New Mexico Medical Insurance Pool

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

Medicare Carve-out Policy

NMMIP Administrator
PO Box 780548
San Antonio, TX 78278
(866) 306-1882
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 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

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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, Texas 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 7am to 7pm MT For Quarters 1 and 4, and then 7am to 6pm MT for the 2nd and 3rd Quarters. 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

ACENTRA
Provider Portal
https://NMMIP.Acentra.com
or call 1 (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: Medical Necessity will follow Medicare's determination as the primary payer. Services for home health, palliative and Hospice will require prior authorization due to the allowance for these services outside of Medicare guidelines.

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

Important: Without enrollment in a Medicare Part D plan, prescription drugs related to pharmacist provided services will **not be covered** under this Plan.

Payment through this Plan will be based on Medicare determination of prescription drug coverage. NMMIP will cover the out-of-pocket on medications that are covered on Medicare Part D Plan formulary. Any appeals or requests for exceptions on covered medication should be submitted to Medicare.

APPEALS AND GRIEVANCES

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

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

1 Your Health Care Policy

This Policy describes the benefits and limitations of the NMMIP 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 NMMIP's 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 Medicare. (See "Provider Choices," in *Section* 2.) If you have questions after you read this Policy, contact NMMIP's 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:

ID Card (Carry At All Times). Your NMMIP identification (ID) card provides the information needed when you require health care services, or when you are contacting a Customer Service Representative. Carry it with you. Have both your NMMIP ID card and your Medicare 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.

In addition, for prescription drug coverage, you must present your Medicare Part-D card and New Mexico Medical Insurance NMMIP Carve Out card at the pharmacy.

Summary of Benefits and Coverage ("SBC"). The Summary of Benefits and Coverage shows 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 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.

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.

Prior Approval

IMPORTANT: This information applies only when a service is not covered by Medicare.

In order to receive full benefits for certain services, you (or your Provider) must call the pre-certification number on the back of the Enrollee's ID card for approval **before** you receive the services. **The following service requires Prior Approval:**

- Inpatient stays when you are admitted as a bed patient in a Hospital, Skilled Nursing Facility, or other facility licensed for overnight care and the service is **not** covered by Medicare; and
- Services for home health, palliative and Hospice will require prior authorization due to

the allowance for these services outside of Medicare guidelines.

If there is an **Emergency Admission**, the Administrator must be notified as soon as reasonably possible.

Call Customer Service: **(866) 306-1882**
Monday through Friday from 7 am to 7 pm MT for quarters 1 and 4, and 7 am to 6 pm for quarters 2 and 3.

ACENTRA
Provider Portal
https://NMMIP.Acentra.com
or call 1 (844) 547-4255
Fax (833) 336-1414

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

Customer Service

If you have any questions about your coverage, call the Administrator's Customer Service department. Representatives are available 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 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.

90 Degree Benefits
(866) 306-1882 or
TTY# 711
11467 Huebner Road
San Antonio, TX 78230
PO Box 780548
San Antonio, TX 78278
Web site: www.nmmip.org

Customer Service can provide assistance to individuals who speak a primary language other than English with the use of the Language Line interpretation services.

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.

Policy Overview

This Policy is designed to "coordinate" benefits with Medicare and usually pays benefits only after Medicare has paid its portion of your covered health care services. Medicare is called the "primary" coverage or carrier and pays its benefits first. The Policy is the "secondary" coverage or carrier.

You may not elect to change the Policy to be the primary carrier and may not elect to bypass Medicare. If services are among those normally covered by Medicare, you or your doctor or Hospital (your health care "Provider") must submit a claim for those services first to Medicare. Medicare will calculate its benefits and will send you an *Explanation of Medicare Benefits* (EOMB) form. This form must be attached to any claim you send to the Administrator. Note: You will usually not have to submit claims. See *Section 6* for details about when you may have to submit your own claims.

Services Covered Only by Medicare. The Policy will cover Medicare-eligible services that are also listed as covered in *Section 3*. However, some benefits are limited under the Policy and benefit payments cannot exceed those limits, even if Medicare covers the service. (For example, chiropractic benefits.) See *Section 6* for examples of how benefits will be calculated under this Policy.

Services Covered by Both Medicare and the Policy. The benefits and services covered under this Policy are described in more detail in *Section 3*.

Under this Policy, the Administrator first calculates your covered Policy benefits subject to the benefits described in *Sections 2 and 3*. This benefit amount, if any, is compared to the balance due on the health care Provider's bill after Medicare has paid its benefits. The Policy then pays the lesser amount of the Policy benefit or the balance due after Medicare.

See *Section 6* for details about how benefits are coordinated with Medicare. It is to your advantage to visit Providers that participate with Medicare.

Services Covered Only by the Policy. A service covered under this Policy may not be covered

by Medicare either because it is not a covered type of service under Medicare or because it is from a Provider that is not covered by Medicare (such as a non-participating Hospital). When such services are covered under this Policy, you can choose to visit any eligible health care Provider you want and still receive benefits as listed.

Note: Some services not covered by Medicare will be denied or benefits for them reduced if you do not receive Prior Approval from the Administrator. If you obtain all necessary approvals and the service is covered by the Policy, then benefits will be paid in accordance with Deductible and co-insurance described in this *Section 2*.

Prior authorization does not guarantee payment. We are not required to pay for an authorized service if your coverage ends before you receive the service.

After Care Review. If you received care without a required prior authorization, we may allow your Provider to request authorization 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.

Authorization Denial. We will inform you in writing if we deny a prior or retroactive authorization request. Our notice to you will explain why we denied the request and will provide you with instructions for disputing our decision if you disagree. A summary of the dispute resolution process begins in *Section 6* of this document. You have a right to request information about the guidance we followed to deny your request, even if you do not dispute our decision.

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.

Medicare-Covered Services. For Medicare-Covered Services, you can choose to see a Provider who accepts Medicare assignment or a Provider who does not accept assignment. (All Medicare-Participating Providers accept Medicare assignment. Non-participating Physicians and other professional Providers may accept a one-time Medicare assignment on a claim-by-claim basis.) **It is very important to understand the difference between Providers who accept assignment and those who do not.** Your choice of Provider affects the amount you will pay for a service. See "Covered Charges," later in this section for an explanation.

