



Sandia Total Health Program Program Summary

Revised: January 1, 2012

Blue Cross and Blue Shield of New Mexico

(Medical/Behavioral/HRA Services)

PayFlex Systems USA, Inc.

(subcontractor to BCBSNM for FSA Service)

Magellan Health Services (EAP Service)

Catalyst Rx (Prescription Drug Service)

Important

This Program Summary applies to employees and pre-Medicare retirees, survivors, and Long Term Disability Terminees effective January 1, 2012.

For more information on other benefit programs, refer to the *Sandia Health Benefits Plan for Employees Summary Plan Description* or the *Sandia Health Benefits Plan for Retirees Summary Plan Description*.

The Sandia Total Health Program is maintained at the discretion of Sandia and is not intended to create a contract of employment and does not change the at will employment relationship between you and Sandia. The Sandia Board of Directors (or designated representative) reserves the right to amend (in writing) any or all provisions of the Sandia Total Health Program, and to terminate (in writing) the Sandia Total Health Program at any time without prior notice, subject to applicable collective bargaining agreements.

The Sandia Total Health Program's terms cannot be modified by written or oral statements to you from human resources representatives or HBE or other Sandia personnel.



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Section 1. Introduction

This summary highlights healthcare benefits of the Sandia Total Health Program (“the Program”), a component of the Sandia Health Benefits Plan for Employees (ERISA Plan 540) and the Sandia Health Benefits Plan for Retirees (ERISA Plan 545). This Program Summary is part of the *Sandia Health Benefits Plan for Employees Summary Plan Description* or the *Sandia Health Benefits Plan for Retirees Summary Plan Description*. It contains important information about your Sandia healthcare benefits.

Certain capitalized words in this Program Summary have special meaning. These words have been defined in [Section 13, Definitions](#).

When the words “we,” “us,” and “our” are used in this document, we are referring to Sandia. When the words “you” and “your” are used throughout this document, we are referring to people who are Members as defined in [Section 13, Definitions](#).

Many sections of this Program Summary are related to other sections of the Program Summary and to information contained in the *Sandia Health Benefits Plan for Employees Summary Plan Description* or the *Sandia Health Benefits Plan for Retirees Summary Plan Document*. You will not have all of the information you need by reading only one section of one booklet.

Refer to the *Sandia Health Benefits Plan for Employees Summary Plan Description* or the *Sandia Health Benefits Plan for Retirees Summary Plan Description* for information about eligibility, enrollment, disenrollment, premiums, termination, coordination of benefits, subrogation, and reimbursement rights, when coverage ends, continuation of coverage provisions, and your rights under the Employee Retirement Income Security Act of 1974 (ERISA) and the Affordable Care Act.

To receive a paper copy of this Program Summary, other Program Summaries, the *Sandia Health Benefits Plan for Employees Summary Plan Description*, or the *Sandia Health Benefits Plan for Retirees Summary Plan Description*, contact Sandia HBE Customer Service at 505-844-HBES (4237) or email hbesupport@mailca.custhelp.com. These documents are also available electronically at hbe.sandia.gov.

Since these documents will continue to be updated, we recommend that you check back on a regular basis for the most recent version.

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Section 2. Summary of Changes

The following are changes effective January 1, 2012:

- FSA First, HRA Second - Medical and prescription drug program claims' patient portion is paid from the Health Care Flexible Spending Account (if applicable) first and second from your Health Reimbursement Account (HRA).
- The Program will cover one (1) hearing aid per hearing-impaired ear every thirty-six (36) months for dependent children under the age of 21. This coverage shall include fitting and dispensing services, including providing ear molds as necessary to maintain optimal fit, provided by a licensed audiologist, a hearing aid dispenser or a physician. Prior Authorization is required.
- The Program has added a smaller network of providers known as Sandia Health Partners Network (SHPN), which may reduce your healthcare expenses through lower deductibles, co-insurance and out-of-pocket maximums when you use these providers.
- Employee payroll contributions have been reduced.
- Employees can earn additional HRA funds through the Virgin HealthMiles program.
- Spouses and same gender domestic partners must complete a health assessment by going to healthassessment.sandia.gov in 2012 in order to earn their \$250 HRA funds for 2013.
- Spouses and same gender domestic partners can earn up to an additional \$250 in HRA funds through the Virgin HealthMiles program in 2012 for 2013.
- Employees living in California will be allowed three Employee Assistance Program (EAP) visits every six months, instead of eight per year.

The following are clarifications to this Program Summary effective January 1, 2012:

- The Virgin HealthMiles Program is not available to retirees, survivors, or Long Term Disability Terminées.
- The Coordination of Benefits Section has been expanded to reflect policies.

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Section 3. Accessing Care

This section describes how to access medical/surgical and behavioral health care under the Sandia Health Partner Network (SHPN), in-network and out-of-network options, Preauthorization requirements, accessing non-Emergency or non-Urgent Care while away from home, the Employee Assistance Program, and other general information. For information, refer to [Section 7, Prescription Drug Program](#).

Sandia Health Partner Network, In-Network, and Out-of-Network Options

The medical plan portion of the Sandia Total Health Program provides you three options for accessing care: SHPN, in-network, and out-of-network. You receive a higher level of benefits under the SHPN option than under the in-network option, while you will receive the lowest level of benefits when you use out-of-network providers.

Members that reside in the Bernalillo, Sandoval, Tarrant, and Valencia counties of New Mexico have out-of-network coverage under the medical plan for Covered Health Services from Presbyterian facilities and providers. Members residing outside these four counties but residing within New Mexico can visit Presbyterian facilities and providers and receive in-network benefits for Covered Health Services.

Sandia Health Partner Network (SHPN) Option

The Sandia HPN (SHPN) in-network option provides you access to a smaller custom network of physicians, facilities and suppliers for a better benefit and lower out-of-pocket expenses for you and your dependents. To find a listing of SHPN providers, go to sandia.hbe.gov or www.sandiahpn.com.

ABQ Health Partners, one of the physician groups under the Sandia HPN, provides a dedicated one-call hotline for Sandia – **505-262-7100**. By calling this number, as the main point of contact for Sandians, you will have direct access to a dedicated representative to help navigate you to one of the ABQ Health Partner providers and to assist you with any of their healthcare services.

The advantages of using the Sandia HPN network option include:

- Lower Coinsurance for you to pay (e.g., 10% versus 20% (in network) or 40% (out-of-network))
- Lower Out-of-Pocket Maximums (e.g., \$1,500 versus \$2,250 (in network) or \$6,000 (out-of-network) per Member which includes Deductible and Coinsurance amounts paid by you)
- No balance billing by the provider
- Certain preventive care services covered at 100%
- Generally, no claims to file
- Auto-pay for the patient responsibility is sent to your provider from your FSA, if enrolled, and then your HRA.
- RAPS providers' (radiology, anesthesiology, and pathology) Covered Health Services while you are a patient at a Lovelace facility will be considered at the Sandia HPN higher benefit level.

If your provider participates in the SHPN, he or she will obtain Preauthorization from BCBSNM (or from the BCBSNM Behavioral Health Unit, when applicable) in the following circumstances):

- When recommending any nonemergency admission, readmission or transfer
- When a covered newborn stays in the hospital longer than the mother
- Before providing or recommending services listed later in this section.

Note: You should always verify that Preauthorization has been requested by your Preferred Provider for these services.

In-Network Option

Outside the Sandia HPN, there is a broader in-network option that provides you access to physicians, facilities, and suppliers who are contracted as “Preferred Providers” with BCBSNM or other BCBS Plans to provide their services at negotiated fees. No referrals are required. Some procedures may require Preauthorization that you are responsible for asking your physicians or treatment facility to obtain from BCBSNM. For the most updated in-network provider listings in your area, contact BCBSNM Customer Service at 877-498-7652 or access the national BCBS website at www.bcbs.com.

The advantages of using the in-network option include:

- Lower Coinsurance for you to pay (e.g., 20% versus 40% (out-of-network))
- Lower Out-of-Pocket Maximums (e.g., \$2,250 versus \$6,000 (out-of-network) per Member which includes Deductible and Coinsurance amounts paid by you)
- No balance billing by the provider
- Certain preventive care services covered at 100%
- Generally, no claims to file
- Auto-pay for the patient responsibility is sent to your provider from your FSA, if enrolled, and then your HRA.
- RAPS providers’ (radiology, anesthesiology, and pathology) Covered Health Services while you are a patient in an in-network hospital will be considered at the in-network benefit level.

BCBSNM Preferred Providers

If the attending physician is a Preferred Provider that contracts directly with BCBSNM, obtaining Preauthorization is not your responsibility – it is the provider’s. Preferred Providers contracting with BCBSNM must obtain Preauthorization from BCBSNM (or from the BCBSNM Behavioral Health Unit, when applicable) in the following circumstances:

- When recommending any nonemergency admission, readmission, or transfer
- When a covered newborn stays in the hospital longer than the mother
- Before providing or recommending services listed later in this section.

You are not responsible for any penalties that apply when a provider who contracts directly with BCBSNM fails to obtain any needed Preauthorization.

Preferred Providers Outside New Mexico

If any Preferred Provider outside New Mexico that does not contract directly with BCBSNM recommends an admission or a service that requires Preauthorization, the provider is not obligated to obtain the Preauthorization for you. In such cases, it is **your responsibility** to ensure that Preauthorization is obtained. If you do not, benefits may be reduced or denied and the unpaid portion will be your responsibility. The provider may call on your behalf, but it is your responsibility to ensure that BCBSNM (or their Behavioral Health Unit, when applicable) is called.

Out-of-Network Option

The out-of-network option offers a lower level of benefit, but enables you to get Covered Health Services from licensed, eligible providers outside the BCBS Association PPO network. No referrals are required. You are responsible for Deductibles, Coinsurance, and amounts exceeding Medicare-Approved Amounts. You are also responsible for filing all claims not filed by the provider.

If you are admitted to a hospital that is not in the network on an Emergency basis and services are covered, in-network benefits will be paid until you are stabilized. Once stabilized, you must be moved to a network hospital to continue in-network benefits. You may elect to remain in the out-of-network hospital and receive out-of-network benefits, as long as BCBSNM confirms the treatment to be Medically Necessary.

If any provider outside New Mexico or any Nonpreferred Provider recommends an admission or a service that requires Preauthorization, the provider is not obligated to obtain the Preauthorization for you. In such cases, it is **your responsibility** to ensure that Preauthorization is obtained. If you do not, benefits may be reduced or denied and the unpaid portion will be your responsibility. The provider may call on your behalf, but it is your responsibility to ensure that BCBSNM (or their Behavioral Health Unit, when applicable) is called.

Note: If you do not have access to any BCBS PPO Network providers within a 30-mile radius of your home, you will be covered under the in-network level of benefits under the Out-of-Area Plan. When you access providers, BCBS determines who will be placed in the Out-of-Area Plan. Reimbursement in such cases is based on billed charges.

Preauthorization Requirements for Medical Services

When you choose to receive certain services (listed below), you are responsible for notifying BCBSNM before you receive these services, otherwise coverage may be denied or reduced. BCBSNM ensures you and/or your covered family members receive the most appropriate and Cost-Effective services available.

IMPORTANT: Although a service may not be on the list of services needing Preauthorization, in order to ensure that services and procedures will be covered, you are encouraged to obtain a predetermination of benefits from BCBSNM.

Inpatient Admissions

You or your provider must request Preauthorization from BCBSNM for:

- Non-emergency admissions: at least five business days before admission
- Maternity delivery admissions: within 48 hours of vaginal delivery (96 hours for a C-section)

Note: If delivery is planned to be at home but requires admission to the hospital, notification is required.

- Emergency admissions: within two business days, or as soon as reasonably possible

The first \$300 of Covered Charges will not be considered covered if you, your authorized representative, or your provider does not contact BCBSNM within the applicable time frames for inpatient services. An exception to this requirement would be, if you have primary health care coverage for these services under Medicare or another non-Sandia health care program and that other coverage did not deny services as being ineligible for any reason.

The Preauthorization number for inpatient care is 800-325-8334.

IMPORTANT: Providers that contract with Blue Cross Blue Shield Plans other than BCBSNM are not familiar with the Preauthorization requirements of the Sandia Total Health Program. You are responsible for being aware of this medical plan's Preauthorization requirements.

Outpatient and Other Medical Services

Other nonemergency services (whether in-network (including Sandia HPN) or out-of-network) that require BCBSNM Preauthorization are listed below. Your benefits for services listed below, if determined to be covered and Medically Necessary will be denied if Preauthorization is not received (except that the penalty for failure to obtain Preauthorization for Medically Necessary air ambulance is a \$300 reduction in benefits).

- Air ambulance services (except in an Emergency)
- Cardiac and pulmonary rehabilitation
- Cardiac CT scans
- Dental services stemming from Illness or Injury
- Durable Medical Equipment for items with a purchase or cumulative rental value of \$1,000 or more
 - Insulin pumps and continuous glucose monitoring systems, regardless of cost
- Enteral nutrition/nutritional supplements
- Genetic testing (including breast cancer genetic testing (BRACA))

- Hearing aids/exams and/or cochlear implants
- Home dialysis
- Home health care
- Hospice care
- Infertility treatment
- Obesity surgery
- Positron emission tomography (PET) scans
- Reconstructive Procedures
- Short-term rehabilitation (includes inpatient rehabilitation facility, skilled nursing facility, Outpatient physical, occupational and speech therapy)
- Sleep disorder studies
- Transplant services, including pre-transplant evaluation
 - Travel and lodging related to a service eligible for such coverage under the Blue Distinction program (explained later in this section under [Provider Networks](#).)

Preauthorization requirements apply to both in-network (including Sandia HPN) and out-of-network services, providers, and facilities. Preauthorization for the above-mentioned medical care services can be requested by calling BCBSNM at 800-325-8334.

Predetermination

Although you are not required to obtain Preauthorization for the following procedures, you are encouraged to notify BCBSNM Customer Service prior to receiving the following services in order for BCBSNM Customer Service to determine if they are covered healthcare services:

- Blepharoplasty (surgery to correct eyelids)
- Vein stripping, ligation, VNUS® Closure, and sclerotherapy (an injection of a chemical to treat varicose veins)
- Any surgery for the diagnosis “ptosis”
- Bunionectomy
- Carpal tunnel repair
- Cholecystectomy
- Intradiscal electrothermal annuloplasty (IDET)
- Sclerotherapy
- Septoplasty
- Uvulopalatopharyngoplasty (UPPP)
- Outpatient hysterectomy

These services will not be covered when determined to be Cosmetic Procedures or not Medically Necessary and you may be responsible for the entire cost.

Preauthorization for Behavioral Health

Preauthorization for behavioral health (mental health or Chemical Dependency) is required before receiving inpatient and Outpatient services whether in-network (including Sandia HPN) or out-of-network.

If preauthorization is not obtained, a \$300 penalty or a denial of claims will occur if you, a family member, or your provider does not contact the BCBSNM Behavioral Health Unit (BHU) within the applicable time frames for the inpatient services listed below. An exception to this requirement would be if you have primary health care coverage for these services under Medicare or another non-Sandia healthcare program.

- Inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility)
- Intensive Outpatient Program treatment
- Psychological testing.

You or your provider must request Preauthorization from BCBSNM:

- For non-Emergency admissions: at least five business days before admission
- For Emergency admissions: within two business days following admission, or as soon as is reasonably possible

Most of the time the Sandia HPN or in-network provider will obtain Preauthorization, however, it is ultimately your responsibility to call the BHU at 888-898-0070 to initiate the review process whether you or your covered family member are using in- or out-of-network services or facilities.

Even when you are not required to call for Preauthorization, please call the BCBSNM BHU at the phone number listed on the back of your ID card for predetermination of Outpatient service benefits. The BHU will coordinate covered services with a network provider near you. **If you do not call, benefits for covered services may be reduced or denied.**

Your provider may be asked to submit clinical information in order to obtain Preauthorization for the Outpatient services you are planning to receive. Services may be authorized or may be denied based on the clinical information received. (*Clinical information* is information based on actual observation and treatment of a particular patient.)

If Preauthorization is not obtained before you receive Outpatient services, your claims may be denied as being **not Medically Necessary**. In such cases, **you may be responsible for all charges**. Therefore, you should make sure that you (or your provider) have obtained Preauthorization when required or predetermination of benefits when not required *before* you start Outpatient treatment.

IMPORTANT: If you are planning on using an out-of-network provider for inpatient or Partial Hospitalization/Day treatments, Residential Treatment Facility, or Intensive Outpatient Program, remember that you must call the BCBSNM Behavioral Health Unit and get Preauthorization. Please note that out-of-network providers for these services may require up-front payment and may not cooperate with the BCBSNM Behavioral Health Unit regarding the Preauthorization process; therefore, your coverage may be reduced or denied.

How Preauthorization Works

When you or your treating healthcare professional call for a Preauthorization, the BCBSNM health services staff will ask for information about your medical condition, the proposed treatment plan, and the estimated length of stay (if you are being admitted). The Health Services staff will evaluate the information and notify the attending physician and the facility if benefits for the proposed hospitalization or other service are approved. If the admission or other service is not authorized, you may appeal the decision. For more information, refer to [Section 11, How to File an Appeal](#).

BCBSNM initially determines whether the service is or is not Medically Necessary. This standard review is completed within 15 working days (an expedited review is completed within 24 hours).

Predetermination of Benefits

IMPORTANT: Just because a service or procedure does not require Preauthorization does not mean it is covered. In order to ensure that services and procedures are covered, you are encouraged to obtain a predetermination of benefits as described below.

The Sandia Total Health Program covers a wide range of medical care treatments and procedures. However, medical treatments that are Investigational, Experimental, or Unproven to be medically effective are **not** covered by the Sandia Total Health Program. Contact BCBSNM before incurring charges that may not be covered.

In addition, some services may be covered only under certain circumstances and/or may be limited in scope, including but not limited to temporomandibular joint (TMJ) syndrome, procedures that may have a cosmetic effect, and unproven therapies. Predetermination of benefits is recommended to help you determine your Out-of-Pocket Maximum expense. Also, some services require Preauthorization as described earlier in this section; therefore, when in doubt, it is important that you call BCBSNM for information on benefits. If you have any questions about how to obtain a predetermination of benefits, contact BCBSNM Customer Service at 877-498-7652.

Provider Networks

Sandia HPN

Your Sandia Total Health Program provides a new higher benefit level when accessing a Sandia HPN provider. The Sandia HPN is an exclusive network of Preferred Providers that have contracted with Imagine Health for Sandia in the greater Albuquerque area. To access the Sandia HPN level of benefits you must use a Lovelace facility for hospital services as well selecting a physician from ABQ Health Partners or one of the additional 250 community physicians included in the Sandia HPN.

The Sandia HPN network of providers are contracted by Imagine Health for Sandia. Imagine Health is responsible for maintaining the provider network. Neither Sandia, Imagine Health nor BCBSNM can guarantee quality of care. Employees always have the choice of what services they receive and who provides their healthcare regardless of what the Sandia Total Health covers or pays.

In the greater Albuquerque area, the physicians, hospitals, and other health care providers/facilities participating in the Sandia HPN network are affiliated with the Lovelace Health System, ABQ Health Partners and direct agreements with approximately 250 additional community providers including behavioral health, laboratories, acupuncture, chiropractors, etc.

Blue Cross Blue Shield PPO

Your Sandia Total Health Program provides your benefits under agreement with an exclusive network of Preferred Providers that contract with Blue Cross Blue Shield (BCBS) Plans throughout the United States and around the world. When you need nonemergency healthcare you must choose a provider from the national BCBS Preferred Provider Option (PPO) network to receive benefits at the in-network benefit level. You may access PPO providers in most areas nationwide.

The BCBS PPO network providers are contracted by BCBS Plans. They are responsible for maintaining their provider networks. Neither Sandia nor BCBSNM nor Health Care Service Corporation (HCSC) can guarantee quality of care. Employees always have the choice of what services they receive and who provides their healthcare regardless of what the Sandia Total Health covers or pays.

In the greater Albuquerque area, the physicians, hospitals, and other health care providers/facilities participating in the BCBSNM PPO network are affiliated with Lovelace Health System, the Heart Hospital of New Mexico, and the University of New Mexico hospitals. In some cases, BCBSNM has established direct contracts with other providers. The PPO providers work with BCBSNM to organize an effective and efficient health care delivery system. Outside the greater Albuquerque area, BCBSNM has also contracted with providers in New Mexico to offer in-network care.

Out-of-Area Plan

If you do not have access to any BCBS PPO in-network providers within a 30-mile radius of your home, you will be covered under the in-network level of benefits under the Out-of-Area Plan. BCBS determines who will be placed in the Out-of-Area Plan. Reimbursement of covered out-of-network care is based on billed charges in such cases. You will be responsible for obtaining preauthorization and for filing all claims for medical plan services received under the Out-of-Area Plan from out-of-network providers.

Network Gap Exception

The Sandia Total Health Program has a Network Gap Exception provision for Covered Health Services. Under this provision, if there are no in-network providers in the required specialty within a 30-mile radius from your home, contact BCBSNM prior to receiving the service to request in-network benefits for Covered Health Services provided by an out-of-network provider. You will be responsible for obtaining preauthorization and for filing all claims for medical plan services received from out-of-network providers.

In northern California, the providers, specialty care physicians, hospitals, and other health care providers/facilities participating in the BCBSCA PPO network are affiliated with multiple facilities. In other areas, BCBS Plans contract with providers all across the United States.

Transition of Care/Special Circumstances

If your health care provider leaves the BCBSNM provider network (for reasons other than medical competence or professional behavior) or if you are a new Member and your provider is not in the BCBS Plans PPO network when you enroll, BCBSNM may authorize you to continue an ongoing course of treatment with the provider for a transitional period of time of not less than 90 days during which that provider's covered services will be eligible for benefits. (If necessary and ordered by the treating provider, BCBSNM may also authorize transitional care from other non-network providers.) The period will be sufficient to permit coordinated transition planning consistent with your condition and needs. Special provisions may apply if the required transitional period exceeds 90 days. If you have entered the third trimester of pregnancy at the effective date of enrollment, the transitional period will include post-partum care directly related to the delivery. Call BCBSNM Customer Service for more details at 877-498-7652.

In addition, you may be eligible for in-network benefits for a previously authorized infertility treatment currently in progress with an out-of-network provider. Also, transplant patients and patients who are on a waiting list to receive an organ or bone marrow, may be eligible for in-network benefits for covered services related to a recent bone marrow or organ transplant received from an out-of-network provider. Call BCBSNM Customer Service for more details at 877-498-7652.

Note: If your provider is interested in becoming an in-network provider, the provider can call BCBSNM Customer Service to inquire about the process.

Finding Network Providers

Provider directories list providers, facilities, and auxiliary services that have contracted to participate in the Sandia HPN or the BCBSNM Preferred Provider Option (PPO) network. You can select your physician from family care physicians, internists, pediatricians, and other Specialists. Remember, by selecting a Sandia PHN provider, you will have a better benefit and lower out of pocket expenses.

To obtain a hard copy PPO provider directory, at no cost to you, for any state within the United States, you can contact BCBSNM Customer Service at 877-498-7652. To obtain a hard copy Sandia HPN provider directory, you can go to hbe.sandia.gov. Directories are current as of the date printed. The provider networks change often. For the most current information, it is recommended that you register on to the BCBSNM website and use the online provider search at www.bcbsnm.com/sandia for a PPO provider for an up-to-date provider listing. For the most up-to-date Sandia HPN provider listing, go to www.sandiahpn.com.

Provider Searches Online

To search for a Sandia HPN provider, go to www.sandiahpn.com. To search for a PPO provider online, go to www.bcbsnm.com/sandia. All that is needed is access to the Internet. Register at this website and create your own username and password (have your ID card handy). You will need your group and Member ID numbers to fill in the information on the Blue Access Member (BAM) registration page.

- Log on (you will need to register)
- Search for physicians and facilities by street address, ZIP Code, or provider name
- Select **Search**
- To find a hospital, select **Hospital** under the Specialty Categories
- To find behavioral health providers, select **Behavioral Health** under the Specialty Categories.

If you are outside New Mexico

The BlueCard Program provides access to a nationwide network of providers. In most cases, when you travel or live outside the BCBSNM services area, you can take advantage of savings that the local Blue Plan has negotiated with doctors and hospitals in the area. You will receive in-network benefits for Covered Health Services received from Preferred Providers throughout the United States and around the world.

Take your BCBSNM Member ID card while you are on travel. Your ID card is required for providers to determine your medical coverage. The back of your BCBSNM Member ID card has the toll-free numbers available to you for assistance concerning your medical coverage and Preauthorizations.

1. Always carry your current BCBSNM Member ID card.
2. In an emergency, go directly to the nearest hospital.
3. To find doctors and hospitals nearby, call BlueCard Access[®] at 800-810-2583 or visit the BlueCard Doctor and Hospital Finder at www.bcbs.com. The Web site includes maps and directions to a provider's location.
4. Call BCBSNM for Preauthorization, if necessary. The phone number is on the back of your Member ID card. This Preauthorization number is different from the BlueCard Access number mentioned above.
5. When you arrive at the Preferred Provider's office or at the Preferred Provider hospital, show the provider your BCBSNM Member ID card.

After you receive care from a Blue Plan PPO network provider, you should:

- Not have to complete any claims forms
- Not have to pay up front for medical services, except for the usual Out-of-Pocket Maximum expenses (noncovered services, Deductible, or Coinsurance)
- Receive an Explanation of Benefits (EOB) from BCBSNM.

Traveling Outside the United States

1. Verify your benefits with BCBSNM before leaving the United States.
2. Always carry your current BCBSNM Member ID card.
3. In an emergency, go directly to the nearest hospital.
4. Call the BlueCard Worldwide Service Center at 800-810-2583 or call collect: 1-804-673-1177. BlueCard Worldwide is available 24 hours a day, 7 days a week for information on doctors, hospitals, and other health care professionals and for medical assistance services around the world. An assistance coordinator, in conjunction with a medical professional, will help arrange a doctor's appointment or hospitalization, if necessary.
5. If you need to be hospitalized, call BCBSNM for Preauthorization. You can find the number on the back of your Member ID card. **Note:** The number for Preauthorization is different from the provider locator number.
6. Pay for any inpatient, Outpatient, or other professional medical care received while traveling outside the United States and as soon as you return home, file your claim.
7. To submit a claim, complete an International Claim Form and send it to the address on the BCBS International Claim Form. You may find the claim form on BCBSNM's website www.bcbsnm.com/sandia.

