. This is coverage for:

- Emergency Services;
- Non-emergency services rendered by a Non-Participating Provider at a Participating Health Care Facility, such as anesthesiologists, radiologists, or pathologists.

Pregnancy Complications and Maternity

Pregnancy Complications. This Policy covers Complications of Pregnancy the same as any other illness. Complications of Pregnancy include C-sections, ectopic pregnancies, toxemia, abruptio placentae, miscarriage, therapeutic termination of pregnancy prior to full term, and other complications as determined by the Administrator.

This Policy covers Medically Necessary hospitalization related to Complications of Pregnancy, including at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a C-section delivery.

Routine Maternity/Elective Termination of Pregnancy. This Policy covers normal, routine Maternity care, including elective abortions.

Covered Services. Covered Maternity services include:

- Hospital or other facility charges for semiprivate room, board, and other services, including the use of labor, delivery, and recovery rooms, including

at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a C-section);

- Delivery services, including prenatal and postnatal medical care provided by a Practitioner acting within the scope of their license (including a Midwife and Certified-Nurse Midwife) delivering services in a Hospital, Birthing Center, or at home;
- Services of an obstetrician, Certified Nurse Midwife, or licensed Midwife in a Hospital, in a licensed Birthing Center staffed by a Certified Nurse Midwife or Physician, or at home (expenses for prenatal and postnatal care are included in the total covered charge for the actual delivery or completion of pregnancy);
- Pregnancy-related diagnostic tests, including genetic testing or counseling sought due to a family history of a sex-linked genetic disorder or to diagnose a possible congenital defect caused by a present, external factor that increases risk, such as advanced maternal age or alcohol abuse (for example, tests such as amniocentesis or ultrasound to determine the sex of a child are not covered.);
- Alpha-fetoprotein IV screening test for pregnant women, generally between sixteen and twenty weeks of pregnancy, to screen for certain genetic abnormalities in the fetus, as required by law;
- Necessary anesthesia services by a Provider qualified to perform such services, including Acupuncture used as an anesthetic during a covered procedure and administered by a Physician, a licensed Doctor of Oriental Medicine, or other practitioner as required by law;
- Services of a Physician who actively assists the operating surgeon in performing a covered procedure when the procedure requires an assistant;
- Elective termination of pregnancy prior to the third trimester;
- Postpartum care in the home shall be made in accordance with accepted maternal and neonatal physician assessments, by a person with appropriate licensure, training and experience to provide postpartum care. Services provided by such a person shall include, but not be limited to, parental education, assistance and training in breast and bottle feeding, and the performance of any necessary and appropriate clinical tests.
- Postpartum care in home shall consist of a minimum of three home visits, unless one or two home visits are determined to be sufficient by the attending physician or person with appropriate licensure, training and experience to provide postpartum care, and the mother. The home visit shall be conducted within the time period ordered by the attending physician or person with appropriate licensure, training and experience to provide postpartum care.

Pre-Exposure Prophylaxis (PrEP)

This Policy covers the PrEP medication, as appropriate for you, and essential PrEP related services without cost-sharing, the same as any other preventive drug or service.

This means that you do not have to make a co-payment, pay coinsurance, satisfy a deductible or pay out-of-pocket for any part of the benefits and services listed in this summary if you receive them from an In-Network provider. You may be required to pay a copay, coinsurance and/or a deductible if you receive PrEP related services from an Out-of-Network provider if the same benefit or service is available from an In-Network provider.

Covered services include:

- At least one FDA-approved PrEP drug, with timely access to the PrEP drug that is medically appropriate for the enrollee, as needed;
- HIV testing;
- Hepatitis B and C testing;
- Creatinine testing and calculated estimated creatine clearance for glomerula filtration rate;
- Pregnancy testing for individuals with childbearing potential;
- Sexually transmitted infection screening and counseling;
- Adherence counseling;
- Office visits associated with each preventive service listed above;
- Quarterly testing for HIV and STIs, and annually for renal functions, is required to maintain a PrEP prescription.

Prescription Drugs and Other Items

This Policy covers the following drugs, supplies, and other products through the outpatient Prescription Drug card program only when dispensed by a Participating Pharmacy under the pharmacy benefit program which includes the Specialty Pharmacy Drug program (unless required as the result of an Emergency, as defined) or ordered through the Pharmacy Benefit Manager's mail order service:

- Drug plan benefits are not subject to the Medical Plan Deductible.
- Drug plan Copayments are applied to the medical plan's Out-of-Pocket Limit and will be waived once the medical plan Out-of-Pocket Limit is met.
- Prescription Drugs and medicines including prescriptive oral agents for controlling blood sugar levels, and prescription contraceptive medications, unless listed as an exclusion;
- Self-administered injections and oral cancer medications dispensed directly to the patient for home use. Any such medications, if eligible, are covered only under this provision of the Policy and are not available under the medical benefit.
- Orally administered anti-cancer medication is covered no less favorably than intravenously administered or injected cancer medications that are covered as medical benefits under the Plan;
- Specialty Pharmacy Drugs including but not limited to self-administered injectable drugs such as growth hormone, Copaxone, and Avonex. Most injectable drugs require Prior Approval from the Administrator. Some self-

administered drugs, whether injectable or not, are identified as Specialty Pharmacy Drugs and may have to be acquired through a participating Specialty Pharmacy Provider in order to be covered.

- Insulin needles, syringes, and diabetic supplies (e.g., glucagon emergency kits, autolet, lancets, lancet devices, blood glucose, and visual reading urine, and ketone test strips). There is a separate Copayment for each item purchased.
- Growth hormones (including expenses for administration);
- Botox. Services and supplies related to the administration of Botox, provided services are Medically Necessary to treat a covered Diagnosis administered in a Physician's office. In addition to the coverage that is provided under the Medical Plan, benefits may be available for Botox as allowable through the Plan's prescription drug program. In such an instance, benefits may be obtained from the Medical Plan, or prescription drug program, but not both. For Botox that is obtained through the Plan's prescription drug program, any Physician's fee associated with dispensing such medication will be eligible for payment under the Medical Plan;
- Special Medical Foods (as defined in *Section 9:* Definitions) that are used to treat and to compensate for the metabolic abnormality of Enrollees with genetic inborn errors of metabolism in order to maintain their adequate nutritional status; and
- Vaccines, limitations may apply. Ask your pharmacy if they administer vaccinations and which vaccinations they administer.

Prior Approval Is Required for Certain Drugs. A list of drugs requiring Prior Approval is available from the Pharmacy Benefit Manager. Your Physician can request the necessary Prior Approval.

Specialty Pharmacy Drugs. All items under this provision of your Policy must be purchased from a Specialty Pharmacy designated by the Pharmacy Benefit Manager in order to be covered under this Policy. Specialty Pharmacy Drugs are high-cost, complex pharmaceuticals (usually injectable) that have unique clinical, administration, distribution, or handling requirements and are not commonly available in traditional community and mail-order pharmacies. The Pharmacy Benefit Manager, and not a local retail pharmacy, will assist you with obtaining drugs from a Specialty Pharmacy. Refer to the Pharmacy Benefit Manager's telephone number and website on the back of your ID card. You can also call the Administrator if you need help identifying Specialty Pharmacy Drugs, ordering, or reordering the Prescription Drug.

You must present your New Mexico Medical Insurance Pool ID card to the pharmacist at the time of purchase to receive this benefit**.**

Note: You do not receive a separate Prescription Drug ID card; use your NMMIP ID card to receive all services covered under this Policy. You can use your ID card to purchase covered items only for yourself. When coverage for you ends, the ID card may not be used to purchase drugs or other items.

If you do not have your ID card with you or if you purchase your prescription or other covered item from a Non-Participating Provider in an Emergency, you must pay for the purchase in full and then submit a claim directly to the Pharmacy Benefit Manager. You should have received the address of the Administrator among the materials you received upon enrollment. If you did not, call a Customer Service Representative for the address.

If you are leaving the country or need an extended supply of medication, call Customer Service at least two weeks before you intend to leave. Extended supplies or vacation overrides are not available through the mail-order service and may be approved through the Pharmacy Benefit Manager only. In some cases, you may be asked to provide proof of continued enrollment eligibility under NMMIP.

Mail-Order Service. Except for supply limitations and Enteral Nutritional Products, all items that are covered under the mail-order service are the same items that are covered under the retail pharmacy program and are subject to the same limitations and exclusions. Specialty Pharmacy Drugs are not available through the mail-order service, and must be purchased from a Specialty Pharmacy in order to be covered. To use the mail-order service, follow the instructions outlined in the materials provided to you in your enrollment packet. If you do not have this information, call a Customer Service Representative. Any pharmacy or mail-order pharmacy can be used if it accepts the terms, conditions and rates equal to a participating pharmacy.

Outside the Country. Prescription Drugs and other items may not be mailed outside the United States. Extended supplies or vacation overrides required when you are outside the country may be approved through the Pharmacy Benefit Manager only.

Step Therapy. The Step Therapy Program helps manage costs of expensive drugs by redirecting patients, when appropriate, to equally effective less expensive, generic alternatives. The program requires that Enrollees starting a new drug treatment use generic drugs first. Generic drugs, which are tested and approved by the U.S. Food & Drug Administration (FDA), have been shown to be safe and effective. If the generic alternative is not effective, a Brand-Name Drug may then be acquired in the second step. You will be required to pay the higher Copays for Brand-Name Drugs.

Brand Name vs. Generic Drug Costs. When there is an FDA-approved generic equivalent available for a Brand-Name Drug that has been prescribed by your Physician, you will receive the generic drug and pay the generic drug Copayment amount. If there is no generic equivalent drug available, you will pay the brand name percentage Copayment amount, which is subject to a maximum Copayment. If there is a generic equivalent drug available and you or your Provider requests the Brand Name Drug, you will pay the generic drug Copayment plus the difference in the total covered drug costs between the brand name and the generic drug. In this case, there is no maximum Copayment limit. (Also, please note, the cost difference you pay for Brand-Name Drugs is not applied to

the medical/surgical plan's Out-of-Pocket Limit nor will it be waived once the medical/surgical plan Out-of-Pocket Limit is met.)

If your Physician feels that the Brand Name Drug is Medically Necessary, you may appeal the benefit payment as described under "Request for Reconsideration" on page of the Policy.

Enrollee Copayments and Supply Limitations. For covered Prescription Drugs, including Specialty Pharmacy Drugs, insulin, diabetic supplies, and nutritional products, you pay a fixed-dollar or a percentage Copayment, not to exceed the actual retail price, for each prescription filled or item purchased not to exceed supply limitations. Copayments are not subject to a Deductible; however, copayments are included in the Out-of-Pocket Limit.

After you have met the Out-of-Pocket Limit for the calendar year, your Prescription Drugs are payable at 100 percent. You may have to pay the difference in cost between a Brand Name Drug and its generic equivalent. This amount does not apply to the Out-of-Pocket Limit.

For commercially packaged items such as an inhaler, a tube of ointment, or a blister pack of tablets or capsules, you will pay the applicable Copayment or percentage amount for a one-month supply under the Retail Pharmacy and Specialty Pharmacy Programs. You will pay three times that amount for up to a 90-day supply of the same item purchased through the Mail-Order Service.

Exclusions. This Policy **does not cover**:

- Non-prescription and over-the-counter drugs unless specifically listed as covered including herbal or homeopathic preparations, or Prescription Drugs that have over-the-counter equivalents;
- Non-commercially available compounded medications, regardless of whether or not one or more ingredients in the compound requires a prescription. Non- commercially available compounds are those made by mixing or reconstituting ingredients in a manner or ratio that is inconsistent with United States Food and Drug Administration approved indications provided by the ingredients' manufacturers.
- Drugs or Special Medical Foods or other items covered only under the Prescription Drug plan purchased from a Non-Participating Pharmacy or other Provider except in cases of Emergency;
- Refills before the normal period of use has expired. Prescriptions cannot be refilled until at least 75 percent of the previously dispensed supply has been exhausted according to the Physician's instructions. Call the Administrator for instructions on obtaining a greater supply if you are leaving home for more than a 30-day period of time.
- Replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced;

- Therapeutic devices or Appliances, including support garments and other non- medicinal substances;
- Medications or preparations used for Cosmetic purposes, such as preparations to promote hair growth or medicated Cosmetics, including tretinoin (sold under such brand names as Retin-A) for Cosmetic purposes;
- Prescription Drugs required for international travel or work; or
- Appetite suppressants or diet aids; weight reduction drugs; food or diet supplements and medication prescribed for body building or similar purposes.

Brand Name Exclusion. NMMIP reserves the right to exclude any injectable drug currently being used by an Enrollee. Proposed new uses for injectable drugs previously approved by the FDA will be evaluated on a medication-by-medication basis. Call the Pharmacy Benefit Manager if you have any questions about this Policy.

Preventive Care Services

This Policy covers the following Preventive Services, not subject to Copays, Coinsurance and Deductible, or benefit maximums:

- All services that are on the USPSTF A and B recommendations list https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
- Immunization for routine use that have in effect a recommendation by the Advisory Committee on Immunizations Practice (ACIP) of the Center for Disease Control and Prevention (CDC) with respect to the individual involved;
- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and
- With respect to women, to the extent not described above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.
- In addition to coverage that is provided for services mandated under the Affordable Care Act, benefits will also be provided for other expenses incurred in relation to other routine care. Services must be identified and billed as routine or part of a routine physical exam, and will include, but are not limited to, wellness or office exams billed by the Physician with a covered preventive diagnosis, immunizations, screenings, and other services.

The services listed are not limited as to the number of times you may receive the service in any given period or as to the age of the patient except when a service is inappropriate for the patient's age group, such as providing a pediatric immunization to an adult. Additionally, preventive services will not be based on the individuals' sex assigned at birth, gender identity or recorded gender. You and your Physician are encouraged to determine how often and at what time you should receive preventive tests and examinations and you will receive coverage according to the benefits and limitations of this Policy.

Examples of Covered Services include, but are not limited to:

- Routine physical, breast, and pelvic examinations;
- Diagnostic or supplemental breast examinations (with no cost-sharing);
- Routine adult and pediatric immunizations, including human papillomavirus vaccine (HPV) for Enrollees aged 9 through 26;
- Well-child visit, including well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorder;
- An annual routine gynecological examination and low-dose mammogram;
- Annual prostate examination and related testing;
- Periodic blood hemoglobin, blood pressure, and blood glucose level tests;
- Screenings, papillomavirus screening, and Pap tests or liquid-based cervical cytopathology, colonoscopies including polyp removal, any pathology exam on a polyp biopsy and a follow up colonoscopy of there's a positive non-invasive stool-based screening test or direct visualization.;
- Vision screening up to age 19, including refraction;
- Hearing screenings in order to detect the need for additional hearing testing in children up to age 21 when received as part of a routine physical exam; and
- Health education and counseling services if recommended by your Physician, including an annual consultation to discuss lifestyle behaviors that promote health and well-being, including smoking/tobacco use cessation counseling and obesity screening and counseling.