Participating Facilities. Participating facilities are those that have contracted with Medicare to provide services to Medicare beneficiaries. Such facilities include acute care Hospitals, skilled nursing facilities, Home Health Care agencies, Hospice programs, rural health clinics, comprehensive Outpatient rehabilitation facilities, community mental health centers, and end-stage renal disease Dialysis centers.

Other Participating Providers. Other Participating Providers (e.g., Physicians, Podiatrists, and other professional Providers) are those non-facility health care Providers that have signed agreements with Medicare to accept Medicare assignment.

Selecting a Medicare-Participating Provider. Before obtaining health care services, check the *Medicare-Participating Provider/Supplier Directory*. If you do not have a current *Medicare-Participating Provider/Supplier Directory*, you can obtain one free of charge from your local Medicare carrier or you can ask your local Medicare carrier for names of some Medicare-Participating Providers in your area. (Call your local Social Security Administration office for more information.) You may also want to ask your Provider if they accept Medicare assignment before you receive services.

For Medicare-Covered Services, your choice of a participating or non-Participating Provider may make a difference in the amount you pay.

Non-participating Facilities. A non-participating facility is one that has chosen to not participate with Medicare. Medicare **does not cover** services provided by non-participating facilities. Non-participating facilities include all facilities outside the Medicare territorial limits.

Other Non-Participating Providers. Other non-Participating Providers are those non-facility health care Providers that have Medicare Provider identification numbers but who have not signed agreements with Medicare to accept the Medicare-approved amount as payment in full. However, on a claim-by-claim basis, non-Participating Providers may agree to accept assignment and the Medicare-approved amount. See "Covered Charges," later in this section, for information about how an "assignment" can affect the amount you have to pay for a service.

Non-Medicare Providers. Non-Medicare Providers are doctors and other health care professionals that do not have Medicare Provider identification numbers. Medicare will not pay for services received from these Providers. The Covered Charges will be covered as described in this *Section 2*.

Privately Contracting Providers. These are Providers with whom you have privately contracted (as set forth in section 4507 of the Balanced Budget Act of 1997). Medicare will not pay for services from a privately contracting Provider and will not accept a claim from them. You will have to provide acceptable documentation to the Administrator indicating that you have privately contracted and are unable to obtain a Medicare EOMB for the service. Benefits for privately contracted services that are Covered Charges will be calculated as if Medicare paid 80 percent of the Provider's billed charge (the balance will be used to calculate Policy benefits). See *Section 6* for information on Policy benefit payments.

Government Facilities. These are Hospitals such as Veterans' Administration facilities, Department of Defense Hospitals, and other government facilities. When you receive care at a government facility for a condition that is not service connected, see *Section 6* for information on Policy benefit payments.

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.

Deductibles, Coinsurance, Out-of-Pocket

Policy Deductible

The Policy Deductible is **$500 per calendar year**, and it is indicated on your ID card. You must pay your Deductible amount before the Policy will begin paying its share of your Covered Charges. This Deductible is separate from the Medicare Part A and B Deductible, but expenses applied to your Medicare Deductibles may also be applied to your Policy Deductible.

Note: Each Calendar Year, satisfaction of a new calendar year Deductible must be fulfilled.

In all cases, the Administrator first calculates what your benefits would be if there was no other coverage. Claims are "processed" (or calculated) in the order they are received by the Administrator. Claims will not be reprocessed in order to redistribute Deductible or member Coinsurance amounts.

Only Covered Charges are applied toward the Deductible. If a service is covered by Medicare, the amount allowed by Medicare is the Maximum Amount that can be applied to your Deductible. If a service is not covered by Medicare, the amount that can be applied to your Deductible is only the amount determined to be a Covered Charge. Covered Charges may be less than the billed amount.

You do not have to meet a Deductible for Preventive Care.

Note: Amounts applied to the annual Deductible and to Enrollee Coinsurance are not used to calculate benefit limitations that are based on a dollar amount (e.g., $1,500 per calendar year). Such limits are based on amounts actually paid out by the Policy.

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

Coinsurance and Out-of-Pocket Limit

Coinsurance. After the Deductible is satisfied, the Policy pays **80 percent** of Covered Charges, except as otherwise specified for certain services, until the calendar year Out-of-Pocket Limit is reached. The Policy Coinsurance is separate from the Coinsurance you pay under Medicare Part B.

Covered Charges may be less than the billed amount. If you receive services from a non-Participating Provider, you may be responsible for paying the Provider any amounts over the Covered Charge, in addition to your Deductible and your percentage of the Covered Charge (Coinsurance).

Out-of-Pocket Limit. The total amount of **Deductible** and **Coinsurance** you must pay each calendar year is called the Out-of-Pocket Limit. The Out-of-Pocket Limit is **$3,300 per calendar year**. After the limit is met, the Policy pays **100 percent** of your Covered Charges for the rest of the calendar year.
Note: Each calendar year, satisfaction of a new Calendar Year Out-of-Pocket Limit is required.

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;
- Any charges denied due to non-compliance with the Plan's Admission Review/Prior Approval requirements; and
- Non-covered expenses.

Admission Review & Other Prior Approvals

Under the Policy, you must obtain Prior Approval for certain services requiring Inpatient Admission if the service is **not** covered by Medicare. Failure to obtain a required approval may result in a denial of benefits.

Note: Prior Approval 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 services are received.

When Medicare makes a determination whether particular health care services are Medically Necessary or non-experimental under its program, the Administrator will use Medicare's decision in determining secondary benefits.

Note: If you are not sure whether or not Medicare will cover or approve a service, you should obtain Prior Approval from the Administrator for the Admission. If Medicare denies the service for any reason, you will need to have approval on file from the Administrator for specified services or Policy benefits may also be reduced or denied. For Prior Approval call:

Customer Service:
(866) 306-1882
Monday through Friday from 7 am to 7 pm MT for quarters 1 and 4, and 7 am to 6 pm for quarters 2 and 3.

Admission Review Approval

IMPORTANT: This information applies only when a service is not covered by Medicare.

When you or your Provider requests Prior Approval for an Inpatient Admission, the Admission may not be approved for payment (for example, due to being experimental, investigational, or unproven, or not Medically Necessary). It is strongly recommended that you request Prior Approval for high-cost services in order to reduce the likelihood of benefits being denied after charges are incurred.

If you are not sure whether or not Medicare will cover or approve a service, you should obtain Prior Approval from the Administrator. If Medicare denies the service for any reason, you will need to have an approval on file for the Admission or Policy benefits may also be denied.

