Sandia National Laboratories

SAND2011-2635P

In-Network Program

for Union-Represented Employees and
Formerly-Represented Non-Medicare Retirees

Revised: January 1, 2011

Administered by:
Blue Cross and Blue Shield of New Mexico
(Medical/Behavioral Health Services)
Magellan Health Services **(EAP Service)**
Catalyst Rx **(Prescription Drug Service)**

Program Summary

Important

This Program Summary applies to union-represented employees and formerly-represented PreMedicare Retirees who retired in 2010 and 2011.

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**.**

National Nuclear Security Administration

Sandia National Laboratories is a multi-program laboratory managed and operated by Sandia Corporation, a wholly owned subsidiary of Lockheed Martin Corporation, for the U.S. Department of Energy's National Nuclear Security Administration under contract DE-AC04-94AL85000. SAND Number:

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Contents

Section 1. Introduction

This is a summary of benefits of the In-Network 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* and 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 12, 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 Covered Members as defined in Section 12, Definitions.

Many sections of this Program Summary are related to other sections of the Program Summary and information contained in the *Sandia Health Benefits Plan for Employees Summary Plan Description* and the *Sandia Health Benefits Plan for Retirees Summary Plan Description*. 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* and 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 https://hbe.sandia.gov. These documents are also available electronically at http://www.sandia.gov/resources/emp-ret/spd/index.html.

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

This section highlights the changes for the In-Network Program.

Blue Cross and Blue Shield of New Mexico is the claims administrator for the medical/ behavioral health portion of the In-Network Program effective January 1, 2011.

The In-Network Program is being offered by Sandia Laboratories only to its union-represented eligible employees and formerly represented non-Medicare retirees who retired in 2010 or 2011 (including non-Medicare Class I eligible family members).

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Section 3. Accessing Care

This section provides contact information and describes how to access medical/surgical and behavioral health care, Preauthorization requirements, accessing care while away from home, the Employee Assistance Program (EAP) and other general information. For information on the Prescription Drug Program, refer to Section 6, Prescription Drug Program.

BCBSNM Member ID Card

Your Member ID card helps your provider identify you as a Member of the medical plan administered by BCBSNM. The ID card provides the information needed when you require medical/surgical, mental health/Chemical Dependency services, or any other items or services covered under your In-Network Program. Have your ID card handy when you are contacting Customer Service, a BCBSNM case manager or care coordinator, and when calling your doctor or hospital to arrange services.

BCBSNM Customer Service is available Monday through Friday from 6:00 a.m. to 8:00 p.m. MT or from 8:00 a.m. to 5:00 p.m. on Saturdays and most holidays. You may call or visit the BCBSNM office in Albuquerque, NM.

Street Address: 4373 Alexander Blvd NE
Customer Service number: 877-498-7652

If you need assistance outside normal business hours, you may call the Customer Service telephone number and leave a message. A Customer Service Advocate will return your call by 5:00 p.m. the next business day.

Mail medical claims, Preauthorizations and inquiries to:

Blue Cross Blue Shield of New Mexico – Medical /Surgical
Attn: NMBB
P. O. Box 27630
Albuquerque, NM 87125-7630

Blue Cross Blue Shield of New Mexico – Mental Health/Chemical Dependency
P. O. Box 92165
Albuquerque, NM 87199-2165

Preauthorizations toll-free numbers

Medical/Surgical (administered by BCBSNM) –
For Preauthorizations related to medical/surgical call a Health Services representative Monday through Friday from 8:00 a.m. to 5:00 p.m. MT at 800-325-8334.

Mental Health and Chemical Dependency (Administered by BCBSNM) –
For Preauthorizations related to mental health or Chemical Dependency services, contact the BCBSNM Behavioral Health administrator 24 hours a day, 7 days a week at 888-898-0070.

Employee Assistance Program (Administered by Magellan Health Services) –
Call Magellan at 800-424-0320 for Preauthorization. You may call to talk to an EAP Counselor or to get a referral to a counselor in your area. Or you can register at www.magellanhealth.com/Member to get a list of EAP providers.

In-Network Program

The In-Network Program provides benefits under agreement with an exclusive network of Preferred Providers that contract with Blue Cross Blue Shield (BCBS) Plans throughout the United States and Worldwide.

When you need non-Emergency health care that is covered under the In-Network Program, you must choose a provider from the BCBS Preferred Provider Option (PPO) network in order to receive benefits. It is a good idea to speak with a provider's office staff directly to verify whether or not they belong to the BCBS Preferred Provider network before making an appointment.

Preferred Provider Services
The Preferred Provider is responsible for filing claims for you directly to the local Blue Cross Blue Shield (BCBS) Plan.
Preferred Providers that contract directly with BCBSNM are responsible for requesting all necessary Preauthorizations for you. (Providers that contract with another BCBS Plan may call for Preauthorization on your behalf, but you will be responsible for making sure that the Preauthorization is obtained when required. If you do not obtain Preauthorization, benefits may be reduced or denied.
This is an Exclusive Provider Organization (EPO) medical Program that generally provides benefits ONLY for services received from a BCBS-Preferred Provider. Although this medical Program uses the same network of provider as the PPO medical Program, this is NOT a "PPO" medical Program. Under the EPO medical Program, if you obtain non-Emergency service from a Non-Preferred (non-PPO) provider, the services will usually NOT be covered. It is your responsibility to determine if a provider is in the national/worldwide BCBS-Preferred Provider network or not.

Out-of-Network Option

The In-Network Program does **not** have an out-of-network option for routine healthcare services. Except for limited situations (e.g., urgent or emergent care or follow-up care after urgent or emergent care while on business travel) out-of-network benefits are not available under the In-Network Program. You are responsible for all expenses for out-of-network medical services.

Preauthorization Requirement

Although Preferred Providers contracting directly with BCBSNM will obtain necessary Preauthorizations for you, there are certain instances in which you will be responsible for obtaining Preauthorization. In such cases, if you do not ensure that the necessary authorizations are obtained, you may have to pay a Preauthorization penalty or you may be responsible for paying the full billed charge to the provider.

Preauthorization requirements will provide you with assurance that you receive the appropriate level of care in the appropriate setting and enables BCBSNM to identify situations that may allow you to receive additional attention (e.g., referrals to disease management or case management programs) based on the type of service requested. Preauthorization does not guarantee your eligibility for coverage, that benefit payment will be made, or that you will receive the highest level of benefits. Eligibility and benefits are based on the date you receive the services. Services not listed as covered, excluded services, services received after your termination date under this Program, and services that are not Medically Necessary will be denied.

BCBSNM Preferred Providers – If the attending Physician is a Preferred Provider that contracts directly with BCBSNM, obtaining a Preauthorization is not your responsibility, it is the provider's responsibility. Preferred Providers contracting with BCBSNM must obtain Preauthorization from BCBSNM (or from the Behavioral Health Unit, when applicable). If Preauthorization is not obtained, a $300 penalty will apply or claims will be denied and you will be responsible for the entire amounts.
If you live or travel outside of New Mexico: Providers that contract with Blue Cross Blue Shield Plans other than BCBSNM are not familiar with the Preauthorization requirements of BCBSNM and/or your particular medical Program. The provider may call on your behalf, but it is your responsibility to ensure that BCBSNM (or the Behavioral Health Unit, when applicable) is called. Unless a provider contracts directly with BCBSNM as a Preferred Provider, the provider is not responsible for being aware of BCBSNM's Preauthorization requirements. If Preauthorization is not obtained, a $300 penalty will apply or claims will be denied and you will be responsible for the entire amounts.

If you call BCBSNM for Preauthorization, you may be told in most cases that your doctor or hospital must call BCBSNM to obtain the Preauthorization for you. If this is the case, please call your doctor and discuss your Preauthorization request with them. Your provider is not obligated to request Preauthorization on your behalf if he/she does not agree that services you are requesting are appropriate or Medically Necessary.

How the Preauthorization Procedure Works – When you or your provider call, BCBSNM's 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 (usually at the time of the call) if benefits for the proposed hospitalization or other services are approved. If the admission or other service is not authorized, you may appeal the decision (see Section 10, How to File an Appeal).