Exclusions. This Policy **does not cover**:

- Employment physicals, insurance examinations, or examinations at the request of a third party; premarital examinations; sports or camp physicals; any other non-preventive physical examination;
- Hearing screening for Enrollees age 21 or older;
- Eye refractions; routine eye examinations for Enrollees age 19 or older;
- Immunizations or medications required for international travel; or
- Hepatitis B immunizations when required due to possible exposure during the Enrollee's work.

Prophylactic Oophorectomy (ovary removal surgery)

This Policy will cover a prophylactic oophorectomy even if a current cancer diagnosis does not exist. The risk-reducing surgery will be considered the same as any other illness when there is an increased risk of breast or ovarian cancer, when documented family history exists of breast or ovarian cancer, or when genetic testing demonstrates the existence of the cancer risk.

Public Health Emergency

This Plan covers health care services for any disease or condition which is the cause of, or the subject of, a public health emergency, including testing and screening for pneumonia and influenza, treatment for pneumonia when due to or a result of a declared public health emergency, and treatment of influenza when associated with such an emergency. Coverage also applies to conditions arising from natural disasters (such as wildfires, floods, hurricanes, or earthquakes), unless the treatment is presumptively unreasonable or is prohibited.

Note: To ensure timely notification regarding this Policy, it is your responsibility to ensure that the Administrator has all of your updated contact information. This includes: your telephone number; physical address; mailing address and or any other contact information i.e., email address. This information is utilized by your Administrator to provide updated information; providing information on your coverage; and or benefits and protections available to you during a public health emergency and/or natural disaster.

Skilled Nursing Facility Services

This Policy covers the first 100 days of confinement in a Skilled Nursing Facility (SNF) each calendar year. Expenses incurred after the 100th day of skilled nursing confinement in a calendar year are not covered, and they cannot be used toward satisfying the Deductible or Out-of-Pocket Limits.

Prior Approval is required for Skilled Nursing Facility services. Conditions of Coverage.

Conditions of Coverage. To be covered, the confinement must satisfy the following conditions:

- Be recommended by a Physician who certifies that 24-hour-a-day nursing care is required;
- Be for the purpose of receiving the care for the condition that caused the Hospital confinement; and
- Be under the supervision of a Physician.

Confinement in an Acute Care Hospital. In some areas of New Mexico, a freestanding Skilled Nursing Facility is not available. Therefore, some Hospitals have set aside some of their semiprivate rooms to provide for Skilled Nursing Care services. Confinement in an acute care Hospital is a covered SNF service or supply if:

- The level of care needed has been reclassified from acute care to Skilled Nursing Care;
- No Skilled Nursing Care beds are available within a 30-mile radius of the Hospital;
- The SNF is Medicare-certified and approved; and
- The SNF is licensed by the State of New Mexico or another state's licensing board.

Exclusions. This Policy **does not cover**:

- Private room expenses, unless your medical condition requires isolation for protection from exposure to bacteria or diseases (e.g., severe burns or conditions that require isolation according to public health laws);
- Admissions related to non-covered services or procedures;
- Extended care;
- Maintenance Therapy or care provided after you have reached your rehabilitative potential. Even if you have not reached your rehabilitative potential, this Policy does not cover services that exceed maximum benefit limits. Or,
- Therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy, except as specified.

Smoking Cessation

This Policy covers smoking and tobacco use cessation treatment subject to Enrollee cost sharing provisions applicable to the type of service received, such as Prescription Drugs, counseling, etc.

These services include: health education and counseling services to discuss lifestyle behaviors that promote health and well-being, including smoking/tobacco use Cessation Counseling:

- Treatment with FDA-approved Prescription Drugs to assist you with quitting tobacco use or smoking;
- Cessation Counseling, restricted to programs that meet minimum requirements; and
- Over the counter tobacco cessation products, such as nicotine gum, nicotine patch, nicotine lozenge, nicotine oral or nasal spray, nicotine inhaler, bupropion and varenicline.

This Policy **does not cover** the following services:

- Cessation Counseling or treatment received from non-approved Providers;
- Acupuncture, biofeedback, or hypnotherapy for smoking/ tobacco use cessation.

Surgery and Related Services

Your Provider is responsible for obtaining Admission review and/or other Prior Approval when necessary.

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

Surgical Dressing. Covered Services include surgical dressings that require a Practitioner's/Provider's prescription, and cannot be purchased over the counter, are Covered when Medically Necessary for the treatment of a wound caused by, or treated by, a surgical procedure.

Gradient compression stockings are Covered for:

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

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

Reconstructive Surgery. Reconstructive Surgery improves or restores bodily function to the level experienced before the event that necessitated the surgery, or in the case of a congenital defect, to a level considered normal. Such surgeries may have a coincidental Cosmetic effect. This Policy covers Reconstructive Surgery and follow up treatment when required to correct a functional disorder caused by:

- An Accidental Injury.
- A disease process or its treatment; and
- A functional congenital defect (any condition, present from birth, that is significantly different from the common form; for example, a cleft palate or certain heart defects) would be covered.

Exclusions. This Policy **does not cover**:

- Cosmetic or plastic surgery or procedures, such as breast augmentation, rhinoplasty, and surgical alteration of the eye that does not materially improve the physiological function of an organ or body part;
- Breast reductions (unless Medically appropriate);
- Procedures to correct Cosmetically unsatisfactory surgical results or surgically induced scars;
- Refractive keratoplasty, including radial keratotomy, or any procedure to correct visual refractive defect;
- Trimming of corns, calluses, toenails, or bunions unless required for Enrollees with diagnosed severe neuropathy of the foot or as part of Medically Necessary diabetic disease management (except surgical treatment such as capsular or bone surgery);
- Subsequent surgical procedures needed because you did not comply with prescribed medical treatment or because of a complication from a previous non- covered procedure (such as a non-covered organ transplant, or previous Cosmetic surgery);
- Procedures to correct anomalies relating to teeth or structures supporting the teeth or for Cosmetic procedures when the surgery does not correct a bodily malfunction; or
- Standby services unless the procedure is identified by the Administrator as requiring the services of an assistant surgeon and the standby Physician actually assists.

Anesthesia Services. This Policy covers necessary anesthesia services, including Acupuncture used as anesthetic, when administered during a covered surgical procedure by a Physician, Certified Registered Nurse Anesthetist (CRNA), a licensed Doctor of Oriental Medicine (for Acupuncture), or other practitioner as required by law.

Assistant Surgeon Services. Covered Services include the services of a Professional Provider who actively assists the operating surgeon in the performance of a covered surgical procedure when the procedure requires an assistant. If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 25% of the Usual and Customary fee for the type of procedure performed.

Exclusions. This Policy **does not cover**:

- Services of an assistant only because the Hospital or other facility requires such services;
- Services performed by a resident, intern, or other salaried employee or person paid by the Hospital; or
- Services of more than one assistant surgeon unless the procedure is identified by the Administrator as requiring the services of more than one assistant surgeon.

Multiple surgical procedures will be Covered Charges subject to the following provisions:

- If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the charge that is allowed for the primary procedure; 50% of the charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
- If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Covered Charge for that procedure.

Telemedicine Services

This Policy covers telemedicine services the same as an in-person office visit. Telemedicine means the use of interactive simultaneous audio and video or store-and-forward technology using information and telecommunications technologies by a health care provider to deliver health care services at a site other than the site where the patient is located, including the use of electronic media for consultation relating to the health care diagnosis or treatment of the patient in real time or through the use of store-and-forward technology. Benefits will also include coverage for Physician to Physician consultations.

Testing Services

This policy covers the following (including but not limited to):

- Artery Calcification Testing
- Computerized Axial Tomography
- (CAT) Scans
- Magnetic Resonance Angiogram (MRA) tests
- Magnetic Resonance Imaging (MRI) tests
- Sleep Disorder Studies (home or facility)
- Bone Density Studies
- Clinical Laboratory Tests and Related Professional Services
- Gastrointestinal Lab Procedures
- Pulmonary Function Tests
- Urinary incontinence screening

Therapy and Rehabilitation

Chemotherapy and Radiation Therapy. This Policy covers the treatment of malignant disease by standard Chemotherapy and treatment of disease by Radiation Therapy. This does not include self- administered injections and oral cancer medications dispensed directly to the patient for home use. Any such medications, if eligible, are covered only under the

"Prescription Drugs and Other Items" provision of the Policy and are not available under this medical benefit.

Cancer Clinical Trials. If you are a participant in an approved Cancer Clinical Trial, you may receive coverage for certain Routine Patient Care Costs incurred in the trial. The trial must be conducted as part of a scientific study of a new therapy or intervention and be designed to study the reoccurrence, early detection, or treatment of cancer. The persons conducting the trial must provide the Administrator with notice of when the Enrollee enters and leaves a qualified clinical trial. The Routine Patient Care Costs that are covered must be the same services or treatments that would be covered if you were receiving standard cancer treatment. Enrollee cost-sharing provisions will apply to these benefits. Benefits also include FDA approved Prescription Drugs that are not paid for by the manufacturer, distributor, or Provider of the drug. If you are denied coverage of cost incurred in Cancer Clinical Trials you may appeal to the Superintendent of Insurance, and the appeal will be expedited to ensure resolution within 30 days.

Cardiac and Pulmonary Rehabilitation. This Policy covers outpatient cardiac rehabilitation programs initiated within six months of a cardiac incident and outpatient Pulmonary Rehabilitation services. Cardiac rehabilitation services are for continuous electrocardiogram (ECG) monitoring, progressive exercises and intermittent ECG monitoring. Pulmonary rehabilitation services are for progressive exercises and monitoring of pulmonary functions.

Short Term Rehabilitation including Outpatient Physical, Occupational, and Speech Therapy. Short-term rehabilitation service for physical therapy and occupational therapy, provided in a rehabilitation facility, skilled nursing facility, home health agency, or outpatient setting. Short-term rehabilitation is designed to assist you in restoring functions that were lost or diminished due to a specific episode of illness or injury (for example stroke, motor vehicle accident, or heart attack).

This Policy covers the following services for the treatment of Accidental Injury, illness, or conditions that existed at birth:

- Occupational Therapy;
- Physical Therapy;
- Speech Therapy, including audio diagnostic testing; and
- Services or supplies necessary for the treatment of illness or Accidental Injury by alignment or manipulation of body joints and the spine not involved with fracture or surgery.

Conditions of Coverage, Requirements and Limitations .

To be eligible for benefits, therapies must meet all of the following conditions:

Requirements:

- Services must be Medically Necessary to restore and improve lost bodily functions following illness or injury.
- There is a documented condition or delay in recovery that can be expected to measurably improve with short-term therapy within two months of beginning active therapy. This period may be extended upon recommendation of the referring Physician, in consultation with the Administrator.
- Improvement would not normally be expected to occur without intervention.
- Outpatient physical and occupational therapy requires that your primary care practitioner or other appropriate treating practitioner/provider must determine in advance that your physical therapy or rehabilitation services can be expected to result in significant improvement in the member's condition.
- The treatment plans that defined expected significant improvement must be established at the initial visit.
- Treatments by a physical or occupational therapy technician must be performed under the direct supervision and in the presence of a licensed physical or occupational therapist.
- Massage therapy is only covered when provided by a licensed physical therapist and as part of prescribed short-term rehabilitation physical therapy program.
- Outpatient speech therapy means language, dysphagia (difficulty swallowing) and hearing therapy. Speech therapy is covered when provided by a licensed or certified speech therapist. With regard to Speech Therapy, services restore a demonstrated ability to speak or swallow or develop or improve speech after surgery to correct a defect that both existed at birth and impairs or would have impaired the ability to speak. The loss must not be due to a mental, psychoneurotic, or personality disorder.

Limitations

- A primary care physician or other physician or practitioner must determine that speech therapy will result in significant improvement in the covered person's condition.
- If short-term rehabilitation therapy is provided in an inpatient setting (such as, but not limited to, rehabilitation facilities, skilled nursing facilities, intensive day-hospital programs that are delivered by a rehabilitation facility) or through home health the therapy may not be subject to the time limitation requirements of outpatient therapies.
- Inpatient and home health therapies may not be included with outpatient services when calculating the accumulated benefit usage.
- Skilled nursing facility stays are limited to 100 days per plan year.

Physical Rehabilitation, Inpatient. This Policy covers inpatient physical rehabilitation services that are Medically Necessary to restore and improve lost bodily or cognitive functions following Accidental Injury, illness, or surgery and that are provided in facilities that are authorized by the Administrator. Hospitalization for rehabilitation must begin within one year after the onset of the condition and while the Enrollee is covered under this Policy. Benefits are limited to a maximum of 30 days per calendar year.

Exclusions. This Policy **does not cover:**

- Athletic trainers or treatments delivered by athletic trainers
- Vocational rehabilitation services
- Long-term therapy or rehabilitation services. These therapies include treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Therapies are considered long-term rehabilitation when:
  o The enrollee has reached maximum rehabilitation potential
  o The enrollee has reached a point where significant improvement is unlikely to occur
  Chronic conditions include, but are not, but are not limited to:
  o Muscular Dystrophy
  o Down Syndrome
  o Cerebral Palsy not associated with a defined event of illness or injury.
- You have had therapy for four consecutive months.
- Speech Therapy or diagnostic testing related to: learning disorders, deafness, or stuttering; or personality, developmental, voice, or rhythm disorders when these conditions are not the direct result of a diagnosed neurological, muscular, or structural abnormality involving the speech organs; such as:
  o Therapy for stuttering
  o Additional benefits described in the speech therapy benefit
- Maintenance Therapy or care provided after you have reached your rehabilitative potential;
- Diagnostic, therapeutic, rehabilitative, or health maintenance services provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered Provider;
- Therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights);
- Massage Therapy (unless Medically Necessary and performed by an M.D., Physical Therapist, or Occupational Therapist);
- Rolfing;
- Private room expenses, unless your medical condition requires isolation for protection from exposure to bacteria or diseases (e.g., severe burns or conditions that require isolation according to public health laws);
- Admissions related to non-Covered Services or procedures; or

- Extended care admissions or admissions to similar institutions.

Transplant Services

Prior Approval Required. Prior Approval is required before a pre-transplant evaluation is scheduled. If approved, a care manager will be assigned to you (the transplant recipient candidate). If you are approved as a transplant recipient candidate, you must ensure that **Prior Approval** for the actual transplant is also received.

Note: Cornea transplants do not require Prior Approval. This is the only exception to the Prior Approval requirement for transplants.