Type of Inpatient Admission, Readmission, or Transfer	When to Obtain Admission Review Approval:
Non-Emergency	**Before the patient is admitted.**
Emergency, non-Maternity	**Within three (3) business days of Inpatient Admission.** If the condition makes it impossible to call within three (3) business days, call as soon as possible. (No approval is required for Emergency room services that do not result in an Inpatient Admission.
Observation hours 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.

NOTE: Although newborns are not covered under this Medicare Carve-out Policy, if you obtain a regular (non-Carve-out) New Mexico Medical Insurance Policy the newborn's Covered Charges will be as specified in *Section 7*.

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 (usually at the time of the call) if benefits for the proposed Hospitalization are approved. If the Admission is not approved, you may appeal the decision as explained in *Section 6*.

Not Obtaining Admission Approval. If you or your Provider do not call, or if you call and do not receive approval for Inpatient benefits, but you choose to be Hospitalized anyway, no benefits may be paid as specified in the table below:

If the Admission is not approved by Medicare and you do not obtain Admission approval and based on a review of the claim:	Then:
The Admission was **not for** a covered service.	Benefits for the facility and all related services may be **denied**.
The Admission was for a covered service, but Hospitalization was **not Medically Necessary.**	Inpatient stay will be **denied.**
The Admission was for **Medically Necessary Covered Services.**	Benefits for the facility's Covered Services **may be denied**.
The charges for non-covered and denied services are not applied to any Deductible or out-of-pocket limit.	

Admission 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 is not approved by the Utilization Review 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.

Remember: Even if you receive Prior Approval for an Inpatient Admission, an additional Admission review approval is required for all transfers, re-Admissions, and extended stay newborn Hospitalizations. Your Provider should assist you in obtaining these approvals. See "Admission Review Approval," earlier in this section.

Advance Benefit Information

If you want to know what benefits will be paid before receiving services or filing a claim, the Administrator may make a written request. The Administrator may also require a written statement from the Provider identifying the circumstances of the case and the specific services that will be provided. An advance confirmation of benefits does not guarantee benefits if the actual circumstances of the case differ from those originally described. When submitted, claims are reviewed according to the terms of this Policy or any other coverage that applies on the date of service.

Utilization Management

To help ensure you receive the right care, in the right place, and at the right time, the Administrator uses a group of programs known as **Utilization Management (UM)**.

Utilization Management is the process of reviewing medical records, claims, and Prior Approval requests to confirm that services are **Medically Necessary**, provided in the most appropriate setting, and match the condition being treated.

- **Prior Approval (Pre-Service Review):** Review before a service is provided.
- **Concurrent Review:** Evaluation while a service is being delivered.
- **Retrospective Review:** Review after a service has been received.

UM decisions are based solely on the appropriateness of care and services. The Administrator does **not** reward providers or staff for denying coverage, nor offer incentives to approve fewer services than you need. Our goal is to make sure you receive all **Covered Services** that are medically necessary — delivered in the safest, most effective way possible.

Request for Authorization Reconsideration and Appeals - NMMIP-Only Covered Services

Note: Services that are normally covered by Medicare but denied as not medically necessary by Medicare are not subject to this appeals process.

This appeals process applies only to services covered exclusively under the New Mexico Medical Insurance Pool (NMMIP) Medicare Carve-out Plan.

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/

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.

CARE MANAGEMENT

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;
- Contacting the family to offer assistance and support;
- Monitoring Hospital or Skilled Nursing Facility;
- 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.

All of these support services are available to you as a member of the New Mexico Medical Insurance 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.

Health Care Fraud Information

Health care and insurance fraud results 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 the Covered Charges as determined by the Administrator. **Reminder:** It is to your financial advantage to receive care from Medicare-Participating Providers.

If a service is not covered by Medicare, the Administrator will determine what services will be covered and what Covered Charges will be. All payments are based on Covered Charges. (See "Covered Charges," in *Section 2*.)

No benefits are available under this Policy for charges related to any service if paying benefits for such services would result in a benefit greater than any calendar year maximum or lifetime benefit payable under the Policy. (e.g., chiropractic services, Home Health Care).

All benefit determinations will be subject to the Policy's Medical Necessity and prior approval provisions.

Medical Necessity/Experimental

Medicare-Covered Services. When Medicare makes a determination whether particular health care services are Medically Necessary or not experimental, investigational, or unproven under its program, the Administrator will generally use Medicare's decision in determining secondary benefits. However, just because a service is covered by Medicare does not make it automatically eligible for Policy benefits. If any maximum benefit limitation under the Policy is exhausted or if a service is listed as an exclusion under this Policy, it will not be covered by the Policy.

Other Plan-Covered Services. For services not covered by Medicare, the Administrator determines whether a service or supply is Medically Necessary and not experimental, investigational, or unproven and whether the expense is covered. **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.

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 12 visits in 90 days; an additional 8 may be allowed if improvement is achieved for a total of 20 visits per Calendar Year. Benefits will follow Medicare's determination of Medical Necessity. 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.

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

- Herbs, homeopathic preparations, or nutritional supplements; or
- 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.
Air Ambulance. Benefits for air Ambulance will be 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 Disorders

This Policy covers Habilitation and Rehabilitation Treatment of Autism Spectrum Disorder through Speech Therapy, Occupational Therapy, Physical Therapy, and Applied Behavioral Analysis (ABA). Providers must be credentialed to provide such therapy.

Treatment must be prescribed by the 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 were 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, however services for ABA and Cognitive Rehabilitation will be payable at 100%, and the calendar year Deductible will not apply. 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, and other managed care provisions.

Exclusions. 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

Benefits will be payable at 100%, and the calendar year Deductible will not apply for 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 is covered when administered by a licensed Provider acting within the scope of licensure, and when necessary for the treatment of a medical condition. Reimbursement is limited to the Covered Charge for the chiropractic treatment itself and associated office visits and benefits will follow Medicare's determination of Medical Necessity.

Covid 19 Services

Benefits will be payable at 100%, and the calendar year Deductible will be waived for 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, that requires the patient to undergo general anesthesia or be Hospitalized.

Prior Approval is required for Inpatient Admissions not covered by Medicare.

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 will follow Medical Necessity as determined by Medicare and will 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;
- Removal of exostoses (bony growths) on the jaws and hard palate, provided the procedure is not done in preparation of the mouth for dentures; and
- 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.

Prior Approval is required for orthognathic surgery requiring Inpatient Admission and that surgery is not covered by Medicare.