Regardless of the decision and/or recommendation of BCBSNM, or what the In-Network Program will pay, it is always up to you and the doctor to decide what, if any, care you receive. BCBSNM does not provide medical advice.

Preauthorization for Inpatient Admissions

($300 penalty will apply to Eligible Expenses if Preauthorization is not obtained)

You or your provider must request Preauthorization from BCBSNM for:

- Non-Emergency admissions: at least seven 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 Eligible Expenses will not be considered coverage 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.

Preauthorization toll free number for inpatient care is 800-325-8334.

Other Preauthorization Requirements

- Other nonEmergency services (whether in- 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).
- Acupuncture (combined with short term rehabilitation)
- 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 Outpatient physical, occupational and speech therapy, spinal manipulation and acupuncture))
- Sleep disorder studies
- Spinal Manipulation (combined with short term rehabilitation)
- Transplantation 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 for the above-mentioned medical care services can be requested by calling BCBSNM's toll free number 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 services for inpatient and Outpatient services.

If Preauthorization is not obtained, a $300 penalty or denial of claims will occur if you, a family member, or your provider does not contact BCBSNM Behavioral Health Unit within the applicable time frames for the 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 health care 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 Behavioral Health Unit:

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

Most of the time the in-network provider will obtain Preauthorization, however, it is ultimately your responsibility to call BCBSNM Behavioral Health Unit at 888-898-0070 to initiate the review process.

How Preauthorization Works

When you or your treating healthcare professional call for a Preauthorization, the 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 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. Refer to Section 10, How

to File an Appeal for more information.

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).

Provider Networks

Your In-Network 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 or Health Care Service Corporation (HCSC) can guarantee quality of care. Members always have the choice of what services they receive and who provides their healthcare regardless of what the Program 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.

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 detail at 877-498-7652.

In addition, until July 2011, you may be eligible for in-network benefits for a previously authorized infertility treatment currently in progress with an out-of-network provider. Also, until January 2012, 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 detail 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 Preferred Provider Option (PPO) network. You can select your Physician from family care Physicians, internists, pediatricians, and other Specialists.

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. 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 on-line provider search at www.bcbsnm.com/sandia for an up-to-date provider listing.

Provider Searches Online

To search for a 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, or 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 website 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:

1. Not have to complete any claims forms
2. Not have to pay up front for medical services, except for the usual Out-of-Pocket Maximum expenses (noncovered services, copays)
3. 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 at 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:

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

You are not required to use a Blue Distinction Center for treatment of the above-mentioned conditions. However, with a transplant received through the Blue Distinction programs you may be eligible for travel and lodging benefits. Travel expenses and lodging benefits in excess of $50 per day are usually considered taxable income.

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.

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 transplant care services at a designated facility through a Blue Distinction Center for Specialty Care Program.

Preauthorized expenses for travel and lodging related to a covered transplant 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 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 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 toll-free 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)

Blue Access® for Members (BAM)

By registering at www.bcbsnm.com/sandia, you can access your personalized information and get the most recently updated provider directories for Physicians, Specialists, behavioral health, and facilities.

Save time using self-service support tools and information by registering onto BlueAccess for Members website. You have secure access to your account information 24 hours a day, 7 days a week.

The following information and resources are available to Members on BAM www.bcbsnm.com/sandia.

- Check status of claims; view and print Explanation of Benefits (EOBs)
- Request new ID cards; print temporary ID cards
- Confirm who is covered under your plan
- Download and print various forms
- View plan information and FAQs
- Access health and wellness tools
- Find doctors, hospitals, or Specialists in your area
- Personal Health Manager:
    - Online health encyclopedia

- Interactive Symptom Checker
- Ask a Question: secure email a nurse, dietitian, trainer, or life coach
- Set up reminders for appointments and screenings

If you need help accessing the Blue Access for Members (BAM) site, call:

BAM Help Desk at 888-706-0583

Help Desk Hours are Monday through Friday, 7:00 a.m. to 9:00 p.m. MT, and Saturdays from 6:00 a.m. to 2:30 p.m. MT.

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 In-Network 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 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 family members 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.

Section 4. Deductibles & Maximums

General Information

The following table summarizes annual Deductibles, annual Out-of-Pocket Maximums, and lifetime maximums that may apply under the In-Network Program.

Member Cost-Sharing/Maximums Features

Type	In-Network Program	
	Individual	Family
Deductible	None	None
Out-of-Pocket Maximum	$1,500	$3,000
Lifetime Maximum Coverage	None	None

Payments Applied to Out-of-Pocket Annual Maximum

The payment for services under the In-Network Program is primarily via a copay to the provider at the time of service. The copays apply to your annual Out-of-Pocket Maximum. Copays for prescription drugs through Catalyst Rx do not apply to the Out-of-Pocket Maximum.

Each covered family Member may contribute toward the family Out-of-Pocket Maximum. However, contribution maximums are limited to the individual Out-of-Pocket Maximum.

Payments Not Applied to Out-of-Pocket Annual Maximum

The following payments do NOT apply to Out-of-Pocket Maximums:

- Expenses in the Prescription Drug Program through Catalyst Rx.
- Penalties caused by failure to obtain Preauthorization
- Ineligible Expenses
- Non-covered health care services

Out-of-Pocket Maximums

With some exceptions (listed below), no additional medical copays will be required for the remainder of the calendar year as follows:

- For the Member, when he or she has incurred his or her Out-of-Pocket Maximum for covered medical expenses
- For the family, when they have incurred their Out-of-Pocket Maximum for covered medical expenses.

BCBSNM will notify you via an explanation of benefits (EOB) statement when the Out-of-Pocket Maximum has been reached. The following table identifies what does and does not apply toward annual Out-of-Pocket Maximums:

Program Features	Applies to Annual Out-of-Pocket Maximum
Copays	Yes
Payments toward the annual Deductible	Not applicable
Charges for non-covered health services	No
Amounts of any reductions in benefits you incur by not following Preauthorization requirements	No
Amounts you pay toward Behavioral Health services	Yes
Outpatient prescription drugs	No

Example: In a calendar year, a family of three meets the In-Network Program's family $3,000 Out-of-Pocket Maximum as follows:

Out-of-Pocket Maximum		
	Out-of-Pocket Expenses	Applied to Out-of-Pocket
Primary Subscriber	$1,500	$1,500
Spouse	$1,500	$1,500
1st Child	$0	$0
Total:	$3,000	$3,000

For the remainder of the calendar year, any additional covered medical expenses submitted by this family under the In-Network Program will be paid at 100% of the Eligible Expenses (with some exceptions).

Section 5. Coverages/Limitations

What the In-Network Program Covers

The In-Network Program provides a wide range of medical care services for you and your family. All coverage is based on medical necessity and whether the service is a Covered Health Service.

The In-Network Program provides coverage for in-network care **only** from a nationwide network of providers contracted with BCBS Plans. The In-Network Program does not provide out-of-network coverage for routine care.

Out-of-network coverage is available only for emergencies and Urgent Care needs.

Coverage for follow-up care must be provided by an in-network provider (exception may apply when you are on Sandia-authorized business travel).

Note: Out-of-network services for emergencies and Urgent Care require you to pay first and then file a claim with BCBSNM.

The In-Network Program does not have any preexisting condition limitations. This means, for example, that if you have a condition such as pregnancy or cancer before you begin coverage under the In-Network Program, you are not required to wait a specific amount of time before you are covered under the In-Network Program.

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

- Provided for the purpose of preventing, diagnosing, or treating Illness, Injury, mental Illness, Substance Abuse, or their symptoms
- Medically Necessary
- Included in this section (subject to limitations and conditions and exclusions as stated in this Program Summary.)
- Provided to those who 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*.

In-Network Program Highlights

The following tables highlight the amounts you will pay for various covered medical services. A copay is a defined dollar amount (e.g., $20 copay for a Primary Care Physician office visit) that you pay for services rendered, and the In-Network Program pays the remainder of the Eligible Expenses from network participating providers and facilities.

Note: If the required Preauthorization is not obtained for Outpatient services, benefits will be denied for all related services.