Facility Must Be an Organ Specific Transplant Center of Excellence Facility. Benefits for Covered Services will be approved only when the transplant is performed at a Transplant Center of Excellence Facility for the specific type of transplant requested or at a Transplant Program of Excellence.

Your care manager will assist your Provider with information on the exclusive Network of Transplant Centers of Excellence or Programs of Excellence facilities and required approvals. Call the NMMIP's Customer Service for information on these approved transplant programs.

Transplant Centers of Excellence and Programs of Excellence are based on demonstrated exceptional clinical performance metrics, such as the following:

- Demonstrated high patient and graft survival rates (100-day, 1-year survival)
- Low rates of complications (e.g., GVHD, infection, readmission)
- Volume thresholds for specific transplant types (e.g., ≥10 allogeneic/year)
- Experience with both adult and pediatric cases (if applicable)

Effect of Medicare Eligibility on Coverage. If you are now eligible for (or are anticipating receiving eligibility for) Medicare benefits, you are solely responsible for contacting Medicare to ensure that the transplant will be eligible for Medicare benefits.

Covered Organ and Tissue Transplants. This Policy covers organ and tissue transplants including parts of the whole of organs, eyes or tissue as required by the NM Benchmark that are Medically Necessary and not experimental and investigational in nature.

Transplant Benefit Period. The Transplant Benefit Period begins ten days prior to the transplant and continues for one year following the date of the actual transplant or re-transplant. Before or after the Transplant Benefit Period services are subject to usual health plan benefits and must be covered under other provisions of this Policy in order to be considered for benefit payment. Travel necessary for pretransplant evaluations is included in the Transplant Benefit Period even if occurring more than ten days prior to

the transplant. The following benefits, limitations, and exclusions apply to this coverage during the Transplant Benefit Period.

Organ Procurement or Donor. If a transplant is covered, the surgical removal, storage, and transportation of an organ acquired from a cadaver are also covered. If there is a living donor that requires surgery to make an organ available for a covered transplant, coverage is available for expenses incurred by the donor for surgery, organ storage expenses, and inpatient follow-up care only. Benefits for the donor are payable only after expenses have been paid for the NMMIP Enrollee.

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

Transplant Recipient Travel and Pier Diem Lodging Expenses. If the Administrator requires you (i.e., the transplant recipient) to temporarily relocate outside of your city of residence for pre-transplant evaluation, to receive a covered transplant, this Policy covers travel to the city where the transplant will be performed as described below:

- Distance requirement. The Designated Transplant Facility must be more than 100 miles away from the patient's residence.
- Travel Allowances per Transplant Benefit Period. Travel is reimbursed between the patient's home and the facility for round trip (air, train or bus) transportation costs (including tolls and parking fees). If traveling by auto to the facility, mileage, parking and toll costs will be reimbursed per IRS guidelines.
- Reimbursement of Lodging Expenses. Reimbursement of expenses incurred by the patient and any companion for lodging expenses will be reimbursed up to a per diem of $150 per day.
- Overall maximum per Transplant Benefit Period. Travel and lodging reimbursement (including taxes) is limited to $10,000 per Transplant Benefit Period. This is a combined maximum for the patient and companion(s).
- Companions. If the transplant recipient is a child under the age of 18, benefits for travel and per diem expenses for two adults to accompany the child are available. One companion is permitted per adult and two parents or guardians are permitted per Child.

Travel expenses are not covered and per diem allowances are not paid if you choose to travel to receive a transplant for which travel is not considered Medically Necessary by the care manager. This Policy does not cover travel or provide per diem allowances for services required outside the Transplant Benefit Period.

Generally, travel expenses are not a benefit of this policy with the exception of transplants and only in certain situations.

Pursuant to state law §59A-23-17(B), Administrator will not deny coverage for organ transplantation or associated care solely on the basis of a covered person's physical or mental disability; deny to a covered person with a physical or mental disability eligibility or continued eligibility to enroll or to renew coverage under the terms of the health benefit policy or plan solely for the purpose of avoiding coverage for organ transplants and associated care; penalize or otherwise reduce or limit the reimbursement or provide monetary or nonmonetary incentives to a health care provider to induce that health care provider not to provide an organ transplant or associated care to a covered person with a physical or mental disability; or reduce or limit coverage benefits to a covered person with a physical or mental disability for the associated care related to organ transplantation as determined in consultation with the physician and patient.

Exclusions. This Policy **does not cover**:

- Implantation of artificial organs or devices (mechanical heart); non-human organ transplants;
- Services related to a transplant performed in a facility that is not a Designated Transplant Facility to provide the required transplant;
- Expenses incurred by an Enrollee of this Policy for the donation of an organ to another person;
- Donor expenses after the donor has been discharged from the transplant facility;
- Lodging, food, beverage, or meal expenses that are not covered by the per diem allowance, if available;
- Travel or per diem expenses incurred before or after the Transplant Benefit Period except for pre-transplant evaluation;
- If the recipient's care manager indicates that travel is not Medically Necessary; or
- Moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; telephone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items).

Urgent Care

Urgent Care is Covered: Urgent Care is medically necessary medical or surgical procedures, treatments, or health care services you receive in an urgent care center or in a practitioner's/provider's office for an unforeseen condition due to illness or injury. Urgent conditions are not life-threatening, but require prompt medical attention to prevent serious deterioration in your health.
The Urgent Care Center must be a contracted Provider

Vision Services - Pediatric

This Policy covers the following vision services for children up to age 19:

- One eye exam (including refraction) every 12 months;
- Eyeglasses every 12 months;

- Replacement lenses; and
- Minor repairs to glasses.

4 General Limitations and Exclusions

These general limitations and exclusions apply to all services listed in this booklet. This Policy does not cover any service or supply not specifically listed as a Covered Service in this booklet. If a service is not covered, then all services performed in conjunction with it are not covered. This Policy will not cover any of the following services, supplies, situations, or related expenses.

Before Effective Date of Coverage. This Policy does not cover any service received, item purchased, prescription filled, or health care expense incurred before your Effective Date of Coverage. If you are an inpatient when coverage either begins or ends, benefits for the Admission will be available only for those Covered Services received on and after your Effective Date of Coverage or those received before your termination date.

Biofeedback. This Policy does not cover services related to biofeedback.

Blood Services. This Policy does not cover blood storage fees unless the blood is to be used for an already scheduled surgical procedure and only if the donor has specifically indicated that you, the policyholder, are to receive the donated blood. This includes situations in which you are donating blood to be used in your own scheduled procedure. Blood storage costs for any other purpose will not be covered. This Policy does not cover blood replaced for or by the patient through donor credit.

Complications of Non-Covered Services. This Policy does not cover any complications of a non-covered service, treatment, or procedure.

Convalescent Care or Rest Cures. This Policy does not cover convalescent care or rest cures.

Cosmetic Services. Cosmetic surgery is beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic. This Policy does not cover Cosmetic surgery, services, or procedures for psychiatric or psychological reasons, or to change family characteristics or conditions caused by aging. This Policy does not cover services related to or required as a result of a Cosmetic service, procedure, or surgery, or subsequent procedures to correct unsatisfactory Cosmetic results attained during an initial surgery.

Examples of Cosmetic procedures include: dermabrasion; revision of surgically induced scars; breast augmentation; rhinoplasty; surgical alteration of the eye; correction of prognathism or micrognathism; excision or reformation of sagging skin on any part of the body including, but not limited to, eyelids, face, neck, abdomen, arms, legs, or buttock; services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body including, but not limited to, breast, face, lips, jaw, chin, nose, ears, or genitals; or any procedures that the Administrator determines are not required to materially improve the physiological function of an organ or body part.

Exception: Cosmetic breast/nipple surgery required due to a mastectomy related to breast cancer may be covered. Also, Reconstructive Surgery, which may have a coincidental Cosmetic effect, may be covered when required as the result of Accidental Injury, illness, or congenital defect.

Custodial Care. This Policy does not cover Custodial Care, or care in a place that is primarily your residence when you do not require skilled nursing.

Dental-Related Services. This Policy does not cover dental-related services, except for those services specifically listed as covered in *Section 3*.

Domiciliary Care. This Policy does not cover domiciliary care or care provided in a residential institution, treatment center, halfway house, or school.

Duplicate (Double) Coverage. This Policy does not cover amounts already paid by other valid coverage or that would have been paid by Medicare as the primary carrier if you were entitled to Medicare, had applied for Medicare, and had claimed Medicare benefits. See *Section 5* for more information. Also, if your prior coverage has an extension of benefits provision, this Policy will not cover charges incurred after your effective date under this Policy that are covered under the prior plan's extension of benefits provision.

Duplicate Testing. This Policy does not cover duplicative diagnostic testing or over-reads of laboratory, pathology, or radiology tests.

Experimental, Investigational, or Unproven Services. This Policy does not cover any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical practice* as defined on the next page (except for Acupuncture services) or those considered experimental, investigational, or unproven, (except for certain services required under New Mexico state law; see "Therapy: Cancer Clinical Trials" and "Autism Spectrum Disorders" in *Section 3* for details about coverage for these services). Also, services must be Medically Necessary and not excluded by any other contract exclusion. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted when services were administered, the service is experimental and will not be covered. To be considered experimental, investigational, or unproven, one or more of the following conditions must be met:

- The device, drug, or medicine cannot be marketed lawfully without approval of the U.S. Food and Drug Administration (FDA), and U.S. FDA approval for marketing had not been given at the time the device, drug, or medicine is furnished to the patient.
- Reliable evidence shows that the treatment, device, drug, or medicine is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug, or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

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

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

- Have been demonstrated in standard medical textbooks published in the United States and/or peer-reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- Are appropriate for the Hospital or other facility Provider in which they were performed; and
- The Physician or other Professional Provider has had the appropriate training and experience to provide the treatment or procedure.

Food or Lodging Expenses. This Policy does not cover food or lodging expenses, except for those that are eligible under the "Transplant Services" provision in *Section 3* or as a covered special medical food for an Enrollee with a genetic Inborn Error of Metabolism.

Genetic Testing or Counseling. This Policy does not cover genetic counseling or testing, unless:

- The services must be sought due to a family history of a sex-linked genetic disorder;
- The services are necessary to diagnose a possible congenital defect caused by a present, external factor that increases risk, such as advanced maternal age or alcohol misuse;
- The services are necessary for targeted disease therapy.

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

Hearing Exams, Procedures, or Aids. This Policy does not cover audio-metric (hearing) tests unless 1) required for the diagnosis and/or treatment of an Accidental Injury or an illness, 2) for prescribing an appropriate hearing aid for a known hearing loss, or 3) covered as a preventive screening service for children through age 19 as described under "Preventive Services" in Section 3. A screening does not include a hearing test to determine the amount and kind of correction needed. For hearing aid benefits and exclusions, including cochlear implantation of a hearing device, see "Equipment, Orthotics, Appliances, Supplies, and Prosthetics."

Hypnotherapy. Hypnosis or services related to hypnosis, except as otherwise specified.

Infertility Services/Artificial Conception. This Policy does not cover artificial conception, infertility testing, treatments, or related services, except as otherwise provided. This Policy does not cover reversal of a prior sterilization procedure. Certain treatments of medical conditions that sometimes result in restored fertility may be covered; see "Family Planning/Infertility Services" in *Section 3*.

Late Claims Filing. This Policy does not cover the services of a Non-Participating Provider, except as otherwise specified. If the claim for such services is received by the Administrator more than 12 months after the date of service, it will not be paid. Participating Providers must file claims within 6 months from the date of service. Claims from Tribal Providers must be received within 24 months of the date of service.

Learning Deficiencies/Behavioral Problems. This Policy does not cover special education, non-medical care, or any other service for learning deficiencies or disabilities or for chronic behavioral problems, whether or not associated with childhood autism, retardation, hyperkinetic syndromes (abnormally increase muscle movement), or attention deficit disorders, except as otherwise specified.

Maintenance Therapy. This Policy does not cover Maintenance Therapy or care or any treatment that does not significantly improve your function or productivity, or care provided after you have reached your rehabilitative potential (unless therapy is covered during an approved Hospice Benefit Period or is specifically listed as covered under "Autism Services" in *Section 3*). In a dispute about whether your rehabilitative potential has been reached, you are responsible for furnishing documentation from your Physician supporting their opinion.

Medical Policy Determinations. Any technologies, procedures, or services for which medical policies have been developed by the Administrator are either limited or excluded as defined in the Medical Policy except for Acupuncture and certain autism-related services required to be covered under state law irrespective of any Medical Policy to the contrary (see "Medical policy" in *Section 9*: Definitions).

Medically Unnecessary Services. This Policy does not cover services that are not Medically Necessary unless such services are specifically listed as covered. The Administrator determines whether a service or supply is Medically Necessary and whether it is covered. Because a Provider prescribes, orders, recommends, or approves a service or supply does not make it Medically Necessary or make it a Covered Service, even if it is not specifically listed as an exclusion. The Administrator determines Medical Necessity. To request a reconsideration of a decision regarding the Medical Necessity determination, see *Section 6*.

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

- Charges made only because benefits are available under this Policy services for which you have received a professional or courtesy discount;
- Volunteer services;
- Services provided by you for yourself or a covered family member, by a person ordinarily residing in your household, or by a family member; and
- Physician charges exceeding the amount specified by CMS when primary benefits are payable under Medicare.

Non-Covered Providers of Service. This Policy does not cover services prescribed or administered by a:

- Member of your immediate family or a person normally residing in your home;
- Physician, other person, supplier, or facility (including staff members) that are not specifically listed as covered in this Policy, such as a:

    - Health spa or health fitness center (whether or not services are provided by a licensed or registered Provider);
    - School infirmary;
    - Halfway house;
    - Massage therapist;
    - Private health resort;
    - Extended care facility or similar institution; or
    - Dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group.

Non-Medical Expenses. This Policy does not cover non-medical expenses, even if medically recommended and regardless of therapeutic value, including costs for services or items such as, but not limited to:

- Adoption or surrogate expenses;
- Educational programs such as behavior modification (except as otherwise specified) and arthritis classes Some diabetic services and other educational programs may be covered; see "Preventive Services" and "Diabetic Services" in *Section 3* for details;

- Vocational or training services and supplies;
- Missed appointments; "get-acquainted" visits without physical assessment or medical care; provision of medical information to perform Admission review or other Prior Approvals; filling out of claim forms; copies of medical records; interest expenses;
- Modifications to home, vehicle, or workplace to accommodate medical conditions; voice synthesizers; other communication devices;
- Membership at spas, health clubs, or other such facilities;
- Personal convenience items such as air conditioners, humidifiers, or exercise equipment, or personal services such as haircuts, shampoos, guest meals, and television rentals;
- Personal comfort services, including homemaker and housekeeping services, except in association with respite care covered during a Hospice Admission;
- Immunizations or medications required for international travel;
- Moving expenses or other personal expenses (e.g., laundry or dry-cleaning expenses, phone calls, day care expenses, taxicab or bus fare, vehicle rental expenses, parking expenses, personal convenience items);
- Physicals or screening exams and immunizations given primarily for insurance, licensing, employment, camp, medical research programs, sports, or for any non-preventive purpose;
- Hepatitis B immunizations when required due to possible exposure during the Enrollee 's work;
- Court-ordered or police-ordered services unless the services would otherwise be covered or services rendered as a condition of parole or probation; or
- The cost of any damage to a treatment facility that are caused by the Enrollee.