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

- Cleanings, fluoride, diagnostic exams and X-rays twice per calendar year;
- Sealants once per 60 months;
- Full mouth or panoramic x-rays, once every 60 months;
- Space maintainers;
- Fillings;
- Crowns;
- Root canals;
- Extractions; and
- Orthodontic Appliances and treatments 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. Services will be covered based on a determination of Medical Necessity by Medicare.

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;
- 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 service;
- 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

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.

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) medication 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 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.**

Care managers will answer your initial questions about Medicare, but you must contact Medicare for complete details.

Equipment, Orthotics, Appliances, Supplies, and Prosthetics

Durable Medical Equipment and Appliances. This Policy covers the following items, and will follow Medicare's determination of Medical Necessity:

- 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;
- Repair of item not due to misuse;
- Oxygen and oxygen equipment, wheelchairs, batteries required for Durable Medical Equipment (based on Medicare's determination), 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.

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 prosthetic 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 Customer Service department 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 Services

Family Planning. Covered family planning services include FDA-approved devices and other procedures such as:

- Sterilization surgery for Women
- Sterilization surgery for Men
- IUD copper
- IUD with Progestin

- Shot/injection,
- Oral contraceptives (The Pill) (Combined Pill) – as determined by Medicare under the Part D prescription benefit
- Oral contraceptives (Extended/Continuous Use) – as determined by Medicare under the Part D prescription benefit
- Patch – as determined by Medicare under the Part D prescription benefit
- Vaginal contraceptive ring
- Diaphragm with spermicide
- Sponge with spermicide
- Cervical cap with spermicide
- Female condom
- Male condom
- Spermicide
- Emergency Contraceptive ("Plan B")
- Emergency Contraceptive ("Ella) as determined by Medicare under the Part D prescription benefit

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.** Benefits will be available as determined by Medicare under your Part D prescription drug benefit. Please refer to your Medicare Part D booklet for information regarding your coverage.
- **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.

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; or
- Therapeutic, infertility drugs, or hormonal manipulation and excess hormones to increase the production of mature ova for fertilizations when administered in Physician's office; (if prescribed and obtained at a pharmacy, benefits will follow determination by Medicare under the Part D prescription benefit);
- Infertility treatments and related services.

The above services are the only infertility-related treatments that will be considered for benefit payment subject to regular Deductible and Coinsurance provisions.

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;
- 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 (benefits will follow determination by Medicare under the Part D prescription benefit), 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. Note: Benefits for Covered Services for the treatment of sexual dysfunction will follow Medicare's determination of Medical Necessity.

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 benefits will follow determination by Medicare under the Part D prescription benefit;
- 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 when administered in Physician's office; (if prescribed and obtained at a pharmacy, benefits will follow determination by Medicare under the Part D prescription benefit).
- Gender-Affirming Hormone Therapy administered in Physician's office; (if prescribed and obtained at a pharmacy, benefits will follow determination by Medicare under the Part D prescription benefit); 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.

Note: Benefits will include coverage for medications administered in Physician's office; (for any medications that are prescribed and obtained at a pharmacy, benefits will follow determination by Medicare under the Part D prescription benefit).

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, biochemical analysis, Medical Supplies, 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., 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.

Note: Benefits will include coverage for medications administered in Physician's office; (for any medications that are prescribed and obtained at a pharmacy, benefits will follow determination by Medicare under the Part D prescription benefit).

Habilitative Services

Habilitative Treatment. Treatment programs that are necessary to: 1) develop, 2) maintain, or 3) skills and functioning for daily living.

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** under Physician's orders. (If the Home Health Care maximum visit is exceeded, coverage will be available under the Palliative Care benefit.) 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 and Palliative Care Services for a Terminally Ill Enrollee received during a Hospice Benefit Period when provided by a Hospice program approved by the Administrator. Benefits for services provided under this provision will be paid at 100% and the calendar year Deductible will not apply.

Prior Approval is required for Inpatient Hospice Care not covered by Medicare.

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; and
- 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.)
- Bereavement or family counseling.

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

- Food, housing, or delivered meals 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.

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

Inpatient Services. 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.)

Prior Approval is required for all non-Emergency Inpatient Admissions not covered by Medicare.

If you are admitted because of an Emergency the Administrator must be called within three business days of the 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 is available when provided by a Provider trained in the use of hypnosis when used for anesthesia.

Lab, X-Ray, Other Diagnostic Services

The NMMIP Medicare Carve Out Plan follows the standardized benefits under Medicare A and B, as well as medical necessity.

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;
- 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 diagnosis, treatment, management, and monitoring; and
- Sleep Disorders. Medically Necessary services and supplies rendered by covered Providers for the treatment of sleep disorders, including sleep studies, if medically appropriate.

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

Benefits will be payable at 100%, and the calendar year Deductible will not apply for the Covered Services listed below. (**Note:** Services related to rehabilitation of Alcoholism or other Chemical Dependency are not covered under this "Mental Health" provision; see "Chemical Dependency" for benefits.)

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. 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 medication;
- 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.

Prior Approval is required for all Inpatient mental health services not covered by Medicare. (Outpatient benefits are not available for services received while you are an Inpatient. Inpatient benefits are not available for services received on an Outpatient basis.)

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 45 kilograms (99.2 pounds) or 100 percent over ideal body weight.

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 Case 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.

Prior Approval is required for all surgical procedures.

Newborn Care

Your newborn child may be covered for 31 days after birth through the NMMIP EPO Policy if you are an adult Policyholder, if you notify us and pay the additional premiums within the first 31 days. After the first 31 days of coverage, your newborn must meet the eligibility requirements to maintain coverage from NMMIP.
Please see Section 7 (Enrollment and Termination Information) for the Newborn and Adopted Children information.

If you meet the requirements above, please note that 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.

PHARMACIST SERVICES

Requirement for Medicare Part D Enrollment
To receive full coverage for prescriptions associated with these pharmacist services (including medications ordered as a result of testing, screening, or treatment), you must be enrolled in a Medicare Part D prescription drug plan

This Plan does **not provide pharmaceutical coverage without active enrollment in Part D**. If you are enrolled in Part D, **State Pharmaceutical Assistance Program (SPAP)** coverage will also be provided in coordination with your Part D plan's formulary, as described in the **Medicare Carve-Out** section of this booklet.

Important: Without enrollment in a Medicare Part D plan, prescription drugs related to pharmacist-provided services will **not be covered** under this Plan.