Blue Distinction Center for Specialty Care Programs

Blue Distinction® is a designation awarded by the Blue Cross and Blue Shield companies to medical facilities that have demonstrated expertise in delivering quality healthcare. The designation is based on rigorous, evidence-based, objective selection criteria established in collaboration with expert physicians' and medical organization's recommendations. Its goal is to help consumers find quality specialty care on a consistent basis, while enabling and encouraging healthcare professionals to improve the overall quality and delivery of healthcare nationwide.

At the core of the Blue Distinction program are the Blue Distinction Centers for Specialty Care®, facilities that BCBS recognizes for their distinguished clinical care and processes in areas such as:

- Bariatric Surgery
- Cardiac Care
- Complex and Rare Cancers
- Knee and Hip Replacement
- Spine Surgery
- Transplants

You are not required to use a Blue Distinction Center for treatment of the above-mentioned conditions. However, through the Blue Distinction programs you may be eligible for travel and lodging benefits.

IMPORTANT: Preauthorization must be requested from BCBSNM before you travel to a Blue Distinction center for cardiac care, cancer, or transplants. If authorized, a BCBSNM case manager will be assigned to you (the covered patient) and, in the case of a transplant, you must contact the case manager with the results of the evaluation.

You must ensure that Preauthorization for the actual admission is received. If Preauthorization is not received, benefits may be denied or reduced by \$300.

For more information on the Blue Distinction program or to find a specialty care facility go to: www.bcbs.com/innovations/bluedistinction.

You may be referred by a physician to a Blue Distinction Center or you may contact the Health Services department at 800-325-8334 (select "Sandia" option #3 from the menu) if you have questions about this program. The Care Coordinator will help you find treatment resources using the Blue Distinction Center, facilitate an introduction to the case manager at the facility, and continue to follow your progress and care throughout the course of treatment.

IMPORTANT: For travel and lodging services to be covered, the patient must be receiving covered cancer, transplant, or cardiac care services at a designated facility through a Blue Distinction Center for Specialty Care Program.

The Sandia Total Health Program covers Preauthorized expenses for travel and lodging related to a covered transplant, cancer treatment, or heart condition treatment as follows:

- Transportation of the Member (covered patient) and one companion who is traveling on the same day(s) to and/or from the site of the treatment center
- Expenses for lodging for the patient (while not a hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to \$50 per day for the patient or up to \$100 per day for the patient plus one companion
- If the patient is an enrolled minor child (i.e., under the age of 18), the transportation expenses of two companions will be covered, and lodging expenses will be reimbursed at a per diem rate of up to \$100 per day

Travel and lodging expenses are only available if the covered patient lives more than 50 miles from the designated Blue Distinction Centers for Specialty Care facility that is being accessed for covered cancer, transplant, or cardiac care services through the Blue Distinction program. BCBSNM must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- Airfare at coach rate
- Taxi or ground transportation and/or
- Mileage reimbursement at the IRS rate for the most direct route between the patient's home and designated Blue Distinction Centers for Specialty Care facility

A combined overall maximum benefit of \$10,000 per covered recipient applies for all travel and lodging expenses reimbursed under this program in connection with all treatments during the entire period that recipient is covered under this provision of the medical plan.

24/7 Nurseline

Questions about health can come up at any time, which is why it is important to have easy access to a trusted source of information and support 24 hours every day. With BCBSNM 24/7 Nurseline, you have such a source – available through telephone conversations, the Internet, or informational recorded messages.

BCBSNM's 24/7 Nurseline provides you with a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week, for routine or urgent health concerns. Call 800-973-6329 to learn more about:

- A recent diagnosis
- A minor Illness or Injury
- Men's, women's, and children's wellness
- How to take prescription drugs safely
- What questions to ask your doctor before a visit
- For help understanding your test results
- Information that can help you decide when the Emergency room, Urgent Care, a doctor visit, or self-care is appropriate

IMPORTANT: If you have a Medical Emergency, call 911.

- Self-care tips and treatment options
- Healthy living habits
- Any other health related topic

Nurseline Audio Health Library

BCBSNM's Nurseline gives you another convenient way to access health information through informational recorded messages. Call 800-973-6329 to listen to one of the Health Information Library's over 1,100 recorded messages.

Special Beginnings Maternity Program

Members must enroll in Special Beginnings® to participate in the full program. Call 888-421-7781 within the first trimester of pregnancy. Members who enroll in the program will receive:

- 24-hour, toll-free phone access and support
- Ongoing personal communication with program staff
- Educational health information covering pregnancy and infant care topics
- A pregnancy website with useful information and tools
- Safe Beginnings – discounts available for baby-related products.

Case Management Program

When BCBSNM helps you, your doctor, and other providers for major services, it is called “case management.” When you have a need for many long-term services or services for more than one condition, BCBSNM case management for medical health care uses a team of medical social workers and nurses (case managers) to help you make sure you are getting the help you need. Case managers are there to help if you:

- Have special health care needs
- Need help with a lot of different appointments or getting community services not covered by this program
- Are going to have a transplant or another serious operation
- Have a high-risk pregnancy or having problems with your pregnancy

Case managers work closely with your doctor to develop a care plan, which will help meet your personal medical needs.

Care Coordination for Special Health Care Needs

Some Members need extra help with their healthcare, may have long-term health problems and need more health care services than most Members, and/or may have physical or mental health problems that limit their ability to function. BCBSNM has programs to help Members with special health care needs, whether at home or in the hospital. For example, if you have special health care needs, the Preauthorization you receive for equipment and medical supplies may be valid for longer than usual so that your doctor doesn't have to order them so often for you.

If you believe you or your covered family member has special health care needs, please call a BCBSNM case manager, who can provide you a list of resources to help you with special needs. BCBSNM also provides education for Members with special health care needs and their care givers. Programs include dealing with stress and information to help you and your family cope with a chronic illness.

If you have special needs, care coordination helps you by:

- Assigning a person at BCBSNM who is responsible for coordinating your healthcare services
- Making sure you have access to providers who are experts for Members with special needs
- Helping you schedule services for complex care, finding community resources such as the local food bank, housing, etc., and helping you get prepared in case of an emergency
- Helping with coordinating health services between doctors in the network as well as facilities in the Blue Distinction programs for cancer treatment and transplants
- Making sure case management is provided when needed

You may call BCBSNM case management at 800-325-8334 (select "Sandia" option #3 from the menu).

Disease Management Program

The disease management program's goal is to assist Members with chronic health conditions by providing resources and education designed to improve health status and quality of life. Blue Care Advisors (credentialed nurses) are able to customize the intervention based on each Member's unique needs. Interventions include written education, automated telephone messages, web-based support, tools for self-management, monitoring tools and, when appropriate, one-on-one telephonic coaching and education.

This disease management program is a voluntary program that helps you manage chronic conditions such as:

- Asthma
- Diabetes
- Hypertension
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease (CAD)

HealthCare Fraud Information

Healthcare and insurance fraud results in cost increases for healthcare plans. You can help by:

- Being wary of offers to waive copays, coinsurance, and Deductibles. These costs are passed on to you eventually.
- Being wary of mobile health testing labs. Ask what your health care insurance will be charged for the tests.
- Reviewing the bills from your providers and the Explanation of Benefits (EOB) form you receive from BCBSNM. Verify that services for all charges were received. If there are any discrepancies, call BCBSNM Customer Service.
- Being very cautious about giving information about your health care insurance over the phone.

If you suspect fraud, contact the BCBSNM Fraud Hotline at 888-841-7998.

Employee Assistance Program

Magellan Health Services is the administrator of the offsite Employee Assistance Program for Sandia Total Health Program Members. Short-term counseling services provided under the Employee Assistance Program (EAP) include help with all types of life issues such as parenting or relationship issues, personal improvement, work issues, emotional issues, and stress. The EAP provides assessments, referrals, and follow-up to you if you are experiencing impairment from personal concerns. Your EAP also provides online tools and resources such as a comprehensive library of articles, screening and self-assessment tools, tip sheets, and personalized improvement plans. The EAP services are provided to you at no additional cost.

Accessing EAP Services

For help identifying an in-network EAP counselor, contact Magellan at 800-424-0320 or visit www.magellanhealth.com/member. You will create your own username and password. After registration, you can locate a provider by zip code and distance in miles from your home, office, or any other start location. The Provider Search will list how many providers were found according to your search criteria. Providers for the Employee Assistance Program include therapists, social workers, and psychologists.

You may click **View detail** under each provider to view the provider's languages spoken, ages treated, and their specialties.

EAP Services and Preauthorization Requirements

Contact Magellan Health Services at 800-424-0320 to receive Preauthorization for EAP services. Your EAP benefit allows up to eight visits per calendar year (California employees are eligible for up to three EAP visits every six months) to an offsite, in-network EAP provider at no cost to you. You are responsible for contacting Magellan health Services prior to receiving any EAP services.

Note: Retirees, survivors, and LTD terminees and their covered dependents are not eligible for EAP benefits.

Confidentiality

EAP counseling services are confidential within the limitations imposed by state and federal law and regulations. When you visit an EAP Counselor for the first time, confidentiality is described in more detail.

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Section 4. Deductibles, Coinsurance, Out-of-Pocket Maximums, and Lifetime Maximums

This section summarizes the annual Deductibles and Out-of-Pocket Maximums, as well as any coinsurance that applies to the Sandia HPN, in-network option and the out-of-network option. In addition, this section describes any lifetime maximums under the Sandia Total Health Program.

Note: If you do not have access to any BCBS PPO Network providers within a 30-mile radius of your home, you will be covered under the in-network level of benefits under the Out-of-Area Plan. When you access providers, BCBS determines who will be placed in the Out-of-Area Plan. Reimbursement in such cases is based on billed charges.

Deductibles

This section describes your Deductibles. You must first pay the annual Deductible before the Sandia Total Health Program begins to pay for Covered Health Services. When you meet the full Deductible amount, the Sandia Total Health Program begins to pay for Covered Charges at the applicable Coinsurance amount. Deductibles are not prorated for mid-year enrollments.

If you retire and are pre-Medicare, and retire mid-year, any amounts applied towards your deductibles under your employee coverage will transfer to your retiree coverage.

If you change medical plans mid-year (e.g. you move from the Kaiser Sandia Total Health to this Program), any amounts applied towards your deductible under the Kaiser STH program will be applied to this program; however, you must contact Kaiser to have your deductible amount transferred.

If you are dual Sandians and you switch coverage mid-year due to a mid-year qualifying event, any amounts applied towards deductibles will transfer (e.g. you marry another Sandian and you change your coverage to be enrolled under your spouse, any amounts applied towards your deductible, as a Primary Covered Member, will be applied towards your dependent deductible under this program). You must contact your former administrator to have your deductible amount transferred.

Amounts above the Medicare-Approved Amount, charges not covered by the Sandia Total Health Program, prescription drug Coinsurance and charges incurred because of failure to obtain required Preauthorization do not apply toward the Deductible.

Annual Deductibles		
Sandia HPN In-Network	BCBS PPO In-Network	Out-of-Network
\$500 Primary Covered Member Only	\$750 Primary Covered Member Only	\$2,000 Primary Covered Member Only
\$1,000 Primary Covered Member + Spouse or + Child(ren)*	\$1,500 Primary Covered Member + Spouse or + Child(ren)*	\$4,000 Primary Covered Member + Spouse or + Child(ren)*
\$1,500 Primary Covered Member + Spouse + Child(ren)* (also referred to as family)	\$2,250 Primary Covered Member + Spouse + Child(ren)* (also referred to as family)	\$6,000 Primary Covered Member + Spouse + Child(ren)* (also referred to as family)
* Spouse or same-gender domestic partner/child(ren) for employees.		

IMPORTANT: The Deductibles cross-apply between the Sandia HPN and In-Network only. The Deductibles do not cross-apply between in-network and out-of-network and Sandia HPN and out-of-network. BCBSNM will notify you via the Explanation of Benefits form when the Deductible has been reached.

Each family member may contribute toward the family Deductible based on usage. However, contribution maximums are limited to the individual Deductible amount.

After the total combined Deductible amount for an entire family reaches three times the individual Deductible amount, the family Deductible is satisfied. No more than the individual Deductible amount will be applied to the family Deductible per Member.

Sandia HPN Example: An employee has a family of five Members. The Sandia HPN Deductible for this family is \$1,500. During the calendar year, the father and mother each incurred expenses of \$700 and \$500, respectively, and this satisfied the Sandia HPN Deductible for this family. The three children incurred expenses as follows: first child, \$500; second child, \$1,000; third child, \$200. These expenses are determined to be Covered Charges and are applied to the Deductible by the claims administrator in the order of receipt of the claims. The individuals contribute to the Sandia HPN Deductible as follows:

Sandia HPN Deductible Example			
	Expenses Incurred	Individual Limit SPHN	Allowable Contribution
Father	\$700	\$500	\$500
Mother	\$500	\$500	\$500
1st Child	\$500	\$500	\$500
2nd Child	\$1,000	\$500	\$0
3rd Child	\$200	\$500	\$0
		Total:	\$1,500

After these charges are applied to the family Deductible, no additional charges are applied even though some family members have not met the individual Deductible.

BCBS PPO In-Network Example: An employee has a family of five Members. The BCBS PPO in-network Deductible for this family is \$2,250. During the calendar year, the father and mother each incurred expenses of \$1,000 and \$500, respectively. The three children incurred expenses as follows: first child, \$500; second child, \$1,000; third child, \$200. These expenses are determined to be Covered Charges and are applied to the Deductible by the claims administrator in the order of receipt of the claims. The individuals contribute to the in-network Deductible as follows:

BCBS PPO In-Network Deductible Example			
	Expenses Incurred	Individual Limit	Allowable Contribution
Father	\$1,000	\$750	\$750
Mother	\$500	\$750	\$500
1st Child	\$500	\$750	\$500
2nd Child	\$1,000	\$750	\$500
3rd Child	\$200	\$750	\$0
		Total:	\$2,250

After these charges are applied to the family Deductible, no additional charges are applied even though some family members have not met the individual Deductible.

Deductible Cross-Application Example: An employee has a family of three Members. During the calendar year, the father and mother used Sandia HPN providers each incurring expenses of \$750 and \$500, respectively. The child incurs \$1,000 of expenses through the Sandia HPN. Each Member contributes \$500 to the Sandia HPN family deductible of \$1,500. Subsequent to that, each Member incurred expenses via BCBS PPO in-network providers. The father and mother each had \$1,000 of expenses. The child had \$500 of expenses. These expenses are determined to be Covered Charges and are applied to the Deductible by the claims administrator in the order of receipt of the claims. The table below illustrates the cross application of the Sandia HPN and in-network deductible:

Deductible Cross-Application Example						
	Sandia HPN			BCBS PPO		
	Expenses Incurred	Individual Limit	Allowable Contribution	Expenses Incurred	Individual Limit	Allowable Contribution
Father	\$750	\$500	\$500	\$1,000	\$750	\$250*
Mother	\$500	\$500	\$500	\$1,000	\$750	\$250*
Child	\$1,000	\$500	\$500	\$500	\$750	\$0
		Total:	\$1,500		Total:	\$500
*The \$500 deductible that was applied under the Sandia HPN is applied towards the in-network deductible.						

Deductibles for Admissions Spanning Two Calendar Years

If a Deductible has been met while you are an inpatient and the admission continues into a new year, no additional Deductible is applied to that admission's Covered Health Services. However, all other services received during the new year are subject to the applicable Deductible for the new year.

Coinsurance

In addition to your Deductible, if applicable, you pay Coinsurance of 10% of the Covered Charge for the Sandia HPN, or 20% of the Covered Charge for BCBS PPO in-network services, and 40% of the Covered Charge for out-of-network services. Please be aware: The difference between the Covered Charge and a provider's billed charge can be significant; an out-of-network provider can bill you for this difference.

Certain preventive care as outlined under [Coverage Details](#) is provided at 100% coverage when you receive the services from an in-network provider, or if you receive services out-of-network, coverage is at 60% of the Medicare-Approved Amount, after the Deductible (out-of-network balance billing may apply). For information on non-covered services, refer to [Section 8, What's Not Covered – Exclusions](#).

IMPORTANT: You are responsible for any amount above the Medicare- Approved Amount if you receive services out-of-network.

Some services require Preauthorization, otherwise you will receive reduced benefits or, in certain cases, no benefits. For a complete listing of these services, refer to [Section 3, Accessing Care](#).

Out-of-Pocket Maximums

This section describes your Out-of-Pocket Maximums.

Note: Out-of-Pocket Maximums are not prorated for mid-year enrollments.

If you retire and are pre-Medicare, and retire mid-year, any amounts applied towards your out-of-pocket maximums under your employee coverage will transfer to your retiree coverage.

If you change medical plans mid-year (e.g. you move from the Kaiser Sandia Total Health to this Program), any amounts applied towards your out-of-pocket maximum under the Kaiser STH Program will be applied under this Program; however, you will need to contact Kaiser to have the amount transferred).

If you are dual Sandians and you switch coverage mid-year due to a mid-year qualifying event, any amounts applied towards out-of-pocket maximums will transfer (e.g. you marry another Sandian and you change your coverage to be enrolled under your spouse, any amounts applied towards your out-of-pocket maximum, as a Primary Covered Member, will be applied towards your dependent deductible under this Program). However, you will need to contact your former administrator to have the amount transferred.

Covered Medical Plan Expenses Administered By BCBSNM (the medical claims administrator)

Annual Out-of-Pocket Maximums		
Sandia HPN In-Network	BCBS PPO In-Network	Out-of-Network
\$1,500 Primary Covered Member Only	\$2,250 Primary Covered Member Only	\$6,000 Primary Covered Member Only
\$3,000 Primary Covered Member + Spouse or + Child(ren)*	\$4,500 Primary Covered Member + Spouse or + Child(ren)*	\$12,000 Primary Covered Member + Spouse or + Child(ren)*
\$4,500 Primary Covered Member + Spouse + Child(ren)* (also referred to as family)	\$6,750 Primary Covered Member + Spouse + Child(ren)* (also referred to as family)	\$18,000 Primary Covered Member + Spouse + Child(ren)* (also referred to as family)
* Spouse or same-gender domestic partner/child(ren) for employees.		

Note: The annual Out-of-Pocket Maximum includes the Deductible and Coinsurance.

IMPORTANT: The Out-of-Pocket Maximums do cross apply between Sandia HPN and In-Network only. The Out-of-Pocket maximums do not cross apply between in-network and out-of-network or Sandia HPN and out-of-network. BCBS will notify you via the Explanation of Benefits form when the Out-of-Pocket Maximum has been reached.

With some exceptions (outlined in the table on page 28), no additional Coinsurance will be required for the remainder of the calendar year after you reach the applicable annual Out-of-Pocket Maximum under the medical plan:

- For you: when you use the Sandia HPN or in-network option and incur your Sandia HPN or in-network Out-of-Pocket Maximum for Covered Charges
- For you (and your spouse or same gender domestic partner); or you (and your child(ren) or same gender domestic partner child(ren): when you (and your spouse or same gender domestic partner); or you (and your child(ren) or same gender domestic partner child(ren) uses the Sandia HPN or in-network option and incurs the Sandia HPN or in-network Out-of-Pocket Maximum for Covered Charges
- For the family: when your family uses the Sandia HPN or in-network option and incurs the Sandia HPN or in-network Out-of-Pocket Maximum for Covered Charges
- For you: when you use the out-of-network option and incur your out-of-network Out-of-Pocket Maximum for Covered Charges

- For you (and your spouse or same gender domestic partner); or you (and your child(ren) or same gender domestic partner child(ren): when you (and your spouse or same gender domestic partner); or you (and your child(ren) or same gender domestic partner child(ren) uses the out-of-network option and incurs the out-of-network Out-of-Pocket Maximum for Covered Charges
- For the family: when your family uses the out-of-network option and incurs the out-of-network Out-of-Pocket Maximum for Covered Charges

Sandia HPN Example: An employee has a family of four Members. The Sandia HPN Out-of-Pocket Maximum is \$4,500. During the calendar year, the father and mother each incurred expenses (through deductibles/coinsurance) of \$3,000 and \$4,000, respectively. The first and second child incurred expenses (through deductibles/coinsurance) of \$1,000 each. These expenses are determined to be Covered Charges and are applied to the Out-of-Pocket Maximum by the claims administrator in the order of receipt of the claims. The individuals contribute to the Sandia HPN Out-of-Pocket Maximum as follows:

Out-of-Pocket Maximum Example			
	Expenses Incurred Through Deductible and Coinsurance	Individual Out-of-Pocket Maximum Limit	Allowable Contributions
Father	\$3,000	\$1,500	\$1,500
Mother	\$4,000	\$1,500	\$1,500
1st Child	\$1,000	\$1,500	\$1,500
2nd Child	\$1,000	\$1,500	\$0
Total:	\$9,000	Total:	\$4,500

The Sandia HPN family Out-of-Pocket Maximum has been met at \$4,500. For the remainder of the calendar year, any additional Covered Health Services submitted by this family under the Sandia HPN option will be paid at 100 percent of Covered Charges (except for prescription drugs and other items obtained through Catalyst Rx). If any Member, however, seeks out-of-network care, the Sandia HPN Out-of-Pocket Maximums will not apply. You will need to meet the out-of-network Out-of-Pocket Maximum for out-of-network care before this medical plan begins paying 100 percent of covered out-of-network charges under the medical plan.

BCBS PPO In-Network Example: An employee has a family of four Members. The BCBS PPO in-network Out-of-Pocket Maximum is \$6,750. During the calendar year, the father and mother each incurred expenses (through deductibles/coinsurance) of \$3,000 and \$4,000, respectively. The first and second child incurred expenses (through deductibles/coinsurance) of \$3,000 each. These expenses are determined to be Covered Charges and are applied to the Out-of-Pocket Maximum by the claims administrator in the order of receipt of the claims. The individuals contribute to the in-network Out-of-Pocket Maximum as follows:

BCBS PPO In-Network, Out-of-Pocket Maximum Example			
	Expenses Incurred Through Deductible and Coinsurance	Individual Out-of-Pocket Limit	Allowable Contributions
Father	\$3,000	\$2,250	\$2,250
Mother	\$4,000	\$2,250	\$2,250
1st Child	\$3,000	\$2,250	\$2,250
2nd Child	\$3,000	\$2,250	\$0
Total:	\$13,000	Total:	\$6,750

The in-network Out-of-Pocket Maximum of \$6,750 for the family has been met. For the remainder of the calendar year, any additional Covered Health Services submitted by this family under the BCBS PPO in-network option will be paid at 100 percent of Covered Charges (except for prescription drugs and other items obtained through Catalyst Rx). If any Member, however, seeks out-of-network care, the BCBS PPO in-network Out-of-Pocket Maximums will not apply. You will need to meet the out-of-network Out-of-Pocket Maximum for out-of-network care before this medical plan begins paying 100 percent of covered out-of-network charges under the medical plan.

Cross-Application Example: An employee has a family of four Members. During the calendar year, the father and mother used Sandia HPN providers each incurring expenses (through deductibles/coinsurance) of \$1,500 and \$4,000, respectively. The first and second child used Sandia HPN providers each incurring expenses (through deductibles/coinsurance) of \$3,000 each. Subsequent to that, each Member incurred expenses via in-network providers. The father and mother each incurred \$5,000 of expenses. The first and second child incurred \$3,000 and \$7,000 of expenses, respectively. These expenses are determined to be Covered Charges and are applied to the Out-of-Pocket Maximum by the claims administrator in the order of receipt of the claims. The individuals contribute to the in-network Out-of-Pocket Maximum as follows:

Sandia HPN/In-Network Cross Application Out-of-Pocket Maximum Example						
	SHPN			BCBS PPO		
	Expenses Incurred	Individual Limit	Allowable Contribution	Expenses Incurred	Individual Limit	Allowable Contribution
Father	\$1,500	\$1,500	\$1,500	\$5,000	\$2,250	\$750
Mother	\$4,000	\$1,500	\$1,500	\$5,000	\$2,250	\$750
1st Child	\$3,000	\$1,500	\$1,500	\$3,000	\$2,250	\$750
2nd Child	\$3,000	\$1,500	\$0	\$7,000	\$2,250	\$0
		Total:	\$4,500		Total:	\$2,250

The Sandia HPN Out-of-Pocket Maximum would have been met at \$4,500 and the BCBS PPO in-network Out-of-Pocket Maximum of \$6,750 has been met. For the remainder of the calendar year, any additional Covered Health Services submitted under the Sandia HPN or BCBS PPO in-network option will be paid at 100 percent of Covered Charges (except for prescription drugs and other items obtained through Catalyst Rx). If any individual, however, seeks out-of-network care, the Sandia HPN/BCBS PPO in-network Out-of-Pocket Maximums will not apply. You will need to meet the out-of-network Out-of-Pocket Maximum for out-of-network care before this Program begins paying 100 percent of covered out-of-network charges under the medical plan.

The following table identifies what does and does not apply toward in-network and out-of-network Out-of-Pocket Maximums:

Features	Applies to the SHPN/BCBS PPO In-Network, Out-of-Pocket Maximum?	Applies to the Out-of-Network, Out-of-Pocket Maximum?
Payments toward the annual Deductible	Yes	Yes
Member Coinsurance payments	Yes	Yes
Charges for non-covered healthcare services	No	No
Amounts of any reductions in benefits you incur by not following Preauthorization requirements	No	No
Amounts you pay toward behavioral health services	Yes	Yes
Charges that exceed Covered Charges	Not applicable	No
Prescription drugs and other items obtained through Catalyst Rx	No	No

Prescription Drug Expenses Incurred through Catalyst Rx (the prescription drug claims administrator)

	In-Network Option	Out-of-Network Option
Annual Out-of-Pocket Maximum	\$1,500 per person	None

IMPORTANT: The in-network Out-of-Pocket Maximum does not apply to prescription drugs and other items purchased out-of-network, therefore, if you have met your in-network per person annual Out-of-Pocket Maximum, and you purchase a prescription at an out-of-network retail pharmacy, you will be responsible for the applicable Coinsurance amount. Refer to [Section 7, Prescription Drug Program](#) for information on your prescription drug benefits.

Once a covered member has met his/her \$1500 Out of Pocket maximum for the year, no additional co-insurance will be required for covered in-network prescription drugs for the remainder of the calendar year.

Lifetime Maximums

The Sandia Total Health Program does not have any lifetime maximums, with the exception of the infertility benefit as described in the *Sandia Health Benefits Plan for Employees Summary Plan Description*.

When you reach the \$30,000 lifetime maximum benefit, no additional reimbursement for any procedures incurred to treat infertility are payable. Other covered procedures related to family planning or reproduction (excluding infertility) may be payable. Refer to [Section 6, Covered Medical Plan Services/Limitations](#).