Non-Participating Provider. This Policy does not cover services obtained from Non-Participating Providers unless the services meet at least one of the exceptions stated under Section 1 “Provider Choices”.

Non-Prescription Drugs. This Policy does not cover outpatient non-prescription or over-the-counter drugs, ointments, medications, or creams (unless specifically listed as covered in *Section* 3) including herbal or homeopathic preparations, or Prescription Drugs that have over-the-counter equivalents.

Nutritional Supplements. This Policy does not cover vitamins, dietary/ nutritional supplements, special foods, formulas, mother's milk, or diets, unless: 1) a prescription is required for the product; or 2) it meets the definition of Special Medical Foods that are used to treat and to compensate for the metabolic abnormality of Enrollees with genetic inborn errors of metabolism (as defined) in order to maintain their adequate nutritional status.

Obesity Treatment. This Policy does not cover dietary or medical treatment of obesity except as stated under "Weight Management" and as preventive screening and counseling that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Service Task Force. The surgical treatment of morbid obesity is covered only if prior approved by the Administrator.

Post-Termination Services. This Policy does not cover any service, item, or drug received after your NMMIP coverage is terminated, even if: 1) Admission review or Prior Approval for such service, item, or drug was received from the Administrator; or 2) the service, item, or drug was needed because of an accident, illness, or other event that occurred while you were covered.

Prior Approval Not Obtained When Required. Failure to obtain Prior Approval may result in the denial of coverage for the health services requested if the services are determined not to be Medically Necessary or not a Covered Service. See Admission Review and Other Prior Approvals in *Section 2*.

Private Duty Nursing Services. This Policy does not cover private duty nursing services.

Take-Home Medications.

Therapy and Counseling Services. This Policy does not cover therapies and counseling programs except as listed in *Section 3*. See *Section 3* for additional exclusions. This Policy does not cover services such as, but not limited to:

- Recreational, sleep, crystal, primal scream, sex, and Z therapies;
- Self-help, stress management, and codependency;
- Services of a massage therapist or Rolfing;
- Transactional analysis, encounter groups, and transcendental meditation;
- (TM); moxibustion; sensitivity or assertiveness training;
- Vision therapy; orthoptics;
- Therapy for chronic conditions, such as, but not limited to, cerebral palsy, except as otherwise specified; and
- Psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education.

Thermography. This Policy does not cover thermography.

Transplant Services. In addition to services excluded by the other general limitations and exclusions listed throughout this *Section 4*, please see "Transplant Services" in *Section 3* for specific transplant services that are covered and related limitations and exclusions. This Policy does not cover any other transplants (or organ-combination transplants) or services related to any other transplants.

Travel and Other Transportation. This Policy does not cover therapeutic travel recommended for mental or physical health reasons or any travel expenses, even if travel is necessary to receive Covered Services unless such services are eligible for coverage under "Transplant Services" or "Ambulance Services" in *Section 3*.

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

Vision Services. This Policy does not cover any services related to refractive keratoplasty (surgery to correct nearsightedness) or any complication related to keratoplasty, including radial keratotomy or any procedure designed to correct visual refractive defect (e.g., farsightedness or astigmatism). This Policy does not cover eyeglasses, contact lenses, prescriptions associated with such procedures, and costs related to the prescribing or fitting of glasses or lenses, unless listed as covered under "Equipment, Orthotics, Appliances, Supplies, and Prosthetics" or listed as covered under "Vision Services - Pediatric" in *Section 3*. This Policy does not cover sunglasses, special tints, or other extra features for eyeglasses or contact lenses.

War-Related Conditions. This Policy does not cover any service required as the result of any act of war or related to an illness or Accidental Injury sustained during combat or active military service.

Weight Management. This Policy does not cover weight-loss or other weight-management programs, dietary control, or medical obesity treatment. This exclusion does not apply to:

- Surgical treatment of Morbid Obesity that has been prior approved by the Administrator, or
- Obesity health education, screening, and counseling services recommended by your Physician.

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

- Occupational disease laws;
- Employer's liability;
- Municipal, state, or federal law (except Medicaid); or
- Workers' Compensation Act.

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

This Policy does not cover a work-related illness or injury, even if:

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

Note: This "Work-Related Conditions" exclusion does not apply to an executive employee or sole proprietor of a professional or business corporation who has affirmatively elected not to accept the provisions of the New Mexico Workers' Compensation Act. You must provide documentation showing that you have waived Workers' Compensation and are eligible for the waiver. The Workers' Compensation Act may also not apply if an employer has a very small number of employees or employs certain types of laborers excluded from the Act.

5 Coordination of Benefits/ Reimbursement

Coordination of Benefits (COB)

Your NMMIP Policy is the last payer of benefits when any other benefit payers or plans are available. Benefits otherwise payable under this Policy will be reduced by all amounts paid or payable through any other Health Insurance or health benefit plan, including Medicare, self-insured plans, all hospital and medical expenses benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance, whether provided on the basis of fault or no-fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law program.

Facility of Payment. Whenever any other plan makes benefit payments that should have been made under this Policy, NMMIP has the right to pay the other plan any amount it would have otherwise paid under this plan that the Administrator determines will satisfy the intent of this provision. Any amount so paid will be considered to be benefits paid under this Policy, and with that payment NMMIP will fully satisfy its liability under this provision.

Right of Recovery. Regardless of who was paid, whenever benefit payments made by NMMIP exceed the amount necessary to satisfy the intent of this provision, the Administrator has the right to recover the excess amount from any persons to or for whom those payments were made, or from any insurance company, service plan, or any other organizations or persons.

Reimbursement

If you incur expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for Covered Services described in this benefit booklet, you agree:

- NMMIP has the right to reimbursement for all benefits provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of that sickness or injury, in the amount of the total Covered Charges for Covered Services for which NMMIP provided benefits to you.
- NMMIP is assigned the right to recover from the third party, or their insurer, to the extent of the benefits NMMIP provided for that sickness or injury.
- NMMIP shall have the right to first reimbursement out of all funds you or your assignee(s) are or were able to obtain for the same expenses for which NMMIP has provided benefits as a result of that sickness or injury.

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

6 Claims Payments and Claims Appeals

Filing Claims

Filing Claims: Network Providers must submit claims within 6 months after the date services or supplies were received. Non-Network Providers must submit claims within 12 months after the date services or supplies were received. Claims from Tribal Providers must be received within 24 months of incurred date.

Participating Providers. All Participating Providers that are contracted with the Network have specific timely filing limits in their contracts with the Administrator. The contract language lets Providers know that they may not bill the Enrollee if they do not meet that filing limit for a service and the claim for that service is denied. Also, Participating Providers file claims with the Administrator and payment is made directly to them. Be sure that these Providers know you have health care coverage administered by 90 Degree Benefits. Do not file claims for these services yourself.

Non-participating Providers. A Non-Participating Provider is one that has no Participating Provider contract, either directly or indirectly, with the Network or NMMIP. If your Non-Participating Provider does not file a claim for you, then you must submit the itemized bills and, if applicable, your other coverage's payment explanation.

Itemized. Claims for Covered Services must be itemized on the Provider's billing forms or letterhead stationery and must show:

- Enrollee's identification number;
- Enrollee's name and address;
- Enrollee's date of birth;
- Name, address, and tax ID or social security number of the health care Provider
- Date of service or purchase, diagnosis, type of service or treatment, procedure, and amount charged for each service (each service must be listed separately); and
- Accident or surgery date (when applicable).

Correctly itemized bills are necessary for your claim to be processed. The only acceptable bills are those from health care Providers. Do not file bills you prepared yourself, canceled checks, balance due statements, or cash register receipts. Make a copy of all itemized bills for your records before you send them. The bills are not returned to you. All information on the claim and itemized bills must be readable. If information is missing or is not readable, the Administrator will return it to you or the Provider.

Do not file for the same service twice unless asked to do so by a Customer Service representative. If your itemized bills include services previously filed, identify clearly the new charges that you are submitting.

All itemized bills for services received outside the United States must be translated into English before being filed with the Administrator.

If You Have Other Coverage. When you have other coverage that is primary over this Policy, you need to file your claim with the other coverage first. *(See Section 5: COB/Reimbursement.)* After your other coverage (including health care insurance, dental or vision plan, Medicare, automobile or other liability insurance, Workers' Compensation, etc.) pays its benefits, a copy of their payment explanation form must be attached to the claim sent to the Administrator, as instructed under "Where to Send Claims Forms," below. If the other coverage pays benefits to you (or your family member) directly, give your Provider a copy of the payment explanation so that they can include it with the claim sent to the Administrator. If a Non-Participating Provider does not file claims for you, attach a copy of the payment explanation to the claim that you send to the Administrator.

Where to Send Claim Forms. If your Provider does not file a claim for you, you (not the Provider) are responsible for filing the claim. Remember: Participating Providers will file claims for you; these procedures are used only when you must file your own claim. See "Participating Providers," on the previous page, for more information.

Medical/Surgical Claims. When Covered Services are received from Non-Participating Providers who will not file the claim for you, mail the forms and itemized bills to:

New Mexico Medical Insurance Pool Administrator
P.O. Box 780548
San Antonio, TX 78278

Prescription Drug. Claims for items covered under the Prescription Drug benefits must be sent to the Pharmacy Benefit Manager, not to the Administrator. If not included in your enrollment materials, you can obtain the name and address of the Administrator and the necessary claim forms from a Customer Service Representative or by contacting the Pharmacy Benefit Manager listed on the back of your ID card.

Claims Payment Provisions

After a claim has been processed, the Enrollee will receive an Explanation of Benefits (EOB). The EOB indicates what charges were covered and what charges, if any, were not. The EOB is sent electronically to Enrollees via the member portal. To request paper copies of EOB's via USPS, members can either change the current "go paperless EOB" receipt preference in the portal by clicking "go paperless EOB" from the navigation menu to delete/change it or contact customer service at 1-866-306-1882 who will change your preferences for you.

Participating Providers. Most services are received from Participating Providers. Payments for Covered Services usually are sent directly to Participating Providers. The EOB you receive explains the payment.

Non-participating Providers. If services are received from a Non-Participating Provider, with an authorization from NMMIP or that meets one of the exceptions listed in the paragraph below, payments are paid to you if you paid for the service or the Provider if you did not pre-pay. The check will be attached to an EOB that explains the Administrator's payment. In these cases, you are responsible for arranging payment to the Provider and for paying any amounts greater than Covered Charges plus Deductibles, Coinsurance, and non-covered expenses.

As noted in Section 2 and Section 3 of this document, NMMIP covers health care services obtained from a Non-Participating Provider if one of the exceptions shown below applies:

- In the event you receive Emergency services at a non-participating emergency room, Hospital, trauma center, or Ambulance for a medical Emergency.
- In the event you receive health care services, that are not emergency care, rendered by a nonparticipating provider (such as radiologists, anesthesiologists, pathologists) at a participating facility, or where:
    - A participating provider is unavailable
    - A non-participating provider renders unforeseen services
    - The covered person has not given specific consent for that nonparticipating provider to render the particular services rendered.
- In the event you receive services from a municipal health department;
- In the event the services received are out of your control:
    - An in-network provider mistakenly makes a referral to an out-of-network provider
    - In the event a non-participating provider performs services at a Network facility.
- In the event you need dialysis services when no participating providers are available.

- In the event you need specific designated medical services necessary to treat your medical condition and no participating providers are available. The Plan will allow Out-of-Network providers at Reasonable and Customary rates.
- In the event the non-participating provider has received a Single Case Agreement for your care from NMMIP.

The amount NMMIP pays for a Covered Service is always based on the Covered Charge for that service. The Covered Charge is always less than or equal to the Provider's billed amount. You may have to pay the difference between the billed amount and the Covered Charge if you receive services from a Non-Participating Provider under one of the exception rules.

If an out-of-network provider balance bills you for an amount above the reimbursement rate, also called a surprise bill, you may follow the NMMIP Appeal Process.

Note: If you require services from a Non-Participating provider on an ongoing basis, request that your Non-Participating provider contact NMMIP's Administrator at 866-306-1882 to obtain a contract.

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

Covered Charge. Provider payments are based upon Participating Provider agreements and the maximum amount allowed, not to exceed billed charges, as determined by the Administrator. You are responsible for paying Copayments, Deductibles, Coinsurance, and non-covered expenses. For Covered Services received in foreign countries, the Administrator will use the exchange rate in effect on the date of service to determine billed charges.

Drug Plan Copayments. When the Copayment for an item is greater than the Covered Charge for the supply being purchased from a Participating Pharmacy, you pay the lesser of: 1) your Copayment, or 2) the pharmacy's retail price. For Non-Participating Pharmacies, you pay the entire amount for the supply being purchased. The Policy does not cover Prescription Drugs purchased from a Non-Participating Pharmacy.

Accident-Related Hospital Services. If services are administered as a result of an accident, a Hospital or treatment facility may place a lien upon a compromise, settlement, or judgement obtained by you when the facility has not been paid its total billed charges from all other sources.

Overpayments. If the Administrator makes an erroneous benefit payment for any reason (e.g., Provider billing error, claims processing error), NMMIP may recover overpayments from you. If you do not refund the overpayment, the Administrator reserves the right to withhold future benefits to apply to the amount that you owe NMMIP, and/or to secure the services of an agency or attorney to collect and recover any payments that were greater than the benefits under this Policy.

Request for Claims Reconsideration and Appeals

You have three options for having a claims decision reconsidered.

1. A reconsideration request to NMMIP's Administrator, 90 Degree Benefits;
2. An Appeal request to the NMMIP Administrator, 90 Degree Benefits;
3. An Appeal request for Executive Review.

Reconsideration Request: If you disagree with the denial or payment of your claim or a Prior Approval request, you may ask for a review. Call a Customer Service representative for assistance. If you continue to disagree, you may ask for an additional reconsideration through the formal appeal process (refer to following "Appeal through the NMMIP Administrator" section).