An in-network pharmacist, operating under a protocol approved by the New Mexico Medical Board, may order, test, screen, treat, and provide preventive services for the following conditions:

- Influenza (Flu)

- Strep Throat
- SARS (Severe Acute Respiratory Syndrome)
- Urinary Tract Infections (UTIs)
- HIV for pre-exposure prophylaxis (PrEP) only
- Any illness that is the subject of an active Public Health Emergency

These services are provided pursuant to a board-approved protocol and are covered when performed by an in-network pharmacist.

Additionally, the Medicare Carve Out Plan does not provide a pharmaceutical benefit. You must be enrolled in a part D plan. The Medicare Carve Out Plan does offer a State Pharmaceutical Assistance Program, which will cover the out-of-pocket cost associated with medications only on your Part D formulary.

If you are not enrolled in a Part D plan, please contact Medicare directly for information related to special and open enrollment periods for Part D.

Physician Visits/Medical Care

This section describes benefits for medical visits to a health care Provider for evaluating your condition and planning a course of treatment. See the topics referenced above for more information regarding a particular type of service. 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.

Pregnancy Complications and Maternity

Pregnancy Complications. This Policy covers the 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 all 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. (This Policy covers all Medically Necessary Hospitalization, 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 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; and
- 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, parent 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.

Note: Benefits will include coverage for medications administered in Physician's office; (for any medications that are prescribed and obtained at a pharmacy, benefits will follow determination by Medicare under the Part D prescription benefit).

Prescription Drugs and Other Items

The Medicare Carve Out Plan does not provide a prescription drug benefit. The Medicare Carve Out Plan offers a State Pharmaceutical Assistance Program (SPAPs) to help members pay for prescription drugs. In order for the member to have prescription drug coverage, the member needs to purchase a Part D Plan, and then the SPAP Plan will cover the out-of-pocket for drugs covered under the Part D formulary.

Aid in Dying. This Policy covers compound medication under the prescription drug benefit, as prescribed by your Physician. No prior authorization is needed.

Preventive 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 Practices (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;
- 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; and
- 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. **Note:** Benefits will follow Medicare's designation. Any expense considered by Medicare as diagnostic will be processed under the regular provisions of the Plan and Deductible and Coinsurance will apply as required.

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, with no cost sharing for diagnostic or supplemental breast examinations;
- 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 if there is 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 though 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 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 not covered by Medicare.

Conditions of Coverage. To be covered, the confinement must satisfy all of 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 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 Admissions;
- 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 (see "Prescription Drugs and Other Items" for benefit details);
- A choice of Cessation Counseling (Covered counseling is restricted to programs that meet minimum requirements; see Definitions section for minimum Cessation Counseling requirements.) and
- Over-the-counter tobacco cessation products, including but not limited to items such as nicotine patches or nicotine gum.

Note: Benefits will include coverage for medications administered in Physician's office; (for any medications that are prescribed and obtained at a pharmacy, benefits will follow determination by Medicare under the Part D prescription benefit).

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; or

Surgery and Related Services

Prior Approval is required for all surgeries requiring your Inpatient Admission that are not covered by Medicare. You are responsible for obtaining Admission review when necessary (see Section 2). Call the Administrator for approval: (866) 306-1882**.**

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.

Morbid Obesity Surgery. This Policy covers the surgical treatment of morbid obesity if it is deemed Medically Necessary to treat the condition. Morbid obesity means the state of being either 45 kilograms (99.2 pounds) or 100 percent over ideal body weight.

Note: Covered Services under this Policy will follow Medicare's determination of Medical Necessity.

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 (unless covered under "Mastectomy Services," earlier in this *Section* 3);
- 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); Note: The Policy's allowance of Covered Services under this provision will follow Medicare's determination of Medical Necessity;
- 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, gender-affirming procedure, 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.

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.

In addition to the above coverage, benefits will also include coverage for telehealth services as provided by Teladoc, a medical service that uses telephone and videoconferencing technology to provide remote medical care via mobile devices, the internet, video and phone. Teladoc provides remote medical assistance and is able to use virtual technology to treat many non-Emergency conditions.

Note: The Deductible will be waived, and $0 consult fee will apply for visits provided through Teladoc medical / behavioral health services.

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.

Note: Benefits will include coverage for medications administered in Physician's office; (for any medications that are prescribed and obtained at a pharmacy, benefits will follow determination by Medicare under the Part D prescription 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.

Note: Benefits will include coverage for medications administered in Physician's office; (for any medications that are prescribed and obtained at a pharmacy, benefits will follow determination by Medicare under the Part D prescription benefit).

Cardiac and Pulmonary Rehabilitation. This Policy covers Outpatient Cardiac Rehabilitation programs initiated within six months of a cardiac incident and Outpatient Pulmonary Rehabilitation services.

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

- Renal Dialysis (hemodialysis);
- Continual ambulatory peritoneal Dialysis (CAPD);
- Apheresis and plasmapheresis; and
- The cost of equipment rentals and supplies for home Dialysis.

Outpatient Physical, Occupational, and Speech Therapy. 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. To be eligible for benefits, therapies must meet all of the following conditions:

- 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 refer- ring Physician, in consultation with the Administrator.
- Improvement would not normally be expected to occur without intervention.
- 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.

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**:

- 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;
- 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;
- 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 (See "Dental-Related/ TMJ Services and Oral Surgery" for an exception.); or
- Extended care Admissions or Admissions to similar institutions.

Transplant Services

Prior Approval Required. Prior Approval **is** required for a transplant covered by Medicare.

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

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.

Facility Must Be in the Transplant Network. If the transplant is **not** covered by Medicare, the

benefits for Covered Services will be approved only when the transplant is performed at a facility that is contracted with a national transplant Network designated by the Administrator. Your case manager will assist your Provider with information on the exclusive Network of contracted facilities and required approvals. Call the Administrator's Customer Service for information on these approved transplant programs.

Covered Transplants. This Policy covers the following organ/organ combination transplant procedures:

- Bone marrow for an Enrollee with aplastic anemia, leukemia, severe combined immunodeficiency disease (SCID), or Wiskott-Aldrich syndrome, and other conditions determined by the Administrator to be Medically Necessary and not experimental or investigational;
- Cornea;
- Heart;
- Heart-lung;
- Kidney;
- Liver;
- Lung;
- Pancreas; and
- Pancreas-kidney.

These are the only transplants and organ-combination transplants that are covered.