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Section 5. Health Reimbursement Account and Health Care Flexible Spending Account

Health Reimbursement Account (HRA) Amounts

The HRA is an arrangement that will allow you to determine how some of your health care dollars are spent. Sandia will allocate an amount to the account that is based on:

- Your enrollment status (single, family, etc.),
- Whether or not you and your covered spouse/same-gender domestic partner (beginning for 2013) have completed a Health Assessment, and
- Whether or not you and your covered spouse/same-gender domestic partner (beginning for 2013) have participated in the Virgin HealthMiles Program.

Note: Retirees, surviving spouses/dependents, Long Term Disability Terminees, and COBRA participants are not required to complete a Health Assessment to receive the full HRA allocations.

2012 HRA Allocations

Only the active employee, Primary Covered Member, is responsible for completing the Health Assessment in 2011 to receive the full HRA contribution in 2012. Covered family members are not required to complete a health assessment (refer to table on next page for requirements in 2013).

Coverage Category / Tier	Health Assessment is taken	Health Assessment is NOT taken	Virgin HealthMiles activity completion	Total Possible HRA allocation ²
Primary Covered Member only	\$250	\$0	\$250	\$500
Primary Covered Member + spouse ¹	\$500	\$250	\$250	\$750
Primary Covered Member + children ¹	\$500	\$250	\$250	\$750
Primary Covered Member + spouse and children ¹	\$750	\$500	\$250	\$1,000
¹ Includes same gender domestic partner and same-gender domestic partner child(ren) for employees. ² This is the only amount that will be placed in your HRA during the calendar year and may be used for any combination of eligible in-network and out-of-network Covered Health Services, including eligible prescription drugs and other items purchased through Catalyst Rx.				

2013 HRA Allocations

Both the active employee (Primary Covered Member) and spouse/same-gender domestic partner are responsible for completing the Health Assessment in 2012 to receive the full HRA contribution in 2013. The spouse/same-gender domestic partner is also eligible to participate in the Virgin HealthMiles Program in 2012 to earn additional HRA funds for 2013.

Coverage Category / Tier	Health Assessment is taken	Health Assessment is NOT taken	Virgin HealthMiles activity completion	Total Possible HRA allocation ²
Primary Covered Member only	\$250	\$0 (employee does not complete)	\$250	\$500
Primary Covered Member + spouse ¹	\$500 (both employee and spouse complete)	\$0 (neither employee nor spouse complete)	\$500	\$1,000
Primary Covered Member + children ¹	\$500	\$250 (employee does not complete)	\$250	\$750
Primary Covered Member + spouse and children ¹	\$750 (both employee and spouse complete)	\$250 (neither employee nor spouse complete)	\$500	\$1,250
¹ Includes same gender domestic partner and same-gender domestic partner child(ren) for employees. ² This is the only amount that will be placed in your HRA during the calendar year and may be used for any combination of eligible in-network and out-of-network Covered Health Services, including eligible prescription drugs and other items purchased through Catalyst Rx.				

In order to receive the Health Assessment portion of the HRA funding for each calendar year, the Primary Covered Member and covered spouse/same-gender domestic partner (beginning for 2013) must complete the Health Assessment by December 31 of the previous year. Other covered dependents are not required to complete a Health Assessment. As shown in the tables above, other covered dependents will receive a \$250 HRA allocation without completing a Health Assessment, and regardless of whether the Primary Covered Member and/or covered spouse complete the Health Assessment. Refer to the [Health Assessment and Biometric Screenings](#) section for instructions on how to complete the Health Assessment.

The HRA is funded entirely by Sandia. You are not permitted to make any contribution to your HRA, whether on a pre-tax or after-tax basis. Your HRA is an “unfunded” account, and benefit dollars are payable solely from Sandia’s general assets. The HRA is not considered taxable income to you.

If you don’t spend all your HRA dollars in a calendar year, and you remain enrolled in the Sandia Total Health Program for the following year, any remaining HRA balance remains in your HRA for the next calendar year. The maximum balance in an HRA at the beginning of any new year is capped as follows:

- \$1,500 for Primary Covered Member only coverage
- \$3,000 for Primary Covered Member plus spouse (or same gender domestic partner) or plus child(ren) including same-gender domestic partner child(ren)
- \$4,500 for family coverage

Note: If you are new to this Program this year, any remaining funds in the HRA from the previous year will not roll over to the next year until 90 days after the end of the plan year. This is to ensure that your previous claims administrator has access to your prior year HRA funds to pay for claims for medical services received in the previous year but processed during this 90-day window.

New Hires

Sandia will automatically make the full applicable Health Assessment portion of the HRA contribution (maximum of \$750) for the calendar year in which you hire. However, to receive the Health Assessment portion of the HRA contribution for the next calendar year, you and your covered spouse/same-gender domestic partner must complete the Health Assessment by December 31.

Eligible Mid-Year Election Change Events

Sandia will automatically make the full applicable HRA contribution for any employees, pre-Medicare retirees, and/or their covered family members who enroll in the Sandia Total Health Program during the calendar year as a result of an eligible mid-year election change event. Examples include:

- If you have waived coverage because you have coverage elsewhere, and you lose that coverage and enroll in the Sandia Total Health Program within 31 calendar days of the loss of coverage, Sandia will contribute the applicable HRA contribution.
- If you get married mid-year, Sandia will contribute the applicable additional HRA contribution (\$250 to include spouse coverage or \$500 for family coverage) if you enroll your new eligible family members within 31 calendar days of marriage.
- If two Sandians marry who had separate Sandia Total Health coverage prior to the marriage, and elect Primary Covered Member + Spouse or Primary Covered Member + Family coverage, the total combined HRA funds will be assigned to the Primary Covered Member after approximately ninety (90) days.
- If two Sandians divorce, legally separate, or annul their marriage, the total combined HRA funds will remain with the original Primary Covered Member.

Open Enrollment Changes for Dual Sandians

If you switch Primary Covered Members during Open Enrollment, the total combined HRA will be assigned to the new Primary Covered Member on or around April 1.

If you have Primary Covered Member + Spouse or Primary Covered Member + Family coverage and switch to Primary Covered Member only coverage, the HRA funds will remain with the original Primary Covered Member.

If you switch from Primary Covered Member or Primary Covered Member + child(ren) coverage to Primary Covered Member + Spouse or Primary Covered Member + Family coverage, the HRA funds will remain with the original Primary Covered Member.

Events Resulting in Loss of HRA Funds

If you terminate employment, you have up to one year to file claims for expenses incurred while you were employed with Sandia. If you do not use your HRA funds and do not elect COBRA coverage, you forfeit any remaining HRA funds. Refer to the *Sandia Health Benefits Plan for Employees Summary Plan Description* for information on continuing coverage under COBRA.

If you are a pre-Medicare Retiree with no enrolled family members, and you become Medicare-eligible, you have up to one year to file claims for expenses incurred while you were under the Sandia Total Health Program. Any HRA funds remaining after the year will be forfeited.

The maximum balance in an HRA at the beginning of any new year is capped at the amounts described previously. If you have an event which forces you to change coverage, your HRA balance will be adjusted accordingly at the beginning of the next calendar year. For example, you are enrolled as Primary Covered Member + spouse and get divorced during the year. At the time of the divorce you have \$2,500 in your HRA. You may keep the HRA funds through the end of the calendar year, but the HRA balance will be reduced to \$1,500 - beginning January 1 of the following calendar year, as that is the maximum balance for Primary Covered Member only coverage. Therefore, if you incur an out-of-pocket medical expense of \$2,000 in December and you don't file the claim with the claims administrator until January, you will only have the \$1,500 in your HRA to cover that medical expense.

What Healthcare Expenses are Eligible for HRA Reimbursement

Your HRA dollars may only be used for Covered Health Services or eligible prescription drugs and other items as defined in this Program Summary. For example, if you receive elective cosmetic surgery that is not eligible under the Sandia Total Health Program, these claims are not eligible for payment by the HRA.

Note: Dental and vision benefits that you receive through the Sandia Dental Care Program or Vision Care Program are not eligible for reimbursement from your HRA.

How the HRA Works

Your HRA dollars are used first to pay for Covered Charges, including prescription drugs and other items that you purchased through Catalyst Rx, up to the amount allocated to your HRA. The complete HRA funds are available for use by any of your covered family members and are not apportioned on a per person basis. For example, if there is \$750 in available HRA funds and a claim is submitted for one Member in the amount of \$750, and the Member has a Sandia HPN Deductible of \$500 or \$750 in-network Deductible. \$500 would be used to cover the Sandia HPN Deductible leaving a balance of \$250 in available HRA funds or the full HRA funds of \$750 will be used to cover the in-network Deductible portion of this first claim.

Using your HRA with the Medical Plan

Your HRA dollars are used automatically to pay providers for your Member portion for Sandia HPN/in-network services under the medical plan. The following is the process for using your HRA for a Sandia HPN/in-network doctor's visit:

1. Present your BCBSNM Member ID card to your doctor's office staff.
2. Your doctor's office submits your claim to BCBSNM.
3. BCBSNM processes your claim and determines your out-of-pocket liability. BCBSNM adjudicates claim and examines your HRA.
 - a. If an HRA balance is available, BCBSNM pays provider directly – you pay nothing
 - b. If HRA has been depleted and there is a balance owed provider, BCBSNM sends you an Explanation of Benefits (EOB) form – you pay doctor; OR

- c. If you are enrolled in a Health Care Flexible Spending Account (HCFSA), BCBSNM will pay the provider first from your HCFSA funds and once those are depleted will pay from your HRA.

HRA Example 1:

Year 1:

You complete a Health Assessment and you have single coverage at the beginning of the year. Sandia allocates \$250 to your HRA. During the course of the year, you incur \$150 in Covered Charges. Your annual Sandia HPN Deductible is \$500 or your in-network Deductible is \$750, and the entire \$150 of Covered Charges you incurred is subject to the Deductible. Your HRA is used to cover the \$150 expense that is applied to the Deductible amount.

Year 1 HRA Beginning Balance	\$250
<u>Less HRA payment</u>	<u>(-\$150)</u>
Year 1 HRA Ending Balance	\$100

- Your HRA balance is sufficient to cover the entire \$150 of your annual healthcare costs. This means that the entire amount that was subject to the Deductible has been paid by the HRA. For year one, you have no out-of-pocket costs.
- You have \$100 of unused funds in your HRA that will roll over to the next calendar year if you continue enrollment in the Sandia Total Health Program.

Year 2:

You complete a Health Assessment for this year and have earned additional \$100 through the Virgin Health Miles incentive, and you have single coverage at the beginning of the year. Sandia allocates \$250 to your HRA. You start the year with a balance of \$450 (\$100 from the previous year plus \$250 from the current year for your HA plus \$100 from Virgin HealthMiles). During the course of the year, you incur \$100 in Covered Charges. The entire \$100 of Covered Charges you incurred is subject to the Deductible. Your HRA is used to cover the \$100 expense that is applied to your Deductible amount.

Year 1 HRA Carryover Balance	\$100
Plus Year 2 HRA	\$250
<u>Plus Virgin HealthMiles</u>	<u>\$100</u>
Year 2 Beginning Balance	\$450
<u>Less HRA payment</u>	<u>(-\$100)</u>
Year 2 HRA Ending Balance	\$350

- Your HRA is sufficient to cover the entire \$100 of your annual healthcare costs. This means that the entire amount that was subject to the Deductible has been paid. For year two, you have no out-of-pocket costs.
- You have \$350 of unused funds in your HRA that will roll over to the next calendar year if you continue enrollment in the Sandia Total Health Program.

Year 3:

You complete a Health Assessment for this year and you have earned additional \$100 through the Virgin Health Miles incentive, and you have single coverage at the beginning of the year. Sandia allocates \$250 to your HRA. You start the year with a balance of \$850 (\$350 from the previous year

plus \$250 from the current year for your HA plus \$250 from Virgin HealthMiles). During the course of the year, you incur \$3,000 in Covered Charges. Your HRA is used to cover the \$500 deductible for the Sandia HPN as well as the Coinsurance of \$250 (\$3,000 less \$500 (deductible) less \$250 (10% Coinsurance of \$2500).

HRA Carryover Balance	\$350
Plus Year 3 HRA	\$250
Plus Virgin HealthMiles	<u>\$250</u>
Year 3 Beginning Balance	\$850
<u>Less HRA payment</u>	<u>(-\$750)</u>
Year 3 HRA Ending Balance	\$100

- Your HRA is sufficient to cover the entire \$3,000 of your annual healthcare costs. This means that the entire amount that was subject to the Deductible has been paid. For year three, you have no out-of-pocket costs.
- You have \$100 of unused funds in your HRA that will roll over to the next calendar year if you continue enrollment in the Sandia Total Health Program.

Note: For simplicity, pharmacy expenses were not illustrated in the examples. But prescription drug expenses can also be paid for with the HRA by filing a manual claim with BCBSNM. Contact BCBSNM Customer Service for assistance.

HRA Example 2:

You have enrolled yourself and your spouse and you have completed your Health Assessment for the 2013 calendar year but **your spouse** did not. You do **not** receive your full \$500 allotment. You only receive \$250. During the course of the year, you incur \$500 in Covered Charges. Your annual Sandia HPN Deductible is \$500. \$500 of Covered Health Services is subject to the Sandia HPN Deductible.

HRA Beginning Balance	\$250
<u>Less HRA payment</u>	<u>(-\$250)</u>
HRA Ending Balance	\$0

- The HRA is used to reimburse \$250 of your annual healthcare costs. You had \$500 in costs; the first \$250 of the Deductible is paid by the HRA. This means that you must pay an additional \$250 to meet your annual Sandia HPN Deductible.
- There is no remaining balance to roll over to the next calendar year.

Tracking Your HRA Account

To help you track claims payments, make health care choices, and reduce health care costs, BCBSNM maintains a flexible array of online programs and tools for Members ages 18 and older. Among its many features, you may review your HRA summary on BlueAccess for Members (BAM) by selecting “My Spending Accounts” tab. Select the “Visits and Claims” tab to check claim status and view and print your EOBs. For a complete description of BAM and the tools and features available to you, see [Section 12, Sandia Total Health Administrative Services](#).

Claims Processing with a HCFSA and/or HRA

BCBSNM providers are asked not to collect a payment at the time of service. The provider will bill BCBSNM and BCBSNM will adjudicate your claim and send you an Explanation of Benefits form showing amounts paid from your HCFSA, if enrolled, and from your HRA to the provider and any amount you owe the provider.

An out-of-network provider may require payment at the time of service. In this case, you will need to pay the provider and then file a claim with BCBSNM.

When the bill is presented to BCBSNM, it will pay in the following order: BCBSNM will determine how much of the bill Sandia Total Health will pay and how much you will pay (Deductible and Coinsurance). Sandia Total Health will pay their portion. Your portion (if any) will be paid first from your HCFSA (if you are enrolled), second from your HRA, and third by you after receiving notification from BCBSNM or the provider.

An out-of-network provider may require payment at the time of service. In this case, you will need to file a manual claim with BCBSNM to access any HRA and/or Health Care Flexible Spending Account (HCFSA) funds.

The Health Reimbursement Account and Health Care Flexible Spending Account will only pay if you have funds available through allocation for the HRA or election for the HCFSA.

IMPORTANT: You cannot be reimbursed from more than one tax-advantaged plan (e.g. HCFSA and HRA) for the same expense. If you receive excess reimbursement from your HCFSA as well as your HRA, contact BCBSNM at 877-498-7652 for instructions on how to repay any excess funds.

Medical Plan Expenses

When you or your covered family member seeks Covered Health Services under the medical plan, you must present your BCBSNM identification card.

An in-network provider will file a claim with BCBSNM on your behalf. If the service requires the Deductible or Coinsurance, BCBSNM will look to see if you have funds in your HCFSA (if you are enrolled) and then your HRA. If you do, BCBSNM will pull your share of the cost of the service from your HCFSA and then your HRA and **pay the provider** directly. Once your BCBSNM claim is processed, all claim, HCFSA and HRA activity will be documented and sent to you on your Explanation of Benefits (EOB) form. You should review this EOB for accuracy and contact BCBSNM if you think there are errors.

If you see an ***out-of-network provider***, you are responsible for filing the claim with BCBSNM. If the service requires the Deductible or Coinsurance, BCBSNM will look to see if you have funds in your HCFSA (if you are enrolled) and then your HRA. If you do, BCBSNM will pull your share of the cost of the service from your HCFSA and then your HRA and **pay you** directly. Once your BCBSNM claim is processed, all claim, HCFSA and HRA activity will be documented and sent to you on your Explanation of Benefits (EOB) form. You should review this EOB for accuracy and contact BCBSNM if you think there are errors.

Your HCFSA (if you are enrolled) will be used first to pay for Covered Health Services (including prescription drugs and other items purchased through Catalyst Rx). The HRA will pay second once your HCFSA funds are depleted. The HCFSA and HRA autopay feature for medical services is fully integrated with your Sandia Total Health Program and **cannot be turned off.**

Note: You can keep track of the dollars in your HCFSA and HRA by going online to www.bcbsnm.com/sandia or by calling the Customer Service toll free number on the back of your ID Card.

Prescription Drugs and Other Items Covered Under the Drug Plan

When you or your covered family member needs to purchase a prescription or other item covered through the prescription drug program, you must present your Catalyst Rx identification card. You pay the patient portion to the pharmacy and then file a manual claim with BCBSNM if you would like to get this patient portion reimbursed from your HCFSA (if you are enrolled) and then your HRA, if any.

When you submit an HCFSA and HRA claim to BCBSNM for payment of drug plan expenses, Sandia Total Health will reimburse your patient portion first out of your HCFSA (if you are enrolled and have funds available) and second from your HRA (if you have funds available). If no funds are available in either the HCFSA or HRA, you will need to pay your Coinsurance through another method. The pharmacy will bill Catalyst for your benefit coverage, which is paid directly to the pharmacy.

Once your HRA claim for your prescription drug program patient portion is processed, all HCFSA and HRA activity will be documented and sent to you on your Explanation of Benefits (EOB) form. You should review this EOB for accuracy and contact BCBSNM if you think there are errors.

Direct Deposit

There is no direct deposit available to you from BCBSNM, Catalyst Rx, or PayFlex for any manual claims that you might file.

Turning Off Autopay Feature

If you have an HRA:

The HRA is fully integrated with your medical plan and cannot be turned off.

If you have an HCFSA:

The HCFSA is fully integrated with your medical plan and cannot be turned off.

If you have both an HRA and HCFSA:

The Sandia Total Health Program HCFSA and HRA benefits pay first from your HCFSA and then second from your HRA for all covered medical and prescription drugs expenses. This hierarchy cannot be altered. If you wish to be reimbursed for out-of-pocket medical and prescription drug expenses incurred during the grace period, please refer to the Frequently Asked Questions regarding HCFSA prior year's funds during the Grace period on hbe.sandia.gov.

Health Assessment

A Health Assessment is a confidential online questionnaire that asks you about your health history, lifestyle behaviors (such as smoking and exercise habits) and your willingness to make changes. You will receive a personalized report of your health status and any health risks you may have now or possibly down the road, and how you can take steps to prevent or manage those risks. If you have no health risks, the report will make suggestions for improving or better managing your health and well-being.

When completing a Health Assessment, you will be asked to enter your cholesterol, glucose, height, weight, waist measurement, and blood pressure. You are strongly encouraged to obtain a biometric screening to input into the Health Assessment so that you have an accurate picture of your health risks.

In order to complete a Health Assessment, you can go to healthassessment.sandia.gov.

Note: The Health Assessment data will be reviewed only in aggregate to determine the need for health management programs for employees.

Biometric Screenings

Employees can get biometric screenings either at the Sandia Onsite Clinic (at no cost) or through their personal physicians.

Retirees are not eligible to use the Sandia Onsite Clinic and will need to get their biometric screenings through their personal physicians.

To obtain the screenings through the Sandia Onsite Clinic, you may schedule an appointment by calling HBE Customer Service at 505-844-HBES (4237) in New Mexico, or by emailing saludca@sandia.gov or calling 925-294-3500 in California.

When you get a biometric screening, a trained technician takes your blood pressure and other measurements, and draws blood for analysis. You may be asked if you want fasting or non-fasting lab tests. Fasting lab test results will typically include total cholesterol, HDL, LDL, triglycerides, and glucose. Non-fasting tests report only total cholesterol and HDL. Fasting labs yield the most comprehensive lab test results, but either option will provide what is needed for the Health Assessment.

Virgin HealthMiles Program

With Virgin HealthMiles, employees and their covered spouses/same-gender domestic partners (in 2012 for 2013) may participate in healthy activities and get rewarded - with better health and with miles! Participants simply track their activities with a *GoZone pedometer* and through the *LifeZone online tracking system*. Visit virginhealthmiles.sandia.gov for more details.

Retirees, surviving spouses, and Long Term Disability Terminees, and their dependents, are not eligible for the Virgin HealthMiles Program. If you participated in the Virgin HealthMiles Program, as an employee, and retired at the beginning of a calendar year, you will **not** receive any HRA funds in the subsequent calendar year. However, if you participated as an employee and retire on or after January 1 of the subsequent calendar year, any Virgin HealthMiles that you earned in the previous year will be applied to your retiree account on January 1 (so long as you have no break in coverage) and you will be eligible to keep those funds.

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Section 6. Covered Medical Plan Services/Limitations

The Sandia Total Health Program provides coverage for a wide range of healthcare services for you and any covered family members. This section outlines the medical plan benefits available under the Sandia Total Health Program. For information on your prescription drug benefits administered by Catalyst Rx, refer to [Section 7, Prescription Drug Program](#).

Program Highlights

The Sandia Total Health Program does not have any pre-existing condition limitations. This means, for example, that if you have a condition such as pregnancy or cancer before you begin coverage, you are not required to wait a specific amount of time before you are eligible for medical plan benefit coverage.

IMPORTANT: Covered Health Services are those health services and supplies that are:

- Provided for the purpose of preventing, diagnosing, or treating Illness, Injury, mental illness, Chemical Dependency, or their symptoms
- Included in this section (subject to limitations and conditions and exclusions as stated in this Program Summary)
- Provided to you, if you meet the eligibility requirements as described in the *Sandia Health Benefits Plan for Employees Summary Plan Description* or the *Sandia Health Benefits Plan for Retirees Summary Plan Description*
- Medically Necessary

If a health service is not listed in this section as a Covered Health Service or in [Section 8, What's Not Covered – Exclusions](#) as a specific exclusion, it may or may not be covered. Contact BCBSNM Customer Service at the telephone number on the back of your Member ID card for information.

Coverage Details

The following information provides detailed descriptions of the covered healthcare services. For information on what is excluded from coverage, refer to [Section 8, What's Not Covered – Exclusions](#).

Acupuncture Services

Acupuncture services are covered as follows:

- X-rays and other services provided by a licensed acupuncturist or doctor of oriental medicine, medical doctor, licensed chiropractor, or doctor of osteopathy (either in- or out-of-network) with no review by BCBSNM required
- A maximum paid benefit of \$750 for acupuncture treatment per calendar year, per Member. This maximum applies to in- and out-of-network acupuncture treatment combined.

Allergy Services

Services related to allergies are covered as follows:

- Office visits
- Allergy testing
- Allergy serum
- Allergy shots

Ambulance Services

Ambulance services provided by a licensed ambulance service are covered as follows:

Ground Ambulance Services

- For Emergency transportation to the nearest hospital where Emergency health services can be performed is paid at the in-network level of benefit
- Transportation from one facility to another is considered an Emergency when ordered by the treating physician
- If there is documentation from the ambulance service provider that it does not differentiate between advanced life support and basic life support, the Sandia Total Health Program will cover the services as billed

Air Ambulance Services

IMPORTANT: Preauthorization is required before receiving services. Refer to [Preauthorization Requirements](#) in Section 3 for more information. If Preauthorization is not received, benefits may be denied or reduced by \$300.

- Air ambulance is covered only when ground transportation is impossible or would put life or health in serious jeopardy
- Transport by air ambulance to nearest facility able to provide medically necessary services is a Covered Health Service if your condition precludes your ability to travel by a nonmedical transport (once you have been stabilized and expected to be long term, BCBSNM would transport you to closest contracted facility near your home)
- If you are in line for a transplant and the transplant has been approved by BCBSNM and there are no commercial flights to the city in which the organ is available, the Sandia Total Health Program will cover the medical transport of the patient via air ambulance or jet (whichever is less expensive)

Auditory Integration Training

Auditory integration training services are covered if the results of the evaluation fall within one of the following guidelines:

- A difference of 20dB or more between the most sensitive and least sensitive frequencies;
- The presence of at least one peak or processes, or an air-bone gap of more than 15 dB; or
- Less than 6/11 frequencies perceived at the same intensity level

Behavioral Health Services

Behavioral health services are subject to reimbursement with demonstrated improvement as determined by BCBSNM. Maintenance behavioral health therapy is not covered.

IMPORTANT: Preauthorization is required before receiving inpatient, Partial Hospitalization, Residential Treatment Center, Intensive Outpatient Programs, or psychological testing services. Refer to [Preauthorization Requirements](#) in Section 3 for more information. If Preauthorization is not received, benefits may be denied or reduced by \$300.

The Sandia Total Health Program covers Outpatient mental health and Chemical Dependency services as follows:

- Evaluations and assessments
- Diagnosis
- Treatment planning
- Referral services
- Medication management
- Individual and group therapeutic services
- Intensive Outpatient therapy programs
- Crisis intervention
- Psychological testing, including neuropsychological testing

The Sandia Total Health Program covers inpatient, Partial Hospitalization, and Residential Treatment Facilities for mental health and Chemical Dependency services as follows:

- Services received on an inpatient or Partial Hospitalization basis in a hospital or an alternate facility that is licensed to provide mental health or Chemical Dependency treatment
- If you are admitted to a facility and do not meet inpatient criteria, the BCBSNM Behavioral Health Unit will review to determine whether you meet Partial Hospitalization criteria. If you do meet Partial Hospitalization criteria, only the cost for Partial Hospitalization in that area will be allowed, and you will be responsible for the remainder of the cost.
- Room and board in a semi-private room (a room with two or more beds)

Note: The Sandia Total Health Program will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice as determined by the BCBSNM Behavioral Health Unit.

- Two Partial Hospitalization days are counted as one 24-hour hospitalization day
- Services received in a Residential Treatment Facility as long as there are at least six hours of therapy provided every calendar day

Types of services that are rendered as a medical service, such as laboratory or radiology, are paid under the medical benefits.