Benefit	In-Network Program
IMPORTANT For detailed benefit provisions, please refer to the information following this table.	
Acupuncture (see short-term rehabilitation therapies for maximum visits)	**Preauthorization Required** $20 copay per visit
Allergy Services • Office visit • Testing • Serum • Allergy shot	 $30 copay per visit $30 copay per visit No copay $10 copay per visit
Ambulance	$75 copay per trip
Behavioral Health (inpatient care includes hospital, Physicians, and other professional services) **Mental Health** Inpatient Intensive Outpatient stay Outpatient **Chemical Dependency** Inpatient Intensive Outpatient stay Outpatient	**Preauthorization Required** $400 per admission $250 per program $30 copay per visit $400 per admission $250 per program $30 copay per visit
Chemotherapy (High dose may require Pre-authorization)	No charge
Chiropractic Services (see short-term rehabilitation therapies for maximum visits)	**Preauthorization Required** $20 copay per visit

Benefit	In-Network Program
IMPORTANT For detailed benefit provisions, please refer to the information following this table.	
Dental Services • Physician's office • Outpatient facility • Inpatient facility	**Preauthorization Required** $30 copay per visit $125 copay per visit $400 per admission
Diagnostic Tests (Outpatient)	No charge
Durable Medical Equipment (DME) (Devices costing $1000 (or more) or requiring long-term rental may require Preauthorization.)	No charge
Emergency Room Care	$125 copay per visit
Employee Assistance Program (Preauthorization exception may apply to first visit.)	**Preauthorization Required** No charge for up to eight visits per year maximum
External Prosthetic Appliances (Devices costing $1000 (or more) or requiring long-term rental may require Preauthorization.)	$200 annual Deductible, then no charge
Eye Exam for non-refractive care due to Illness or Injury to the eye	$20 PCP copay per visit $30 Specialist copay per visit
Eyeglasses/Contact Lenses (initial pair only when required due to the loss of a natural lens)	See DME benefit
Family Planning	$20 PCP copay per visit $30 Specialist copay per visit
Hearing Aids/Exam (For initial hearing aid due to Illness or Injury.)	**Preauthorization Required** See DME benefit and/or per office visit copay
Home Health Care; Home I.V. services; Dialysis	**Preauthorization Required** No copay
Hospice Services	**Preauthorization Required** No copay
Infertility Treatment	**Not available under the In-Network Program**
Injections in Physician office (other than those covered under Preventive Care or allergy shot) – certain injections require Preauthorization	$20 PCP copay per visit $30 Specialist copay per visit
Inpatient Services	**Preauthorization Required** $400 per admission
Lab (Outpatient)	No charge (some may require Preauthorization)

Benefit	In-Network Program
IMPORTANT For detailed benefit provisions, please refer to the information following this table.	
Maternity • Initial visit to determine pregnancy status • Prenatal and postnatal care • Delivery • Nursery care for well-baby newborn	 $20 PCP copay per visit $30 Specialist copay per visit No copay $400 per admission No copay
Nutritional Counseling	$20 copay per visit
Occupational Therapy (see short-term rehabilitation therapies for maximum visits)	**Preauthorization Required** $20 copay per visit
Office Care/Visits • Primary Care Physician • Specialist	 $20 copay per visit $30 copay per visit
Organ Transplant	**Preauthorization Required** $400 per admission
Outpatient Surgery • Physician's office • Outpatient facility	**Preauthorization May Be Required for Some Surgical Procedures** $30 copay $125 copay
Physical Therapy (see short-term rehabilitation therapies for maximum visits)	**Preauthorization Required** $20 copay per visit
Prescription dispensed other than at pharmacy (i.e., Physicians office)	No copay
Preventive Care	No charge
Prosthetic Appliances (Devices costing $1000 (or more) or requiring long-term rental may require Pre-authorization.)	See External Prosthetic Appliances
Radiology	**Preauthorization Required For Some Services (e.g., PET scan, cardiac CT scan)** No charge
Radiation Therapy	No charge
Rehabilitation Hospital (combined maximum with Skilled Nursing Facility of 60 days per calendar year)	**Preauthorization Required** No copay

Benefit	In-Network Program
IMPORTANT For detailed benefit provisions, please refer to the information following this table.	
Skilled Nursing Facility (combined maximum with rehabilitation hospital of 60 days per calendar year)	**Preauthorization Required** No copay
Short-Term Rehabilitation Therapies (Outpatient) • Acupuncture • Spinal Manipulation • Occupational • Physical • Speech **(combined therapies listed here — 60 visits per calendar-year benefit)**	**Preauthorization Required** $20 copay per visit
Speech Therapy (see short-term rehabilitation therapies for maximum visits)	**Preauthorization Required** $20 copay per visit
Supplies	No copay
Urgent Care Facilities	$40 copay per visit

Coverage Details

Inpatient Preauthorization is required for all non-Emergency, non-obstetric inpatient admissions (including inpatient/acute hospital, Hospice, skilled nursing facilities, extended care facilities, and rehab admissions). The BCBSNM network of Preferred Providers will obtain Preauthorization for the patient. When outside New Mexico, the patient is responsible for making sure that BCBSNM (or the Behavioral Health Unit, when applicable) is called for Preauthorization. See Section 3, Accessing Care for details.

Preauthorization is required for certain Outpatient procedures (for example, acupuncture, speech therapy, cardiac/pulmonary rehab, prosthetic appliances, durable medical equipment, etc.). See Section 3, Accessing Care for details.

The following information provides detailed descriptions of the covered services.

Acupuncture Services

See Short-Term Rehabilitation for combined annual benefit maximum.

- Includes x-rays and other services provided by a licensed acupuncturist, licensed doctor of oriental medicine, medical doctor, licensed chiropractor, or doctor of osteopathy.

Allergy Services

Services related to allergies are covered as follows:

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

Ambulance Services

This In-Network Program covers ambulance services and transportation provided by a licensed ambulance 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 as 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 In-Network Program will cover the service as billed.

Air ambulance services:

- 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 his/her ability to travel by a nonmedical transport (once the Member has been stabilized and expected to be long term, BCBSNM would transport Member to closest contracted facility near the Member's 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 where the organ is available, the In-Network Program will cover the medical transport of the patient via air ambulance or a jet (whichever is less expensive)

If there is no in-network ambulance service available, the ambulance will be covered at the in-network level of benefit for Emergency transportation.

Other than what is listed above, non-Emergency ambulance services are **not** covered.

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

The In-Network 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 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, BCBSNM Behavioral Health 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)
- 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

If there are multiple diagnoses, this 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

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. The In-Network Program covers oncology services as follows:

- Office visit
- Professional fees for surgical and medical services
- Inpatient services
- Outpatient surgical services
- High-dose chemotherapy may require Preauthorization

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 for you. While you are not required to receive treatment at a Blue Distinction Center, if you are enrolled in a Blue Distinction Center for cancer treatment, at the time the treatment or service is given, 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 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

The In-Network Program covers Outpatient cardiac rehabilitation programs initiated within six months of a cardiac incident and Outpatient pulmonary rehabilitation services.

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

Note: While you can select any in-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.

Chiropractic Services

See Short-Term Rehabilitation for combined maximum.

- Includes X-rays and other services provided by an in-network licensed chiropractor or doctor of oriental medicine

Dental Services

The In-Network 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) when provided by a doctor of dental surgery (DDS) or doctor of medical dentistry (DMD) 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

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 In-Network 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 crowns or other prostheses required as a result of implants, you cannot submit any remaining portion to the In-Network Program.

- Orthognathic surgery limited to documented skeletal Class II and Class III conditions as determined by cephalometric diagnosis, provided the condition is:
    - both functional and esthetic
    - 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

Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not covered.

Diabetic Services/Device/Supplies

The In-Network Program covers diagnostic tests as follows:

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

The 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. Marked dawn phenomenon and/or
        c. 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 Section 3, Accessing Care for Preauthorization requirements.

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.

Dialysis

The In-Network 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

The In-Network Program covers diagnostic tests 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
- Position Emission Tomography (PET) scans
- Sleep disorder studies
- Other diagnostic tests

Durable Medical Equipment

Durable medical equipment (DME) 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 an 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 coverage.

Examples of DME include, but 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
- Implantable insulin pumps
- 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 required. 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).

BCBSNM will decide if the equipment should be purchased or rented, and you must purchase or rent the DME from the vendor BCBSNM identifies.