The following benefits, limitations, and exclusions apply to this coverage for one year following the date of the actual transplant or re-transplant. After one year, 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:

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. Donor expenses are applied to the lifetime maximum transplant benefit described on the next page. Benefits for the donor are payable only after expenses have been paid for the NMMIP Enrollee and only if the maximum benefit for transplants has not yet been reached.

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 Per Diem Expenses. If the Administrator requires you (i.e., the transplant recipient) to temporarily relocate outside of your city of residence for pre-transplant evaluation or 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. Meals, travel, and lodging reimbursement (including taxes) are 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 of the Transplant Benefit Period, except as otherwise specified.

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 case 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).

Vision Services – Pediatric

This Policy covers the following vision services, at 100% and the calendar year Deductible will not apply, 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 the Policy (or benefit 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 are: 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 or to diagnose a possible congenital defect caused by a present, external factor that increases risk, such as advanced maternal age or alcohol misuse, or are necessary for targeted disease therapy.

Note: Benefits for Covered Services under this provision will be based on a determination of Medical Necessity by Medicare.

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.

Note: In the event of a determination of Medical Necessity by Medicare, services will be covered.

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 specified. 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.

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*.

Medicare-Denied Services. This Policy does not cover any service denied by Medicare as being medically unnecessary, experimental, investigational, or unproven, Cosmetic, custodial, domiciliary, for Maintenance Therapy, non-medical, for personal convenience, war-related, or work-related. The guidelines and practices of Medicare, the FDA, or other government programs or agencies may be considered in a determination made by the Administrator for the Policy; however, approval by other bodies will neither constitute nor necessitate approval by the Administrator.

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; telephone consultations; 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-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 (as defined) 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 (non- surgical) 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. Please note – prior authorization is not a guarantee of payment.

Prior Approval Not Obtained When Required. Failure to obtain prior authorization may result in the denial of coverage or the authorization for the health service requested, if the services are not Medically Necessary or not a covered benefit. 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 or developmental delay, except as specified; or
- 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 "Pediatric Vision Services" 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, except for the surgical treatment of morbid obesity that has been prior approved by the Administrator or health education and counseling services if recommended by your Physician, including obesity screening and counseling.

Note: Covered Services under this provision will follow Medicare's determination of Medical Necessity.

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. You may not retain coverage under this Policy if you obtain other health care insurance, other than Medicare, after enrollment.

Coordinating With Medicare. Benefits are based on the Covered Charge determined by either Medicare or by the Administrator. Here are examples of how claims payments are calculated:

Provider Accepts Medicare Assignment. For Medicare-Covered Services from Providers accepting Medicare assignment, the Covered Charge is Medicare's approved amount. The Provider cannot charge you for amounts greater than the Medicare-approved amount. All Medicare-Participating Providers accept assignment; non-Participating Providers may accept a one-time Medicare assignment on a claim-by-claim basis.

Assigned Claim Payment Example:

You receive Medicare-Covered Services from a Provider that accepts Medicare assignment. You have not yet satisfied your Policy Deductible.

Provider's billed charge	$200.00
Covered Charge = Medicare-approved amount	$175.00
Medicare Deductible: ($175 - $100 = $75 balance)	-$100.00
Medicare's payment (80% of $75)	$60.00
Balance due from Medicare beneficiary ($175 - $60)	$115.00
Policy's usual benefit = Medicare-approved amount (the "Covered Charge") applied to the Carve-out Policy	$0.00
Policy's coordinated benefit = Lesser of balance due ($115) or the usual benefit ($0)	$0.00
Total member share ($175 less $60. $115 applied to Policy Deductible and to annual Out-of-Pocket Limit.	**$115.00**

Assigned Claim Payment Example:

You receive Medicare-Covered Services from a Provider that accepts Medicare assignment. You have satisfied your Policy Deductible.

Provider's billed charge	$200.00
Covered Charge = Medicare-approved amount	$175.00
Medicare Deductible: ($175 - $100 = $75 balance)	- $100.00
Medicare's payment (80% of $75)	$ 60.00
Balance due from Medicare beneficiary ($175 - $60)	$115.00
Policy's usual benefit = Medicare-approved amount (the "Covered Charge") paid at 80%.	$140.00
Policy's coordinated benefit = Lesser of balance due ($115) or the usual benefit ($140)	$115.00
Total member share (Policy Coinsurance of $35 applied to Policy's annual Out-of-Pocket Limit.)	**$0.00**

Provider Does Not Accept Medicare Assignment. When a Physician or other professional Provider does not accept Medicare assignment, the Covered Charge is calculated using one of the two methods described below (and on the next page).

Medicare Limiting Charge. For most Medicare-Covered Services from Physicians that do not accept Medicare assignment, the Covered Charge is the Medicare limiting charge that is set by Medicare. The Provider cannot charge you for amounts greater than the limiting charge (which is greater than the Medicare-approved amount). You are responsible for this difference between the Medicare-approved amount and the limiting charge. The Administrator considers this amount when determining benefit payments.

Medicare Limiting Charge Example:

You receive services from a Physician that does **not** accept Medicare assignment and both the Medicare/Policy Deductible have been met. Medicare imposes a limiting charge.

Provider's billed charge	$300.00
Medicare-approved amount	$200.00
Medicare limiting charge (115% of Medicare-approved amount. Provider cannot bill you for more than this amount.)	$230.00
Medicare's payment (80% of $200)	- $160.00

Balance due from beneficiary ($230 - $160)	$ 70.00
Policy's usual benefit = 80% of the **limiting charge** of $230	$184.00
Policy's coordinated benefit = Lesser of balance due ($70) or the usual benefit ($184)	$ 70.00
Balance due from member = Policy Coinsurance of $46 applied to Policy's annual Out-of-Pocket Limit.	**$ 0.00**

Administrator's Maximum Allowable Fee. In those few cases in which Medicare does not impose a limiting charge (e.g., Durable Medical Equipment), the Administrator uses the Covered Charge as established by the Administrator. This amount is the same Covered Charge that is used for services when no Medicare is involved. In these cases, the Provider can collect the full billed charge from you.

Administrator Maximum Allowable Fee Payment Example:

You receive Medicare-covered Durable Medical Equipment from a supplier that does not accept Medicare assignment and both the Medicare and Policy Deductibles have been satisfied. Medicare You received Medicare-covered durable medical equipment from a supplier that does not accept Medicare assignment and both the Medicare and Policy Deductibles have been satisfied. Medicare does not impose a limiting charge.