If there are multiple diagnoses, the Sandia Total Health Program will only pay for treatment of the diagnoses that are identified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

Cancer Services

Oncology services are covered as follows:

- Office visits
- Professional fees for surgical and medical services
- Inpatient services
- Outpatient surgical services
- High-dose chemotherapy

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer.

Cancer clinical trials and related treatment and services may be eligible for coverage. While you are not required to receive treatment at a Blue Distinction Center, if you do select such a facility and it is more than 50 miles from your home, you may be eligible for the travel and lodging benefit described in Section 3. Facilities selected as Blue Distinction Centers feature:

- Multi-disciplinary team input, including sub-specialty trained teams for complex and rare cancers and demonstrated depth of expertise across cancer disciplines in medicine, surgery, radiation oncology, pathology and radiology
- Ongoing quality management and improvement programs for cancer care
- Ongoing commitment to using clinical data registries and providing access to appropriate clinical research for complex and rare cancers
- Sufficient volume of experience in treating rare and complex cancers such as:
 - Acute leukemia (inpatient/nonsurgical)
 - Bladder cancer
 - Bone cancer
 - Brain cancer – primary
 - Esophageal, gastric, liver pancreatic, and rectal cancers
 - Head and neck cancers
 - Ocular melanoma
 - Soft tissue sarcomas
 - Thyroid cancer – medullary or anaplastic

Note: While you can select any in-network or out-of-network provider/facility for your care, the Blue Distinction Centers for Complex and Rare Cancers® program can help you find the program that meets your needs. For more information call BCBSNM Health Services at 800-325-8334.

Cardiac Care and Pulmonary Rehabilitation

This Sandia Total Health Program covers Outpatient cardiac rehabilitation programs initiated within six months of a cardiac incident and Outpatient pulmonary rehabilitation services.

Chiropractic Services

Chiropractic services are covered as follows:

- X-rays and other services provided by a licensed chiropractor or doctor of oriental medicine, medical doctor, doctor of osteopathy, licensed acupuncturist, or physical therapist (either in- or out-of-network) with no review by BCBSNM required, except that physical therapy requires Preauthorization or benefits may be reduced or denied
- A maximum paid benefit of \$750 for spinal manipulation treatment per calendar year, per Covered Member. This maximum applies to in- and out-of-network benefits combined.

Congenital Heart Disease

Congenital heart disease services that are covered include:

- Office visits
- Outpatient diagnostic testing
- Evaluation
- Professional fees for surgical and medical services
- Inpatient services
- Outpatient surgical services
- Interventional cardiac catheterization (insertion of a tubular device into the heart)
- Fetal echocardiograms (examination, measurement, and diagnosis of the heart using ultrasound technology) and
- Approved fetal intervention

While you are not required to receive treatment at a Blue Distinction Center, if you do select such a facility and it is more than 50 miles from your home, you may be eligible for the travel and lodging benefit described earlier.

Note: While you can select any in-network or out-of-network provider/facility for your care, the Blue Distinction Centers for Cardiac Care® program can help you find the program that meets your needs. For more information call BCBSNM Health Services at 800-325-8334.

Dental Services

IMPORTANT: Preauthorization is required before receiving dental services. Refer to [Preauthorization Requirements](#) in Section 3 for more information. If Preauthorization is not received, benefits may be denied or reduced by \$300.

The Sandia Total Health Program covers dental services due to Illness or Injury to Sound, Natural Teeth, or Injury to the jaw (if an accident includes Injury to the TMJ, the Program may cover orthodontia) as follows:

- As a result of accidental Injury to sound, natural teeth and jaw
- As a result of tooth or bone loss, due to a medical condition (e.g., osteoporosis, radiation to the mouth, etc.)
- Oral surgery if performed in a hospital because of a complicating medical condition that has been documented by the attending physician
- Anesthesia, hospital and/or ambulatory surgical center expenses for dental procedures when services must be provided in that setting due to disability or for young children as determined by the attending physician
- Dental implants, implant-related surgery, and associated crowns or prosthetics are covered in situations where:
 - Permanent teeth are congenitally missing (anodontia), the result of anodontia is impaired function (e.g., chewing/eating), and the implants are not done solely for cosmetic reasons
 - Tooth loss occurs as a result of accidental Injury to a Sound, Natural Tooth
 - As a result of tooth or bone loss, due to a medical condition (e.g., osteoporosis, radiation to the mouth, etc.)

For services that are provided as a result of an accident, initial treatment must have been started within one year of Injury regardless of whether you were covered under a Sandia medical plan or another employer plan.

IMPORTANT: If you receive coverage under the Sandia Total Health Program for implants, crowns or other prostheses required as a result of implants, you cannot submit any remaining portion to the Dental Care Program for coordination of benefits. If you receive coverage under the Dental Care Program for implants, crowns or other prostheses required as a result of implants, you cannot submit any remaining portion to the Sandia Total Health Program.

- Orthognathic surgery limited to documented skeletal Class II and Class III conditions as determined by cephalometric diagnosis, provided the condition is:
 1. Both functional and aesthetic
 2. Not adequately treatable by conventional orthodontic therapy
- Dental services related to medical transplant procedures
- Initiation of immunosuppressive therapy
- Direct treatment of cancer or cleft palate

Diabetes Services/Device/Supplies

The Sandia Total Health Program covers diabetes services as follows:

- Outpatient self-management training and education
- Medical nutrition therapy services
- Medical eye examinations (dilated retinal examinations)
- Preventive foot care

The Sandia Total Health Program covers diabetes devices and supplies as follows:

- External Insulin pump that delivers insulin by continuous subcutaneous infusion for treating patients with diabetes. Disposal external insulin pumps are considered equivalent to standard insulin pumps. Insulin pump criteria:
 1. Type 1 diabetes or Type 2 diabetes requiring basal and bolus insulin AND
 2. Inability to achieve adequate glycemic control with intensive insulin therapy using multiple daily injections (MDI) as evidenced by:
 - a. A1c>7% and/or
 - b. Frequent hypoglycemia and/or
 - c. Marked dawn phenomenon and/or
 - d. Marked glycemic variability (this may be related to lifestyle issues such as participation in athletics or frequent travel AND
 3. Demonstrated ability and motivation to monitor glucose frequently (at least four times daily), count carbohydrates, and adjust the insulin regime as needed to achieve glycemic control.
- Supplies for external insulin pump and continuous glucose monitoring system
- Blood glucose meters, if you are diagnosed with diabetes Type I or Type II
- Long-term continuous glucose monitoring system (greater than 72 hours) criteria:
 1. Type 1 diabetes or Type 2 diabetes requiring basal and bolus insulin AND
 2. Willingness to wear the rt-CGM device at least 60% of the time AND
 3. Have demonstrated the ability to perform self-monitoring blood glucose frequently and to adjust the diabetes regimen based on the data obtained with monitoring.

IMPORTANT: Preauthorization is required (with the exception of blood glucose meters) before receiving. Refer to [Preauthorization Requirements](#) in Section 3 for more information. If Preauthorization is not received, benefits may be denied.

For items with a purchase or cumulative rental value of \$1,000 or more, BCBSNM will decide if the equipment should be purchased or rented, and you must purchase or rent the device from the vendor BCBSNM identifies for in-network benefit level.

Dialysis

This medical Sandia Total Health Program covers the following services when received from a dialysis provider or when Preauthorized by BCBSNM, when received in your home:

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

Diagnostic Tests

Diagnostic tests are covered as follows:

- Laboratory and pathology tests
- X-ray and radiology services, ultrasound and imaging studies
- Computerized Tomography (CT) scans (Preauthorization Required for cardiac CT scans)
- EKG, EEG, and other electronic diagnostic medical procedures
- Genetic testing (Preauthorization Required)
- Echocardiograms
- Electroencephalograms
- Magnetic Resonance Imaging (MRI)
- Nuclear medicine
- Psychological testing (Preauthorization Required)
- Position Emission Tomography (PET) scans (Preauthorization Required)
- Sleep disorder studies
- Other diagnostic tests

Durable Medical Equipment (DME)

IMPORTANT: Preauthorization is required before receiving services with a purchase or cumulative rental value of \$1,000 or more. Refer to [Preauthorization Requirements](#) in Section 3 for more information. If Preauthorization is not received, benefits may be denied.

Durable medical equipment is covered as follows:

- Ordered or provided by a physician for Outpatient use
- Used for medical purposes
- Not consumable or disposable
- Not of use to a person in the absence of a Illness, Injury, or disability
- Durable enough to withstand repeated use
- Appropriate for use in the home

IMPORTANT: For items with a purchase or cumulative rental value of \$1,000 or more, BCBSNM will decide if the equipment should be purchased or rented, and you must purchase or rent the DME from the vendor BCBSNM identifies to receive in-network benefit level.

Examples of DME include, but are not limited to:

- Wheelchairs
- Hospital Beds
- Equipment for the treatment of chronic or acute respiratory failure or conditions
- Equipment to administer oxygen
- Orthotic appliances when custom manufactured or custom fitted to you
- Oxygen
- Orthopedic shoes:
 - Up to two pairs of custom-made orthopedic shoes per year when necessary due to illness such as diabetes, post polio, or other such conditions
- Mastectomy bras
 - Up to two bras per calendar year following a mastectomy
- C-PAP machine
- Bilirubin lights
- Braces that stabilize an injured body part and braces to treat curvature of the spine
- Delivery pumps for tube feedings, including tubing and connectors
- Lenses for aphakic patients (those with no lens in the eye) and soft lenses or sclera shells (white supporting tissue of eyeball)

One educational training session will be allowed to learn how to operate the DME, if necessary. Additional sessions will be allowed if there is a change in equipment.

More than one piece of DME will be allowed if deemed Medically Necessary by BCBSNM (e.g., an oxygen tank in the home and a portable oxygen tank).

At BCBSNM's discretion, benefits are provided for the replacement of a type of durable medical equipment once every three years. If the purchased/owned DME is lost or stolen, the Sandia Total Health Program will not pay for replacement unless the DME is at least three years old. The Sandia Total Health Program will not pay to replace leased/rented DME; however, some rental agreements may cover it if lost or stolen.

Replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed the new purchase price, if the DME breaks or is otherwise irreparable as a result of normal use, or when a change in your medical condition occurs sooner than the three-year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc. for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three-year timeline for replacement.

Emergency Care

IMPORTANT: If you have a Medical Emergency, go to the nearest hospital Emergency room. These facilities are open 24 hours a day, seven days a week.

Medical Emergency care worldwide is covered as follows:

- Emergency services obtained from a Sandia Health Partner Network (HPN) or in-network provider will be considered at the in-network level of benefits if it is a Medical Emergency.
- Emergency services obtained from an out-of-network provider (including those outside the United States) will be considered at the in-network level of benefits if it is a Medical Emergency.
- If you are hospitalized in an out-of-network hospital, you will be transferred to a Sandia HPN or in-network hospital when medically feasible, with any ground ambulance charges reimbursed at the in-network level of benefits. If you decline to be transferred, coverage will be provided under the out-of-network benefit level.

Follow-up care worldwide is covered as follows:

- Follow-up care that results from a Medical Emergency while on travel outside the United States will be covered at the out-of-network level of benefit for services from a out-of-network provider and at the in-network level of benefit for services from an in-network provider.
- Follow-up care that results from a Medical Emergency while on travel within the United States will be covered at the in-network level of benefits only if the place of care is not located within 30 miles of any in-network provider. Covered Charges for services that you should have received before leaving your state of residence or that could have been postponed safely until your return home are eligible for coverage at the out-of-network benefit level.

Note: If you are on Sandia-authorized business travel, you may be eligible to have follow-up care covered at the in-network level of benefits. Contact BCBSNM for details.

What is not an Emergency

The Emergency room should never be used because it seems easier for you or your family. You may have to wait to be seen for a very long time and the charges for Emergency room services are very expensive – even if you have only a small problem. Members who use an Emergency room when it is not necessary will be responsible for paying all Emergency room charges.

You should not go to the Emergency room for conditions such as (but not limited to) sore throat, earache, runny nose or cold, rash, and stomach ache. If you have one of these problems or any other condition that is not an emergency, call your doctor first. If you can't reach your doctor or the doctor's office is closed, call the BCBSNM 24/7 Nurseline at 800-973-6329, 24 hours a day/7 days a week. A nurse will help you decide what to do to get better on your own or where you should go to get the kind of care that you need. The nurse may tell you to go to your doctor or an Urgent Care Center.

Employee Assistance Program (EAP)

The Employee Assistance Program is administered by Magellan Health Services. Preauthorization from Magellan is required by calling 800-424-0320.

IMPORTANT: Preauthorization is not required for the initial visit. Continued visits require Preauthorization. If Preauthorization is not received, benefits may be denied.

The Sandia Total Health Program covers up to eight visits per calendar year, or for California employees, up to three visits every six months, at no cost to the employee for assessment, referral, and follow-up counseling for employees and their covered family members experiencing some impairment from personal concerns that adversely affects their day-to-day activities.

Note: Retirees, survivors, and LTD termines and their covered dependents are not eligible for Employee Assistance benefits.

Eye Exam/Eyeglasses/Contact Lenses

The Sandia Total Health Program covers eye exams for non-refractive care due to Illness or Injury of the eye such as conjunctivitis, diabetic retinopathy, glaucoma, and cataracts. An initial pair of contact lenses or glasses when required due to the loss of a natural lens or cataract surgery is allowed.

Employees and their covered family members that are enrolled in the Sandia Vision Care Program are eligible to receive services related to refractive care under that program. Refer to the [Preventive Care](#) benefits in this section for information on vision screenings.

Family Planning

Family planning services are covered as follows:

- Sterilization procedures such as vasectomies and tubal ligations
- Medically Necessary ultrasounds and laparoscopies
- Family planning devices that are implanted or injected by the physician such as IUDs or Depo-Provera
- Reversals of prior sterilizations
- Surgical, nonsurgical, or drug-induced pregnancy termination
- Health services and associated expenses for elective or therapeutic abortion

Diaphragms and any other birth control obtained at a pharmacy are eligible for coverage under Catalyst Rx.

Genetic Testing

IMPORTANT: Preauthorization is required before receiving services. Refer to [Preauthorization Requirements](#) in Section 3 for more information. If Preauthorization is not received, benefits may be denied.

The Sandia Total Health Program covers Medically Necessary genetic testing. Examples of covered genetic tests include testing related to breast and ovarian cancer. Genetic testing for breast cancer is covered under Preventive Care. Refer to [Section 8, What's Not Covered – Exclusions](#) for information on what is excluded under genetic testing/counseling.

Hearing Aids/Exam

IMPORTANT: Preauthorization is required before receiving services. Refer to [Preauthorization Requirements](#) in Section 3 for more information. If Preauthorization is not received, benefits may be denied.

The Sandia Total Health Program covers the initial hearing exam and purchase of hearing aid(s) if the hearing loss resulted from an Injury or an Illness. Refer to the [Preventive Care](#) benefits in this section for information on hearing screenings.

The Sandia Total Health Program will cover one (1) hearing aid per hearing-impaired ear every thirty-six (36) months for dependent children under the age of 21. This coverage shall include fitting and dispensing services, including providing ear molds as necessary to maintain optimal fit, provided by a licensed audiologist, a hearing aid dispenser or a physician.

Home Health Care Services

IMPORTANT: Preauthorization is required before receiving services. Refer to [Preauthorization Requirements](#) in Section 3 for more information. If Preauthorization is not received, benefits may be denied.

Covered Health Services are services that a home health agency provides if you are homebound due to the nature of your condition. Services must be:

- Ordered by a physician
- Provided by or supervised by a registered nurse in your home
- Not considered Custodial Care in nature
- Provided on a part-time, intermittent schedule when skilled home health care is required

Hospice Services

IMPORTANT: Preauthorization is required before receiving services. Refer to [Preauthorization Requirements](#) in Section 3 for more information. If Preauthorization is not received, benefits may be denied or reduced by \$300.

Hospice care is covered as follows:

- Provided on an inpatient basis
- Provided in your home
- Physical, psychological, social, and spiritual care for the terminally ill person
- Short-term grief counseling for immediate family members

Benefits are available only when Hospice care is received from a licensed Hospice agency or hospital.

Infertility Services

In general, the Sandia Total Health Program pays benefits for infertility services and associated expenses for the diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a physician.

IMPORTANT: Preauthorization is required before receiving services. Refer to [Preauthorization Requirements](#) in Section 3 for more information. If Preauthorization is not received, benefits may be denied or reduced by \$300.

A maximum lifetime benefit of \$30,000 per Member is allowed for infertility treatments. This maximum is accumulated from any expenses related to infertility treatment paid following a confirmed diagnosis of infertility. Expenses for infertility services incurred without a diagnosis of infertility will not be reimbursed. There are limitations to eligible procedures (refer to [Section 8, What's Not Covered – Exclusions](#) for more information).

The maximum lifetime benefit does not include expenses related to diagnosing infertility, testing relating to determining the cause of infertility or the diagnosis and treatment of an underlying medical condition (e.g., endometriosis) that causes infertility. However, testing and treatments after a confirmed diagnosis of infertility will be applied to the \$30,000 lifetime maximum such as:

- Medically Necessary laparoscopies and ultrasounds
- Artificial insemination
- In Vitro Fertilization (IVF)
- Gamete intrafallopian transfers (GIFT)
- Zygote intrafallopian transfer (ZIFT)
- Embryo transplantation
- Laparoscopies for egg retrieval
- Purchase of sperm, if billed separately
- Limited donor expenses for egg donor (only the same charges that would be eligible to extract the egg from a covered employee are allowed for the donor; prescription medications taken by a donor are not allowable charges)
- Storing and preserving embryos for up to two years

Prescription Drugs for Infertility Treatments

Prescription drugs related to infertility are covered under the Prescription Drug Program. Prescription drugs obtained through the Prescription Drug Program and used for infertility treatment may require a diagnosis of infertility. The cost of these drugs is not applied to the \$30,000 infertility maximum if received through the Prescription Drug Program.

If the prescription drug is provided by the physician and billed through the provider's office or facility charges, BCBSNM will review the charge to determine eligibility for reimbursement. If categorized as an infertility treatment, the charges will be applied to the \$30,000 maximum. These charges may also be applied to the appropriate Program Deductibles and Out-of-Pocket Maximums. Coverage for prescriptions for donors is not covered.

Injections in Physician's Office

Injections in a physician's office are covered as follows:

- Sandia HPN/In-network:
 1. Allergy shots – you pay 10 or 20 percent of Covered Charges, after the Deductible
 2. Immunizations/vaccines – no cost to you as outlined under the [Preventive Care](#) benefit in this section
 3. All other injections (e.g., cortisone, Depo-Provera, etc.) – 10 or 20 percent of Covered Charges, after the Deductible
- For out-of-network services, you pay 40 percent of Covered Charges, after the Deductible.

Inpatient Care

IMPORTANT: Preauthorization is required before receiving services. Refer to [Preauthorization Requirements](#) in Section 3 for more information. If Preauthorization is not received, benefits may be denied or reduced by \$300.

Inpatient services in a hospital are covered as follows:

- Services and supplies received during an Inpatient Stay
- Room and board in a semi-private room (a room with two or more beds)
- Intensive care

Note: The Sandia Total Health Program will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice as determined by BCBSNM.

Benefits for an Inpatient Stay in the hospital are available only when the Inpatient Stay is necessary to prevent, diagnose, or treat an Illness or Injury.

If you are admitted to a hospital on an Emergency basis that is not in the network and services are covered, in-network benefits will be paid until you are stabilized. Once stabilized, you must be moved to a network hospital to continue in-network benefits. You may elect to remain in the out-of-network hospital and receive out-of-network benefits, as long as BCBSNM confirms the treatment to be Medically Necessary.

Maternity Services

IMPORTANT: Newborn and Mother's Health Protection Act: Under federal law, mothers and their newborns that are covered under group health plans are guaranteed a stay in the hospital of not less than 48 hours following a normal delivery or not less than 96 hours following a cesarean section. Notification to BCBSNM is required **ONLY** if your stay will be longer than 48 hours following a normal delivery or longer than 96 hours following a cesarean section.

Stays longer than those mentioned above require Preauthorization. If Preauthorization is not received, benefits may be reduced by \$300.

Maternity services are covered as follows:

- Initial visit to the physician to determine pregnancy status
- Pre-natal and post-natal visits
- Charges related to delivery
- Charges for newborn delivery services, paid as follows:
 1. Charges billed for well-baby care are paid under the newborn but at the mother's level of benefit, subject to her Deductible and Out-of-Pocket Maximum (e.g., if mom has met her Out-of-Pocket Maximum, well-baby charges will be reimbursed as if the newborn's Out-of-Pocket Maximum was met as well)
 2. Charges billed for the newborn under any other non-well baby ICD-9 code are paid under the newborn and subject to the newborn's Deductible and Out-of-Pocket Maximum

Note: The Sandia Total Health Program will pay for Covered Health Services for the newborn for the first 31 calendar days of life. This is regardless of whether you enroll the eligible child within the applicable time frame as referenced in the *Sandia Health Benefits Plan for Employees Plan Summary Plan Description* or the *Sandia Health Benefits Plan for Retirees Summary Plan Description* for continued coverage.

The Sandia Total Health Program will pay for maternity services for you, your covered spouse, your covered same-gender domestic partner, and your covered children.

Licensed birthing centers are covered to include charges from the birthing center, physician, midwife, surgeon, assistant surgeon (if medically necessary), and anesthesiologist. Benefits for birthing services rendered in the home will be paid according to the network status of the physician with whom the licensed nurse midwife is affiliated. If the licensed nurse midwife is not affiliated with a physician and is not a part of the network, reimbursement will be paid on an out-of-network level. If you are admitted to a hospital, you must notify BCBSNM within the time frames indicated above.

Refer to the [Preventive Care](#) in this section for information on preventive services related to maternity.

Special Beginnings

This is a maternity program that is completely voluntary and free to Members. The program can help you better understand and manage your pregnancy. You may enroll in the program within three months of becoming pregnant. When you enroll, you'll receive a questionnaire to find out if there may be any problems with your pregnancy to watch out for, information on nutrition, newborn care, and other topics helpful to new parents. You will also receive personal and private phone calls from an experienced nurse – all the way from pregnancy to six weeks after your child is born. To learn more or to enroll, call 888-421-7781.

Extended Stay Newborn Care

You must ensure that BCBSNM is called before the mother is discharged from the hospital. If you do not, benefits for the newborn's covered facility services will be reduced by \$300. The baby's services will be subject to a separate Deductible and Coinsurance and a separate Out-of-Pocket Maximum.

Medical Supplies

Certain medical supplies are covered, to include, but not limited to:

- Ostomy supplies
- Up to 6 pair or 12 individual, medically necessary, surgical or compression stocking, per calendar year
- Aero chambers, aero chambers with masks or nebulizers (you can obtain these either under the medical benefits or the Prescription Drug Program but not both)

Lancets, alcohol swabs, diagnostic testing agents, syringes, Novopen and insulin auto-injectors, and allergic Emergency kits can be obtained under the prescription drug benefits (refer to [Section 7, Prescription Drug Program](#)).

Nutritional Counseling

The Sandia Total Health Program covers certain services provided by a registered dietician in an individual session if you have a medical condition that requires a special diet. Some examples of such medical conditions include:

- Diabetes mellitus
- Coronary artery disease
- Congestive heart failure
- Gout (a form of arthritis)
- Renal failure
- Phenylketonuria (a genetic disorder diagnosed at infancy)
- Hyperlipidemia (excess of fatty substances in the blood)

Diet counseling for adults at higher risk for chronic diseases is covered under the preventive benefits. Refer to [Preventive Care](#) under this section.

Obesity Surgery

IMPORTANT: Preauthorization is required before receiving services. Refer to [Preauthorization Requirements](#) in Section 3 for more information. If Preauthorization is not received, benefits may be denied or reduced by \$300.

Surgical treatment for morbid obesity when received on an inpatient basis provided all of the following are true:

- Body Mass Index (BMI) of 35 to 39.9 with one or more obesity related co-morbid medical conditions, OR
- BMI equal or greater than 40 and demonstration that dietary attempts at weight control have been ineffective and the individual is 18 years of age or older or has reached full expected skeletal growth. Documentation of a structured diet program includes physician or other health care provider notes and/or diet or weight logs from a structured weight loss program for a minimum of six months.

Note: While you can select any in-network or out-of-network provider/facility for your surgery, the Blue Distinction Centers for Bariatric Surgery[®] program can help you find the program that meets your needs. For more information call BCBSNM Health Services at 800-325-8334 or visit their website at www.bcbs.com/innovations/bluedistinction.

Office Visits

The following services provided in the physician's office are covered as follows:

- Consultations
- Second opinions
- Post-operative follow-up
- Services after hours and Emergency office visits (allowed separately)
- Office surgery
- Supplies dispensed by the provider
- Diagnostic tests
- Laboratory services
- Radiology services
- Chemotherapy
- Radiation therapy

Organ Transplants

IMPORTANT: Preauthorization must be requested in writing from BCBSNM. Authorization must be obtained from BCBSNM before a pre-transplant evaluation is scheduled. A pre-transplant evaluation is not covered if Preauthorization is not obtained from BCBSNM. If authorized, a BCBSNM case manager will be assigned to you (the transplant recipient candidate) and you must contact the case manager with the results of the evaluation.

If you are approved as a transplant recipient candidate, you must ensure that Preauthorization for the actual transplant is received. If Preauthorization is not received, benefits may be denied or reduced by \$300.

Benefits are available to the donor and the recipient when the recipient is covered under the Sandia Total Health Program. The transplant must be a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which the Program will pay include but are not limited to:

- Heart
- Heart/lung
- Lung
- Kidney
- Kidney/pancreas
- Liver
- Liver/kidney
- Liver/intestinal
- Pancreas
- Intestinal
- Bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high-dose chemotherapy. Not all bone marrow transplants are Covered Health Services.

The search for bone marrow/stem cells from a donor who is not biologically related to the patient is a Covered Health Service. If a separate charge is made for a bone marrow/stem cell search, the Program will pay up to \$25,000 for all charges made in connection with the search.

Note: If you receive Preauthorization, you can select any in-network or out-of-network provider/facility for your transplant. The Blue Distinction Centers for Transplants[®] program can help you find the transplant program that meets your needs. For more information call BCBSNM Health Services at 800-325-8334.

Outpatient Surgical Services

Outpatient Surgery and related services are covered as follows:

- Facility charge
- Anesthesia
- Supplies related to the surgery
- Equipment related to the surgery

Benefits for professional fees are described under [Professional Fees for Surgical Procedures](#) in this section. Also, see the list of procedures in Section 3 that require Preauthorization.