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, BCBSNM will not pay for replacement unless the DME is at least three years old. BCBSNM 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. Request 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 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 an in-network provider will be covered if it is a Medical Emergency.
- Emergency services obtained from an out-of-network provider (including those outside the United States) will be considered for coverage if it is a Medical Emergency.
- If you are hospitalized in an out-of-network hospital, you will be transferred to an in-network hospital when medically feasible, with any ground ambulance charges also covered. If you decline to be transferred, coverage is not available under the In-Network Program.

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 only when received from an in-network provider.
- Follow-up care that results from a Medical Emergency while on travel within the United States will be covered only when received from an in-network provider.

Note: If you are on Sandia-authorized business travel, you may be eligible to have follow-up care covered. Contact BCBSNM Customer Service for details on how to file your claim for covered Emergency care.

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, please call the 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. Pre-Authorization 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 Employee Assistance Program covers up to eight visits per calendar year at no cost to you, when obtained in-network, for assessment, referral, and follow-up counseling for employees and their covered family Members experiencing impairment from personal concerns that adversely affect their day-to-day activity.

IMPORTANT: Retirees, Survivors, LTD Terminees, and any covered family Members are not eligible for EAP benefits.

Eye Exam/Eyeglasses/Contact Lenses

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

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 for information on vision screenings.

Family Planning

The In-Network Program covers family planning services 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 intrauterine devices (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 the Catalyst Rx Prescription Drug Program.

Genetic Testing

The In-Network 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 7, What's Not Covered – Exclusions for information on what is excluded under genetic testing/counseling. Preauthorization is required.

Hearing Aids/Exam

The In-Network Program will cover the initial hearing exam and initial hearing aid purchase if hearing loss results from Injury or Illness. Natural hearing loss is not covered. Refer to the Preventive Care benefits for information on hearing screenings. Preauthorization is required.

Home Health Care Services

IMPORTANT: Preauthorization is required before receiving services. Refer to Section 3, Accessing Care for Preauthorization requirements. 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

IMPORTANT: Preauthorization is required before receiving services. Refer to Section 3, Accessing Care for Preauthorization requirements. If Preauthorization is not received, benefits may be denied.

Hospice care is covered as follows:

- Provided on an inpatient basis
- Provided on an Outpatient basis
- 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

Infertility services are **not** covered under the In-Network Program.

Injections in Physician's Office

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

- Allergy shots – $10 copay
- Immunizations/vaccines – no cost to you per the Preventive Care benefit in this section
- All other injections (e.g., cortisone, Depo-Provera, etc) – $20 for PCP office visit or $30 for Specialist office visit

Inpatient Care

An Inpatient Stay is defined as an uninterrupted hospital stay of 24 hours or more. If a hospital stay is billed as inpatient with charges for room and board, it will be considered inpatient. If a hospital stay is billed as Outpatient, no room and board charges will be considered.

The In-Network Program covers inpatient care in a hospital 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

The In-Network 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.

Benefits for an Inpatient Stay in a 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 coverage.

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

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.

The In-Network Program pays for maternity services as follows:

- Initial visit to the Physician to determine pregnancy status
- Prenatal and postnatal visits
- Charges related to delivery
- Charges for newborn delivery services, which are 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 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 Out-of-Pocket Maximum

Note: The In-Network Program will pay for covered medical 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 Summary*

The In-Network 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 under the In-Network Program 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 an in-network Physician and is not a part of the network, coverage is not available under the In-Network Program. If you are admitted to a hospital, you must notify BCBSNM within the time frames listed 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 out-of-pocket limit.

Medical Supplies

The In-Network Program covers certain medical supplies 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 plan or the Prescription Drug Program, but not both)

Lancets, alcohol swabs, diagnostic testing agents, syringes, Novopen and insulin auto-injectors, and allergic Emergency kits through the Prescription Drug Program (refer to Section 6, Prescription Drug Program).

Nutritional Counseling

The In-Network 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

The In-Network Program covers surgical treatment of morbid obesity 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 (6) months.

Note: While you can select any in-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.

Occupational Therapy

See Short-Term Rehabilitation for combined maximum.

- Includes x-rays and other services provided by an in-network licensed therapist or doctor of oriental medicine.

Office Care/Visits

The In-Network Program pays for the following services provided in the Physician's office at the applicable office visit copay:

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

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 reduced or denied.

- Benefits are available to the donor and the recipient when the recipient is covered under the In-Network Program. The transplant must be a Covered Health Service and cannot be Experimental, Investigational, or Unproven. Examples of transplants for which the program will pay for 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 meet the definition of a covered health service (see below).

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 In-Network 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 provider/ facility for your transplant, but 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

The In-Network Program covers Outpatient Surgery (other than in a Physician's office) and related services as follows:

- Anesthesia
- Equipment related to the surgery
- Facility charges
- Supplies related to the surgery
- Surgeon

Benefits for professional fees are described under Professional Fees for Surgical Services in this section. Also, see the list of procedures in Section 3 that require Preauthorization.

Physical Therapy

See Short-Term Rehabilitation for combined maximum. Preauthorization is required.

- Includes X-rays and other services provided by an in-network licensed therapist or doctor of oriental medicine.

Prescription Drugs (other than those dispensed by Catalyst Rx)

The In-Network Program will cover prescription drugs as follows:

- Enteral nutrition/nutritional supplements/prescription drugs for:

1. Diagnosis of dysphagia (difficulty swallowing),
2. As the sole source of nutrition,
3. Genetic disorder of Phenylketonuria (PKU),
4. RH factor disorders, or
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
- You can receive coverage for intravenous medications, enteral nutrition or nutritional supplements through either the medical plan or the Prescription Drug Program, but not both. Refer to Section 6, 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 6, Prescription Drug Program for information about covered preventive medications.

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 applicable 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.

The In-Network Program covers certain services under the preventive care benefit as outlined below. These services are covered at 100 percent of the Eligible Expenses when received from in-network providers.

Well-Baby Care (ages 0-2 years)

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)

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)

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)

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
- Syphillis 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 the Immunization/Vaccines/Flu Shot Services, Cancer Screenings, Laboratory Services, and Bone Density Testing sections for information on these covered services.

Immunizations/Vaccines/Flu Shot Services

The In-Network Program will pay 100 percent of the in-network Eligible Expenses related to immunizations, flu shots, vaccines, and immunizations needed related to personal travel. If you are unable to obtain the type of immunization related to personal travel at the Physician's office (e.g., malaria pills), contact BCBSNM Customer Service at 877-498-7652 for assistance.

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 where you obtain the immunizations.

Laboratory Services

Covered services include, when age-appropriate:

- Complete blood count (CBC) with differential which includes white blood count, red blood count, hemoglobin, hematocrit, platelet, mcv, mchc, rdw. Differential includes neutrophils, lymphocytes, monosite, eosinophil, basophile, absolute neutrophil, absolute lymphocyte, absolute monocyte, absolute eosinophile, absolute basophile, diff type, platelet estimate, red blood cell morphology.
- Complete urinalysis, including 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, including sodium, potassium, chloride, Co2, anion, glucose, bun, creatinine, calcium, total protein, albumin, globulin, bilirubin total, alkphos, asp, and alt
- Diabetes screening, including a two-hour postprandial blood sugar and HbA1c
- Thyroid screening, including 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 categories 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.

IMPORTANT: 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.

Cancer Screening Services

Covered services include, when age-appropriate:

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

* 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.

**You are entitled to the following:

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.

**A barium enema once every five years in lieu of a colonoscopy or sigmoidoscopy

Note: From time to time, Sandia will sponsor mobile mammogram screenings at Sandia or in the community through this program. Screenings are available to 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

For the following pregnancy-related services, on an as needed basis, the In-Network Program will pay 100 percent of the Eligible Expenses:

- 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 incompatability screening and follow-up testing for women at higher risk
- Syphillis screening
- Tobacco use screening and counseling as needed

Bone Density Testing

The In-Network Program will pay 100 percent of the Eligible Expense for bone density testing once every three years upon turning 50 years of age.