To ensure timely notification regarding claims denials, it is your responsibility to ensure that the Administrator has all your updated contact information, and you have "opted in" to receiving this information by mail. Your updated contact information includes: your telephone number; physical address; mailing address and/or any other contact information, i.e. email address. This information is utilized by your Administrator to provide updated information; claims status; information on your coverage; and/or benefits and protections available to you.

Appeal through the NMMIP Administrator, 90 Degree Benefits, if the claims denial is upheld: Send your request for reconsideration appeal in writing to the Administrator address noted below and, if possible, please include:

- A copy of the *Explanation of Benefits* (EOB) and/or denial letter;
- Copies of related medical records from your Provider; and
- Any additional information from your Provider in support of your request.

The reconsideration/appeal request must be filed to the Administrator within 180 days of the date the first denial is mailed. If you do not file the reconsideration/appeal request within the 180-day period, you waive your right to reconsideration/appeal request.

The Administrator will acknowledge receipt of the request for reconsideration/appeal. The Administrator will review your request and give you a decision within 60 calendar days, unless you are asked for more information. If there is no change in the original decision, you are provided reasons in writing.

If you are still not satisfied after having completed the Administrator's reconsideration procedure above, you may submit an appeal to NMMIP Executive Review.

Appeal Request to NMMIP – Executive Review: In order to submit an appeal request to NMMIP, you will need to provide a copy of the Administrator's reconsideration/appeal decision (or a copy of the notification from the Administrator denying your claim); a fully executed

release form authorizing NMMIP to obtain any necessary medical records from the Administrator or other health care service Provider; and any other supporting documentation. During this process, the claims history is thoroughly reviewed with the Administrator to determine the appropriateness of the claims payments.

You must complete the NMMIP Administrator's reconsideration and/or reconsideration appeal process before appealing to the NMMIP's Executive Review.

Legal Action. You may not take legal action to recover benefits under this Policy after three years from the date that the claim in question must be filed with the Administrator.

Certain Defenses

Nothing contained in this Policy, including but not limited to terms, conditions, or representations, shall give rise to any right, action, or cause of action, either at law or in equity, by the Enrollee against NMMIP, the NMMIP Board of Directors, or its Administrator for any act or omission of any person, firm, or corporation who is involved directly or indirectly in furnishing any item or providing any services to an Enrollee.

Catastrophic Events

In case of fire, flood, war, civil disturbance, court order, strike, or other cause beyond the Administrator's control, the Administrator may be unable to process claims or provide Prior Approval for services on a timely basis.

Sending Notices

All notices to you are considered to be sent to and received by you when deposited in the United States mail and addressed to the Enrollee at the latest address on the Administrator's membership records.

7 Enrollment and Termination Information

Term of Coverage

Your coverage begins on the Policy's effective date at 12:01 a.m. Standard Time where you live. Each time you renew your Policy by paying the required premium, the new term begins immediately after the prior term ends. Premiums are due by the end of the month prior to the renewed month of coverage. If full payment is received your coverage remains in force without interruption.

Example: For coverage from February 1 through February 28 (or 29), the premium payment must be received by January 31.

If payment is not received prior to the renewed coverage month, **benefits during this month may not be available**. You have until the end of the uncovered month for your payment to be received and for you to be reinstated, under this Policy's Grace Period provisions.

Example: For coverage from February 1 through February 28 (or 29), the premium payment must be received by January 31(due date). If payment is not received by the due date, policy will terminate, and you will have until the end of February to submit payment and be reinstated.

Who Is Eligible

To be eligible for the NMMIP program, you must be and continue to be a resident of the state of New Mexico who lives within the state of New Mexico with a permanent physical street address and be in one of the qualifying situations listed below under "HIPAA-Eligible Individuals" or "Other Qualifying Situations." Unless otherwise indicated below, you must apply for NMMIP coverage within the time frames indicated, if any, after satisfying the condition that caused you to become eligible. An application is dated on the later of the requested effective date or the day the application was received by NMMIP.

HIPAA-Eligible Individuals. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that, if you are a New Mexico resident, you are eligible for NMMIP coverage if:

- You have had a total of at least 18 months of Creditable Coverage, the last of which must be a group coverage health plan, Governmental Plan, or Church Plan with no single gap in coverage of more than 95 days (the most recent coverage must have been under a Group Health Plan); and
- You have applied for NMMIP coverage within 95 days of involuntarily losing prior Group Health Plan coverage (involuntary loss of coverage includes reaching a general lifetime maximum benefit under your prior coverage or moving outside the service area of your health plan); and
- You do not have, and are not eligible for, group coverage. Eligibility for individual insurance does not disqualify you under HIPAA.

Proof of such prior coverage, totaling 18 months of coverage for all policies combined (the last of which must have been group coverage) must be included with the application for NMMIP coverage.

If you are offered group continuation coverage through COBRA or some other continuation coverage (such as under New Mexico's state six-month continuation right or similar program in another state), you do not have to accept such coverage before being eligible for NMMIP. If you elected continuation coverage, you do not have to exhaust such coverage before transferring to the NMMIP.

NOTE: If the most recent Creditable Coverage available to you under this provision was terminated as a result of fraud, you are not eligible for NMMIP coverage.

Other Qualifying Situations. If you are not a HIPAA-Eligible Individual as described above, but you are a New Mexico resident, you are eligible for NMMIP coverage if you have received one or more of the following:

1. A notice of rejection for Comprehensive Medical Insurance Coverage in the last 12 months (e.g. denial of coverage received due to closed enrollment for health care coverage on or off the marketplace, if you have missed open enrollment through your employer's group coverage, or you have voluntarily chosen not to participate in your employer's group coverage and you are not eligible for special enrollment period).
2. Proof that your current premium rate for in-force individual coverage (or a quote received within the last 12 months applied for individual Health Insurance coverage) exceeds the NMMIP's qualifying rate (as posted on the NMMIP website) for similar Deductible options for your age and sex.
3. A notice stating that your most recent individual coverage has terminated, or will, terminate because the insurer stopped issuing coverage in New Mexico or because you reached the maximum allowable coverage limit under that policy.

4. A notice stating that your coverage in another state's high-risk pool ended because you moved to New Mexico. In order to prevent a lapse in coverage, you must apply for NMMIP coverage within 31 days after termination of prior high risk pool coverage and pay premiums for the entire coverage period.
5. A notice stating that you are on Medicare due to a disability and under the age of 65**.** Persons eligible due to this criterion will only be eligible for the New Mexico Medical Insurance Pool Medicare Carve-Out Policy and must be enrolled in both Parts A and B of Medicare.

NOTE: If the most recent Creditable Coverage available to you was individual coverage that was terminated as a result of non-payment of premium and that coverage would NOT have qualified you for NMMIP entrance as described above (for example, you cancelled your prior coverage but it did not exceed NMMIP's qualifying rate or it did not restrict your coverage), the termination will be considered voluntary.

Each member of a family covered under NMMIP must individually meet the eligibility provisions of this Policy, except newborns up to 31 days old. There are no family rates; each family member who is enrolled will be charged the rate applicable to their age.

Non-Discrimination

The Plan will not discriminate in the enrollment process and will not refuse to insure, or refuse to continue to insure, or limit the amount, extent or kind of coverage available to an individual, or charge an individual a different rate for the same coverage including, but not limited to, on the basis of the following:

A. Blindless, including partial blindness
B. Health status; medical condition, including both physical and mental illness
C. Claims experience
D. Receipt of healthcare
E. Medical History
F. Genetic Information
G. Evidence of insurability, including conditions arising out of acts of domestic violence
H. Disability
I. Gender
J. National Origin
K. Sexual Orientation
L. Any other health status-related factor that the Superintendent specifies in rules of the Office of the Superintendent of Insurance

Who is Not Eligible. You are not eligible to enroll if any of the following conditions apply to you:

- You have or are eligible for Medicare (unless you are under age 65) or Medicaid, unless such coverage is limited to coverage for amounts in excess of limited policies such as dread disease, cancer policies, or hospital indemnity policies. In

such instances Medicare or Medicaid coverage will be the primary payer and NMMIP will be the secondary payer. If you are under age 65 and become eligible for both Parts of Medicare after enrollment in NMMIP, you must notify the Administrator. You are only eligible for NMMIP coverage under the Medicare Carve-out plan. If you reach age 65 and become eligible for Medicare after January 1, 2006, you may not continue coverage under any NMMIP Policy. If you are age 65 or older and enrolled for coverage under this Policy before January 1, 2006, you may continue coverage under this Policy, whether or not you are eligible for Medicare.

- You are eligible for coverage under a Group Health Plan or have other "Comprehensive Medical Health Insurance Coverage" (see the Glossary), including benefits consisting of medical care, items, or services provided directly, through insurance or reimbursement, or otherwise under any Hospital or medical service policy or certificate, Hospital or medical service plan contract or health maintenance organization (HMO) contract. You may continue coverage under NMMIP while satisfying a waiting period under the other Group Health Plan or Health Insurance policy. You may also continue other coverage if you qualify for NMMIP coverage under a non-comprehensive policy, or a condition rider. The NMMIP Policy is secondary to all other coverage.
- You were offered the option of continuing coverage under a federal COBRA provision or similar state program, but the coverage also meets the conditions for eligibility described under number 2 on the previous page (e.g., there is an exclusion for a condition specific to you, or the rate is higher than NMMIP's qualifying rate). If you have 18 months of Creditable Coverage and meet the HIPAA eligibility requirements you do not need to exhaust your COBRA benefits.
- You have voluntarily terminated a Pool Policy within the past 12 months. However, if you terminated NMMIP coverage because you became eligible for and covered by a health plan and such coverage was then involuntarily terminated in less than 12 months, you may re-apply for a NMMIP Policy. Persons who are HIPAA-Eligible Individuals at the time of re-application are also eligible to reapply for NMMIP coverage within a 12-month period.
- You are an inmate of a public institution or eligible for public programs for which medical care is provided.

Children. A child is considered to be a specific age on the first day of the month following their birthday, and includes your unmarried:

- Natural or legally adopted child;
- Child under age 26 placed in your home for purposes of adoption; and
- Stepchild who depends upon you for support and maintenance and resides with you in a parent-child relationship.

If three or more children (family members), as defined above, are Enrollees of the NMMIP program, they can qualify as a family even if you or your spouse are not covered. However, if a

child qualifying as part of a family has their own child, the newborn child may not qualify as part of the same family. The newborn, if eligible, must switch to their own Policy and the additional premium for the newborn must be paid.

Family Provision. While NMMIP does not offer a "Family" Policy, if you have three or more qualified family members on NMMIP Policies with the same Deductible you may receive reduced Deductible and Out-of-Pocket Limits as indicated on the chart *Deductible Options Table* on page 6.

Eligibility of Family Members. Family members covered under the NMMIP program must each meet the eligibility requirements of NMMIP. The Administrator may require acceptable proof (such as copies of income tax forms, legal adoption or legal guardianship papers, or court orders) that an individual qualifies as a family member. Unless listed as a qualified family member, no other relative or person is counted as a family member for purposes of calculating Deductible or Out-of-Pocket Limits.

If a child is under the age of 26, their parent, legal guardian, or other responsible party must submit the application for coverage on the child's behalf. Also, for any child covered under a NMMIP Policy, any obligations of the policyholder set forth in this benefit booklet, any endorsements, addenda, or riders will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the child's behalf.

You may not apply for a NMMIP Policy on behalf of a non-disabled adult child without obtaining authorization from the child to enter into a health insurance contract; therefore, an application for any such coverage of an adult child, whether as a tax dependent or as the subscriber, must be signed by the child. If the adult child is disabled and unable to sign the application, their legal guardian may apply for coverage on their behalf and, by doing so, accepts any obligations of the subscriber set forth in the Policy, including any endorsements, addenda, or riders. You may be required to provide a copy of a power of attorney for an adult child.

Qualified Family. In order to qualify as a member of a family for purposes of calculating Deductible and out of pocket limits, the members must be related to you in one of the following ways:

- Your legal spouse;
- Your unmarried child through the end of the monthly billing period in which the child becomes age 26. At that time, the child is automatically removed from the Family provision;
- Your unmarried child over age 26 who was enrolled for NMMIP coverage at the time of reaching age 26, and who is medically certified as disabled and chiefly dependent upon you for support and maintenance. Such condition must be certified by a Physician and the Administrator. Also, a child may continue to be eligible for coverage under a "Family" discount beyond the age of 26 only if the condition began before or during the month in which the child would lose coverage due to their age status. Proof of incapacity and dependency must be furnished to the Administrator within 120 days of the child's 26th birthday.

The Administrator may request subsequent proof of incapacity and dependency but no more often than on an annual basis after a two-year period following attainment of the limiting age. A child who is not able to continue coverage under your "Family" discount, but who meets the criteria for continued coverage under NMMIP, may apply for their own NMMIP Policy.

Newborn Children. See Section 3 Covered Services, Newborn Care for the description of Newborn Coverage.

Adopted Children: If you are an Enrollee of NMMIP a child physically placed in your home for the purpose of adoption, or your newly adopted child is automatically eligible for 31 consecutive calendar days of coverage if you enroll such child for NMMIP coverage and pay an additional premium. This provision applies only to children of adult policyholders. The child of a child does not qualify under your "Family" discount. To obtain automatic coverage (limited to 31 days) for the newborn or newly adopted child, the NMMIP Enrollee other than your spouse must switch to their own Policy and pay the additional premium for the newborn or adopted child.

You must complete an application for coverage and submit it to the Administrator within 31 days of the placement in the home, or legal adoption. In such cases, the child does not have to establish eligibility for NMMIP coverage and in the case of a child who has been placed in your home or adopted, for 31 days following placement or adoption if the additional premium is paid.

Eligibility must be established for the child to remain on the Policy beyond 31 days**.** A child under age 26 who is placed in your home by a court of competent jurisdiction for the purposes of adoption may acquire NMMIP coverage as soon as the child is physically placed in the home or upon completion of the legal adoption (or any time in between) for the first 31 days provided the Administrator receives an enrollment application within 31 days and additional premium is paid. They must still establish continued eligibility to be covered beyond the 31-day period.

Eligibility Denials Appeal Process

If you were denied enrollment, you may appeal your enrollment denial.

You may appeal this denial decision within 90 days from the date of the denial.

The first level of appeal is to NMMIP's Administrator- 90 Degree Benefits.

Eligibility denials because the individual voluntarily terminated previous group coverage are investigated to ensure there is no inappropriate "dumping". In that case, you must provide additional information and documentation to prove there was no targeted dumping and that you are locked out of group coverage.

If there are other reasons for eligibility denials, you must provide additional information and documentation regarding your eligibility and/or successful payment of the first month's premium.