Prescription Drugs (other than those dispensed by Catalyst Rx)

Enteral nutrition/nutritional supplements/prescription drugs under this Sandia Total Health Program are covered under the medical plan as follows:

- Enteral nutrition/nutritional supplements for:
 1. Diagnosis of dysphagia (difficulty swallowing)
 2. As the sole source of nutrition
 3. Genetic disorder of Phenylketonuria (PKU)
 4. RH factor disorders
 5. Terminal cancer
- Intravenous medications
- Medication that is dispensed and/or administered by a licensed facility or provider, such as a hospital, home health care agency, or physician's office, and the charges are included in the facility or provider bill

Note: Medication obtained through a mail order service is not eligible for reimbursement under BCBSNM. It may be eligible for reimbursement under Catalyst Rx on an out-of-network basis.

You can receive coverage for intravenous medications, enteral nutrition or nutritional supplements through either BCBSNM or Catalyst Rx, but not both. Refer to [Section 7, Prescription Drug Program](#) for information on coverage of prescription drugs not mentioned above.

Preventive Care

Sandia's preventive care benefits are based on the recommendations of the U.S. Preventive Services Task Force (USPST), American Academy of Pediatrics, and national medical standards.

For a snapshot of the Sandia preventive care benefits, see the [Preventive Health Benefits Quick Reference Guide](#).

See [Section 7, Prescription Drug Coverage](#) for information about covered preventive medications.

Preventive care benefits are covered as described below.

IMPORTANT: In order to receive the preventive care benefit, the service must be submitted with a preventive ICD-9 diagnostic code. If it is submitted with a non-preventive ICD-9 diagnostic code, the service will be reimbursed at the non-routine, diagnostic benefit level.

Routine annual physical exams will be covered under the preventive benefit, even if billed with a non-preventive ICD-9 diagnostic code, as long as a preventive ICD-9 diagnostic code is also billed.

It is solely up to the provider as to whether the service is coded as preventive or diagnostic. Neither Sandia nor BCBSNM can direct the provider to bill a service in any particular way. The issue as to how it is billed is between you and your provider.

Well-Baby Care (ages 0-2 years)

The Sandia Total Health Program provides preventive care coverage at 100 percent of the Covered Charges for covered SHPN/in-network services and at 60 percent of the Covered Charges, after the Deductible, for covered out-of-network services.

Covered Health Services include:

- Routine physical exams (including height and weight) at birth and at one, two, four, six, nine, 12, 15, 18, and 24 months
- Autism screening at 18 and 24 months
- Behavioral assessment as needed
- Congenital Hypothyroidism screening for newborns
- Development screening – surveillance throughout childhood as needed
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screenings as needed
- Hematocrit or hemoglobin screening as needed
- Hemoglobinopathies or sickle cell screening for newborns
- Lead screening as needed
- Phenylketonuria (PKU) screening in newborns
- Thyroid screening as needed
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening as needed (A screening does not include an eye exam, refraction, or other test to determine the amount and kind of correction needed.)

Refer to the [Immunization/Vaccines/Flu Shot Services section](#) for information on these covered services.

Well-Child Care (ages 3-10 years)

The Sandia Total Health Program provides preventive care coverage at 100 percent of the Covered Charges for covered SHPN/in-network services and at 60 percent of the Covered Charges, after the Deductible, for covered out-of-network services.

Covered Health Services include:

- One routine physical/annual exam (including height, weight, and body mass index measurements) is allowed each calendar year regardless of the date of the previous routine physical/annual exam, but no more frequently than one per calendar year. Allowable exams include routine preventive physicals, including annual exams and sports physicals.
- Behavioral assessment as needed
- Development screening – surveillance throughout childhood as needed
- Dyslipidemia screening for children at higher risk of lipid disorders
- Hearing screening as needed
- Hematocrit or hemoglobin screening as needed
- Lead screening as needed
- Obesity screening and counseling as needed
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening as needed (A screening does not include an eye exam, refraction, or other test to determine the amount and kind of correction needed.)

Refer to the [Immunization/Vaccines/Flu Shot Services section](#) for information on these covered services.

Well-Adolescent Care (ages 11-18 years)

The Sandia Total Health Program provides preventive care coverage at 100 percent of the Covered Charges for covered SHPN/in-network services and at 60 percent of the Covered Charges, after the Deductible, for covered out-of-network services.

Covered Health Services include:

- One routine physical/annual exam (including height, weight, and body mass index measurements) is allowed each calendar year regardless of the date of the previous routine physical/annual exam, but no more frequently than one per calendar year. Allowable exams include routine preventive physicals, including annual exams and sports physicals.
- Alcohol and drug use assessment as needed
- Behavioral assessment as needed
- Chlamydia infection screening as needed
- Cervical dysplasia screening as needed for sexually active females
- Development screening – surveillance throughout childhood as needed
- Dyslipidemia screening for children at higher risk of lipid disorders
- Hematocrit or hemoglobin screening as needed
- HIV screening as needed for adolescents at higher risk

- Lead screening as needed
- Obesity screening and counseling as needed
- Rubella screening (once per lifetime)
- Sexually transmitted infection prevention counseling for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening as needed (A screening does not include an eye exam, refraction, or other test to determine the amount and kind of correction needed.)

Refer to the [Immunization/Vaccines/Flu Shot Services section](#) for information on these covered services.

Well-Adult Care (19 years of age and older)

The Sandia Total Health Program provides preventive care coverage at 100 percent of the Covered Charges for covered SHPN/in-network services and at 60 percent of the Covered Charges, after the Deductible, for covered out-of-network services.

Covered Health Services include:

- One routine physical/annual exam (including height, weight, and body mass index measurements) is allowed each calendar year regardless of the date of the previous routine physical/annual exam, but no more frequently than one per calendar year. Allowable exams include routine preventive physicals, including annual exams and sports physicals.
- Abdominal aortic aneurysm one-time screening for men between the ages of 65 and 74 who have ever smoked
- Alcohol misuse screening and counseling as needed
- Blood pressure screening as needed
- BRCA genetic counseling and testing for women at higher risk
- Breast cancer chemoprevention counseling for women at higher risk
- Cervical cancer screening for sexually active women
- Chlamydia infection screening as needed
- Depression screening as needed
- Diet counseling for adults at higher risk for chronic disease
- Gonorrhea screening for women at higher risk
- HIV screening as needed for adults at higher risk
- Obesity screening and counseling as needed
- Rubella screening (once per lifetime)
- Sexually transmitted infection prevention counseling for adults at higher risk
- Syphilis screening as needed for adults at higher risk
- Tobacco use screening as needed and cessation interventions for tobacco users
- Well woman exam annually

Refer to [Immunization/Vaccines/Flu Shot Services](#), [Cancer Screenings](#), [Laboratory Services](#), and [Bone Density Testing](#) later in this section for information on these covered services.

Immunizations/Vaccines/Flu Shot Services

The Sandia Total Health Program provides preventive care coverage at 100 percent of the Covered Charges for covered SHPN/in-network services and at 60 percent of the Covered Charges, after the Deductible, for covered out-of-network services.

Covered Health Services include immunizations, flu shots, vaccines, and immunizations related to personal travel. If you are unable to obtain the type of immunization required for personal travel at the physician's office (e.g., malaria pills), contact BCBSNM Customer Service at 877-498-7652 for assistance.

Flu shots and some immunizations/vaccines are available at no cost to you at an in-network retail pharmacy under the Prescription Drug Program (see [Section 7](#)).

IMPORTANT: Immunizations for Sandia-business-related travel must be given at the Sandia's onsite clinic; however, if Sandia's onsite clinic directs the employee to obtain immunizations offsite, you will be reimbursed at 100 percent of the charge, regardless of whether you obtain the immunizations in- or out-of-network.

Laboratory Services

The Sandia Total Health Program provides preventive care coverage at 100 percent of the Covered Charges for covered SHPN/in-network services and at 60 percent of the Covered Charges, after the Deductible, for covered out-of-network services.

Covered Health Services include:

- Complete blood count (CBC) with differential, which includes white blood count, red blood count, hemoglobin, hematocrit, platelet, mcv, mchc, rdw. Differential includes neutrophils, lymphocytes, monocyte, eosinophil, basophile, absolute neutrophil, absolute lymphocyte, absolute monocyte, absolute eosinophile, absolute basophile, diff type, platelet estimate, red blood cell morphology.
- Complete urinalysis, which includes source, color, appearance, specific gravity, urine PH, protein, urine glucose, urine ketones, urine bilirubin, blood, nitrate, urobilinogen, leukocyte estrase, red blood count, white blood count, squamous epithelial, calcium oxylate
- Complete metabolic profile, which includes sodium, potassium, chloride, CO₂, anion, glucose, bun, creatinine, calcium, total protein, albumin, globulin, bilirubin total, alkphos, asp, alt
- Diabetes screening, which includes a two-hour postprandial blood sugar and HbA1c
- Thyroid screening, which includes free T4 and TSH
- Lipid panel, which includes triglycerides, total cholesterol, HDL, and calculated LDL cholesterol

As ordered by the physician, you are entitled to one of each of the above category once every calendar year. If the physician orders one or more components within one of the above categories but not the complete set, and it is submitted with a preventive code, it will still be eligible for reimbursement under the preventive benefit.

Cancer Screening Services

The Sandia Total Health Program provides preventive care coverage at 100 percent of the Covered Charges for covered SHPN/in-network services and at 60 percent of the Covered Charges, after the Deductible, for covered out-of-network services.

Covered Health Services include:

Service	Allowed Frequency	Allowable Age
Pap Test	As needed	Age 11 and older
Prostrate Antigen Test	Annual	Upon turning 50
Mammogram*	Baseline, Annual	Between ages 35-39, upon turning 40
Fecal Occult Blood Test	Annual	Upon turning 50
Sigmoidoscopy**	Once every five years	Upon turning 50
Colonoscopy**	Once every ten years	Upon turning 50
Barium Enema**	Once every five years	Upon turning 50
<p>* High-risk women with an immediate family history (mother or sister) of breast cancer are eligible for an annual mammogram upon turning 25. The mammogram preventive benefit also includes the computer-aided detection test. The preventive benefit also includes the charge by the provider for interpreting the test results.</p> <p>**You are entitled to the following:</p> <ul style="list-style-type: none">• A sigmoidoscopy once every five years, OR• A colonoscopy once every 10 years, OR• A sigmoidoscopy or colonoscopy under age 50 or more frequently if you have an immediate family history (mother, father, sister, brother only) of colorectal cancer or you have a personal history of colonic polyps. Polyp removal during a preventive colonoscopy will be covered under the preventive colonoscopy benefit. <p>**A barium enema once every five years in lieu of a colonoscopy or sigmoidoscopy</p>		

Note: From time to time, Sandia will sponsor mobile mammogram screenings at Sandia or in the community through this program. Screenings are available to covered Members age 35 and above (or for high risk women as outlined above). In addition, the annual requirement is waived for these screenings.

Pregnancy-Related Preventive Care Services

The Sandia Total Health Program provides preventive care coverage for the following pregnancy-related services, on an as needed basis, at 100 percent of the Covered Charges for covered SHPN/in-network services and at 60 percent of the Covered Charges, after the Deductible, for covered out-of-network services.

- Multiple marker screening between weeks 15 and 18 for pregnant women age 35 and older
- Serum alpha-fetoprotein between weeks 16 and 18 based on personal risk factors

- Chorionic villus sampling before week 13 or amniocentesis between weeks 15 and 18 in women who are 35 and older and at risk for passing on certain chromosomal disorders
- Hemoglobiopathy screening if at risk for passing on certain blood disorders
- Screening for gestational diabetes between 24 and 28 weeks
- Screening for group B strep between 35 and 37 weeks
- Anemia screening on a routine basis
- Bacteriuria urinary tract or other infection screening
- Breast feeding interventions to support and promote breast feeding
- Hepatitis B screening at first prenatal visit
- Rh incompatibility screening and follow-up testing for women at higher risk
- Syphilis screening
- Tobacco use screening and counseling as needed

Bone Density Testing

The Sandia Total Health Program provides preventive care coverage for bone density testing once every three years upon turning age 50 at 100 percent of the Covered Charges for covered SHPN/in-network services, and at 60 percent of the Covered Charges, after the Deductible, for covered out-of-network services.

Professional Fees for Surgical Procedures

The Sandia Total Health Program pays professional fees for surgical procedures and other medical care received from a physician in a hospital, Skilled Nursing Facility, inpatient rehabilitation facility, or Outpatient Surgery facility.

The Program will pay the following surgical expenses:

- Only one charge is allowed for the operating room and for anesthesia.
- A surgeon will not be paid as both a co-surgeon and an assistant surgeon.
- Expenses for certified first assistants are allowed.
- Incidental procedures are those services carried out at the same time as a more complex, primary procedure. The incidental procedure may be a part of the primary procedure and require little or very little additional time and resources; therefore, they are usually not covered.
- A surgical procedure that is performed and not considered incidental to the primary procedure will be reimbursed at half of the allowable. For example: When bilateral surgical procedures are performed by one or two surgeons, the Sandia Total Health Program will consider the first procedure at the full allowed amount, and the second procedure will be considered at half of the allowed amount of the listed surgical unit value
- Foot surgery – for a single surgical field/incision or two surgical fields/incisions on the same foot, the Sandia Total Health Program will allow the full amount for the procedure commanding the greatest value; half of the full amount for the second procedure; half of the full amount for the third procedure; and a quarter of the full amount for each subsequent procedure. Also, if procedure 11721 is billed in conjunction with 10056 and 10057, these will be reimbursed separately without bundling when billed with a medical diagnosis.

Prosthetic Devices/Appliances

The Sandia Total Health Program covers prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include:

- Artificial limbs
- Artificial eyes
- Breast prosthesis following a mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras (see Durable Medical Equipment) and lymph edema stockings. There are no limitations on the number of prostheses and no time limitations from the date of the mastectomy. Refer to Reconstructive Procedures for more information.

If more than one prosthetic device can meet your functional needs, benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a physician, or under a physician's direction.

Benefits are provided for the replacement of each type of prosthetic device once every five calendar years. At BCBSNM's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement, if the device or appliance breaks, or is otherwise irreparable, or when a change in the your medical condition occurs sooner than the five year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part. If the prosthetic device or appliance is lost or stolen, the Sandia Total Health Program will not pay for replacement unless the device or appliance is at least five years old.

Reconstructive Procedures

IMPORTANT: Preauthorization is required before receiving services. Refer to [Preauthorization Requirements](#) in Section 3 for more information. If Preauthorization is not received, benefits may be denied or reduced by \$300.

The Sandia Total Health Program covers certain Reconstructive Procedures where a physical impairment exists and the expected outcome is a restored or improved physiological function for an organ or body part.

Improving or restoring physiological function means that the organ or body part is made to work better. The fact that you may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored. There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Upper eyelid surgery, for example, is sometimes performed to improve vision, which is considered a Reconstructive Procedure, but in other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure and is not covered. Refer to [Section 8, What's Not Covered – Exclusions](#) for more information.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy. Coverage is provided for all stages of reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Replacement of an existing breast implant is covered if the initial breast implant followed mastectomy.

Rehabilitation Services (Outpatient Therapies)

IMPORTANT: Preauthorization is required before receiving services. Refer to [Preauthorization Requirements](#) in Section 3 for more information. If Preauthorization is not received, benefits may be denied or reduced by \$300.

Outpatient rehabilitation services for the following types of therapy are covered:

- Physical
- Occupational
- Speech
- Pulmonary rehabilitation
- Cardiac and pulmonary rehabilitation

Rehabilitation services must be provided by a licensed therapy provider and be under the direction of a physician. Physical, occupational, and speech therapy are subject to reimbursement with demonstrated improvement as determined by BCBSNM. Maintenance therapy is not covered.

Note: Speech, physical, and occupational therapies rendered for developmental disorders are covered only until the patient is at a Maintenance level of care as determined by BCBSNM.

Manual therapy techniques for lymphatic drainage, including manual traction, etc., are covered when performed by a licensed chiropractor, physical therapist, or physician.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

IMPORTANT: Preauthorization is required before receiving services. Refer to Section 3 for Preauthorization requirements. If Preauthorization is not received, benefits may be denied or reduced by \$300.

Facility services for an Inpatient Stay in a Skilled Nursing Facility or inpatient rehabilitation facility are covered. Benefits include:

- Services and supplies received during the Inpatient Stay
- Room and board in a semi-private room (a room with two or more beds)

Note: The Sandia Total Health Program will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice as determined by BCBSNM.

Benefits are available when skilled nursing and/or inpatient rehabilitation facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or inpatient rehabilitation facility for treatment of an Illness or Injury that would have otherwise required an Inpatient Stay in a hospital.

The intent of skilled nursing is to provide benefits if, as a result of an Injury or Illness, you require:

- An intensity of care less than that provided at a general acute hospital but greater than that available in a home setting
- A combination of skilled nursing, rehabilitation, and facility services

The Program does not pay benefits for Custodial Care, even if ordered by a physician.

Temporomandibular Joint (TMJ) Syndrome

The Sandia Total Health Program covers diagnostic and surgical treatment of conditions affecting the temporomandibular joint, including splints, when provided by or under the direction of a physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology. Covered services may include orthodontic appliances and treatment, crowns, bridges, or dentures only if services are required because of an accidental Injury to Sound Natural Teeth involving the temporomandibular or craniomandibular joint.

Urgent Care

The Sandia Total Health Program will cover Urgent Care as follows:

- If you receive care at a Sandia Health Partner Network (HPN) within the SHPN service area, or in-network Urgent Care Facility within the United States, you will be reimbursed under the Sandia HPN or in-network level of benefits, whichever is applicable.
- If you receive care at an out-of-network Urgent Care Facility within the United States, you will be reimbursed under the out-of-network level of benefits.

Note: If you are traveling within the United States and there are no in-network facilities available within a 30-mile radius, your claim will be processed at the in-network benefit level.

- If you are traveling outside the United States, your claim will be processed at the in-network benefit level for Urgent Care.
- Follow-up care while traveling outside the United States will be covered at the out-of-network level of benefit if you receive care from an out-of-network provider.
- Follow-up care while traveling outside the United States will be covered at the in-network level of benefit if you receive care from an in-network provider.
- Follow-up care while traveling within the United States will be covered at the in-network level of benefits if the place of care is not located within 30 miles of any in-network provider.

Urgent Care is needed for sudden Illness or Injuries that are not life threatening. You can wait a day or more to receive care without putting your life or a body part in danger. If you need Urgent Care, you have a choice of taking any of the following steps to receive care:

- Call your doctor's office and tell them you need to see a doctor as soon as possible, but that there is no Emergency. If your doctor tells you to go to the Emergency room because he or she cannot see you right away and you do not believe you have an Emergency, call the 24/7 Nurseline toll-free at 800-973-6329 for advice.
- Ask your doctor to recommend another provider if he/she is unable to see you within 24 hours.
- Visit the nearest Urgent Care Center, Preferred Provider, for in-network benefit.
- Visit any Urgent Care Center, out-of-network, for out-of-network benefit.

Section 7. Prescription Drug Program

The Prescription Drug Program (PDP), although part of the Sandia Total Health Program, is administered separately by Catalyst Rx. For information on filing claims, claim denials, and appeals, refer to Section 10, How to File a Claim, and Section 11, How to File an Appeal.

IMPORTANT: All claims must be submitted to Catalyst Rx within one year after the date of service in order to be eligible for consideration of payment. This one-year requirement will not apply if you are legally incapacitated.

The following chart summarizes your coinsurance responsibility as well as coverage for purchases under the Mail-Order Program and the Catalyst Rx network and out-of-network retail pharmacies.

Mail-Order Program	Catalyst Rx Network Retail Pharmacies	Out-of-Network Retail Pharmacies
Refer to Specialty Drug Management Program for information on coverage for specialty drugs.		
For maintenance prescription drugs:		
Coinsurance of 20% of mail order discount price with a \$10 minimum and \$20 maximum for generic prescription drugs	Coinsurance of 20% of retail discount price with a \$5 minimum and \$10 maximum for generic prescription drugs	50% reimbursement
Coinsurance of 30% of mail order discount price with a \$50 minimum and \$80 maximum for preferred brand name prescription drugs	Coinsurance of 30% of retail discount price with a \$25 minimum and \$40 maximum for preferred brand name prescription drugs	50% reimbursement
Coinsurance of 40% of mail order discount price with a \$80 minimum and \$120 maximum for non-preferred brand name prescription drugs	Coinsurance of 40% of retail discount price with a \$40 minimum and \$60 maximum for non-preferred brand name prescription drugs	50% reimbursement
Maximum of 90-day supply	Maximum of 30-day supply	Maximum of 30-day supply File your claims with Catalyst Rx
An out-of-pocket maximum (safety net) of \$1,500 per person per year applies for prescription drugs that are purchased from an in-network provider – refer to Section 4, Deductibles and Maximums for more information.		The out-of-pocket maximum does not apply when prescription drugs are purchased from an out-of-network provider.
<p>If a multi-source generic drug is reclassified as a single source brand name, the Coinsurance will change from 20% to 30% or 40% with the applicable minimum and maximum copays.</p> <p>Prescription drug Coinsurance amounts do not apply to the Sandia Total Health Program medical plan Deductible and/or Out-of-Pocket Maximum.</p> <p>Reimbursement for prescriptions purchased outside the United States will be reimbursed at the applicable retail Coinsurance, limited to a maximum of a 30-day supply.</p>		

Eligibility

If you are eligible for coverage under the Sandia Total Health Program, then you are eligible for the PDP. If you have primary prescription drug coverage under another group health care plan or Medicare, you are not eligible to use the Mail-Order Program or purchase drugs from retail network pharmacies at the coinsurance benefit.

Coordination of Benefits applies. If you or your dependent has primary prescription drug coverage elsewhere, file the claim first with the appropriate plan, and then file with Catalyst Rx, attaching a copy of the EOB. Catalyst Rx will allow 50 percent of the price submitted, with no days-supply limit, up to the amount you pay out-of-pocket.

IMPORTANT: If you are enrolled in a Medicare Part D Plan, refer to your Medicare Part D Notice of Creditable Coverage for information on how your Part D Plan may coordinate with your coverage under the Sandia Total Health Program.

Covered Prescriptions

IMPORTANT: FDA approval of a drug does not guarantee inclusion in the PDP. New drugs may be subject to review before being covered under the PDP or may be excluded based on program guidelines and policies.

Any licensed provider is legally authorized to prescribe medications to issue your prescription. To be covered, the prescription must be considered Medically Necessary. Consideration of Medical Necessity occurs when a clinician's request falls outside standard criteria. Medical Necessity is a case-by-case assessment based upon substantiated justification as documented by the treating health care professional. It must be in accordance with standard medical practice and clinical appropriateness to include but not limited to off-label and non-indicated uses. The PDP covers the following categories of drugs:

- Federal Legend Drugs – A medicinal substance that bears the legend “Caution: Federal Law prohibits dispensing without a prescription”
- State Restricted Drugs – A medicinal substance that, by state law, may be dispensed by prescription only
- Compounded Medications – A compounded prescription in a customized dosage form that contains at least one federal legend drug
- The following over-the-counter (OTC) medications/supplies:
 1. Transdermal patches for smoking cessation
 2. Nutritional supplements [requires a Prior Authorization (see [Prescriptions Requiring Prior Authorization](#) on page 75)]

3. Insulin and Diabetic Supplies – Supplies, including lancets, alcohol swabs, ketone test-strips (both blood and urine), and syringes, can be purchased in-network with a prescription and with coinsurance, or in-network without a prescription by paying the full price and submitting the claim to Catalyst Rx for reimbursement. (You will be reimbursed at the appropriate coinsurance.) The Mail-Order Program is also available for insulin and diabetic supplies purchased with a prescription. Continuous glucose monitoring systems (CGMS), insulin pump, and CGMS and insulin pump supplies, are not covered under the Prescription Drug Program.

Note: Medicare covers lancets and test strips.

- The following prescription devices/supplies:
 1. Insulin auto-injectors
 2. Lancet auto-injectors
 3. Glucagon auto-injectors (quantity limits apply)
 4. Epi-Pens (quantity limits apply)
 5. Aero-chambers, aero-chambers with masks, nebulizer masks (you may receive coverage under either the medical portion with BCBSNM or the Prescription Drug Program but not both)

Note: The PDP covers immunizations obtained and/or administered at retail network pharmacies at no cost to you. In addition, Catalyst Rx maintains a program whereby certified pharmacists within New Mexico are licensed to prescribe and administer certain vaccinations. To inquire about this program, contact Catalyst Rx at 866-854-8851.

Covered Preventive Medications

The Sandia Total Health Program will pay 100 percent of the cost at a retail network pharmacy for the following medications:

- One aspirin per day (generic only) to prevent cardiovascular disease for men age 45 to 79 and women age 55-79 as follows:
 - Aspirin 81 mg to 325 mg
 - Aspirin chew 81 mg to 325 mg
 - Aspirin delayed release 81 mg to 325 mg
 - Aspirin dispersible tab 80 mg
- Oral fluoride supplementation (prescription only) for children between the ages of 6 months and 5 years whose primary water source is deficient in fluoride as follows:
 - Sodium fluoride tab 0.5 mg
 - Sodium fluoride chew tab 0.25 mg to 0.5 mg
 - Sodium fluoride solution

- Folic acid tab 0.4 mg and 0.8 mg (one per day) for women age 55 or younger who may become pregnant
- Gardasil – 3 doses over a 6 month period – females age 9 to 26
- Hepatitis A and B vaccine
- Influenza vaccine
- Iron supplementation for children birth to one year of age as follows:
 - Iron suspension
 - Ferrous sulfate elixir, syrup and solution
- Meningococcal vaccine
- Pneumococcal vaccine – as needed
- Tobacco cessation products as follows:
 - Nicotrol Inhaler and Nasal Spray (refer to Prescriptions with Quantit Limits)
 - Zyban
 - Chantix
 - Nicotine patches
- Varicella (chicken pox)
- Zoster (Zostavax)/shingles – adults age 60 and older

Note: All preventive medications require a prescription, whether they are over the counter or not.

Preferred Versus Non-Preferred Status

Catalyst Rx maintains a Preferred Drug List (also known as a Formulary). Medications listed on the Preferred Drug List are selected according to safety, efficacy (whether the drug works for the indicated purpose), therapeutic merit (how appropriate the drug is for the treatment of a particular condition), current standard of practice, and cost. If a brand name drug appears on this List, you will pay the cost for the preferred brand name prescription drugs as outlined above. If a brand name drug does not appear on this List, you will pay the cost for the non-preferred brand name drugs as outlined above. Deletions to the Preferred Drug List are made on an annual basis with an effective date of January 1. Additions to the List are made quarterly.