Professional Fees for Surgical Procedures

The In-Network 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 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 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 In-Network Program covers prosthetic devices and appliances that replace a limb or body part or help an impaired limb or body part work. Examples include, but are not limited to:

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

If more than one prosthetic device meets your functional needs, benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided 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 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 In-Network Program will not pay for replacement unless the device or appliance is at least five years old.

Reconstructive Procedures

This In-Network Program covers certain reconstructive procedures where a physical impairment exists and the expected outcome is restored or improved physiological function for an organ or body part.

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

Improving or restoring physiological function means that the organ or body part is made to work better. 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, such as in upper eyelid surgery. At times, this procedure is done to improve vision, which is considered a reconstructive procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a cosmetic procedure and is not covered. Refer to Section 7, 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.

Short-Term Rehabilitation (Outpatient)

Combined maximum of 60 visits per calendar year including:

- Acupuncture
- Chiropractic therapy (including spinal manipulation)
- Occupational therapy
- Physical therapy
- Speech therapy

Rehabilitation services must be provided by a licensed therapy provider and 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. Preauthorization is required.

Note: Speech, physical, and occupational therapies rendered for developmental disorders are covered 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.

Cardiac and pulmonary rehabilitation are covered, but not included in the 60 visits per calendar year limitation.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Service

Facility services for an Inpatient Stay in a Skilled Nursing Facility or inpatient rehabilitation facility are covered under the In-Network Program. 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 In-Network Program will pay the difference in cost between 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 service is 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.

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

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 or
- A combination of skilled nursing, rehabilitation, and facility services

The In-Network Program does not pay benefits for Custodial Care even if ordered by a Physician.

Speech Therapy

See the Short-Term Rehabilitation section for combined maximum.

Temporomandibular Joint (TMJ) Syndrome

The In-Network 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 In-Network Program will cover Urgent Care as follows:

- If you receive care, including necessary follow-up services, at an in-network Urgent Care Facility within the United States,
- If you receive care, including necessary follow-up services, at an out-of-network Urgent Care Facility while on business travel
- 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 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.

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Section 6. Prescription Drug Program

The Prescription Drug Program (PDP), although part of the In-Network Program, is administered separately by Catalyst Rx. Any licensed provider is legally authorized to prescribe medications to issue your prescription. For information on filing claims, claims denials, and appeals, refer to Section 9, How to File a Claim and Section 10, How to File an Appeal.

IMPORTANT: All claims must be submitted 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 the copayments and coinsurances with minimum and maximum copayments 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 the Specialty Drug Management Program in this section for information on coverage for specialty drugs.		
For maintenance prescription drugs Coinsurance of 20% of mail order price with a $12 minimum and $24 maximum for generic prescription drugs Coinsurance of 30% of mail order price with a $50 minimum and $80 maximum for preferred brand name prescription drugs Coinsurance of 40% of mail order price with a $80 minimum and $120 maximum for Non-Preferred brand name prescription drugs Maximum of 90-day supply	Coinsurance of 20% of retail discount price with a $6 minimum and $12 maximum for generic prescription drugs Coinsurance of 30% of retail discount price with a $25 minimum and $40 maximum for 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 Maximum of 30-day supply	50% reimbursement of retail network price, less the applicable minimum retail network copayment Maximum of 30-day supply File your claims with Catalyst Rx
Important: If the cost of the prescription is less than the copayment, you will pay only the actual cost of the prescription. Prescription drug Copayment/coinsurance amounts do not apply to Deductible and Out-of-Pocket Maximum for the medical coverage portion. Reimbursement for prescriptions purchased outside the United States will be reimbursed down to the applicable retail copay/coinsurance, limited to a maximum of a 30-day supply.		

Eligibility

If you are eligible for coverage under the In-Network Program, then you are eligible for the Prescription Drug Program with Catalyst Rx. In-Network Program Members who have primary prescription drug coverage under another group health care plan or Medicare are not eligible to use the Mail-Order Program or purchase drugs from retail network pharmacies at the copayment/coinsurance benefit.

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

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 PDP guidelines and policies.

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 Preauthorization(see page 6-4)]
    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 a copayment, or in-network without a prescription by paying the full price and submitting the claim to Catalyst Rx for reimbursement. (You will be reimbursed down to the appropriate copayment.) The Mail-Order Program is also

available for insulin and diabetic supplies purchased with a prescription.

- 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 BCBSNM or Catalyst Rx, 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. For more information, contact Catalyst Rx at 866-854-8851.

Covered Preventive Medications

The In-Network 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 medication. 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. 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 copayment/coinsurance amount.

Prescriptions Requiring Prior Authorization

A Prior Authorization, also known as a 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 Prior Authorization 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 the PDP. 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)
- Anorexiant agents (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 BCBSNM or Catalyst Rx, but not both)
- Osteoarthritis agents (e.g., Synvisc)
- Prescription vitamins (other than pediatric and prenatal)
- Rebetron
- Synagis
- Thyrogen
- Tussionex Suspension
- 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.

- Remicade
- Revatio
- Byetta
- Symlin
- Viracept

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 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 (limit to three per year)
- Glucagon auto-injection (limit to two per year)
- Insulin auto injectors (limit to two per year)
- Lovenox (limit 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)
- Relenza diskhaler (one per year)
- 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 1-866-854-8851, 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 copayment for each prescription up to a 90-day

supply.

If you send in a prescription through the Mail-Order 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 copayment. 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 copayment. 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 Sandia website 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 copayment 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.

Step	Action	
4	Refills	Refilling a mail-order prescription can be done by phone, by fax, by 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, post-age-paid envelope. Refill through 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 acceptable 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-Order 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 copayment.

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 for those Members who 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 you as a Member in order to remit the appropriate copayment. 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 (minimum and maximum copayments apply) and hold the rest as refills. When you need a refill, return to the pharmacy, pay another copayment/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 retail network price, less the applicable minimum retail copayment, for up to a 30-day supply. Any amounts over a 30-day supply will be denied. Refer to Section 9, 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 the Specialty Drug Management Program, your prescription will be limited to a 30 day supply and will be subject to the retail copayment/coinsurance level of benefits. Any amounts over a 30-day supply will be denied. There is no additional cost to you above your required copayment/coinsurance amount. 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, as necessary.
2	Payment	Walgreens Specialty will call you to confirm your insurance and to let you know what the copayment will be. You must have a credit card on file. Walgreens Specialty will bill the card you have on file for the applicable copay.
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 to14 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.

Section 7. What's Not Covered - Exclusions

What the In-Network Program Does Not Cover

Although the In-Network Program provides benefits for a wide range of covered medical services, there are specific conditions or circumstances for which it will not provide benefit payments. In general, the In-Network Program will not pay for any expense that is primarily for your convenience or comfort or that of your family, caretaker, Physician, or other medical provider. Refer to Section 6, Prescription Drug Program for additional exclusions under the PDP.

The In-Network Program does **not** provide out-of-network coverage except for Emergency and Urgent Care that is Medically Necessary.

You should be aware of 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 Eligible Expenses Insurance filing fees, attorney fees, Physician charges for information released to the claims administrator, and other service charges and finance or interest charges Amount you pay for failure to contact the claims administrator for Preauthorization, including unauthorized care Employee Assistance Program services when you do not obtain Preauthoriation 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 Services	Non-Emergency ambulance services are not covered (e.g., home to Physician for an office visit
Behavioral Health Services	Family therapy, including marriage counseling and bereavement counseling. Family therapy, marriage counseling, and bereavement counseling are covered for employees and their family Members only through the EAP (call Magellan Health Services at 1-800-424-0320). 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 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 Behavioral Health Unit to be for your personal growth or enrichment Court-ordered placements when such orders are inconsistent with the recommendations for treatment by BCBSNM Behavioral Health participating provider for mental health, the Primary Care Physician, or BCBSNM Behavioral Health Unit.