If the denial is upheld, the second level of appeal is to the Executive Director (ED) of NMMIP who will review all documentation and determine if an exception is warranted. During this process, a thorough review of 90 Degree Benefits decision criteria is conducted, and potential extenuating factors for an exception are considered.

If the denial is upheld, the final level of appeal is to the NMMIP Board of Directors. This appeal must be in writing to the ED. The member appealing will be notified that this case will be considered at the regularly scheduled Board of Directors meeting. All previous documentation will be submitted to the Board of Directors for their discussion. The ED and Legal Counsel will not participate except to answer questions, and the member appealing will not attend unless invited.

The member appealing will be notified in writing within 15 days of the final enrollment decision being made.

When Coverage Begins

Your NMMIP coverage begins on the latter of the first day of the month specified on your enrollment application or the first of the month following the date your application is accepted and the premium is paid. This date is your effective date. NMMIP pays for Covered Services that you receive after the Effective Date of Coverage. In some instances, coverage may begin on the first of the month during which your prior coverage terminated; in such cases, retroactive premium may be required.

This Policy does not cover any service received or any Admission that begins before your Effective Date of Coverage. Also, if your prior coverage has an extension of benefits provision, this Policy will not cover those charges incurred after your effective date that are covered under the prior plan.

Any Services that span coverage of previous policy and coverage under the NMMIP policy will require coordination of benefits.

Premium

Your Policy will be renewed each time the required premium payment is made. Premiums are due and payable to the Administrator by the end of the month prior to the month of coverage. Payment must be received in advance of each period for which coverage is to be in effect.

A Grace Period is granted following the premium due date. No benefits are available for services received during the Grace Period unless the premium is received by the Administrator

before the expiration of the Grace Period. Please refer to Section 7, Term of Coverage, for additional information.

Failure to receive a premium notice does not relieve you of responsibility for paying the premium when due. To ensure timely receipt of premium notices, please update the Administrator of any changes to your mailing address and contact information.

Rates are established annually and may be adjusted based on various factors, including your age, the new rates will become effective January 1 of each year. Your premium may increase on the first of the month following your birthday. The Administrator will notify you at least 60 days before any increase resulting from the annual rate re-evaluation. You may not receive advance notice of a rate increase that occurs due to age.

Low Income Premium Program:

Income does not determine NMMIP eligibility. The Low Income Premium Program (LIPP) is designed to help persons who qualify for New Mexico Medical Insurance Pool (NMMIP) coverage by offering a reduced premium. To determine if you meet the LIPP eligibility requirements, you must complete and submit a LIPP Application with a NMMIP Application for Coverage. Once a NMMIP member, if you have a change in income, you may apply for LIPP any time of the year by submitting a LIPP Application.

Eligibility for LIPP is determined annually through certification of household income and number of individuals in the household compared with the Health and Human Services (HHS) Poverty Guidelines. The current year's LIPP rates corresponding to household size and HHS Poverty Guidelines can be found on the LIPP application. The general discount for LIPP is as follows:

- 0-199% of HHS Poverty Guidelines: 75% premium reduction
- 200-299% of HHS Poverty Guidelines: 50% premium reduction
- 300-399% of HHS Poverty Guidelines: 25% premium reduction

Current LIPP members need to recertify annually by December 15. You will receive an Annual Policyholder Notification and packet in the mail in November. This packet will include information about LIPP recertification. Members who first apply for LIPP with a coverage start date between October 1 to December 31 do not need to recertify until the following fall.

If you do not recertify for LIPP by December 15 you will no longer be eligible for any discounted premium and will be increased to full premium for your coverage beginning January 1. If you wish to continue coverage with a reduced premium, you must respond by December 15 every year.

To ensure timely receipt of the Annual Policyholder Notification and packet, it is your responsibility to ensure that the Administrator has all your updated contact information. This includes: your telephone number; physical address; mailing address and or any other contact information i.e., email address.

For more information on LIPP, please contact 90 Degree Benefits at 1-866-306-1882 or NMMIP_Customerservice@90degreebenefits.com.

LIPP Reconsiderations and Appeals:
Continued participation in LIPP is contingent on the annual recertification process. If a member does not recertify for LIPP by the annual deadline, or no longer qualifies, notice of a change to full premium rates will be sent to the member.

Members who did not recertify for LIPP by the annual deadline can contact NMMIP's Third-Party Administrator (TPA) within 30 days of their full premium due date to request *reconsideration.* The TPA will request a new LIPP application and proof of income to determine the member's eligibility for continued participation in LIPP. If the TPA finds that the member does not qualify for LIPP, the member will be informed in writing with information on submitting an appeal.

Following the 30-day reconsideration period, members have the right to appeal LIPP recertification denials to the Executive Director (ED) through the TPA. Appeal requests must include any and all supporting documentation. Note that the appeal decision may not be retroactive and is final. For more information about appeals, please contact 90 Degree Benefits at:

1-866-306- 1882 or NMMIP_Customerservice@90degreebenefits.com.

Policy Termination

Unless stated otherwise, coverage ends at the end of the last-paid billing period during which one of the following events occurs:

- When the Administrator does not receive the premium payment on time. If the month's premium is not received by the beginning of the renewed month of coverage or by the end of the "Grace Period", your coverage will be terminated at the end of the last period for which premium was paid.
- When you become covered by a group plan. Such termination may be made retroactively upon disclosure of the group coverage. If you are subject to a waiting period under the group coverage, NMMIP coverage will terminate on the date the waiting period ends.
- When you are no longer eligible for coverage under the New Mexico Medical Insurance Pool program.
- When you are no longer a New Mexico resident.

- When you do not reply within 31 days after the date that the Administrator makes an inquiry concerning your place of residence.
- When you request this Policy to end.
- When New Mexico statutes require cancellation of this Policy.

If you knowingly gave false material information in connection with your or a family member's eligibility or enrollment, the Administrator may terminate the coverage of you and all family members retroactively to the date of initial enrollment. You are liable for any benefit payments made as a result of such improper actions.

Re-Entering NMMIP After Termination

If you fail to pay the premium in accordance with the terms of this Policy, or if you voluntarily leave NMMIP, you will not be eligible to re-apply until 365 days have passed from the date of termination of coverage. However, if you terminated NMMIP coverage because you became covered by a health plan that was then involuntarily terminated in less than 12 months, you may re-apply for NMMIP coverage.

Reinstatement Denial Appeal Process

If you were denied reinstatement, you may appeal your reinstatement denial within 30 days from the date on the termination letter.

Members retain the right to appeal the decision to the Executive Director (ED) of NMMIP by providing the following information in writing within 30 days from the date of the termination letter:

- The reason for not paying your premium timely
- Any extenuating circumstances/information to support the appeal

For more information on requesting reinstatement of coverage, please contact 90 Degree Benefits at 1-866-306-1882,

or

NMMIP_Customerservice@90degreebenefits.com.

8 General Provisions

Availability of Provider Services

The Administrator does not guarantee that a certain type of room or service will be available at any Hospital or other facility within the Network or that the services of a particular Hospital, Physician, or other Provider will be available.

Changes to the Health Care Policy

This Policy and any attachments are the entire Policy of Insurance. Only the Board of Directors of New Mexico Medical Insurance Pool or the Legislature of the State of New Mexico can approve a change to the Policy. Any such change(s) must be shown in your Policy.

Disclaimer of Liability

The Administrator has no control over any diagnosis, treatment, care, or other service provided to you by any facility or Professional Provider, whether participating or not. NMMIP and its contractors and subcontractors are not liable for any loss or injury caused by any health care Provider by reason of negligence or otherwise.

Disclosure and Release of Information

The Administrator and NMMIP will only disclose information as permitted or required under state and federal law.

Execution of Papers

You must, upon request, execute and deliver to the Administrator any documents and papers necessary to carry out the provisions of this Policy.

Independent Contractors

Physicians and other Providers are not agents or employees of the Administrator, and the Administrator and its employees are not employees or agents of any Network Provider. The Administrator will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any Participating Provider.

9 Definitions

It is important for you to understand the meaning of the following terms. The definition of many terms determines your benefit eligibility. These terms are capitalized when used in this Policy.

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

Acupuncture. The use of needles inserted into the body for the prevention, cure, or correction of any disease, illness, injury, pain, or other condition by controlling and regulating the flow and balance of energy and functioning of the person to restore health.

Administrator. The company that has been selected to administer eligibility, billing, claims administration, and customer services for the NMMIP program.

Admission. The period of time between the dates a patient enters a facility as an inpatient and is discharged as an inpatient.

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

Alcoholism Treatment Facility, Alcoholism Treatment Program. An appropriately licensed Provider of detoxification and rehabilitation treatment for Alcoholism.

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

Ambulatory Surgical Facility. Ambulatory surgery centers, or ASCs, are facilities where surgeries that do not require hospital admission are performed. ASCs provide cost-effective services and a convenient environment that is less stressful than what many hospitals can offer. Patients who choose to have surgery in an ASC arrive on the day of their procedure, have their surgery in a fully equipped operating room and recover under the care of highly skilled nurses, all without hospital admission.

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

Applied Behavioral Analysis (ABA). Services that include behavior modification training programs that are based on the theory that behavior is learned through interaction between an individual and the environment. The goal of behavior management is to reinforce and increase desirable, functional behaviors while reducing undesirable, maladaptive behaviors.

Autism Spectrum Disorder. A condition that meets the diagnostic criteria for the pervasive developmental disorders published in the current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, including autistic disorder; Asperger's disorder; pervasive development disorder not otherwise specified; Rhett's disorder; and childhood integrative disorder.

Birthing Center. A health care facility for childbirth where care is provided in the midwifery and wellness model independent of a Hospital and accredited according to the laws of the State.

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

Cancer Clinical Trial. A course of treatment provided to a patient for the prevention of reoccurrence, early detection, or treatment or palliation of cancer for which standard cancer treatment has not been effective or does not exist. It does not include trials designed to test toxicity or disease pathophysiology, but must have a therapeutic intent and be provided as part of a study being conducted in a Cancer Clinical Trial. The scientific study must have been approved by an institutional review board that has an active federal-wide assurance of protection for human subjects, and include all of the following: (i) specific goals, a rationale and background for the study, (ii) criteria for patient selection, specific direction for administering the therapy or intervention and for monitoring patients, (iii) a definition of quantitative measures for determining treatment response, (iv) methods for documenting and treating adverse reactions, and a reasonable expectation, based on clinical or pre-clinical data, that the treatment will be at least as efficacious as standard cancer treatment. The trial must have been approved by a United State federal agency or by a qualified research entity that meets the criteria established by the federal National Institutes of Health for grant eligibility.

Cardiac Rehabilitation. An individualized, supervised physical reconditioning exercise session lasting from 4 to 12 weeks. Also includes education on nutrition and heart disease.

Certified Nurse Midwife. A person who is licensed by the Board of Nursing as a Registered Nurse and who is licensed by the New Mexico Department of Health (or appropriate state regulatory body) as a Certified Nurse Midwife.

Certified Nurse Practitioner. A Registered Nurse whose qualifications are endorsed by the Board of Nursing for expanded practice as a Certified Nurse Practitioner and whose name and pertinent information is entered on the list of Certified Nurse Practitioners maintained by the Board of Nursing.

Certified Registered Nurse Anesthetist (CRNA). A person who is a licensed professional nurse providing the same anesthesia services as an anesthesiologist (MD) and who is acting within the scope of their medical license in the state in which the service is rendered.

Cessation Counseling. As applied to the Smoking/Tobacco Use Cessation benefit described in *Section 3*, Cessation Counseling means a program, including individual, group or proactive telephone quit line, that:

- Is designed to build positive behavior change practices and provides counseling at a minimum on: establishment of reasons for quitting, understanding nicotine addiction, techniques for quitting, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse preventive and follow-up;
- Operates under a written program outline that meets minimum requirements established by the Superintendent of Insurance;
- Employs counselors who have formal training and experience in tobacco cessation programming and are active in relevant continuing education activities; and
- Uses a formal evaluation process, including mechanisms for data collection and-measuring participant rate and impact of the program.

Chemical Dependency. Conditions defined by patterns of usage that continues despite occupational, marital, or physical problems that are related to compulsive use of alcohol, drugs, or other substance. Chemical Dependency (also referred to as "substance use," which includes Alcoholism and Drug Abuse) may also be defined. There is a significant risk of severe withdrawal symptoms if the use of alcohol, drugs, or other substance is discontinued.

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

Chiropractor. A person who is a Doctor of Chiropractic (D.C.) licensed by the appropriate governmental agency to practice chiropractic medicine.

Church Plan. The term is defined pursuant to Section 3(33) of the federal Employee Retirement Income Security Act of 1974.

Clinical Psychologist. A person with a doctoral degree in clinical psychology licensed or certified in accordance with the New Mexico Professional Psychologist Act or similar statute in another state.

COBRA Continuation Coverage. Continued health coverage when a person involuntarily loses eligibility under a Group Health Plan (such as due to termination of employment, divorce, reaching a dependent age limit). The coverage may continue only for a certain time period of time and only under certain conditions. The program was created under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), which applies only to certain large Group Health

Plans. Groups that do not have to offer continued coverage under COBRA may have to provide continued coverage under state laws (such as New Mexico's six-month continuation coverage).

Coinsurance. The percentage of a Covered Charge that is your responsibility to pay for most Covered Services. For Covered Services that are subject to Coinsurance, you pay the percentage (indicated on the *Deductible Plan Options Table*) of the Policy's Covered Charge after the Deductible (if any) has been met.

Complications of Pregnancy. C-sections, ectopic pregnancies, toxemia, abruptio placentae, miscarriages, therapeutic termination of pregnancy prior to full term, and other complications as determined by the Administrator. Elective abortions are not considered a Complication of Pregnancy under this Policy.

Comprehensive Medical Health Insurance Coverage. Policies of this category are designed to provide coverage for major Hospital, medical, and surgical expenses incurred as a result of a covered illness or injury. Coverage is provided for hospital room and board, other hospital services, surgical services, anesthesia services, inpatient medical services, and out-of-hospital care, subject to any deductibles, coinsurance provisions, or other limitations which may be set forth in the policy. Comprehensive major medical does not include the following types of coverage: (i) accident-only, (ii) disability income, (iii) liability, (iv) auto (including auto medical payment), (v) credit only or workers' compensation insurance; (vi) on-site clinic plans; (vii) dental- only or vision-only plans; (viii) long-term care plans; (ix) specific disease plans or hospital indemnity plans, when not offered in coordination with a Group Health Plan; (x) supplemental plans such as Medicare supplement, CHAMPUS supplement or hospital supplement plans.

Copay/Copayment. A copay is a cost-sharing method that requires a covered person to pay a fixed dollar amount when a medical or pharmaceutical service is received, with the Plan paying the allowed balance; there may be different copayment amounts for different types of services under the same health benefits plan. When calculating the cost-sharing requirement, the plan must credit the enrollee for the full value of discounts provided or payments made by a 3rd party.