The Preferred Drug List is the same for both the Mail-Order Program and the retail network pharmacies and is comprehensive for all major categories of acute and maintenance medications. To find out if a drug qualifies as a preferred brand name drug, you can either call Catalyst Rx at 866-854-8851 or look on the web at www.catalystrx.com (enter the Member ID# from your ID card, your date of birth and “Sandia” in the Rx Group Number field). Drugs listed on the Catalyst Rx Preferred Drug List may or may not be covered under the PDP. If, for some reason, you are unable to take any of the preferred alternatives, you, your pharmacist or your physician can initiate a Prior Authorization (PA) by contacting Catalyst Rx directly and requesting a PA for the medication. Refer to the information below for PA information. Catalyst Rx will contact your doctor and request the information necessary for a non-preferred brand name drug. Catalyst Rx will review the letter and make the decision as to whether you will be able to receive the non-preferred drug for the preferred brand name coinsurance amount.

Prescriptions Requiring Prior Authorization

A Prior Authorization (PA) is a clinical program that ensures appropriate use of prescription medications. You, your pharmacist or your physician can initiate a PA for the medication by contacting Catalyst Rx directly and requesting a PA for the medication. Medications subject to a PA require pre-approval from the Catalyst Rx Prior Authorization Team before they can qualify for coverage under this Program. The following prescriptions or therapeutic class of prescriptions are subject to the Prior Authorization process. This list is not all inclusive and is subject to change:

- Acne products for those ages 26 and older (e.g., Retin A/Renova/Differen/Avita)
- Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD) agents for those over the age of 17 (e.g., Ritalin)
- Anabolic steroids (e.g., Anadrol)
- Anorexiants (e.g., Meridia)
- Biologicals—immune globulins (e.g., Gamimune N)
- Botox
- Growth hormones (e.g., Humatrope)
- Nutritional supplements (e.g., Ensure, Phenyl-Free) (you may receive coverage under either the medical portion with BCBSNM or under the Prescription Drug Program but not both)
- Osteoarthritis agents (e.g., Synvisc)
- Prescription vitamins (other than pediatric and prenatal)
- Rebetrone
- Remicade
- Revatio
- Synagis
- Thyrogen
- Tussionex Suspension
- Viracept
- Zyvox
- Prescriptions that cost over \$1,000 at retail and \$3,000 at mail

Prescriptions Subject to Step Therapy Program

Step Therapy is a program designed to encourage the safe and cost-effective use of medication. Step Therapy requires that you try a “first-line medication” before a “second-line medication” will be covered. Drugs considered first-line therapy are well-supported treatment options and represents the most cost-effective agent for a given condition. The following prescriptions or therapeutic class of prescriptions are subject to the Step Therapy process. This list is not all-inclusive and is subject to change:

- Byetta
- Glucagon Kits/Pens
- Symlin

Prescriptions Subject to Quantity Limits

A Quantity Limit is a limitation on the number (or amount) of a prescription medication covered within a certain time period. Quantity Limits are established to ensure that prescribed quantities are consistent with clinical dosing guidelines, to control for billing errors by pharmacies, to encourage dose consolidation, appropriate utilization and to avoid misuse/abuse of the medication. Established quantity limits are based on the Federal Drug Administration and manufacturer dosing recommendations and/or current literature. Prescriptions written for quantities in excess of the established limits will require a Prior Authorization (refer to page 7-4) before the prescription can be filled. The following prescriptions or therapeutic class of prescriptions are subject to Quantity Limits. This list is not all-inclusive and is subject to change:

- Emergency contraceptive (e.g., Plan B) limited to two per year
- Epi-Pen (limited to three per year)
- Glucagon auto-injection (limited to two per year)
- Insulin auto injectors (limited to two per year)
- Lovenox (limited to seven days/14 injections)
- Nicotrol Nasal Spray (three inhaler kits per 30 days with a maximum of 360 days per lifetime)
- Sexual dysfunction drugs (e.g., Viagra) are limited to males only and eight pills/30 days at retail or 24 pills/90 days at mail
- Sleep aids (e.g., Ambien) are limited to 15 pills/30 days at retail or 45 pills/90 days at mail (limitation is waived if dispensed by a physician who is a sleep Specialist as determined by Catalyst Rx)
- Relpenza diskhaler (one per year)
- Revatio and Adcirca (93 in 31 days)
- Tamiflu (ten capsules per year)

Mail Service Program

Catalyst Rx partners with Walgreens Mail Service to offer a Mail Service Benefit. Walgreens Mail Service is a licensed pharmacy specializing in filling prescription drug orders for maintenance prescriptions. Maintenance prescription drugs are those taken routinely over a long period of time for an ongoing medical condition. Let your physician know that you are planning to use the Mail Service Program and request a 90-day prescription (with up to three refills). Verify that the prescription specifies the exact information for daily dosage, strength, quantity (e.g., number of pills, inhalers, tubes), and number of refills.

Registered pharmacist technicians are available 24 hours a day, seven days a week, at 866-854-8851, to answer medication-related questions. Prescriptions are delivered to your home. (You are not responsible for shipping and handling fees unless you request special shipping arrangements.) To obtain a maintenance prescription through the Mail Service Program, you pay the appropriate coinsurance for each prescription up to a 90-day supply.

If you send in a prescription through the Mail Service Program and Walgreens Mail Service does not carry the medication or if it is out of stock and Walgreens Mail Service does not anticipate getting the medication in a timely manner, you will be allowed to receive a 90-day supply at a retail network pharmacy for the applicable mail-order coinsurance. Contact Catalyst Rx at 866-854-8851 for assistance.

Note: If you are a patient in a nursing home that does not accept mail-order prescriptions, contact Catalyst Rx to make arrangements to receive up to a 90-day supply of medication at a retail network pharmacy for the applicable mail-order coinsurance. You must provide proof of residency in a nursing home.

Steps for Ordering and Receiving Mail Order Prescriptions (other than Specialty Medications)

Step	Action
1	Forms Obtain a Walgreens Mail Service Registration & Prescription Order Form from the hbe.sandia.gov or www.catalystrx.com .
2	Ordering Original Prescriptions Complete the Walgreens Mail Service Registration & Prescription Order Form. Attach your original written prescription (with your Member Identification number and address written on the back). Make sure your physician has written the prescription for a 90-day supply with applicable refills. Enclose the required coinsurance using a check or money order, or complete the credit card section on the form. Mail all to Walgreens Mail Service, P.O. Box 29061, Phoenix, AZ 85038-9061. Your physician may also call in the prescription to Walgreens at 866-854-8851 or fax it to 800-332-9581. Note: If you need medication immediately, ask your doctor for two (2) separate prescriptions – one for a 30-day supply to be filled at a network retail pharmacy, and one to be filled by mail service. Wait and send in your mail service prescription two weeks after you fill your prescription at the retail network pharmacy to avoid any delays with your mail service prescription.
3	Delivery Expect delivery to your home by first-class mail or second-day carrier within seven to ten working days from the date you mail your order. Signature from an adult may be required for acceptance.
4	Refills Refilling a mail service order prescription can be done by phone, fax, mail, or through the web. It is recommended that you order three weeks in advance of your current mail service prescription running out. Refill-by-Phone: Call 866-854-8851 to order refills. You may use the automated refill system 24 hours a day. Customer service representatives are available Monday through Friday from 6:00 a.m. to 8:00 p.m. MT and on Saturday and Sunday from 6:00 a.m. to 3:00 p.m. MT. Refill-by-Fax: Have your physician complete the Fax Order Form (which is part of the Walgreens Mail Service Registration & Prescription Order Form). The physician (not you) must fax the form to 1-800-332-9581. Note: Schedule II prescriptions cannot be faxed. Refill-by-Mail: Complete the Prescription Order Form (attached to the bottom of your customer receipt), making sure you adhere the refill label provided or write the prescription number in the space provided. Mail in the self-addressed, postage-paid envelope. Refill through the Web: Go to www.catalystrx.com . On the left hand side of your screen, select “Mail Service Refills.” Next, click on WalgreensMail.com on the right hand side of your screen. From there, follow the instructions to place your refill order. You must access the mail order website from www.catalystrx.com . You will need to use one of the accepted credit cards for payment.

Brand-To-Generic Substitution

Every prescription drug has two names: the trademark, or brand name; and the chemical, or generic name. By law, both brand name and generic drugs must meet the same standards for safety, purity, strength, and quality.

Example: Tetracycline is the generic name for a widely used antibiotic. Achromycin is the brand name.

Many drugs are available in generic form. Generic drugs offer substantial cost savings over brand names; therefore, the Mail-Service Program has a generic substitution component. Unless your doctor has specified that the prescription be dispensed as written, your prescription will be filled with the least expensive acceptable generic equivalent when available and permissible by law. If you receive a generic medication in place of the brand name medication, and you want the brand name medication, you will need to obtain a new prescription stating “no substitution” or “dispense as written” and resubmit it along with the required coinsurance.

EXCEPTION: This provision does not apply to brand name drugs that do not have an FDA A- or AB-rated generic equivalent available.

Retail Pharmacies

Retail pharmacies are available if you need immediate, short-term prescription medications, and/or prescription medications that cannot be shipped through the mail.

Using the Network Retail Pharmacies

Catalyst Rx has contracted with specific retail pharmacies across the nation that will provide prescriptions to Sandia at discounted rates. These pharmacies are known as retail network pharmacies. To locate the pharmacy nearest you, call Catalyst Rx at 866-854-8851 or visit www.catalystrx.com.

To obtain a medication through a retail network pharmacy, you will need a written prescription from your physician. Present the prescription and your Catalyst Rx ID card to the pharmacist. The card is required to identify that you are covered under the Program in order to remit the appropriate coinsurance. If you do not show your ID card at a retail network pharmacy, you will be required to pay the full non-discounted price and you cannot submit this for reimbursement.

If you request a prescription to be filled in a retail network pharmacy for more than a 30 day supply, the pharmacist will fill only 30 days for the appropriate coinsurance of 20 percent, 30 percent, or 40 percent and hold the rest as refills. When you need a refill, return to the pharmacy, pay another coinsurance amount, and receive another maximum 30-day supply (or up to the amount prescribed by the physician).

Using the Out-of-Network Retail Pharmacies

If you choose to purchase a prescription through an out-of-network pharmacy, you will be reimbursed 50 percent of the cost for up to a 30 day supply. Any amounts over a 30 day supply will be denied. Refer to Section 10, How to File a Claim.

Specialty Drug Management Program

Specialty medications must be purchased through the Catalyst Rx Specialty Drug Management Program, supported through the Walgreens Specialty Pharmacy, in order to be eligible for coverage. Specialty drugs are prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions such as cancer, hepatitis C, multiple sclerosis, rheumatoid arthritis, etc. To find out if your prescription falls into this category, call Catalyst Rx at 866-854-8851.

Under this Program, your prescription will be limited to a 30-day supply and will be subject to the retail coinsurance level of benefits. Any amounts over a 30-day supply will be denied. There is no additional cost to you above your required coinsurance. In addition to your medication, you will also receive the necessary supplies for administration such as alcohol swabs and syringes at no additional cost. The Specialty Pharmacy is staffed by experienced pharmacists who are specially trained in complex health conditions and the latest therapies to provide support, counseling and assistance with medication management. The Specialty Pharmacy can be reached at 866-823-2712 Monday through Friday, 8:00 a.m. to 7:00 p.m. ET.

Steps for Ordering and Receiving Specialty Prescriptions

Step	Action	
1	Ordering Original Prescriptions	Your physician submits the prescription for you directly to Walgreens Specialty Pharmacy by fax, telephone or mail. Your information is entered into the ordering system and a pharmacist reviews it for completeness and contacts your physician, if necessary.
2	Payment	Walgreens Specialty will call you to confirm your insurance and to let you know what the coinsurance will be. You must have a credit card on file. Walgreens Specialty will bill the card you have on file for the applicable coinsurance.
3	Delivery	Walgreens Specialty will call you to schedule a delivery date. Expect delivery to your home (unless you made alternative shipping arrangements with Walgreens Specialty directly) via overnight mail. Most orders ship via UPS or Federal Express for next day delivery.
4	Refills	Once enrolled, Walgreens Specialty Pharmacy will call you 10-14 days prior to your next dose. However, if you have not received a phone call, please contact Walgreens Specialty to avoid any disruption in your therapy. Walgreens Specialty will confirm your information and schedule a delivery date at your convenience.

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Section 8. What's Not Covered – Exclusions

Although the Sandia Total Health Program provides benefits for a wide range of Covered Health Services, there are specific conditions or circumstances for which the Sandia Total Health Program will not provide benefit payments. In general, any expense that is primarily for your convenience or comfort or that of your family, caretaker, physician, or other medical provider will not be covered. For additional limitations under the Prescription Drug Program, refer to Section 7, Prescription Drug Program.

You should be aware of these exclusions that include, but are not limited to, items in the following table.

Exclusions	Examples
Administrative fees, penalties, and limits	Charges that exceed what the claims administrator determines are Covered Charges, as defined Insurance filing fees, attorney fees, physician charges for information released to claims administrator, and other service charges and finance or interest charges Amount you pay as a result of failure to contact BCBSNM for Preauthorization, including unauthorized care Employee Assistance Program services when you do not obtain Preauthorization from Magellan Health Services Charges incurred for services rendered that are not within the scope of a provider's licensure Charges for missed appointments
Ambulance	Non-Emergency ambulance services (e.g., home to physician for an office visit)
Behavioral Health Services	Behavioral health services that are considered to be at a maintenance level of care. Family therapy, including marriage counseling and bereavement counseling. Family therapy, marriage counseling, and bereavement counseling are covered for employees and their dependents only through the Employee Assistance Program. Conduct disturbances unless related to a coexisting condition or diagnosis otherwise covered Educational, vocational, and/or recreational services as Outpatient procedures Biofeedback for treatment of diagnosed medical conditions Treatment for learning disabilities and pervasive developmental disorders (including autism) other than diagnostic evaluation Treatment for insomnia, other sleep disorders, dementia, neurological disorders, and other disorders with a known physical basis (certain treatments may be covered under the medical portion of this Program) Treatment that is determined by BCBSNM to be for your personal growth or enrichment Court-ordered placements when such orders are inconsistent with the recommendations for treatment of a BCBS PPO network provider for mental health or Chemical Dependency Services to treat conditions that are identified by the most current edition of the Diagnostic and Statistical Manual of Mental Disorders as not being attributable to a mental disorder Sex transformations Any services or supplies that are not Medically Necessary Custodial Care

Exclusions	Examples
Behavioral Health Services (cont.)	<p>Pastoral counseling</p> <p>Developmental Care</p> <p>Treatment for caffeine or tobacco addictions, withdrawal, or dependence</p> <p>Aversion therapies</p> <p>Treatment for codependency</p> <p>Non-abstinence-based or nutritionally-based treatment for Chemical Dependency</p> <p>Services, supplies, or treatments that are covered under the medical part of this Program</p> <p>Treatment or consultations provided via telephone</p> <p>Services, treatments, or supplies provided as a result of a Worker's Compensation law or similar legislation, or obtained through, or required by, any government agency or program, whether federal, state, or any subdivision, or caused by the conduct or omission of a third party for which you have a claim for damages or relief, unless you provide UBH with a lien against the claim for damages or relief in a form and manner satisfactory to UBH</p> <p>Non-organic erectile dysfunction (psychosexual dysfunction)</p> <p>Treatment for conduct and impulse control disorders, personality disorders, paraphilias (unusual sexual urges), and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by BCBSNM</p> <p>Services or supplies that:</p> <ul style="list-style-type: none"> • Are considered Unproven, Experimental or Investigational drugs, devices, treatments, or procedures • Result from or relate to the application of such Experimental or Investigational drugs, devices, treatments, or procedures <p>Wilderness programs, boot camp-type programs, work camp-type programs, or recreational-type programs</p> <p>Services or supplies that are primarily for your education, training, or development of skills needed to cope with an Injury or Illness</p> <p>Chemical Dependency benefits for Class II dependents</p>
Biofeedback	Biofeedback is not a Covered Health Service
Congenital Heart Disease	CHD services other than as listed under "Coverage Details" under Section 6, Covered Medical Plan Services/Limitations.
Dental Procedures	<p>Dental procedures are not covered under this Sandia Total Health Program except for Injuries to Sound, Natural Teeth, the jawbone, or surrounding tissue, or birth defects. Treatment must be initiated within one year of Injury.</p> <p>Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not covered.</p>
Drugs	<p>In addition to the clinical guideline limitation imposed by Catalyst Rx (see Section 7, "Prescription Drug Program" – Covered Prescriptions), the Program excludes coverage for certain drugs, supplies, and treatments, which include, but are not limited to, the following:</p> <p>Over-the-counter medications unless specifically included</p> <p>Fluoride preparations (other than for ages 6 months to 5 years) and dental rinses</p> <p>Contraceptive foams, jellies, and ointments</p> <p>Drugs labeled "Caution: Limited by Federal Law to Investigational use or Experimental drugs"</p>

Exclusions	Examples
Drugs (cont.)	<ul style="list-style-type: none"> Experimental drugs are defined as “a therapy that has not been or is not scientifically validated with respect to safety and efficacy.” Investigational drugs are defined as “those substances in any of the clinical stages of evaluation which have not been released by the Food and Drug Administration (FDA) for general use or cleared for sale in interstate commerce. It also includes those drugs that are in any of the clinical stages of evaluation (Phase I, II, and III) which have not been released by the FDA for general use or cleared for sale in interstate commerce.” <p>Glucose tablets</p> <p>Drugs used for cosmetic purposes</p> <p>Prescription drugs that may be properly received without charge under local, state, or federal programs, including Workers Compensation</p> <p>Refills of prescriptions in excess of the number specified by the physician</p> <p>Refills dispensed after one year from the date of order by the physician</p> <p>Prescription Drugs purchased for those who are ineligible for coverage under the Sandia Total Health Program</p> <p>Prescription Drugs taken by a donor who is not insured under the Sandia Total Health Program</p> <p>Medicine not Medically Necessary for the treatment of a disease or an Injury</p> <p>The following are excluded by the Prescription Drug Program but may be covered by BCBSNM if Medically Necessary:</p> <ul style="list-style-type: none"> Ostomy supplies Blood glucose meters Implantable birth control devices such IUDs Allergy serum External Insulin pumps and supplies Continuous glucose monitoring systems and supplies Medication that is dispensed and/or administered by a licensed facility or provider such as a hospital, home health care agency, or physician’s office, and the charges are included in the facility or provider bill to BCBSNM
Equipment	<p>Exercise equipment (e.g., exercycles, weights, etc.)</p> <p>Hearing aids for hearing loss except for dependents up to age 21 and for Illness or Injury (see benefit under hearing aids for more details)</p> <p>Braces prescribed to prevent injuries while you are participating in athletic activities</p> <p>Household items, including, but not limited to</p> <ul style="list-style-type: none"> Air cleaners and/or humidifiers Bathing apparatus Scales or calorie counters Blood pressure kits Water beds <p>Personal items, including, but not limited to</p> <ul style="list-style-type: none"> Support hose, except Medically Necessary surgical or compression stockings Foam cushions Pajamas <p>Equipment rental fees above the purchase price, with the exception of oxygen equipment</p>

Exclusions	Examples
Experimental or Investigative or Unproven Treatment	<p>Experimental or Investigational Services or Unproven Services, unless the Sandia Total Health Program has agreed to cover them in Section 6, "Covered Medical Plan Services/Limitations."</p> <p>Note: This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices, or pharmacological regimens are the only available treatment option for your condition.</p> <p>Note: This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which benefits are provided as described under clinical trials.</p>
Genetic Testing/Counseling	<p>Experimental or Investigational or Unproven genetic testing is not covered. In addition, genetic counseling, including service for evaluation and explaining the implications of genetic or inherited disease, whether provided by physicians or non-physician health professionals, for the interpretation of family and medical histories to assess the risk of disease occurrence or recurrence, and for assisting in making treatment decisions based upon the risk of disease occurrence or recurrence is not covered. Refer to Genetic Testing/Counseling and Preventive Care for covered services.</p>
Hospital Fees	<p>Expenses incurred in any federal hospital, unless you are legally obligated to pay Hospital room and board charges in excess of the semi-private room rate unless Medically Necessary and approved by BCBSNM</p> <p>In-hospital personal charges (e.g., telephone, barber, TV service, toothbrushes, slippers)</p>
Hypnotherapy	<p>Hypnotherapy is not a Covered Health Service</p>
Infertility, Reproductive, and Family Planning	<p>Purchase of eggs</p> <p>Services related to or provided to anonymous donors</p> <p>Services provided by a doula (labor aide)</p> <p>Storing and preserving sperm</p> <p>Donor expenses related to donating eggs/sperm (including prescription drugs); however, charges to extract the eggs from a covered employee for a donor are allowed</p> <p>Expenses incurred by surrogate mothers</p> <p>Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes</p> <p>Over-the-counter medications for birth control/prevention</p> <p>Parenting, pre-natal, or birthing classes</p>
Miscellaneous	<p>Eye exams except as outlined under Section 6, "Covered Medical Plan Services/Limitations"</p> <p>Eyeglasses or contact lenses prescribed, except as outlined under Section 6, "Covered Medical Plan Services/Limitations." Contact lenses are not considered a prosthetic device.</p> <p>Modifications to vehicles and houses for wheelchair access</p> <p>Health club memberships and programs or spa treatments</p> <p>Treatment or services</p> <ul style="list-style-type: none"> Incurred when the patient was not covered under this Sandia Total Health Program even if the medical condition being treated began before the date your coverage under the Sandia Total Health Program ends For Illness or Injury resulting from your intentional acts of aggression,

Exclusions	Examples
Miscellaneous (cont.)	<p>including armed aggression, except for injuries inflicted on an innocent bystander (e.g., you did not start the act of aggression)</p> <ul style="list-style-type: none"> • For job-incurred Injury or illness for which payments are payable under any Workers Compensation Act, Occupational Disease Law, or similar law • While on active military duty • That are reimbursable through any public program other than Medicare or through no-fault automobile insurance <p>Charges in connection with surgical procedures for sex changes</p> <p>Charges for blood or blood plasma that is replaced by or for the patient</p> <p>Conditions resulting from insurrection, except for injuries inflicted on an innocent bystander who is covered under this Sandia Total Health Program</p> <p>Christian Science practitioners and facilities</p> <p>Food of any kind unless it is the only source of nutrition, there is a diagnosis of dysphagia (difficulty swallowing), in case of terminal cancer, or in cases of PKU or RH factor.</p> <p>Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk unless listed as covered</p> <p>Foods to control weight, treat obesity (including liquid diets), lower cholesterol, or control diabetes</p> <p>Oral vitamins and minerals (with the exception of certain prescription vitamins) as outlined in Section 7, "Prescription Drug Program"</p> <p>Herbs and over-the-counter medications except as specifically allowed under the Sandia Total Health Program</p> <p>Charges prohibited by federal anti-kickback or self-referral statutes</p> <p>Chelation therapy, except to treat heavy metal poisoning</p> <p>Diagnostic tests that are:</p> <ul style="list-style-type: none"> • Delivered in other than a physician's office or health care facility • Self-administered home-diagnostic tests, including, but not limited to, HIV and pregnancy tests <p>Domiciliary care</p> <p>Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for ten seconds or longer). Appliances for snoring are always excluded.</p> <p>Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments when:</p> <p>Required solely for purposes of career, education, camp, employment, insurance, marriage or adoption; or as a result of incarceration</p> <ul style="list-style-type: none"> • Conducted for purposes of medical research • Related to judicial or administrative proceedings or orders or • Required to obtain or maintain a license of any type <p>Private duty nursing received on an inpatient basis</p> <p>Respite care</p>

Exclusions	Examples
Miscellaneous (cont.)	Rest cures Storage of blood, umbilical cord, or other material for use in a Covered Health Service, except if needed for an imminent surgery
Not a Covered Health Service and/ or Not Medically Necessary	<p>These health services, including services, supplies which are not:</p> <ul style="list-style-type: none"> • Provided for the purpose of preventing, diagnosing or treating Illness, Injury, mental illness, Chemical Dependency or their symptoms; • Consistent with nationally recognized scientific evidence, as available, and prevailing medical standards and clinical guidelines; • For the convenience of the covered person, physician, facility or any other person; • Included in Section 6, "Covered Medical Plan Services/Limitations"; • Provided to a Member who meets the Sandia Total Health Program's eligibility requirements; and • Not identified in general Program exclusions.
Old Claims	Claims received one year after the date charges are incurred
Physical Appearance	<p>Breast reduction/augmentation surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which the claims administrator determines is requested to treat a physiologic functional impairment or coverage required by the Women's Health and Cancer Right's Act of 1998.</p> <p>Any loss, expense, or charge that results from cosmetic or reconstructive surgery, except after breast cancer. Exceptions to this exclusion include:</p> <ul style="list-style-type: none"> • Repair of defects that result from surgery for which you were paid benefits under the Program • Reconstructive (not cosmetic) repair of a congenital defect that materially corrects a bodily malfunction. <p>Note: For the purposes of this exclusion, poor self-image or emotional or psychological distress does not constitute a bodily malfunction.</p> <p>Liposuction</p> <p>Pharmacological regimens</p> <p>Nutritional procedures or treatments</p> <p>Tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures)</p> <p>Replacement of an existing intact breast implant unless there is documented evidence of silicon leakage</p> <p>Physical conditioning programs, such as athletic training, body building, exercise, fitness, flexibility, and diversion or general motivation</p> <p>Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity (except that certain surgical procedures may be covered if the patient meets criteria listed in Section 6 and has the procedure Preauthorized by BCBSNM)</p> <p>Wigs regardless of the reason for hair loss</p> <p>Treatments for hair loss</p>

Exclusions	Examples
Providers	<p>Services:</p> <ul style="list-style-type: none"> • Performed by a provider who is a family member by birth or marriage, including your spouse, brother, sister, parent, or child • A provider may perform on himself or herself • Performed by a provider with your same legal residence • Provided at a diagnostic facility (hospital or otherwise) without a written order from a provider • Ordered by a provider affiliated with a diagnostic facility (hospital or otherwise) when that provider is not actively involved in your medical care <ul style="list-style-type: none"> ○ Prior to ordering the service or ○ After the service is received <p>This exclusion does not apply to mammography testing.</p>
Services, supplies, therapy, or treatments	<p>Charges that are:</p> <ul style="list-style-type: none"> • Custodial in nature • Otherwise free of charge to you • Furnished under an alternative medical plan provided by Sandia • For aromatherapy or rolfing (holistic tissue massage) • For Developmental Care after a maintenance level of care has been reached • For Maintenance Care • For massage therapy unless performed by a licensed chiropractor, physical therapist, or physician as a manual therapy technique for lymphatic drainage • Educational therapy when not Medically Necessary • Educational testing • Smoking-cessation programs unless covered under Preventive Care in Section 6 • Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia, and astigmatism, including but not limited to procedures such as laser and other refractive eye surgery and radial keratotomy
Surgical and nonsurgical treatment for obesity	<p>Treatment for over-the-counter appetite control, food addictions, or eating disorders that are not documented cases of bulimia or anorexia meeting standard diagnostic criteria as determined by BCBSNM/BCBSNM Behavioral Health</p> <p>The following treatments for obesity:</p> <ul style="list-style-type: none"> • Non-surgical treatment, even if for morbid obesity, and • Surgical operations for the correction of morbid obesity determined by BCBSNM not to be Medically Necessary and/or not meeting the criteria outlined in Section 6

Exclusions	Examples
Transplants	<p>Health services for organ and tissue transplants except as identified under Organ Transplants in Section 6, “Covered Medical Plan Services/Limitations,” unless BCBSNM determines the transplant to be appropriate according to BCBSNM’s transplant guidelines.</p> <p>Determined by BCBSNM to be Unproven procedures for the involved diagnoses</p> <p>Not consistent with the diagnosis of the condition</p> <p>Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available)</p> <p>Donor costs for organ or tissue transplantation to another person unless the recipient is covered under the Sandia Total Health Program</p>
Transportation	<p>Non-Emergency ambulance services are not covered.</p> <p>Transportation, except ground ambulance and air ambulance services as outlined in Section 6, Covered Medical Plan Services/Limitations and as described in Section 3 if the Member uses a Blue Distinction Center for Specialty Care for a covered transplant, cardiac care admission, or cancer treatment</p>
Travel	<p>Travel or transportation expenses, even if ordered by a physician, except as identified under Travel and Lodging in Section 3, Accessing Care.</p>

Section 9. Coordination of Benefits (COB)

Coordination of Benefits (COB) is the provision that allows families with different employer group health plan coverage to receive up to 100 percent coverage for Covered Health Services. Under COB your health plan as the employee provides primary coverage for you and your spouse's health plan through his or her employer provides primary coverage for him or her.