Exclusions	Examples
Behavioral Health Services (cont.)	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 mental disorder Sex transformations Any services or supplies that are not Medically Necessary or appropriate Custodial Care Pastoral counseling Developmental Care Treatment for caffeine or tobacco addiction, withdrawal, or dependence Aversion therapies Treatment for codependency Non-abstinence-based or nutritionally based treatment for Substance Abuse Services, supplies, or treatments that are covered for benefits under the medical part of the In-Network Program Treatment or consultations provided via phone Services, treatments, or supplies provided as a result of any Worker's Compensation law or similar legislation, or obtained through, or required by, any government agency or program, whether federal, state, or subdivision of, or caused by the conduct or omission of a third party for which you have a claim for damages or relief, unless you provide BCBSNM Behavioral Health Unit with a lien against such claim for damages or relief in a form and manner satisfactory to BCBSNM Behavioral Health Unit. Conditions resulting from insurrection, except for injuries inflicted on an innocent bystander who is covered under the In-Network Program Nonorganic erectile dysfunction (psychosexual dysfunction) 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 Behavioral Health Unit Services or supplies that • Are considered Experimental or Investigational (such as drugs, devices, treatments, or procedures) • Result from or relate to the application of such Experimental or Investigational drugs, devices, treatments, or procedures Wilderness programs, boot-camp-type programs, and work-camp-type programs, or recreational type programs Services or supplies that are primarily for your education, training, or development of skills needed to cope with an Injury or Illness
Biofeedback	Biofeedback is not a covered health service
Congenital Heart Disease	CHD services other than as listed under Coverage Details in Section 5, Coverages/ Limitations.

Exclusions	Examples
Dental Procedures	Dental procedures are not covered under the In-Network Program except for injuries to sound, natural teeth, the jaw bone, or surrounding tissue or birth defects. Treatment must be initiated within one year of Injury. Jaw joint disorders (TMJ) and orthognathic surgery are covered only if Medically Necessary. Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not covered.
Drugs	In addition to the clinical guideline limitation imposed by Catalyst Rx (see Section 6, Prescription Drug Program), the In-Network Program excludes coverage for certain drugs, supplies, and treatments, which include, but are not limited to, the following: Over-the-counter medications unless specifically included Fluoride preparations (other than for ages 6 months to 5 years) and dental rinses Contraceptive foams, jellies, and ointments Drugs labeled "Caution: Limited by Federal Law to Investigational use or Experimental drugs" 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." Glucose tablets Drugs used for cosmetic purposes Prescription drugs that may be properly received without charge under local, state, or federal programs, including Workers Compensation Refills of prescriptions in excess of the number specified by the Physician Refills dispensed after one year from the date of order by the Physician Prescription drugs purchased for those who are ineligible for coverage under the In-Network Program Prescription drugs taken by a donor who is not insured under the In-Network Program Medicine not Medically Necessary for the treatment of a disease or an Injury The following are excluded by the Prescription Drug Program but may be covered by the medical benefit under BCBSNM if Medically Necessary: Ostomy supplies Blood glucose meters Implantable birth control devices such as IUDs Allergy serum External Insulin pumps and supplies Continuous glucose monitoring systems and supplies 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 to BCBSNM.

Exclusions	Examples
Equipment	Exercise equipment (e.g., exercycles, weights, etc.) Hearing aids for hearing loss (see details in Section 5, Coverages/Limitations) Braces prescribed to prevent injuries while you are participating in athletic activities Household items, including but not limited to: Air cleaners and/or humidifiers Bathing apparatus Scales or calorie counters Blood pressure kits Water beds Personal items, including but not limited to: Support hose, except Medically Necessary surgical or compression stockings Foam cushions Pajamas Equipment rental fees above the purchase price, with the exception of oxygen equipment
Experimental or Investigative or Unproven treatment	Experimental or Investigational Services or Unproven Services, unless In-Network Program has agreed to cover them in Section 5. **Note:** This exclusion applies even if Experimental, Investigational, or Unproven services, treatments, devices, or pharmacological regimens are the only available treatment option for your condition. **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.
Genetic Testing / Counseling	Experimental, 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.
Hospital fees	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 , the claims administrator In-hospital personal charges (e.g., telephone, barber, TV service, toothbrushes, slippers)
Hypnotherapy	Hypnotherapy is not a covered health service.
Infertility, Reproductive, and Family Planning	**Note:** Infertility treatment is **not** a covered benefit under the In-Network Program. Items that are not covered include, but not limited to: Purchase of eggs Services related to or provided to anonymous donors Services provided by a doula (labor aide) Storing and preserving sperm Donor expenses related to donating eggs/sperm, including prescription drugs Expenses incurred by surrogate mothers Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes Over-the-counter medications for birth control/prevention Parenting, prenatal, or birthing classes

Exclusions	Examples
Miscellaneous	Eye exams except as outlined in Section 5, Coverages / Limitations Eyeglasses or contact lenses prescribed, except as outlined in Section 5, Coverages / Limitations. Contact lenses are not considered a prosthetic device Modifications to vehicles and houses for wheelchair access Health club Memberships or spa treatments Treatment or services: Incurred when the patient was not covered under the In-Network Program even if the medical condition being treated began before the date your coverage under the In-Network Program ends For Illness or Injury resulting from your intentional acts of aggression, including armed aggression, except for injuries inflicted on an innocent bystander (e.g., you did not start the act of aggression) 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. Charges in connection with surgical procedures for sex changes Charges for blood or blood plasma that is replaced by or for the patient Conditions resulting from insurrection, except for injuries inflicted on an innocent bystander who is covered under the In-Network Program. Christian Science practitioners and facilities Food of any kind unless it is the only source of nutrition, there is a diagnosis of dysphagia (difficulty swallowing), RH factor, PKU, or cancer. Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk Foods to control weight, treat obesity (including liquid diets), lower cholesterol, or control diabetes Oral vitamins and minerals (with the exception of certain prescription vitamins) as outlined in the Section 6, Prescription Drug Program Herbs and over-the-counter medications, except as specifically allowed in this In-Network Program Charges prohibited by federal anti-kickback or self-referral statutes Chelation therapy, except to treat heavy metal poisoning Diagnostic tests that are: 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 test Domiciliary care 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. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: Required solely for purposes of career, education, camp, employment, insurance, marriage, or adoption, or as a result of incarceration

Exclusions	Examples
Miscellaneous (cont.)	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 Private duty nursing received on an inpatient basis Respite care Rest cures Storage of blood, umbilical cord, or other material for use in a covered health service, except, if needed for imminent surgery
Not a covered health service and/or not Medically Necessary	These health services, including services, supplies which are not: 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 5, Coverages/Limitations; Provided to a covered person who meets the Program's eligibility requirements; and Not identified in general program exclusions.
Old Claims	Claims received one year after the date charges were incurred
Physical Appearance	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. Any loss, expense or charge that results from cosmetic or reconstructive surgery (except after breast cancer). Exceptions to this exclusion include: Repair of defects that result from surgery for which you were paid benefits under the policy Reconstructive (not cosmetic) repair of a congenital defect that materially corrects a bodily malfunction. **Note:** For the purpose of this exclusion, poor self-image or emotional or psychological distress do not constitute a bodily malfunction. Liposuction Pharmacological regimens Nutritional procedures or treatments Tattoo or scar removal or revision procedures, such as salabrasion, chemosurgery and other skin abrasion procedures Replacement of an existing intact breast implant unless there is documented evidence of silicon leakage Physical conditioning programs, such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity Wigs regardless of the reasons for hair loss Treatments for hair loss

Exclusions	Examples
Providers	Services: 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 prior to ordering the service or after the service is received This exclusion does not apply to mammography testing.
Services, supplies, therapy, or treatments	Charges that are: Custodial in nature Otherwise free of charge to you Furnished under an alternative medical program 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 For educational therapy when not Medically Necessary For educational testing For smoking-cessation programs For 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 non-surgical treatment for obesity	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 . The following treatments for obesity: Non-surgical treatment, even if morbid obesity, and Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described in Section 5, Coverages/Limitations.
Transplants	Organ and tissue transplants, including multiple transplants except as identified in Section 5, Coverages/Limitations, and determined by BCBSNM not to be a proven procedure for the involved diagnosis and not consistent with the diagnosis of the condition. 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). Donor costs for organ or tissue transplantation to another person unless the recipient is covered under the In-Network Program.

Exclusions	Examples
Transportation	Non-Emergency ambulance services are **not** covered. Transportation, except ambulances and air ambulance, to the nearest hospital except when Medically Necessary and for the movement between hospitals when Medically Necessary to a facility in the area of your permanent residence or for approved transplant services.
Travel	Travel and transportation expenses, even if ordered by a Physician, except as identified in Section 5, Coverages/Limitations.