Cosmetic. See the "Cosmetic Services" exclusion in *Section 4.*

Cost-Effective. A procedure, service, or supply that is an economically efficient use of resources, relative to the benefits and harms associated with the procedure, service, or supply. When determining cost effectiveness, the situation and characteristics of the individual patient are considered.

Covered Charge. The maximum amount that will be allowed for Covered Services, as determined by the Administrator, using a variety of pricing methods and based on generally accepted claim coding rules. Also See "Claims Payment Provisions" in *Section 6*.

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

Creditable Coverage. Health care coverage through an employment-based Group Health Plan; Health Insurance coverage; Part A or B of Title 18 of the Social Security Act (Medicare); Title 19 of the Social Security Act (Medicaid) except coverage consisting solely of benefits pursuant to section 1928 of that title; 10 USCA Chapter 55 (military benefits); the NM Medical Insurance Pool Act or similar state sponsored Health Insurance pool; a health plan offered pursuant to 5 USCA Chapter 89; a public health plan as defined in federal regulations, whether foreign or domestic; any coverage provided by a governmental entity, whether or not insured, a State Children's Health Insurance Program; or a health benefit plan offered pursuant to section 5(e) of federal Peace Corps Act.

Custodial Care. Services to assist in activities of daily living (such as sitter's or homemaker's services), or services not requiring the continuous attention of skilled medical or paramedical personnel, regardless of where they are furnished or by whom they are recommended. See the "Custodial Care" exclusion in *Section 4*.

Deductible. The fixed dollar amount that a covered person may be required to pay during a benefit period before the Plan begins payment for covered benefits; the Plan may have individual deductibles and separate deductibles for specific services.

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

Dentist, Oral Surgeon. A doctor of dental surgery (D.D.S.) or doctor of medical dentistry (D.M.D.) who is licensed to practice prevention, diagnosis, and treatment of diseases, accidental injuries, and malformation of the teeth, jaws, and mouth.

Diagnostic Breast Examination. A Medically Necessary and clinically appropriate examination of the breast using diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound that evaluates an abnormality seen or suspected from a screening examination, or detected by another means of examination.

Diagnostic Services. Procedures such as laboratory and pathology tests, x-ray services, EKGs, and EEGs that do not require the use of an operating or recovery room, and that are ordered by a Provider to determine a condition or disease.

Dialysis. The treatment of a kidney ailment during which impurities are mechanically removed from the body with Dialysis equipment.

Doctor of Oriental Medicine. A person who is a Doctor of Oriental Medicine (D.O.M.) licensed by the appropriate governmental agency to practice Acupuncture and oriental medicine.

Drug Abuse. A condition defined by patterns of usage that continue despite occupational, marital, or physical problems related to compulsive use of drugs or other substance. There may

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

Durable Medical Equipment. Any equipment that can withstand repeated use, is made to serve a medical purpose, and is generally considered useless to a person who is not ill or injured. This equipment is designed for repeated use, and includes items such as oxygen tents, wheelchairs, hospital beds, crutches, and other medical equipment.

Effective Date of Coverage. 12:01 A.M. of the date on which an Enrollee's coverage begins.

Emergency Medical Condition / Emergency Services. Medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to their health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part, or disfigurement. Examples of Emergency Conditions include, but are not limited to: heart attack or suspected heart attack, coma, loss of respiration, stroke, acute appendicitis, severe allergic reaction, or poisoning.

Emergency shall mean, with respect to an Emergency Medical Condition, the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

Enrollee. The person who is enrolled for coverage and entitled to receive benefits under this Policy in accordance with the law passed by the Legislature of the State of New Mexico. Throughout this booklet, the terms "you" and "your" refer to each Enrollee.

Enteral Nutritional Product. A product designed to provide calories, protein, and essential micronutrients by the enteral route (i.e., by the gastrointestinal tract, which includes the stomach and small intestine only).

Gender-Affirming Hormone Therapy. A course of hormone replacement therapy intended to induce or change secondary sex characteristics.

Gender-Affirming Surgery. A surgery to change primary or secondary sex characteristics to affirm a person's gender identity. Also known as gender confirmation surgery or sex reassignment surgery.

Gender Dysphoria. A sense of unease that a person may have because of a mismatch between their sex assigned at birth and their gender identity. Also known as gender identity disorder.

Gonadotropin-Releasing Hormone Therapy (GnRH). A course of reversible puberal or gonadal suppression therapy used to block the development of secondary sex characteristics in adolescents.

Governmental Plan. The term as defined in Section 3(32) of the federal Employee Retirement Income Security Act of 1974 and includes a federal Governmental Plan (a Governmental Plan established or maintained for its employees by the United States government or an instrumentality of that government).

Grace Period. The Grace Period is the time allowed after the premium due date during which you may still make payment and be reinstated to maintain coverage. Under this Policy, the Grace Period begins after the premium due date, which is the last day of the month prior to the renewed month of coverage and extends through the end of the unpaid coverage month.

Premiums are due by the end of the month prior to the renewed coverage month (the "due date"). If payment is not received by the due date, coverage is subject to termination at the end of the last-paid billing period. If full premium payment is received at any time during the Grace Period, coverage will be reinstated. If payment is not received, coverage will terminate retroactively to the end of the last period for which premium was paid.

No benefits will be paid for services received during the Grace Period unless the premium is received.

Group Health Plan. An employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care and includes items and services paid for as medical care (directly or through insurance, reimbursement, or otherwise) to employees or their dependents (as defined under the terms of the plan).

Habilitative Treatment. Treatment programs that are necessary to: 1) develop, 2) maintain, and 3) restore to the maximum extent practicable the functioning of an individual. All three conditions must be met in order to be considered habilitative.

Health Insurance. For purposes of determining NMMIP eligibility, Health Insurance is a hospital and medical expense-incurred policy; non-profit health care service plan contract; health maintenance organization subscriber contract; short-term, accident, fixed indemnity or specified disease policy; disability income contracts; limited benefit insurance; credit insurance; or other coverage as defined by Section 56A-7-3-NMSA 1978. Health Insurance does not include insurance arising out of the Workers' Compensation Act or similar law, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is required by law to be contained in a liability insurance policy.

HIPAA-Eligible Individual. Any person who has had 18 or more months of Creditable Coverage (the last of which was group coverage), received notice of termination of such coverage (including COBRA continuation), submits an application for NMMIP coverage within 95 days of losing coverage under a Group Health Plan, and provides proof of such 18 months of Creditable Coverage with the application for NMMIP coverage.

Home Health Care Services. Covered Services, as listed under "Home Health Care/Home I.V. Services" in *Section 3*, that are provided in the home according to a treatment plan by a certified home health care agency under active Physician and nursing management. Registered nurses must coordinate the services on behalf of the home health care agency and the patient's Physician.

Hospice. A licensed program providing care and support to Terminally Ill Patients and their families. An approved Hospice must be licensed when required, Medicare- certified as, or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as, a Hospice.

Hospice Benefit Period. The period of time during which Hospice benefits are available. It begins on the date the attending Physician certifies that the Enrollee is terminally ill and ends six months after the period began (or upon the Enrollee's death, if sooner). At the Administrator's discretion, the Hospice Benefit Period may be extended if the attending Physician recertifies you are terminally ill. The Hospice Benefit Period must begin while the Enrollee is covered for these benefits, and Policy coverage must be maintained throughout the Hospice Benefit Period.

Hospice Care. An alternative way of caring for Terminally Ill Patients in the home or institutional setting, which stresses controlling pain and relieving symptoms but does not cure. Supportive services are offered to the family before and after the death of the patient.

Hospital. A facility offering inpatient services, nursing and overnight care for three or more individuals on a 24-hours-per-day, seven-days-per-week basis for the diagnosis and treatment of physical, behavioral or rehabilitative health conditions.

Inborn Error of Metabolism. A rare, inherited genetic disorder that is present at birth; if untreated, results in intellectual disabilities or death; and causes the necessity for consumption of Special Medical Foods.

Independent Freestanding Emergency Department. Independent Freestanding Emergency Department means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

Inpatient Services. Care provided while you are confined as an inpatient in a Hospital or treatment center for at least 24 hours. Inpatient care includes partial hospitalization (a non-residential program that includes from 3-12 hours of continuous psychiatric care in a treatment facility).

Impacted Teeth. Teeth that are fully or partially prevented from erupting in the dental arch by bone. Extraction of teeth that are only prevented from erupting by tissue, or fully Impacted Teeth that must be extracted in preparation of the mouth for dentures or orthodontic services are not covered.

Investigational Drug or Device. For purposes of the Cancer Clinical Trial benefit described in *Section 3* under "Therapy and Rehabilitation," an "Investigational Drug or Device" means a drug or device that has not been approved by the federal Food and Drug Administration.

Licensed Practical Nurse (L.P.N.). A nurse who has graduated from a formal practical nursing education program and is licensed by an appropriate state authority.

Maintenance Therapy. Treatment that does not significantly enhance or increase the patient's function or productivity, or care provided after the patient has reached their rehabilitative potential.

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

Maternity. Any condition that is related to pregnancy. Maternity care includes prenatal and postnatal care; elective abortion; and care for the Complications of Pregnancy, such as ectopic pregnancy, spontaneous abortion (miscarriage), or C- section.

Maximum Amount or Maximum Allowable Charge. Maximum Amount and/or Maximum Allowable Charge shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will or may be the lesser of:

1. The Usual and Customary amount (unless prohibited by the PPO Contract);
2. The allowable charge specified under the terms of the Plan;
3. The Reasonable charge specified under the terms of the Plan;
4. The negotiated rate established in a contractual arrangement with a Provider; or
5. The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

For claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprises Bills") if no negotiated rate exists, the Maximum Allowable Charge will be:

- An amount determined by an applicable all-payer model agreement; or
- If no such amount exists, an amount determined by applicable state law; or
- If neither such amount exists, an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

The Plan will utilize a vendor to provide Medicare and Cost based provider reimbursement data which will be utilized to establish the Maximum Allowable Charge for Providers as specified below. (The Maximum Allowable Charge as described below will not apply to those Providers for which a negotiated rate has been established by a contractual agreement.) In most cases, coverage will be limited to Network Providers only, except as specified.

At the Plan Administrators sole discretion, and if applicable, the Maximum Allowable Charge will not exceed:

1. Non-Network Facility claims will be reimbursed at the greater of 150% of Medicare or cost plus 20%. If no Medicare pricing data or cost data is available, payment will be based upon 150% of a regional Medicare approximate provided by a third-party vendor. In the event there is a negotiated maximum allowable rate established with the provider, the rate will create the Maximum Allowable Charge.
2. Non-Network Physician, or other professional service Providers, claims will be reimbursed at 150% of Medicare. If no Medicare pricing data is available payment will be based upon 150% of a regional Medicare approximate provided by a third-party vendor. In the event there is a negotiated maximum allowable rate established with the provider, the rate will create the Maximum Allowable Charge.

In instances where the Plan utilizes a network of contracted providers, individually contracted medical providers, or uses a contractually based fee schedule and the provider will not accept the defined "Maximum Amount" or "Maximum Allowable Charge" plan payment options, the Plan will pay the provider in accordance with the reimbursement required by the contract and in accordance with the Plan's benefits provisions as outlined herein.

The Plan Administrator has the discretionary authority to decide if a charge is Reasonable and otherwise covered under the Plan. The "Maximum Allowable Amount" / "Maximum Allowable Charge" will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Note: In the event further information is required in order to make a benefit determination for either a Network or Non-Network provider, the Plan Administrator may require, at its discretion, an itemized bill or manufacturer's invoice.

Medicaid. A state-funded program that provides medical care for indigent persons, as established under Title XIV of the Social Security Act of 1965, as amended.

Medical Detoxification. Treatment in an acute care facility for withdrawal from the physiological effects of Alcoholism or Drug Abuse (usually takes about three days in an acute care facility).

Medical Policy. A coverage position developed by the Administrator that summarizes the scientific knowledge currently available concerning new or existing technology, products, devices, procedures, treatment, services, supplies, or drugs and used by the Administrator to adjudicate claims and provide benefits for Covered Services. Specific medical policies may be requested in writing from a Customer Service representative.

Medical Supplies. Expendable items (except Prescription Drugs), ordered by a Physician or other Professional Provider, that are required for the treatment of an illness or injury.

Medical Necessity or Medically Necessary. Health care services determined by a Provider, in consultation with the health care insurer, to be appropriate or necessary, according to:

a) Any applicable generally accepted principles and practices of good medical care;
b) Practice guidelines developed by the federal government, national or professional medical societies, boards and associations; or
c) Any applicable clinical protocols or practice guidelines developed by the health insurance carrier consistent with such federal, national and professional practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical or behavioral health condition, illness, injury or disease.

Medicare. The program of health care for the aged, end-stage renal disease (ESRD) patients, and disabled persons established by Title XVIII of the Social Security Act of 1965, as amended.

Mental Illness, Mental Disorder. A clinically significant behavioral or psychological syndrome or condition that causes distress and disability and for which improvement can be expected with relatively short-term treatment. Mental illness does not include transitional responses to stress, adult situational reactions, social maladjustments, developmental disability, Alcoholism, other Chemical Dependency, or learning disability.

Midwife (Licensed). A person who practices lay midwifery and is registered as a licensed Midwife by the New Mexico Department of Health (or appropriate state regulatory body).

Network. A group or groups of participating providers who provide health care services under a network plan. These facilities, Providers and suppliers who have by contract via a medical Provider Network or direct or indirect contract with NMMIP agreed to allow NMMIP access to

discounted fees for service(s) provided to Enrollees, and by whose terms they have agreed to accept Assignment of Benefits and the discounted fees thereby paid to them by NMMIP as payment in full for Covered Charges. If applicable, the Provider Network will be identified on the Enrollee's identification card.

90 Degree Benefits. The Administrator of this New Mexico Medical Insurance Pool program.

Occupational Therapist. A person registered to practice Occupational Therapy.

Occupational Therapy. The use of rehabilitative techniques to improve a patient's functional ability to perform activities of daily living.

Optometrist. A licensed doctor of optometry (O.D.).

Orthopedic Appliance. An individualized rigid or semi-rigid support that eliminates, restricts, or supports motion of a weak, injured, deformed, or diseased body part; for example, functional hand or leg brace, Milwaukee brace, or fracture brace.

Out-of-Pocket Limit. The maximum amount of Coinsurance, Deductible, and Copays, including Prescription Drug Copays, that you pay for most Covered Services in a calendar year. After the Out-of-Pocket Limit is reached, NMMIP pays 100 percent of most of your Covered Charges for the rest of that calendar year, not to exceed any benefit limits.