Provider's billed charge	$250.00
Medicare-approved amount	$200.00
Medicare's payment (80% of $200)	- $160.00
Policy's Covered Charge (or "maximum allowable fee") = $230. The Provider may not bill for the $20 difference between $250 bill and the Policy's Covered Charge of $230.	$230.00
Balance due from beneficiary ($230 - $160)	$ 70.00
Carve-out Policy's usual benefit = 80% of the **Covered Charge** of $230. The remaining 20% ($46) is member Coinsurance.	$184.00
Policy's coordinated payment (lesser of $70 balance due and $184 usual benefit)	$ 70.00
Total member share = Policy Coinsurance of $46 applied to Policy's annual Out-of-Pocket Limit. Provider writes off $20 in excess of Covered Charge. If you had visited a non-contracted Provider, you would also be responsible for paying the $20 difference.	$0.00

Other Coordination Provisions. There are two instances in which Medicare does not pay benefits, and for which you will not receive full Policy benefits:

Members Who Privately Contract with a Provider. When services are not paid by Medicare because you have privately contracted with a Provider (as set forth in section 4507 of the Balanced Budget Act of 1997), secondary benefit payments for services that would have otherwise been covered by Medicare Part B will be calculated as if Medicare had paid 80 percent of the billed charge for a covered service. The remaining 20 percent of the billed charge is considered the balance due from you after Medicare.

Government Facilities. When Outpatient Services are received at a Veterans' Administration, Department of Defense, or other government facility for a non- service-connected condition, Covered Charges will be calculated as if Medicare paid 80 percent of the Provider's billed charge. For Inpatient Services, benefits for services that are Covered Charges will be calculated as if Medicare paid all but an amount equal to the Medicare Part A Hospital Deductible. You will not be responsible for the balance.

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

Claim Filing Deadlines.

Medicare-Covered Services
For services or supplies covered by Medicare, **providers must submit claims within 12 months** from the date the services or supplies were received.

Services Covered Under the NMMIP Medicare Carve-Out Plan Only

For services that are **not covered by Medicare but are covered under the NMMIP Medicare Carve-Out Plan**, the following filing deadlines apply:

- **Network Providers:** Claims must be submitted **within 6 months** after the date services or supplies were received.
- **Non-Network Providers:** Claims must be submitted **within 12 months** after the date services or supplies were received.
- **Tribal Providers: Claims must be submitted within 24 months after the incurred date.**

Medicare also has time limits for filing claims. Contact the local Social Security Office for information on Medicare Hospital and medical insurance filing deadlines.

When you receive care from Providers, be sure to present both your Medicare and New Mexico Medical Insurance Policy identification cards. Also, please note the following.

Medicare-Covered Facility Services. All New Mexico Medicare-Participating Providers of Part A services, including skilled nursing facilities and Hospices, will submit claims directly to Medicare. To file claims, the facility must have the information from the identification cards issued to you by both Medicare and the Administrator. Even though Providers may file claims on your behalf, it is your responsibility to make sure that the claim is filed with the Administrator. A copy of the Medicare EOMB must be attached to the itemized bill submitted to the Administrator.

Medicare-Covered Professional Services. A claim for Physician and other professional Provider services must be filed first with Medicare Part B Medical Insurance. (All Providers must file claims for you to Medicare.) Even though Providers may file claims on your behalf, it is your responsibility to make sure that the claim is filed with the Administrator. A copy of the Medicare EOMB must be attached to the itemized bill submitted to the Administrator.

Services Not Covered by Medicare. An EOMB indicating Medicare denied the service is required on all claims except claims for services received outside the Medicare territorial limits, for services received from licensed professional clinical mental health counselors (L.P.C.C.) and licensed marriage and family therapists (L.M.F.T.), and for Acupuncture.

Services Outside Medicare Territorial Limits. You have health care coverage for services received inside and outside the Medicare territorial limits. Medicare defines Medicare territorial limits as the United States, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. This Policy may provide benefits for services outside the territorial limits of Medicare (they must be covered under the Policy, Medically Necessary, not excluded, and be prior approved when required). When services are received outside the Medicare territorial limits, you must pay for the services or supplies. Keep copies of your receipts and translate the language into English**.** File claims as you would for any other service not covered by Medicare.

To submit a claim for services received outside the Medicare territorial limits, you do not need an EOMB.

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.

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.

Medical/Surgical Claims. When Covered Services are received from 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

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.

Medicare-Covered Services. If Medicare pays the Provider directly, the Policy will generally also pay the Provider. If Medicare does not pay the Provider, the Policy will generally pay the Medicare beneficiary unless the beneficiary has agreed to an Assignment of Benefits with the Provider and proof of such assignment is submitted with the claim.

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 use 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 on 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 in order 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 Pharmacy claims, you pay the sum of the drug ingredient cost that exceeds the Network Allowed Amount, the dispensing fee that would be payable to a Participating Pharmacy, and any sales tax minus the applicable Copay.

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 Medicare Claims Reconsideration

When Medicare Part A or B denies part or all of a claim, you can obtain information from a local Social Security Office on how to request reconsideration or review of denied Medicare claims and a description of your right to appeal Medicare claims decisions. If Medicare makes an additional payment after reconsideration, file the new Explanation of Medicare Benefits to the Administrator for additional reimbursement under this Policy.

Request for Claims Reconsideration and Appeals NMMIP-Only Covered Services

Note: Services that are normally covered by Medicare but denied by Medicare are not subject to this appeals process.

This appeals process applies only to services covered exclusively under the New Mexico Medical Insurance Pool (NMMIP) Medicare Carve-out Plan.

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.

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.

Appeals are to be made in writing at the following address:

New Mexico Medical Insurance Pool
Attn: Appeals Department
Post Office Box 780548
San Antonio, TX 78278
Telephone number: (866) 306-1882

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 New Mexico Medical Insurance Pool 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 starts 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 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 to enroll in the Medicare Carveout option you must satisfy all of the following requirements:

- You must be and continue to be a resident of the state of New Mexico (a resident is any person who resides within the state of New Mexico in a place of permanent habitation).
- You must be under age 65.
- You must be enrolled in both Parts A and B of Medicare.
- You must not be eligible, either as the insured or as a dependent, for any health plan that provides coverage for comprehensive major medical or comprehensive Physician and Hospital services, other than Medicare Part A and Part B.