Section 8. Coordination of Benefits

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 medical 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 coordination of benefits policy and rules for determining which plan provides primary coverage.

This medical Program contains a coordination of benefits (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 Program. The medical 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 Program.

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 of "Special Rules for Covered Medicare-Primary Members" and "Provision for 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 a medical program during the year. If you do not provide this information to BCBSNM, your family Member's claims may be denied. You may update your other insurance information by calling BCBSNM at 877-498-7652.

Refer to Section 6, Prescription Drug Program for information on eligibility to use the Prescription Drug Program, as well as how coordination of benefits works, if your family Member has other insurance coverage.

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Section 9. How to File a Claim

This section provides an overview of how to file a claim and receipt of benefit payments.

Filing an Initial Claim

IMPORTANT: All claims must be submitted 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. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends. We recommend 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 Member Service at 877-498-7652 for medical services or Catalyst Rx at 866-854-8851 for prescription drugs.

Refer to the 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 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.

In-Network Claim Processing

Generally, when you seek services through an in-network provider, the provider verifies eligibility and submits the claims directly to the claims administrator for processing.

Out-of-Network Medical Claims Processing

You may need to file a claim in certain situations, such as for urgent or Emergency care while you are on travel. The provider may not verify eligibility. It is your responsibility to verify you are eligible for benefits by calling the claims administrator.

Pricing of Non-Contracted Provider Claims

NonEmergency services are generally **not covered** under EPO plans when received out-of-network. The pricing methods apply **only** when the claim for out-of-network services has been authorized for payment and does not satisfy any of the conditions below:

- Pricing for the following categories of claims for Covered Health Services from Non-Preferred Providers will be priced at billed charges or at an amount negotiated by BCBSNM with the provider, whichever is less:
    - Covered Health Services required during an Emergency and received in a hospital, trauma center, or ambulance
    - Covered claims priced by another BCBS Plan through BlueCard using

local pricing methods

- Services from Non-Preferred Providers that satisfy at least one of the three conditions below and, as a result, are eligible for in-network coverage under this Medical Program:
    - Covered Health Services from Non-Preferred Providers within the United States that are classified as "unsolicited" (Non-Preferred Providers) as determined by the Member's Host Plan while outside the service area of BCBSNM
    - Preauthorized transition of care services received from Non-Preferred Providers
    - Covered Health Services received from a Non-Preferred anesthesiologist, pathologist, or radiologist while you are a patient at a **contracted** facility receiving Covered Health Services or procedures that have been preauthorized, if needed
    - Preauthorized services from Non-Preferred Providers when eligible for benefits due to network availability issues as explained in Section 3, Accessing Care.

BCBSNM will use essentially the same claims processing rules and/or edits for Non-Preferred Providers' claims that are used for Preferred Providers' claims, which may change the Eligible Expense for a particular service. If BCBSNM does not have any claim edits or rules for a particular Covered Health Service, BCBSNM may use the rules or edits used by Medicare in processing the claims. Changes made by CMS to the way services or claims are priced for Medicare will be applied by BCBSNM within 90-145 days of the date that such change is implemented by CMS or its successor.

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 Member 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 provider outside of the United States. 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

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.

Prescription Drugs

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

Benefits Payment

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.

BCBSNM will send payment to the provider, unless the provider is not contracted with BCBSNM and you submit a receipt that shows you paid in full (a zero balance) with your itemized bill and the claim form. BCBSNM reserves the right to request additional documentation, such as medical records, prior to processing your claim.

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

BCBSNM will send you an EOB statement after processing the claim. The EOB will let you know if there is a balance due by the patient. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. You can also view and print your EOBs online at www.bcbsnm.com/sandia.

Catalyst Rx will send you an EOB statement for eligible prescription drug claims processed through a Direct Member Reimbursement form.

Pricing of Noncontracted Provider Claims

The BCBSNM Eligible Expense for some Covered Health Services received from Non-Preferred 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 Program 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 percent of the base Medicare Allowable.

Certain categories of claims for **Covered Health Services** from Non-Preferred 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 Eligible Expense is 50 percent of the billed charge)
- home health claims (the Eligible Expense 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 Program 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 Program. You can inspect all records concerning your Membership in this Program 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 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 In-Network Program for Eligible Expenses 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 In-Network Program, you agree to reimburse payments made in error and cooperate in the recovery of excess payments.

Section 10. 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 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, 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 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 services 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 In-Network 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 *Sandia Health Benefits Plan for Employees Summary Plan Description* or the *Sandia Health Benefits Plan for Retirees Summary Plan Description*
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 at 877-498-7652. 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 medical 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: 505-816-3837

Send Prescription Drugs written appeal 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 9, 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 9, 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

You or your authorized representative may make a request for a independent external review or expedited external review of an adverse benefit determination or *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 independent external review with BCBSNM 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:
    - 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;
    - 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);
    - You have exhausted BCBSNM's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the "Exhaustion" section below for additional information and exhaustion of the internal appeal process; and
    - You or your authorized representative have provided all the information and forms required to process an 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 at 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 accrediting 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, of 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 in 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, considered 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 Claim 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 or *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:
    - An adverse benefit 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
    - A Final Internal Adverse Benefit Determination, if the timeframe for completion of an independent 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 of 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 section. BCBSNM must immediately send you a notice of its eligibility determination that meets the requirements set forth in the Independent External Review section.
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 section. 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 an independent external 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 the final external review decision, in accordance with the requirements set forth in the Independent External Review section, 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 health plan.

Catalyst Rx Appeals Process

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

Pre-Service and Post-Service Claims (Prescription Drug Program)

- 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 your 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 the current independent review organization: MCMC LLC. You must submit this request within 180 calendar days of your receipt of the second-level appeal review denial. MCMC LLC 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 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 overturn the Adverse Determination, the benefit will be allowed.

Urgent Claims (Expedited) Appeal (Prescription Drug Program)

- An expedited appeal may be filed by you, your representative or your prescriber, acting on your behalf. Contact Catalyst Rx customer service at 1-866-854-8851.
- 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 your 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 the current independent review organization: MCMC LLC, which 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.

IMPORTANT: You must exhaust the appeal process before you request an external review or seek any legal recourse.

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Section 11. 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 In-Network Program. For Medical and Behavioral Health, 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.

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. (Refer to Section 9, How to File a Claim for more information.)

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 Customer Service

For Member assistance with medical/behavioral services contact BCBSNM Member Services at 877-498-7652, Monday through Friday, from 8:00 a.m. to 6:00 p.m. (MST). Assistance includes:

- Benefits information
- Claims status
- ID cards
- Provider searches
- Utilization review

If you are not satisfied with Customer Service, a BCBSNM representative is available on-site or directly by telephone to assist you with day-to-day questions and issues, including explanation of In-Network Program provisions, network providers, access to care, billing issues, appeals, and referrals to case management. For assistance in getting in touch with a BCBSNM representative, call Sandia HBE Customer Service at (505) 844-HBES (4237).

In-Network Member ID Card

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 by calling BCBSNM Customer Service at 877-498-7652. The Member ID card identifies you to providers as a 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
- Copays
- 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

Hospital Admissions

Call BCBSNM at 877-498-7652 whenever you are hospitalized. It is your responsibility to make sure that you have received the necessary Preauthorization for your hospital stay. Call BCBSNM at a minimum of five days before a scheduled admission. If you are unable to call seven days in advance, you should call as soon as you know you will need hospital care. The phone number is on the back of your BCBSNM ID card.

If the service is for mental health or Chemical Dependency call a Behavioral Health representative at 888-898-0070.

Emergencies

Call 911 immediately or have someone call for you. Don't delay!

Emergency medical care is covered under the In-Network Program 24 hours a day, seven days a week, no matter where you are. Whenever you have a serious accident or sudden Illness, and symptoms are severe and occur unexpectedly, seek medical help immediately.

Examples of Emergency situations include:

- Uncontrolled bleeding
- Seizure or loss of consciousness
- Shortness of breath
- Chest pain or squeezing sensation in the chests
- Suspected overdose of medication or poisoning
- Sudden paralysis or slurred speech
- Severe burns
- Broken bones
- Severe pain

Call BCBSNM at 800-325-8334. You may also have someone call for you within 48 hours or as soon as possible.