Refer to the *Sandia Health Benefits Plan for Employees Summary Plan Description* or the *Sandia Health Benefits Plan for Retirees Summary Plan Description* for more information on COB policy and rules for determining which plan provides primary coverage.

This medical Sandia Total Health Program contains a COB provision so that the benefits paid or provided by all employer group plans are not more than the total allowable expenses under this medical Sandia Total Health Program. The medical Sandia Total Health Program will not pay more than 100 percent of the cost of the medical treatment, nor will it pay for treatment or services not covered under this medical Sandia Total Health Program.

"Covered Health Expense" means a health care expense, including deductibles, Coinsurance, and Copayments, that is covered at least in part by any of the group health plans covering the person. An expense or an expense for a Covered Health Service that is not covered by any of the group health plans is not a Covered Health Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not a Covered Health Expense. The following are additional examples of expenses or Services that are not Covered Health Expenses:

- If a covered person is confined in a private hospital room, the difference between the cost of a semi-private hospital room and the private room (unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice, or one of the group health plans routinely provides coverage for hospital private rooms) is not a Covered Health Expense.
- If a person is covered by two or more group health plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest of the usual and customary fees (or other reimbursement amount) for a specific benefit is not a Covered Health Expense.
- If a person is covered by two or more group health plans that provide benefits or Services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not a Covered Health Expense.
- If a person is covered by one group health plan that calculates its benefits or Services on the basis of usual and customary fees and another group health plan that provides its benefits or Services on the basis of negotiated fees, the primary plan's payment arrangements shall be the Covered Health Expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or Service for a payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Covered Health Expense used by the secondary plan to determine its benefits.
- The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions is not a Covered Health Expense. Examples of these provisions are second surgical opinions, precertification of admissions, etc.

Refer to Section 3 of the *Sandia Health Benefits Plan for Employees Summary Plan Description* or the *Sandia Health Benefits Plan for Retirees Summary Plan Description* for more information on “Special Rules for Covered Medicare-Primary Members” and “Provision for Covered Members with End-Stage Renal Disease (ESRD).”

Beginning January 1 of every year or if you are a new enrollee, you are required to provide an update to BCBSNM on whether any of your covered family members have other insurance. This notification is also required if your family member enrolls in another medical plan during the year. If you do not provide this information to BCBSNM, your covered family members’ claims may be denied. You may update your other insurance information by calling BCBSNM at 877-498-7652.

Refer to Section 7, Prescription Drug Program for information on eligibility to use the Prescription Drug Program, as well as how COB works, if your covered family member has other insurance coverage.

Section 10. How to File a Claim

This section provides an overview of how to file a claim and the receipt of benefit payments under the Sandia Total Health Program.

Filing an Initial Claim

Refer to Section 8, Claims and Appeals of the *Sandia Health Benefits Plan for Employees Summary Plan Description* or the *Sandia Health Benefits Plan for Retirees Summary Plan Description* for claim definitions, timeframes for disposition of Urgent Care, pre-service, concurrent care, and post-service claims, and the information that you are entitled to receive from the claims administrator upon processing of your claim.

IMPORTANT: All claims must be submitted within one year from the date of service in order to be eligible for consideration of payment. This one-year requirement will not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends. It is recommended that claims be submitted as soon as possible after the medical or prescription expenses are incurred. If you need assistance in filing a claim, call BCBSNM Customer Service at 877-498-7652 for medical claims or call Catalyst Rx for prescription drug claims at 866-854-8851.

Sandia Health Partner Network (HPN)/In-Network Claims Processing

Generally, when you seek services through a Sandia HPN or in-network provider, the provider verifies eligibility and submits the claims directly to the claims administrator for processing. There are generally no claim forms necessary to obtain Sandia HPN/ in-network benefits. Refer to [Section 5, Health Reimbursement Account](#) for information on payments from your HRA, and [Section 7, Prescription Drug Program](#) for information on how to use network retail and mail order pharmacy benefits.

Out-of-Network Claims Processing

When you seek services through an out-of-network provider, you will need to submit the claim for reimbursement. The provider may not verify eligibility. It is your responsibility to verify you are eligible for benefits by either calling the claims administrator or going to www.bcbsnm.com/sandia or www.catalystrx.com. You can obtain claim forms from the claims administrator or at hbe.sandia.gov.

Submit the claim form to the claims administrator immediately after the expense is incurred but no later than one year from the date of service. Refer to the Important box on the previous page. Completion and submission of the claim form does not guarantee eligibility for benefits.

Process for Out-of-Network Claims Processing for Medical Care

To obtain reimbursement for medical care, attach the itemized medical bill to the claim form and mail it to the address shown on the claim form or the address on your BCBSNM Member ID card. Itemized medical bills should include:

- Patient's full name and relationship to the Primary Covered Member

- Primary Covered Member's name and BCBSNM identification number and group number
- Date and place of treatment or purchase
- Diagnosis
- Type of service provided
- Amount charged
- Name and address of provider and tax identification number, if available
- If other insurance is primary, the EOB (from the primary insurer) attached to your claim form

When covered services are received from nonparticipating providers, mail the forms and itemized bills to the local Blue Cross Blue Shield Plan in the state where services were received. If a provider will not file a claim for you, ask for an itemized bill and complete the claim form the same way that you would for services received from any other nonparticipating provider. Send claims to:

Blue Cross and Blue Shield of New Mexico
P.O. Box 27630
Albuquerque, New Mexico 87125-7630

If services are received from a Nonpreferred Provider in New Mexico, payments are usually made to the Primary Covered Member (or to the applicable alternate payee when a *Qualified Medical Child Support Order* is in effect). The check will be attached to an EOB that explains BCBSNM's payment. In these cases, you are responsible for arranging payment to the provider and for paying any amounts greater than Covered Charges plus Deductibles, Coinsurance, any penalty amounts, and noncovered expenses.

If a *Qualified Medical Child Support Order* (QMCSO) or a properly completed *National Medical Support Notice* (NMSN) is in effect and conforms to ERISA requirements, the QMCSO or NMSN provisions will be followed. Refer to the *Sandia Health Benefits Plan for Employees Summary Plan Description* or the *Sandia Health Benefits Plan for Retirees Summary Plan Description* for more information.

Medicaid — Payment of benefits for Members eligible for Medicaid is made to the appropriate state agency or to the provider when required by law.

Outside the United States, U.S. Virgin Islands, Jamaica, Puerto Rico, or Canada — For covered **inpatient hospital** services received outside the United States (including Puerto Rico, Jamaica, and the U.S. Virgin Islands) and Canada, show your Plan ID card issued by BCBSNM. BCBSNM participates in a claims payment program with the Blue Cross and Blue Shield Association. If the hospital has an agreement with the Association, the hospital files the claim for you to the appropriate Blue Cross Plan. Payment is made to the hospital by that Plan, and then BCBSNM reimburses the other Plan.

You will need to pay up front for care received from a **doctor**, a **participating Outpatient hospital**, and/or a **nonparticipating hospital**. Then, complete an international claim form and send it with the bill(s) to the BlueCard Worldwide Service Center (the address is on the form). The *International Claim Form* is available from BCBSNM, the BlueCard Worldwide Service Center, or online at www.bcbs.com/coverage/bluecard/bluecard-worldwide.html.

The BlueCard Worldwide *International Claim Form* is to be used to submit institutional and professional claims for benefits for covered services received outside the United States, Puerto Rico, Jamaica and the U.S. Virgin Islands. The *International Claim Form* must be completed for each patient in full, and accompanied by fully itemized bills. It is not necessary for you to provide an English translation or convert currency.

Since the claim cannot be returned, please be sure to keep photocopies of all bills and supporting documentation for your personal records. The Member should submit an *International Claim Form*, attach itemized bills, and mail to BlueCard Worldwide at the address below. BlueCard Worldwide will then translate the information, if necessary, and convert the charges to United States dollars. They also will contact BCBSNM for benefit information in order to process the claim. Once the claim is finalized, and *Explanation of Benefits* will be mailed to the Primary Covered Member and payment, if applicable, will be made to the subscriber via wire transfer or check. Mail international claims to:

**BlueCard Worldwide Service Center
P.O. Box 72017
Richmond, VA 23255-2017 USA**

Process for Out-of-Network Claims Processing for Prescription Drugs

If you have a prescription filled by an out-of-network pharmacy, complete a Direct Member Reimbursement Form, attach pharmacy receipts, and send your claim to Catalyst Rx, P.O. Box 1069, Rockville, MD 20849-1069.

Benefits Payments

Refer to the *Sandia Health Benefits Plan for Employees Summary Plan Description* or the *Sandia Health Benefits Plan for Retirees Summary Plan Description* for general information on benefits payments.

BCBSNM will pay benefits directly to you for all Out-of-Network providers.

Catalyst Rx will pay benefits to the provider when you use a network or mail order pharmacy. If you use an out-of-network provider, Catalyst Rx will pay any applicable benefits to you.

Note: The person who receives a service is ultimately responsible for payment of services received from the providers.

BCBSNM will send you an Explanation of Benefits (EOB) each time they process a claim for you or a covered family member. The EOB statement is a summary of your recent claims, plus remaining balances for your HRA, Deductibles, and Out-of-Pocket Maximums in one easy-to-read format. You may also view your EOBs online through BlueAccess for Member at www.bcbsnm.com/sandia.

If any claims are denied in whole or in part, you will still receive an Explanation of Benefits (EOB) which will include the reason for the denial or partial payment. The EOB will let you know if there is any portion of the bill you need to pay.

If you would rather track claims online, you may elect to discontinue receipt of paper EOBs at www.bcbsnm.com/sandia. You may also elect to continue to receive EOBs by making the appropriate elections online or by calling BCBSNM Customer Service at 877-498-7652.

For eligible prescription drug claims processed through a Direct Member Reimbursement Form, you will receive an EOB with the payment from Catalyst Rx.

Pricing of Non-contracted Provider Claims

The BCBSNM Covered Charge for some Covered Health Services received from Nonpreferred Providers is the lesser of the provider's billed charges or the BCBSNM "Noncontracting Allowable Amount." The BCBSNM Noncontracting Allowable Amount is based on the **Medicare Allowable** amount for a particular service, which is determined by the Centers for Medicaid and Medicare Services (CMS). The Medicare Allowable is determined for a service covered under this medical plan using information on each specific claim and, based on place of treatment and date of service, is multiplied by an "adjustment factor" to calculate the BCBSNM Noncontracting Allowable Amount. The adjustment factors for nonemergency services are 100% of the base Medicare Allowable.

Certain categories of claims for **Covered Health Services** from Nonpreferred Providers are excluded from this noncontracted provider pricing method. These include:

- Services for which a Medicare Allowable cannot be determined based on the information submitted on the claim (in such cases, the Covered Charge is 50 percent of the billed charge)
- Home health claims (the Covered Charge is 50 percent of the billed charge)
- Services administered and priced by any subcontractor of BCBSNM or by the Blue Cross Blue Shield Association
- Claims paid by Medicare as primary coverage and submitted to this medical plan for secondary payment
- Ground ambulance claims (for which the state's Public Regulatory Commission sets fares)

BlueCard Program

BCBSNM hereby informs you that other Blue Cross and Blue Shield Plans outside of New Mexico ("Host Blue") may have contracts with certain providers in their service areas. Under BlueCard, when you receive Covered Health Services outside of New Mexico from a Host Blue contracting provider that does not have a contract with BCBSNM, the amount you pay for Covered Health Services is calculated on the lower of:

- The billed charges for your Covered Health Services, or
- The negotiated price that the Host Blue passes on to BCBSNM.

Often, this "negotiated price" is a **simple discount** that reflects the actual price the Host Blue pays. Sometimes, it is an **estimated price** that takes into account special arrangements the Host Blue has with an individual provider or a group of providers. Such arrangements may include settlements, withholds, non-claims transactions, and/or other types of variable payments. The "negotiated price" may also be an **average price** based on a discount that results in expected average savings (after taking into account the same special arrangements used to obtain an estimated price). Average prices tend to vary more from actual prices than estimated prices.

Negotiated prices may be adjusted from time to time to correct for over- or under-estimation of past prices. However, the amount used by BCBSNM to calculate your share of the billed amount is considered a final price.

Laws in a small number of states may require the Host Blue to 1) use another method for, or 2) add a surcharge to, your liability calculation. If any state laws mandate other liability calculation methods, including a surcharge, BCBSNM would calculate your liability for any covered services according to the applicable state law in effect when you received care. Surcharges are not your responsibility.

Independent Contractors

The relationship between BCBSNM and its network providers is that of independent contractors; physicians and other providers are not agents or employees of BCBSNM, and BCBSNM and its employees are not employees or agents of any network provider. BCBSNM 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 network provider. The relationship between BCBSNM and Sandia National Labs is that of independent contractors; the employer is not an agent or employee of BCBSNM, and BCBSNM and its employees are not employees or agents of Sandia National Labs.

Sending Notices

All notices to you are considered to be sent to and received by you when deposited in the United States mail with first-class postage prepaid and addressed to the Primary Covered Member at the latest address on BCBSNM membership records or to the employer.

Membership Records

BCBSNM will keep membership records, and Sandia will periodically forward information to BCBSNM to administer the benefits of this medical plan. You can inspect all records concerning your membership in this medical plan during normal business hours given reasonable advance notice.

Disclosure and Release of Information

BCBSNM will only disclose information as permitted or required under state and federal law.

Research Fees

BCBSNM reserves the right to charge you an administrative fee when extensive research is necessary to reconstruct information that has already been provided to you in the Explanations of Benefits, letters, or other forms.

Recovery of Excess Payment

The claims administrator has the right at any time to recover any amount paid by the Sandia Total Health Program for covered charges in excess of the amount that should have been paid under the provisions. Payments may be recovered from you, providers of service, and other medical care plans.

IMPORTANT: By accepting benefits under the Sandia Total Health Program, you agree to reimburse payments made in error and cooperate in the recovery of excess payments.

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Section 11. How to File an Appeal

This section outlines how to file an appeal with either BCBSNM or Catalyst Rx. The respective claims administrator will notify you of the decision regarding any appeal within the applicable time frames. Refer to Section 8, Claims and Appeals section of the *Sandia Health Benefits Plan for Employees Summary Plan Description* or the *Sandia Health Benefits Plan for Retirees Summary Plan Description* for information on general appeal time frames under ERISA, as well as your right to information that you are entitled to receive from the claims administrator upon the denial of an appeal.

Filing an Appeal

IMPORTANT: Upon denial of a claim, dissatisfaction with the way a claim is paid, or the denial of a request for service, you have 180 calendar days of receipt of the notification of Adverse Benefit Determination to appeal the claim. You must exhaust the appeals process before you can seek other legal recourse.

If a request for service or a claim for benefits is denied in part or in whole, you have the right to appeal the denial. A request for further information (such as a diagnosis) from the provider of service is not a claim denial.

IMPORTANT: Regardless of the decision and/or recommendation of the claims administrator, Sandia Corporation, or what the Sandia Total Health Program will pay, it is always up to you and the doctor to decide what, if any, care you receive.

The table below outlines who to contact based on the reason for the claim denial:

If you have a claim denied because of...	Then...
Eligibility (except for incapacitation determinations)	See Eligibility Appeals Procedure in the <i>Sandia Health Benefits Plan for Employees Summary Plan Description</i> or the <i>Sandia Health Benefits Plan for Retirees Summary Plan Description</i>
Eligibility based on incapacitation determinations	Contact the Sandia Benefits Department for assistance
Benefit Determinations	Refer to the procedures noted below

Before requesting a formal appeal, you may informally contact the claims administrator's Customer Service. If the Customer Service Advocate cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing at the address noted below (you may also call Customer Service and ask for assistance with your appeal). However, if you are not satisfied with a claim determination, you may appeal it as described below, without first informally contacting Customer Service.

If you are appealing an Urgent Care claim denial, please refer to Urgent Claims Appeals under BCBSNM or Expedited Appeal under Catalyst Rx.

If you disagree with a pre-service or post-service claim determination, you can contact the Claims Administrator by telephone or in writing to formally request an appeal. Written communication should include:

- Patient's name and ID number as shown on the ID card
- Provider's name
- Date of service
- Reason you think your claim should be paid
- Any documentation or other written information to support your request

You, your authorized representative (if you want someone to represent you in the appeal process, you must submit written authorization to BCBSNM designating the name of the person) or your doctor, can send the written appeal to:

Medical/Behavioral Health Appeals to:

BCBSNM Appeals Unit
PO Box 27630
Albuquerque, NM 87125-9815
Phone: 800-205-9926
Fax: 505-773-1521

Prescription Drugs Appeals to:

Catalyst Rx
Attention: Appeals Process
1650 Spring Gate Lane
Las Vegas, NV 89134
Fax: 888-852-1832

BCBSNM Appeals Process

A qualified individual who was not previously involved in the claim decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not previously involved in the prior determination. BCBSNM may consult with, or seek the participation of, medical experts as part of the appeal resolution process. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim appeal for benefits.

Pre-Service and Post-Service Claim Appeals

You will be provided written notification of the decision on your appeal as follows:

- For appeals of Preauthorization requests (as defined in [Section 10, How to File a Claim](#)), the first level will be conducted and you will be notified by BCBSNM of the decision within 15 calendar days from receipt of a request for appeal of a denied request. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to BCBSNM in writing within 60 calendar days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified by BCBSNM of the decision within 15 calendar days from receipt of the request for review of the first level appeal decision.
- For appeals of post-service claims (as defined in [Section 10, How to File a Claim](#)), the first level appeal will be conducted and you will be notified by BCBSNM of the decision within 30 calendar days from receipt of a request for appeal of a denied or partially paid claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to BCBSNM in writing within 60 calendar days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified by BCBSNM of the decision within 30 calendar days from receipt of the request for review of the first level appeal decision.

Urgent Claims Appeals

Your appeal of a Preauthorization or concurrent review denial may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. The appeal does not need to be submitted in writing. You or your physician should call BCBSNM at 877-498-7652 as soon as possible. BCBSNM will provide you with a verbal or written determination within 72 hours following receipt by BCBSNM of your request for review taking into account the seriousness of your condition.

Independent External Review Program

You or your authorized representative may make a request for a standard external review or expedited external review of an adverse benefit determination of *Final Internal Adverse Benefit Determination* by an independent review organization (IRO).

1. **Request for external review.** Within four months after the date of receipt of a notice of an adverse benefit determination or *Final Internal Adverse Benefit Determination* from BCBSNM, you or your authorized representative must file your request for standard external review with BCBSNM's Appeal Unit. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.
2. **Preliminary review.** Within five business days following the date of receipt of the external review request, BCBSNM must complete a preliminary review of the request to determine whether:
 - a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;

- b. The adverse benefit determination or the *Final Adverse Benefit Determination* does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
- c. You have exhausted BCBSNM's internal appeal process unless you are not required to exhaust the internal appeal process under the interim final regulations. Please read the *Exhaustion* section on page 110 for additional information and exhaustion of the internal appeal process; and
- d. You or your authorized representative have provided all the information and forms required to process the external review

You will be notified within one business day after BCBSNM completes the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, BCBSNM will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

3. **Referral to Independent Review Organization.** When an eligible request for external review is completed within the time period allowed, BCBSNM will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accredited organization. Moreover, BCBSNM will take action against bias and to ensure independence. Accordingly, BCBSNM must contract with at least three IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

- Utilization of legal experts where appropriate to make coverage determinations under the plan.
- Timely notification to you or your authorized representative, in writing, or the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may accept and consider additional information submitted after 10 business days.
- Within five business days after the date of assignment of the IRO, BCBSNM must provide to the assigned IRO the documents and any information considered making the adverse benefit determination or Final Internal Adverse Benefit Determination. Failure by BCBSNM to timely provide the documents and information must not delay the conduct of the external review. If BCBSNM fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify BCBSNM and you or your authorized representative.
- Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to BCBSNM. Upon receipt of any such information, BCBSNM may reconsider its adverse benefit

determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by BCBSNM must not delay the external review. The external review may be terminated as a result of the reconsideration only if BCBSNM decides, upon completion of its reconsideration, to reverse its adverse benefit determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, BCBSNM must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from BCBSNM.

- Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during BCBSNM's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
 - Your medical records;
 - The attending health care professional's recommendation;
 - Reports from appropriate health care professionals and other documents submitted by BCBSNM, you, or your treating provider;
 - The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
 - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
 - Any applicable clinical review criteria developed and used by BCBSNM, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
 - The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to BCBSNM and you or your authorized representative.
- The notice of final external review decision will contain:
 - A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considering in reaching its decision;
 - A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either BCBSNM and you or your authorized representative;
 - A statement that judicial review may be available to you or your authorized representative; and
 - Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
- After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the claims administrator, state, or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws, and you or your authorized representative.
4. **Reversal of plan's decision.** Upon receipt of a notice of a final external review decision reversing the adverse benefit determination of *Final Internal Adverse Benefit Determination* immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

1. **Request for expedited external review.** BCBSNM must allow you or your authorized representative to make a request for an expedited external review with BCBSNM at the time you receive:
 - a. An adverse determination if the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
 - b. A *Final Internal Adverse Benefit Determination*, if the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the *Final Internal Adverse Benefit Determination* concerns an admission, availability or care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.
2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, BCBSNM must determine whether the request meets the reviewability requirements set forth in the *Independent External Review Program* section on page 99. BCBSNM must immediately send you a notice of its eligibility determination that meets the requirements set forth in the "Standard External Review" section above.

3. **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, BCBSNM will assign an IRO pursuant to the requirements set forth in the *Independent External Review Program* section on page 99. BCBSNM must provide or transmit all necessary documents and information considered in making the adverse benefit determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during BCBSNM's internal claims and appeals process.

4. **Notice of final external review decision.** BCBSNM's contract with the assigned IRO must require the IRO to provide notice of final external review decision, in accordance with the requirements set forth in the *Independent External Review Program* section on page 99, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to BCBSNM and you or your authorized representative.

Exhaustion

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the *Final Internal Adverse Benefit Determination*. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if BCBSNM waives the internal review process or has failed to comply with the internal claims and appeals process. If you have been deemed to exhaust the internal review process due to BCBSNM's failure to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or under state law.

External review may not be requested for an adverse benefit determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

Other External Actions

If you are still not satisfied after having completed the complaint, appeal, grievance, or reconsideration procedure, you may have the option of taking one of the following steps. No legal action may be taken earlier than 60 days after BCBSNM has received the claim for benefits or Preauthorization request, or later than three years after the date that the claim for benefits should have been filed with BCBSNM.

External Appeal for ERISA Plans – If you are still not satisfied after having completed the complaint, grievance, appeal, or reconsideration process administered by BCBSNM (described above), you may have a right to bring a civil action under ERISA section 502(a).

Retaliatory Action

BCBSNM shall not take any retaliatory action against you for making a complaint or filing an appeal under this medical plan.

Catalyst Rx Appeals Process

Two levels of appeal are permitted for each type of claim that is denied (called an Adverse Determination). Appeal determinations will be rendered as specified in Section 8, Claims and Appeals Procedures, of the *Sandia Health Benefits Plan for Employees Summary Plan Description* or the *Sandia Health Benefits Plan for Retirees Summary Plan Description*.