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

- You are not eligible for one or both Parts of Medicare.
- You are age 65 or older. (If you turn 65 while covered under the New Mexico Medical Insurance Carve-out Policy, you may continue your coverage as long as you remain

otherwise eligible.).

- You are eligible for coverage under a Group Health Plan or have Health Insurance coverage of any type (excluding Medicare), 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 contract.
- You have voluntarily terminated a New Mexico Medical Insurance Policy within the past 12 months.
- However, if you terminated a New Mexico Medical Insurance Policy 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 coverage.
- You are an inmate of a public institution or eligible for public programs for which medical care is provided.

Family members are not covered under the Policy program.

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 NMMIP.

Newborn and Adopted Children. Newborn and Adopted Children are not covered under this NMMIP Carve-Out Policy; however, they may be covered under the NMMIP EPO Policy for 31 days if you are an Enrollee of NMMIP. Please see NMMIP EPO Policy Book for full explanation of Newborn and Adopted Children benefits.
Your newborn child, 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. If a NMMIP Enrollee is the dependent child of another Policyholder/Enrollee and has their own child, the child of the dependent may qualify for automatic coverage but the dependent must switch to their own Policy and pay the additional premium for the newborn.

You must complete an application for regular (non-Carve-out) NMMIP coverage and submit it to the Administrator within 31 days of the birth, placement in the home, or legal adoption. The child is not eligible for coverage under the Carve-out Policy. In such cases, the child does not have to establish eligibility for NMMIP coverage and the newborn is covered at birth or, 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. **Note:** A child under age 18 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. **Please see NMMIP EPO Policy Book for full explanation of Newborn and Adopted Children eligibility requirements.**

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 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 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 the 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.

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 regulation 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. An appropriately licensed Provider with an organized staff of Physicians that meets all of the following criteria:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
- Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
- Does not provide Inpatient accommodations; *and*
- Is not a facility used primarily as an office or clinic for the private practice of a Physician or other Provider.

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.

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 abuse," which includes Alcoholism and Drug Abuse) may also be defined. There is 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 of the Policy's Covered Charge after the Deductible (if any) has been met.

Complications of Pregnancy. C-sections, ectopic pregnancies, toxemia, abruption placentae, miscarriages, 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.

Copayment. A Copay is the amount of money, a fixed dollar amount, that is paid by the Enrollee each time a particular services is used. There may be Copays on some services and other services may not have any Copays. The fixed-dollar amount (or in some cases, a percentage) of a Covered Charge that you pay for covered services and supplies.

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/ Allowed Amount. The Maximum Amount that will be allowed for a covered service, as determined by the Administrator, using a variety of pricing methods and based on generally accepted claim coding. Also See "Claims Payment Provisions" in *Section 6*.

Covered Services. Services or supplies that are listed in this Policy, including 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 amount that you must pay in a calendar year before this Policy pays benefits for all or part of your remaining Covered Charges incurred during the rest of the calendar year. Your individual Deductible amount is indicated on your NMMIP ID card.

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 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.

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 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). The Hospice Benefit Period must begin while the Enrollee is covered for these benefits, and coverage must be maintained throughout the Hospice Benefit Period.

Hospice Care. An alternative way of caring for Terminally Ill individuals 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 health institution offering facilities, beds, and continuous services 24 hours a day, 7 days a week. The Hospital must meet all licensing and certification requirements of local and state regulatory agencies. Services provided include:

- Diagnosis and treatment of illness, injury, deformity, abnormality, or pregnancy;
- Clinical laboratory, diagnostic x-ray, and definitive medical treatment provided by an organized medical staff within the institution; and
- Treatment facilities for Emergency and Surgical Services either within the institution or through a contractual arrangement with another licensed Hospital (These contracted services must be documented by a well-defined plan and related to community needs.).

A Hospital is not, other than incidentally, a Skilled Nursing Facility, nursing home, Custodial Care home, health resort, spa, or sanatorium; is not a place for rest, the aging, or the treatment of Mental Illness, Alcoholism, Drug Abuse, or pulmonary tuberculosis; ordinarily does not provide Hospice or rehabilitation care.

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.

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.

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).

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 appropriate state authority.

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

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.

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

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.

For services the Medicare does not cover, or if the amount exceeds Medicare limits/amounts but are eligible under this Plan, at the Plan Administrators sole discretion, and if applicable, the Maximum Allowable Charge will not exceed:

1. 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. 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 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 any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by the 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.

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, ordered by a Physician or other professional Provider, that are required for the treatment of an illness or injury.

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. The 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, Copays, and Deductible 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 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 Pharmacy. See "Provider," on the next page.

Participating Provider. See "Provider," on the next page.

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 or evidence of coverage, which explains the benefits, limitations, exclusions, terms, and conditions of your health coverage under NMMIP. Also referred to as a benefit booklet.

Practitioner. Any Physician, professional Provider, 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 of the healing arts may be a primary care Provider.

Note: A Practitioner will also include a Pharmacist (acting within the scope of licensure), and a Certified Diabetes Educator (C.D.E.).

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.

Prior Approval. A requirement that you or your Provider must obtain authorization from the Administrator before you are admitted as an Inpatient (Admission review approval) and before you receive certain types of services (other Prior Approvals).

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 duly licensed Hospital, Physician, or other professional Provider authorized to furnish health care services within the scope of licensure.

- **Health care facility.** An institution providing health care services, including a Hospital or other licensed Inpatient center, an ambulatory surgical or treatment center, 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.

- **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, telocobalt, and radioactive isotope treatment for malignant diseases and other medical conditions.

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.

Note: Although newborns are not covered under this Medicare Carve-out Policy, if you obtain

a regular (non-Carve-out) New Mexico Medical Insurance Policy the newborn's Covered Charges will be covered as specified above.

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. Note: 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;
- 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 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. A Specialist is a Physician who concentrates on medical activities in a particular specialty of medicine based on education and qualifications. A Specialist is not a general medicine Practitioner, internal medicine Practitioner, pediatrician, family practice Physician, obstetrician, gynecologist, mental health or substance use/Chemical Dependency Practitioner.

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 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 month or less, as certified in writing by the attending Physician.

Tertiary Care Facility. A Hospital unit that provides complete perinatal care (occurring in the period shortly before and after birth), and intensive care of intrapartum (occurring during childbirth or delivery) and perinatal high-risk patients. This Hospital unit also has responsibilities for coordination of transport, communication, 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.