Outpatient Services. Medical/Surgical Services received in the outpatient department of a Hospital, emergency room, Ambulatory Surgical Facility, freestanding Designated Dialysis Facility, or other covered outpatient treatment facility, such as intensive outpatient (IOP) services. Outpatient may also include office and Urgent Care Facility services.

Participating Health Care Facility. Participating Health Care Facility shall mean a Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

Participating Pharmacy. See Definition of "Provider," on page 106.

Participating Provider. See Definition of "Provider," on page 106.

Physical Therapist. A licensed Physical Therapist. Where there is no licensure law, the Physical Therapist must be certified by the appropriate professional body.

Physical Therapy. The use of physical agents to treat disability resulting from disease or injury. Physical agents include heat, cold, electrical currents, ultrasound, ultra- violet radiation, and therapeutic exercise.

Physician. A doctor of medicine (M.D.) or osteopathy (D.O.) or an individual who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

Podiatrist. A licensed doctor of podiatric medicine (D.P.M).

Policy. This document explains the benefits, limitations, exclusions, terms, and conditions of your health coverage under NMMIP. Also referred to as a benefit booklet.

Practitioner. Any Physician, General Practitioner, Family Practice Physician, Internist, Pediatrician, and Obstetrician, Gynecologists, Physician Assistant, Pharmacist (acting within the scope of licensure), Certified Diabetes Educator (C.D.E.), Nurse Practitioner, or other person holding a license or certificate provided for in Chapter 61, Article 4,5,6, or 14A NMSA 1978 authorizing the licensee to offer or undertake to diagnose, treat, operate on, or prescribe for any human pain, injury, disease, deformity or physical or mental condition. A Practitioner may be a primary care Provider.

Prescription Drugs. Those that are taken at a direction and under the supervision of a Provider, that require a prescription before being dispensed, and are labeled as such on their packages. All drugs and medicines must be approved by the FDA, and must not be experimental, investigational, or unproven. (See the "Experimental, Investigational, or Unproven Services" exclusion in *Section 4).*

Preventive Care Services. Professional services rendered for the early detection of asymptomatic illnesses or abnormalities and to prevent illness or other conditions.

Primary Care Physician. Primary Care Physician (PCP) means a Family Practitioner, a General Practitioner, an Internist, a Nurse Practitioner, an Obstetrician/Gynecologist, a Pediatrician, a Physician's Assistant, or any provider covered by the Plan who is treating a Mental Disorder and/or Substance Use.

Prior Approval. A requirement that your Provider must obtain authorization from the Administrator before you are admitted as an inpatient and before you receive certain types of Outpatient Services.

Prosthesis or Prosthetic Device. An externally attached or surgically implanted artificial substitute for an absent body part; for example, an artificial eye or limb.

Provider. A licensed health care professional, hospital or other facility authorized to furnish health care services.

- **Health Care Facility.** An institution providing health care services, including a Hospital or other licensed inpatient center, an ambulatory surgical or treatment center, Free-Standing Emergency Room, a Skilled Nursing Facility, a home health care agency, a diagnostic laboratory or imaging center, and a rehabilitation or other therapeutic health setting.

- **Professional Provider.** A Physician or health care practitioner, including a pharmacist, who is licensed, certified, or otherwise authorized by the state to provide health care services consistent with state law.

- **Participating Provider.** Health care professionals, facilities, and other ancillary providers that, for the service being provided, have contracted with the Network or with NMMIP as "participating" Providers.

- **Participating Pharmacy.** A retail supplier that has contracted with the Pharmacy Benefit Manager or its authorized representative to dispense covered Prescription Drugs and medicines, insulin, diabetic supplies, and Special Medical Foods to NMMIP program individuals, and that has contractually accepted the terms and conditions as set forth by the Pharmacy Benefit Manager and/or its authorized representative. Some Participating Pharmacies are not retail suppliers and are contracted with the Pharmacy Benefit Manager to provide Specialty Pharmacy Drugs to Program Enrollees; these pharmacies are called "Specialty Pharmacies" (or Specialty Pharmacy)" and some drugs must be dispensed by these Specialty Pharmacies in order to be covered.

- **Non-Participating Provider.** An appropriately licensed health care Provider that has not contracted with the Network or with NMMIP for the service being provided.

- **Other Mental Health/Chemical Dependency Providers.** An Alcoholism Treatment Program that complies with the Alcohol and Drug Abuse Program standards required by the state of New Mexico, a psychiatrist, Clinical Psychologists and the following masters-degreed psychotherapists (an independently licensed Professional Provider with either a M.A. or M.S. degree in psychology or counseling): licensed independent social workers (L.I.S.W.); licensed professional clinical mental health counselors (L.P.C.C.); masters-level Registered Nurse certified in psychiatric counseling (R.N.C.); licensed marriage and family therapist (L.M.F.T.). For Chemical Dependency services, a Provider also includes a licensed alcohol and Drug Abuse counselor (L.A.D.A.C.).

In all cases, the Provider agrees to provide health care services to Enrollees with an expectation of receiving payment (other than Copayments, Coinsurance, or Deductibles) directly or indirectly from the Administrator (or other entity with whom the Provider has contracted.) A Network Provider agrees to bill the Administrator (or other contracting entity) directly and to accept this Policy's payment (provided in accordance with the provisions of the contract) plus the Enrollee's share (Coinsurance, Deductibles, Copayments, etc.) as payment in full for Covered Services. However, if there is other coverage for your services (for example, auto insurance, workers' compensation insurance, or other health plans), the Participating Provider may be able to collect the billed charge amounts not covered by the Policy payment. The Administrator (or other contracting entity) will pay the Network Provider directly.

Psychiatric Hospital. A psychiatric facility licensed to an acute care facility or a psychiatric unit in a medical facility that is licensed as an acute care facility. Services are provided by or under the supervision of an organized staff of Physicians. Continuous 24-hour nursing services are provided under the supervision of a Registered Nurse.

Pulmonary Rehabilitation. An individualized, supervised physical conditioning program. Occupational therapists teach you how to pace yourself, conserve energy, and simplify tasks. Respiratory therapists train you in bronchial hygiene, proper use of inhalers, and proper breathing.

Radiation Therapy. X-ray, radon, cobalt, betatron, telecobalt, and radioactive isotope treatment for malignant diseases and other medical conditions.

Recognized Amount. Recognized Amount shall mean, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider's billed charge or the Qualifying Payment Amount.

Reconstructive Surgery. Reconstructive surgery improves or restores bodily function to the level experienced before the event that necessitated the surgery, or in the case of a congenital defect, to a level considered normal. Such surgeries may have a coincidental Cosmetic effect.

Registered Lay Midwife. A person registered by the State of New Mexico to provide health care services in pregnancy and childbirth within the scope of New Mexico lay midwifery regulations.

Registered Nurse (R.N.). A nurse who has graduated from a formal program of nursing education (diploma school, associate degree, or baccalaureate program) and is licensed by an appropriate state authority.

Rehabilitation Hospital. An appropriately licensed facility that provides rehabilitation care services on an inpatient basis. Rehabilitation care services consist of the combined use of a multidisciplinary team of Physical, Occupational, Speech, and Respiratory Therapists, medical social workers, and rehabilitation nurses to enable patients disabled by illness or Accidental Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

Rehabilitative Treatment. Health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include Physical, Occupational, and Speech Therapy, and psychiatric rehabilitation services in a variety of inpatient and outpatient settings.

Respiratory Therapist. A person qualified for employment in the field of respiratory therapy.

Routine Newborn Care. Care of a child immediately following birth that includes: routine Hospital nursery services; routine medical care in the Hospital after delivery, including alpha-fetoprotein IV screening; pediatrician standby care at a Cesarean section procedure; and services related to circumcision of a male newborn.

Routine Patient Care Cost. For purposes of the Cancer Clinical Trial benefit described under "Therapy and Rehabilitation" in *Section 3*, a "Routine Patient Care Cost" means a medical service or treatment that is covered under a health plan that would be covered if you were receiving standard cancer treatment, or an FDA-approved drug provided to you during a Cancer Clinical Trial, but only to the extent that the drug is not paid for by the manufacturer, distributor, or Provider of the drug. For a covered Cancer Clinical Trial, it is not necessary for the FDA to approve the drug for use in treating your particular condition. A "Routine Patient Care Cost" does not include the cost of any investigational drug, device, or procedure, the cost of a non-health care service that you must receive as a result of your participation in the clinical trial, costs for managing the research, costs that would not be covered or that would not be rendered if non-investigational treatments were provided, or costs paid or not charged for by the trial Providers.

Sexually Transmitted Infection. Your Plan covers, and no cost-sharing applies to, contraception methods that are prescribed for the prevention of STIs, which means chlamydia, syphilis, gonorrhea, HIV, and relevant types of hepatitis, as well as any other sexually transmitted infection, regardless of mode of transportation.

Skilled Nursing Care. Care that can be provided only by someone with at least the qualifications of a Licensed Practical Nurse (L.P.N.) or Registered Nurse (R.N.).

Skilled Nursing Facility. A facility or part of a facility that:

- Is licensed in accordance with state or local law;
- Is a Medicare-participating facility;
- Is primarily engaged in providing Skilled Nursing Care to inpatients under the supervision of a duly licensed Physician;
- Provides continuous 24-hour nursing service by or under the supervision of a Registered Nurse; and
- Does not include any facility that is primarily a rest home, a facility for the care of the aged, or for treatment of Drug Abuse, mental disease, or tuberculosis, or for intermediate, custodial, or educational care.

Sound Natural Teeth. Teeth that are whole, without impairment, without periodontal or other conditions, and not in need of treatment for any reason other than the Accidental Injury. Teeth with crowns or restorations (even if required due to a previous injury) are not Sound Natural Teeth. Therefore, injury to a restored tooth will not be covered as an accident-related expense. Your Provider must submit x-rays taken before the dental or surgical procedure in order for the Administrator to determine whether the tooth was "sound."

Special Care Unit. A designated unit that has concentrated facilities, equipment, and supportive services to provide an intensive level of care for critically ill patients. Examples of Special Care Units are intensive unit (ICU), cardiac care unit (CCU), sub intensive care unit, and isolation room.

Specialist. Specialist means those providers other than a Family Practitioner, a General Practitioner, an Internist, a Nurse Practitioner, an Obstetrician/Gynecologist, a Pediatrician, a Physician's Assistant or any provider covered by the Plan who is treating a Mental Disorder and/or Substance Use. Note: Nurse Practitioners, (N.P.), Physician Assistants (P.A.), and Certified Clinical Nurse Specialists are not considered Specialists, and the Specialist copay will not apply.

Special Medical Foods. Nutritional substances, in any form, that are:

- Formulated to be consumed or administered internally under the supervision of a Physician;
- Specifically processed or formulated to be distinct in one or more nutrients present in natural form;
- Intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary food-stuffs or certain nutrients contained in ordinary food-stuffs or who have other specific nutrient requirements as established by medical evaluation; and
- Essential to optimize growth, health, and metabolic homeostasis.

Specialty Pharmacy. A Specialty Pharmacy is a unique class of professional pharmacy practice that includes a comprehensive and coordinated model of care for patients with chronic illnesses and complex medical conditions. Specialty Pharmacies provide expert therapy management services, coupled with patient education and counseling, that collectively drive adherence, compliance, and persistence, manage dosing, and monitor appropriate medication use. This patient-centric model is organized to dispense/distribute typically high cost, injectable/infusible/oral and other hard to manage therapies within a collaborative framework designed to achieve superior clinical, humanistic, and economic outcomes.

Specialty Pharmacy Drugs. Specialty pharmacy drugs must meet at least two of the following criteria: (i) they are high cost, (ii) they are for use in limited patient population or indications, (iii) they are typically self-injected, (iv) they have limited availability, require special dispensing, or delivery and/or patient support is required and, therefore, they are difficult to obtain via traditional pharmacy channels, (v) complex reimbursement procedures are required, and/or (vi)

a considerable portion of the use and costs are frequently generated through office-based medical claims.

Speech Therapist. A speech pathologist certified by the American Speech and Hearing Association.

Speech Therapy. Services used for the diagnosis and treatment of speech and language disorders.

Summary of Benefits and Coverage (SBC). The Summary of Benefits and Coverage provides an overview of Covered Services.

Supplemental Breast Examination. A Medically Necessary and clinically appropriate examination of the breast using breast magnetic resonance imaging of breast ultrasound that is used to screen for breast cancer when there is no abnormality seen or suspected and based on personal or family medical history or additional factors that may increase the risk of breast cancer.

Surgical Services. Any of a variety of technical procedures for treatment or diagnosis of anatomical disease or injury including, but not limited to: cutting; microsurgery (use of scopes); laser procedures; grafting, suturing, castings; treatment of fractures and dislocations; electrical, chemical, or medical destruction of tissue; endoscopic examinations; anesthetic epidural procedures; other invasive procedures. Benefits for Surgical Services also include usual and related local anesthesia, necessary assistant surgeon expenses, and pre- and post- operative care, including recasting.

Tanner Stages. Used to describe the onset and progression of puberty.

Telemedicine. The use of interactive simultaneous audio and video or store-and- forward technology using information and telecommunications technologies by a health care provider to deliver health care services at a site other than the site where the patient is located, including the use of electronic media for consultation relating to the health care diagnosis or treatment of the patient in real time or through the use of store-and-forward technology.

Temporomandibular Joint (TMJ). A condition that may include painful Temporomandibular Joints, tenderness in muscles that move the jaw, clicking of joints, and limitation of jaw movement.

Terminally Ill Patient. A patient with a life expectancy of six months or less, as certified in writing by the attending Physician.

Tertiary Care Facility. A Hospital unit that provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education, and data analysis systems for the geographic area served.

Transplant. A surgical process that involves the removal of an organ from one person and placement of the organ into another. Transplant can also mean removal of organs or tissue from a person for the purpose of treatment and re-implanting the removed organ or tissue into the same person.

Transplant-Related Services. Any hospitalizations and medical or Surgical Services related to a covered transplant or retransplant, and any subsequent hospitalizations and medical or Surgical Services related to a covered transplant or retransplant and received within one year of the transplant or retransplant.

Urgent Care. Medically necessary health care services received for an unforeseen condition that is not life-threatening. This condition does, however, require prompt medical attention to prevent a serious deterioration in your health (e.g., high fever, cuts requiring stitches).

Urgent Care Facility. A facility in a location distinct from a Hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Walk-In Retail Health Clinic/Convenience Care. A walk-in health clinic, other than an office, Urgent Care Facility, pharmacy or independent clinic and not described by any other place of service code adopted by the Centers for Medicare and Medicaid Services that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.