Pre-Service and Post-Service Claim

- An appeal may be filed by you, your representative, or by a prescriber (on your behalf).
- You, your representative or prescriber, on your behalf, may submit written comments, documents, records and other information relevant to your request for an appeal. All such information is taken into account during the appeal process without regard to whether such information was submitted or considered when making the initial Adverse Determination.
- Upon initial receipt of an appeal, a clinical pharmacist will review the appeal (First-Level) and may overturn the initial Adverse Determination, if appropriate. If the initial Adverse Determination is overturned, you and the prescriber, if the prescriber filed the appeal on your behalf, will be notified of the determination in writing.
- If the clinical pharmacist does not overturn the Adverse Determination, Catalyst Rx will forward the appeal request to a physician (Second-Level) in the same profession and in a similar specialty that typically manages the medical condition, procedure, or treatment as mutually deemed appropriate. The physician reviewer will make the appeal determination. The clinical pharmacist completing the review of the appeal and the reviewing physician must hold an active, unrestricted license and board certification, if applicable, by the American Board of Medical Specialties (doctors of medicine) or the Advisory Board of Osteopathic Specialists (doctors of osteopathic medicine).
- If you are not satisfied with the decision following completion of the second-level appeal process, you may request that Catalyst Rx forward your appeal request to an independent review organization (IRO). Catalyst is currently contracted with two IRO's; specifically MRIOA and Advanced Medical Review. By July 1, 2012, Catalyst will contract with a third IRO. Catalyst will rotate external assignments between these IRO's. You must submit this request within 180 calendar days of your receipt of the Second-Level appeal review denial. The IRO will engage a physician in the same profession and in a similar specialty that typically manages the medical condition, procedure, or treatment as mutually deemed appropriate. The physician reviewer will make the appeal determination. The reviewing physician will hold an active, unrestricted license and board certification, if applicable, by the American Board of Medical Specialties (doctors of medicine) or the Advisory Board of Osteopathic Specialists (doctors of osteopathic medicine).
- As with any Adverse Determination, approved clinical criteria will be employed to evaluate the claim under review during an appeal.

- If within five (5) working days after the filing date of the appeal there is not sufficient information to process the appeal, you, your representative or the prescriber, who filed the appeal on your behalf, will be notified by written communication of the information required in order to process the appeal and directions on how to resubmit the appeal.
- If any of the appeal reviews overturns the Adverse Determination, the benefit will be allowed.

Urgent Claims (Expedited) Appeal:

- An expedited appeal may be filed by you, your representative or a prescriber, acting on your behalf. Contact Catalyst Rx customer service at 866-854-8851 to initiate an appeal.
- The clinical pharmacist or physician reviewer, in discussion with you and/or independent third party review organization, will determine whether the appeal constitutes an expedited appeal.
- Upon initially receiving an expedited appeal, a clinical pharmacist will review the expedited appeal and may overturn the initial Adverse Determination, if appropriate. If the initial Adverse Determination is overturned, you and the prescriber, on your behalf, will be notified of the outcome in writing.
- If the clinical pharmacist upholds the Adverse Determination, Catalyst Rx will forward the appeal request to an external Independent Review Organization (IRO). Catalyst is currently contracted with two IRO's; specifically MRIOA and Advanced Medical Review. By July 1, 2012, Catalyst will contract with a third IRO. Catalyst will rotate external assignments between these IRO's. The IRO will engage a physician in the same profession and in a similar specialty that typically manages the medical condition, procedure, or treatment as mutually deemed appropriate. The physician reviewer will make the Appeal determination. The clinical pharmacist completing the review of the appeal and the reviewing physician will each hold an active, unrestricted license and board certification, if applicable, by the American Board of Medical Specialties (doctors of medicine) or the Advisory Board of Osteopathic Specialists (doctors of osteopathic medicine).
- If within 24 hours after the filing date of the expedited appeal, there is not sufficient information to process the appeal, you, your representative or the prescriber, who filed the appeal on your behalf, will be notified verbally with a follow up in writing of the information required in order to process the appeal and directions on how to resubmit the appeal.
- The decision on an expedited appeal will be rendered and communicated verbally within 72 hours of receipt of the appeal request.

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Section 12. Sandia Total Health Administrative Services

Claims Administrators

The Claims Administrators are the third parties designated by Sandia to receive, process, and pay claims according to the provisions of the Sandia Total Health Program. For medical/surgical, behavioral health, and the Health Reimbursement Account this is BCBSNM.

Blue Cross and Blue Shield of New Mexico is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association. BCBSNM provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Claims Administrators are third parties designated by Sandia to receive, process, and pay claims according to the provisions of the Sandia Total Health Program. For medical and behavioral health claims, this is BCBSNM. Sandia delegates to the Claims Administrators the discretionary authority necessary to fulfill this role. The claims administrators have sole authority and discretion to determine whether submitted services/costs are eligible for benefits and to interpret, construe, and apply the provisions of their respective Program (with the exception of a claim that is applicable only to participant eligibility provisions which, except for incapacitated dependent status, are determined by Sandia) in processing and adjudicating claims. For more information, refer to [Section 10, How to File a Claim](#).

PayFlex Systems USA, Inc. is the claims administrator for your health Flexible Spending Account. PayFlex is a subcontractor to BCBSNM.

Catalyst Rx is the claims administrator for Outpatient prescription drugs.

There are no claims associated with your Employee Assistance Program, but the service is provided by Magellan Health Services.

BCBSNM Member Identification Cards

IMPORTANT: Always present your current Member identification card when obtaining health care. You have a Member ID card for healthcare services from BCBSNM and a Member ID card for prescription drugs from Catalyst Rx.

If you have elected single coverage, you will receive one Member ID card. If you have elected any other coverage, you will receive two Member ID cards. You may obtain additional ID cards through by calling BCBSNM Customer Service at 877-498-7652. The Member ID card identifies you to providers as a covered Member. This card contains:

- Your name as the Primary Covered Member
- A unique subscriber (Primary Covered Member) ID number that has been assigned to you by BCBSNM and is linked to the Primary Covered Member's Social Security number in the BCBSNM system
- The group number
- The claims filing address
- On the back of your Member ID card you will find:
 - Customer Service phone numbers
 - Preauthorization phone number for medical/surgical
 - Preauthorization phone number for mental health/Chemical Dependency
 - 24/7 Nurseline assistance phone number
 - Blue Card Access phone number for national provider location
 - EAP Magellan phone number for Preauthorization, provider location, and assistance

Catalyst Rx Member Identification Cards

If you are a new enrollee in the Sandia Total Health Program, you will receive new Catalyst Rx ID cards. If you need additional identification cards, you may call Catalyst Rx Customer Service at 866-854-8851 and request them.

IMPORTANT: Always present your Catalyst Rx Member ID card when obtaining prescriptions at a retail pharmacy. If you do not use your card, you are not eligible to receive reimbursement for the prescription.

Blue Access for Members (BAM) Website

The BCBSNM Member website, www.bcbsnm.com/member, provides information at your fingertips anywhere and anytime you have access to the Internet. The BAM website offers practical and personalized tools and information so you can get the most out of your benefits. Once you have registered, you can:

- Learn about health conditions, treatments, and procedures
- Search for in-network providers
- Access information on wellness topics
- Complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques, and access health improvement resources

- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your geographical area
- Use the hospital comparison tool to compare hospitals in your area on various patient safety and quality measures
- Make real-time inquiries into the status and history of your claims
- View eligibility and benefit information
- View and print EOB statements online
- Print a temporary ID card or request a replacement ID card
- Update coordination of benefits status

Note: If you have not already registered as a BAM Member, go to bcbsnm.com/member and click on **Register Now**. Have your BCBSNM ID card ready for your Group and Member ID numbers.

Catalyst Rx Website

The Catalyst Rx Member website, www.catalystrx.com, provides information at your fingertips anywhere and anytime you have access to the Internet. Catalystrx.com offers practical and personalized tools and information so you can get the most out of your benefits. Log on to:

- Locate retail network pharmacies
- Price prescription drugs at retail network pharmacies and mail service
- Refill prescriptions through mail service
- Find out what drugs are covered under the Prescription Drug Program

You can also access the above information on the Catalyst Rx phone app from any smartphone. Simply enter catalystrx.com into your smartphone browser or download the app by going to the Apple App Store, Android Market or Blackberry World

Contact Telephone Numbers and Hours of Operation

Function	Telephone Numbers
ABQ Health Partners Ambassador hotline – 505-262-7100	
BCBSNM – www.bcbsnm.com/member	
Customer Service <ul style="list-style-type: none"> • Claims questions • Check eligibility • Benefit information • Preferred (PPO) providers list • Case management 	1-877-498-7652 TTY 711 in New Mexico or outside NM call 1-800-746-7289 6:00 a.m. - 8:00 p.m. MT, Monday – Friday 8:00 a.m. – 5:00 p.m. MT Saturdays 4373 Alexander Blvd NE Albuquerque, NM
BCBSNM Health Services <ul style="list-style-type: none"> • Medical/Surgical Preauthorization 	1-800-325-8334 8:00 a.m. - 5:00 p.m. MT, Monday – Friday BCBSNM Medical Claims Address: BCBSNM P. O. Box 27630 Albuquerque, NM 87125-7630
BCBSNM Behavioral Health Unit <ul style="list-style-type: none"> • Mental health preauthorization • Chemical Dependency preauthorization • Claims • Inquiries 	1-888-898-0070 24 hours/day, 7 days/week BCBSNM Behavioral Health Claims Address: BCBSNM Behavioral Health P. O. Box 92165 Albuquerque, NM 87199-2165
BCBSNM Medical and Behavioral Health Appeals Address: BCBSNM Appeals Unit P. O. Box 27630 Albuquerque, NM 87125-9815 Phone: 1-800-205-9926 Fax: 1-800-773-1521	
Magellan Health Services <ul style="list-style-type: none"> • Employee Assistance Program (EAP) Preauthorization • Participating providers 	1-800-424-0320 24 hours/day, 7 days/week
BCBSNM 24/7 Nurseline <ul style="list-style-type: none"> • Advice on medical care 	1-800-973-6329 24 hours/day, 7 days/week
BCBSNM On-Site Representative <ul style="list-style-type: none"> • Escalated issues which the BCBSNM Customer Service toll-free number is unable to resolve 	505-284-8669 8:00 a.m. to 12 noon and 12:30 to 4:00 p.m. MT Mondays and Thursdays Sandia Benefits Office Bldg 832, Room 40
Special Beginnings® Healthy Pregnancy Program provides information about: <ul style="list-style-type: none"> • nutrition • newborn care 	1-888-421-7781 8:00 a.m. - 5:00 p.m. MT Monday - Friday

Function	Telephone Numbers
ABQ Health Partners Ambassador hotline – 505-262-7100	
BCBSNM – www.bcbsnm.com/member	
Blue Distinction Centers for Specialty Care® <ul style="list-style-type: none"> • Bariatric Surgery • Cardiac Care • Complex and Rare Cancers • Knee and Hip Replacement • Spine Surgery • Transplants 	1-800-325-8334 www.bcbs.com/innovations/bluedistinction
BlueExtras SM Discount Program	1-877-498-7652 www.bcbsnm.com/member
Blue Access for Members (BAM) Help Desk <ul style="list-style-type: none"> • Member website assistance 	1-888-706-0583 7 a.m. to 9 p.m. MT, Monday – Friday 6 a.m. to 2:30 p.m. MT, Saturday
BlueCard Access® <ul style="list-style-type: none"> • Preferred (PPO) provider search while on travel • BlueCard Doctor and Hospital Finder 	1-800-810-2583 (BLUE) www.bcbs.com
Catalyst Rx Prescription Drug Program– www.catalystrx.com	
Customer Service <ul style="list-style-type: none"> • Refill a mail order prescription • Determine if a pharmacy is in the pharmacy network • Obtain information about your benefits • Speak with a pharmacist about a prescription • Request additional ID cards 	1-866-854-8851 24 hours/day, 7 days/week
Sandia National Laboratories – https://hbe.sandia.gov	
HBE Customer Service Center <ul style="list-style-type: none"> • Forms • General questions • Benefit information • Address changes 	505-844-4237 or 1-800-417-2634, then dial 844-4237 8:00 a.m. to 4:30 p.m. MT Fax: 505-844-7535
Extend Health <ul style="list-style-type: none"> • Pre-Medicare Retiree Assistance • Enrollment/disenrollment in retiree plans • Address changes 	1-888-598-7809 www.SandiaRetireeBenefits.com

When You Change Your Address

When you move, you must change your address in the Sandia database. Active employees can change their address through Sandia's internal website or their Center secretary. Retirees need to change their address with Extend Health and Sandia Benefits.

If you move to California and wish to enroll in the Kaiser Sandia Total Health, you must enroll through Sandia HBE within 31 calendar days of the move.

Section 13. Definitions

Please note that certain capitalized words in this Program Summary have special meanings. These words have been defined in this section. You can refer to this section as you read this document to have a clearer understanding of your benefits.

Adverse Benefit Determination or Adverse Determination	<p>A denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a service. An adverse benefit determination includes a decision to deny benefits based on:</p> <ul style="list-style-type: none"> • An individual being ineligible to participate in the Sandia Total Health; • Utilization review; • A service being characterized as Experimental or Investigational or not Medically Necessary or appropriate; • A concurrent care decision; and • For medical claims, certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at any time.
Chemical Dependency	<p>Conditions defined by patterns of usage that continue despite occupational, marital, or physical problems that are related to compulsive use of alcohol or drugs. Chemical Dependency (alcoholism and drug abuse) may also be defined by significant risk of severe withdrawal symptoms if the use of alcohol or drugs is discontinued. Chemical Dependency does not include nicotine addiction or alcohol use.</p>
Coinsurance	<p>The percentage of a Covered Health Service which the Member pays after you've met the Deductible.</p>
Congenital Anomaly	<p>A physical developmental defect that is present at birth</p>
Cost Effective	<p>A procedure, service, or supply that is an economically efficient use of resources with respect to cost, 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.</p>
Cosmetic Procedures	<p>Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the claims administrator. Reshaping a nose with a prominent bump is an example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function, such as in breathing.</p>
Covered Charge (applicable to medical plan)	<p>The amount that BCBSNM allows for Covered Health Services using a variety of pricing methods and based on generally accepted claim coding rules. The Covered Charge for services from "contracted providers" is the amount the provider, by contract with BCBSNM (or another entity, such as another BCBS Plan), will accept as payment in full under this medical program. For Medicare-covered services, the Covered Charge is Medicare's Approved Amount for assigned claims, or the Medicare Limiting Charge (115 percent of the Medicare-Approved Amount) for non-assigned claims.</p>

<p>Covered Charge (applicable to medical plan) (cont.)</p>	<p>Noncontracting Allowable Amount — The maximum amount, not to exceed billed charges that will be allowed for a covered service received from a noncontracted provider in most cases. The BCBSNM Noncontracting Allowable Amount is based on the Medicare Allowable amount for a particular service, which is determined by the Centers for Medicaid and Medicare Services (CMS).</p> <p>Medicare Allowable — The amount allowed by CMS for Medicare-participating provider services, which is also used as a base for calculating noncontracted providers' claims payments for some Covered Health Services of noncontracted providers under this medical plan. The Medicare Allowable amount will not include any additional payments that are not directly tied to a specific claim, for example, medical education payments. If Medicare is primary over this medical plan, and has paid for a service, the Covered Charge under this medical plan may be one of the two following amounts:</p> <p>Medicare-Approved Amount — The Medicare fee schedule amount upon which Medicare bases its payments. When Medicare is the primary carrier, it is the amount used to calculate secondary benefits under this medical plan when no "Medicare limiting charge" is available. The Medicare-Approved Amount may be less than the billed charge.</p> <p>Medicare Limiting Charge — As determined by Medicare, the limit on the amount that a nonparticipating provider can charge a Medicare beneficiary for some services. When Medicare is the primary carrier and a Medicare Limiting Charge has been calculated by Medicare, this is the amount used to determine your secondary benefits under this medical plan. Note: Not all Medicare-covered services from nonparticipating providers are restricted by a Medicare Limiting Charge.</p>
<p>Covered Member</p>	<p>See Member.</p>
<p>Covered Health Services (applicable to medical plan)</p>	<p>Covered Health Services are those health services and supplies that are:</p> <ul style="list-style-type: none"> • Provided for the purpose of preventing, diagnosing, or treating Illness, Injury, mental illness, Chemical Dependency, or their symptoms • Included in Section 6 of this Program Summary (subject to the limitations and conditions and exclusions as stated in this Program Summary) • Provided to you, if you meet the eligibility requirements as described in the booklet entitled "Sandia Health Benefits Plan for Employees Summary Plan Description" or "Sandia Health Benefits Plan for Retirees Summary Plan Description" and have enrolled into the Program • Medically Necessary/appropriate

Custodial Care	<p>Services or supplies, regardless of where or by whom they are provided, that a person without medical skills or background could provide or could be trained to provide or are provided mainly to help you with daily living activities, including (but not limited to):</p> <ol style="list-style-type: none"> 1. Walking, getting in and/or out of bed, exercising and moving 2. Bathing, toileting, administering enemas, dressing, and assisting with any other physical or oral hygiene needs 3. Assistance with eating by utensil, tube, or gastrostomy 4. Homemaking, such as preparation of meals or special diets, and house cleaning 5. Acting as a companion or sitter 6. Supervising the administration of medications that can usually be self-administered, including reminders of when to take such medications <ul style="list-style-type: none"> • Provide a protective environment. • Are part of a maintenance treatment plan or are not part of an active treatment plan intended to or reasonably expected to improve your illness, injury, or functional ability, or • Are provided for the convenience of you or the caregiver or are provided because your own home arrangements are not appropriate or adequate.
Deductible	<p>Covered Charges incurred during a calendar year that you must pay in full before the Sandia Total Health Program pays benefits. Does not apply to covered, in-network Preventive Care or to Outpatient prescription drugs purchased through Catalyst Rx.</p>
Developmental Care	<p>Services or supplies, regardless of where or by whom they are provided, that:</p> <ul style="list-style-type: none"> • Are provided to you if you have not previously reached the level of development expected for your age in the following areas of major life activity: <ol style="list-style-type: none"> 1. Intellectual 2. Physical 3. Receptive and expressive language 4. Learning 5. Mobility 6. Self-direction 7. Capacity for independent living 8. Economic self-sufficiency • Are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to Injury or Illness) or are educational in nature
Emergency	<p>See Medical Emergency</p>

Experimental or Investigational (applicable to medical plan)	<p>Experimental or Investigational Services: medical, surgical, diagnostic, psychiatric, Chemical Dependency or other health care services, technologies, supplies treatments, procedures, drug therapies, medications or devices that, at the time BCBSNM makes a determination regarding coverage in a particular case, are determined to be any of the following:</p> <p>Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;</p> <p>Subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational); or</p> <p>The subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight</p> <p>EXCEPTIONS:</p> <p>Clinical trials for which benefits are available as described under clinical trials:</p> <p>If you have a life threatening illness or condition (one that is likely to cause death within one year of the request for treatment), BCBSNM may, at their discretion, consider an otherwise Experimental or Investigational service to be a Covered Health Service for that illness or condition. Prior to such consideration, BCBSNM must determine that, although Unproven, the service has significant potential as an effective treatment for that illness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.</p> <p>Refer to Section 7. Prescription Drug Program for Experimental or Investigational language for Catalyst Rx.</p>
Health Assessment	A Health Assessment is a confidential online questionnaire that asks you about health history, lifestyle behaviors (such as smoking and exercise habits) and your willingness to make changes.
Hospice	A program provided by a licensed facility or agency that provides home health care, homemaker services, emotional support services, and other service provided to a terminally ill person whose life expectancy is six months or less as certified by the person's physician.
Illness	A disease, disorder, or condition that requires treatment by a physician. For a female Member, Illness includes childbirth or pregnancy. The term Illness as used in this Program Summary does not include mental illness or Chemical Dependency, regardless of the cause or origin of the mental illness or Chemical Dependency.
Injury	Bodily damage from trauma other than Illness, including all related conditions and recurrent symptoms.
Inpatient Stay	An uninterrupted confinement of at least 24 hours following formal admission to a hospital, Skilled Nursing Facility or inpatient rehabilitation facility.
Intensive Outpatient Program	A program that provides 9 to 20 hours per week (less than four hours per day) of professionally directed evaluation and/or treatment.

Maintenance Care	Treatment beyond the point where material or significant improvement is to be expected. The treatment results in no measurable or objective improvement. For modality treatments, such as Nonsurgical Spinal Treatment or physical therapy, the treatment provides no evidence of lasting benefit; treatment provides only relief of symptoms.
Medical Emergency	An accidental Injury or a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) serious jeopardy to his/her health (or, if pregnant, to the unborn child); 2) serious impairment to the bodily functions; or 3) serious dysfunction of any bodily organ or part. (In addition, services must be received in an Emergency room, trauma center, or ambulance to qualify as an Emergency.)
Medically Necessary or Medically Appropriate (applicable to medical plan)	<p>A service or supply that is ordered by a physician, the medical director, and/or a qualified party or entity selected by BCBSNM, and determined as:</p> <p>Provided for the diagnosis or direct treatment of an Injury or Illness</p> <p>Appropriate and consistent with the symptoms and findings or diagnosis and treatment of your Injury or Illness</p> <p>Provided in accordance with generally accepted medical practice on a national basis</p> <p>The most appropriate supply or level of service that can be provided on a Cost-Effective basis including, but not limited to, inpatient vs. Outpatient care, electric vs. manual wheelchair, surgical vs. medical or other types of care</p> <p>Allowable under the provisions of the Sandia Total Health Program as prescribed by your physician.</p> <p>IMPORTANT: The fact that a physician may provide, prescribe, order, recommend, or approve a service or supply does not in itself make the service or supply Medically Necessary or make the charge for it allowable even though the service or supply is not specifically listed as an exclusion in the Sandia Total Health Program.</p>
Medicare-Approved Amount (applicable to medical plan)	The Medicare fee schedule amount upon which Medicare bases its payments. This amount may be less than the actual amount charged by the provider. The out-of-network coverage for Covered Health Services under the medical plan is based on 100% of the Medicare-Approved Amount.
Member	An enrolled participant or enrolled family member. This term refers to a person only while enrolled under the Sandia Total Health Program. References to “you” and “your” throughout this document are references to a Member.
Nonpreferred Provider	A provider that is not contracted with a BCBS Plan to be part of the BCBS Preferred Provider network.
Nonsurgical Spinal Treatment	Detection or nonsurgical correction (by manual or mechanical means) of a condition of the vertebral column, including distortion, misalignment, and subluxation to relieve the effects of nerve interference that results from or relates to such conditions of the vertebral column.

Out-of-Pocket Maximum	Your financial responsibility for covered expenses before the Sandia Total Health reimburses additional Covered Charges at 100%, with no Deductible, for the remaining portion of that calendar year.
Outpatient	A person who visits an office, a clinic, Emergency room, or health facility and receives health care without being admitted as an overnight patient (under 24-hour stay).
Outpatient Surgery	Any invasive procedure performed in a hospital or surgical center setting when a patient is confined for a stay of less than 24 consecutive hours.
Partial (or day) Hospitalization	A program that provides Covered Health Services to persons who are receiving professionally directed evaluation or treatment and who spend only part of a 24-hour period (but at least four hours per day) or 20 hours per week in a hospital or treatment center.
Preauthorization	The process whereby you and/or your physician call to obtain prior approval for certain healthcare services and employee assistance program benefits.
Preferred Provider	Healthcare professionals and facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, the BCBS Association, or another BCBS Plan as "preferred" (PPO) providers. An "HMO" or a "participating-only" provider is not a Preferred Provider under the medical plan. When scheduling an appointment for "in-network" services, ask if the provider is a BCBS "Preferred Provider."
Primary Covered Member	The person to whom the coverage is issued; that is, Sandia employee, retiree, surviving spouse, Long Term Disability Terminée or the individual who is purchasing temporary continued coverage.
Residential Treatment Facility	A Residential Treatment Facility provides acute overnight services for the care of a Chemical Dependency disorder or overnight mental health services for those who do not require acute care.
Skilled Nursing Facility	A nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a hospital is considered a Skilled Nursing Facility for purposes of the medical plan.
Sound Natural Teeth	Teeth that are whole or properly restored; are without impairment or periodontal disease, and are not in need of the treatment provided for reasons other than dental injury.
Specialist	Any physician who is devoted to a medical specialty.
Unproven Services (applicable to medical plan)	<p>Health services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.</p> <p>Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.</p> <p>Well-conducted cohort studies are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.</p> <p>BCBSNM has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time,</p>

Unproven Services (applicable to medical plan) (cont.)	<p>BCBSNM issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice.</p> <p>Note: If you have a life-threatening illness or condition (one that is likely to cause death within one year of the request for treatment), BCBSNM may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that illness or condition. Prior to such a consideration, BCBSNM must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that illness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.</p> <p>BCBSNM may, in their discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Member with an illness or injury that is not life-threatening. For that to occur, all of the following conditions must be met:</p> <ul style="list-style-type: none"> • If the service is one that requires review by the U.S. Food and Drug Administration (FDA), • It must be FDA-approved • It must be performed by a physician and in a facility with demonstrated experience and expertise • You must consent to the procedure acknowledging that BCBSNM does not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective • At least two studies must be available in published peer-reviewed medical literature that would allow BCBSNM to conclude that the service is promising but Unproven • The service must be available from a network physician and/or network facility • The decision about whether such a service can be deemed a Covered Health Service is solely at BCBSNM's discretion. Other apparently similar promising but Unproven Services may not qualify.
Urgent Care	<p>Treatment of an unexpected illness or injury that is not life threatening but requires Outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering such as high fever, a skin rash, or an ear infection.</p>
Urgent Care Center	<p>Can be attached to a hospital or be freestanding, staffed by licensed physicians and nurses, and providing health care services.</p>

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Section 14. Blue Extras

Sandia National Laboratories is providing the following information strictly as a convenience to BCBSNM Members. Sandia cannot guarantee any discounts, results, or performance for the discount programs. The discounts and services available to Members may change at any time and Sandia and BCBSNM do not guarantee that a particular discount or service will be available at a given time.

Money Saving Programs to BCBSNM Members

BlueExtrasSM gives Members and covered dependents access to savings on a variety of health care and wellness products and services.

To use BlueExtras, show your BCBSNM Member ID card to a participating provider to receive the special offer.

- Jenny Craig, www.jennycraig.com/corporatechannel/bcbsnm.aspx (800-965-3669)
Jenny Craig is a weight loss and healthy weight management program.
- Life Time Fitness, www.lifetimefitness.com
Life Time Fitness offers health fitness experience for varying fitness level, interests, schedule, or budget.
- Complementary Alternative Medicine, www.bcbsnm.com/member (866-656-6069)
As a BCBSNM Member you are eligible to receive up to a 30 percent off standard fees through the Healthways WholeHealth network of more than 35,000 practitioners, spas, and wellness and fitness centers. You can access the www.wholehealthmd.com website to search for a network practitioner, by logging in to Blue Access[®] for Members website.
- TruHearing, www.truhearing.com (800-988-2674)
Digital hearing aids savings and hearing test. Hearing aid styles at various price levels.

For additional information about the products and services offered through BlueExtras, log in to Blue Access[®] for Members (BAM) at www.bcbsnm.com/member. Click the “My Health” tab, and then the BlueExtras Discount Program link.

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