If you have any questions about your situation and whether it is an Emergency, call your personal doctor.

Urgent Care

Call your personal doctor for prompt medical attention for severe sore throat, ear or eye infection, sprains or strains, and fever. Your personal doctor may recommend steps you can take to be more comfortable and may prescribe medication if necessary. If you need to be examined, your doctor will direct you to the most appropriate type of care — Emergency room, Urgent Care center, or office visit.

Routine Care

Routine physicals, immunizations, colds, flu, follow-ups for injuries or broken bones, and prescription needs are all situations that should be handled through regular, scheduled office visits with your doctor.

Catalyst Rx Member Services

This PDP provides out-patient prescription drug coverage through Catalyst Rx. For assistance with out-patient prescription drugs contact Catalyst Rx at 1-866-854-8851 Monday through Friday. Assistance includes:

- Benefits information

- ID cards
- Refill a mail order prescription
- Determine if a pharmacy is in the network
- Speak with a pharmacist about a prescription

Catalyst Rx Identification Cards

If you are a new enrollee in the In-Network Program, you will receive new Catalyst Rx identification 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 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.

Catalyst Rx Website

Catalyst Rx's 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 PDP

Contact Telephone Numbers and Hours of Operation

Function	Telephone Numbers
BCBSNM – www.bcbsnm.com/sandia	
Customer Service • Claims questions • Check eligibility • Benefit information • Participating providers • 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. Saturdays 4373 Alexander Blvd NE Albuquerque, NM, 87107
BCBSNM Health Services • Medical/Surgical Preauthorization	1-800-325-8334 8:00 a.m. - 5:00 p.m. (MST), Monday – Friday **BCBSNM Medical Claims Address:** BCBSNM P. O. Box 27630 Albuquerque, NM 87125-7630
BCBSNM Behavioral Health Unit • Mental health Preauthorization • Chemical Dependency Preauthorization • Claims • Inquiries	1-888-898-0070 24 hours/day, 7 days/week **BCBSNM Behavioral Health Unit Claims:** BCBSNM Behavioral Health Unit P. O. Box 92165 Albuquerque, NM 87199-2165
BCBSNM Medical and Behavioral Health Unit 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 • Employee Assistance Program (EAP) Preauthorization • Participating providers	1-800-424-0320 24 hours a day, 7 days a week
BCBSNM Nurseline • Advise on medical care	1-800-973-6329 24 hours a day, 7 days a week
BCBSNM On-Site Representative • Escalated issues which the toll-free number is unable to resolve	505-284-8669
Special Beginnings® Healthy Pregnancy Program provide information about: • nutrition • newborn care	1-888-421-7781 Monday – Friday; 8:00 a.m. - 5:00 p.m. MT

Function	Telephone Numbers
BCBSNM – www.bcbsnm.com/sandia	
Blue Distinction Centers for Specialty Care® • Bariatric Surgery • Cardiac Care • Complex and Rare Cancers • Knee and Hip Replacement • Spine Surgery • Transplants	1-800-325-8334 www.bcbsnm.com/sandia
BlueExtras℠ Discount Program	1-877-498-7652 www.bcbsnm.com/sandia
Blue Access for Members Help Desk • 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® • Participating providers search while on travel	1-800-810-2583 (BLUE)
Catalyst Rx Prescription Drug Program– www.catalystrx.com	
Customer Service • 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 Monday - Friday 24 hours a day seven days a week
Sandia National Laboratories – https://hbe.sandia.gov	
HBE Customer Service Center • Forms • General questions • Benefit information • Address changes	505-844-4237 or 1-800-417-2634, then dial 844-4237 Fax: 505-844-7535 8:00 a.m. to 4:30 p.m. MT
Extend Health • Pre-Medicare Retiree Assistance • Enrollment/disenrollment • Address changes	1-888-598-7809 www.extendhealth.com/sandia

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.

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Section 12. Definitions

Adverse Determination	An Adverse Determination is (a) a denial, reduction, or termination of, or (b) a failure to provide or make payment (in whole or in part) for a benefit.
Body Mass Index (BMI)	A calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.
Chemical Dependency	A condition 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.
Congenital Anomaly	A physical developmental defect that is present at birth.
Cost-Effective	Least expensive equipment that performs the necessary function. Applies to Durable Medical Equipment and prosthetic appliances/devices.
Cosmetic Procedures	Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the claims administrator.
Covered Member	See "Member"
Covered Health Services (applies to medical plan)	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 Section 5 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 *Sandia Health Benefits Plan for Employees Summary Plan Description* or the *Sandia Health Benefits Plan for Retirees Summary Plan Description* and have enrolled into the Program • Medically Necessary/appropriate

Custodial Care	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 • Are provided mainly to help you with daily living activities, including (but not limited to): 1. Walking, getting in and/or out of bed, exercising, and moving 2. Bathing, using the toilet, 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 7. Provide a protective environment 8. 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 your convenience or that of the caregiver, or are provided because your own home arrangement is not appropriate or adequate.
Developmental Care	Services or supplies, regardless of where or by whom they are provided, that • Are provided to you, if you have not previously reached the level of development expected for your age in the following area of major life activity: 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
Dual Sandians	Both spouses are employed by or retired from Sandia, or one spouse may be employed by Sandia and the other may be retired from Sandia.
EAP Counselor	A licensed master's level mental health clinician who provides information, assessment, short-term counseling, and referrals.

Eligible Expenses (applies to medical program only)	Charges for Covered Health Services that are provided while the In-Network Program is in effect, determined as follows: • In-network benefits—contracted rates with the provider • This provision does not apply if you receive Covered Health Services from an out-of-network provider in an Emergency. In that case, Eligible Expenses are the amounts billed by the provider, unless BCBSNM negotiates lower rates.
Emergency	See "Medical Emergency"
Experimental / Investigative (applies to medical plan only)	Any treatment, procedure, facility, equipment, drug, device, technology, therapy, service, or supply not accepted as standard medical practice in the state in which services are provided. In addition, if federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is Experimental. To be considered standard medical practice and not Experimental or Investigative, treatment must meet all five of the following criteria: • A technology must have final approval from the appropriate regulatory governing bodies • The scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes • The technology must improve the net health outcome • The technology must be as beneficial as any established alternatives • The improvement must be attainable outside the investigational settings
Hospice	A program, provided by a licensed facility or agency, that provides home health care, homemaker services, emotional support services, and other service 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 description does not include mental Illness or Substance Abuse, regardless of the cause or origin of the mental Illness or Substance Abuse.
Injury	Bodily damage from trauma other than Illness, including all related conditions and recurrent symptoms.
Inpatient Stay	A person who is formally admitted to a hospital, Skilled Nursing Facility, or inpatient rehabilitation facility, and who occupies a hospital bed, crib, or bassinet while under observation, care, diagnosis, or treatment for at least a 24-hour, uninterrupted, confinement period.
Intensive Outpatient Program	A program that provides 9 to 20 hours per week (less than 4 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 (applies to medical program only)	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: • Provided for the diagnosis or direct treatment of an Injury or Illness • Appropriate and consistent with symptoms and findings or diagnosis and treatment of an Injury or Illness, and not Experimental or Investigative • Provided in accordance with generally accepted medical practice on a national basis • Not solely for the convenience of you, the Physicians, or other health care plan providers • The most appropriate supply or level of service that can be provided on a Cost-Effective basis including, but not limited to, inpatient versus Outpatient care, electric versus manual wheelchair, surgical versus medical or other types of care • Allowable under the provisions of this Program Summary as prescribed by your Physician **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 this Program Summary.
Member	An enrolled participant or enrolled family member. This term refers to a person only while enrolled under the In-Network Program. References to "you" and "your" throughout this document are references to a Member.
Non-Preferred 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 • 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 medical expenses before the In-Network Program reimburses additional Eligible Expenses at 100% for the remaining portion of that calendar year.
Outpatient	A person who visits a clinic, Emergency room, or health facility and receives health care without being admitted as an overnight patient (under a 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.
Outpatient Surgery Facility	A facility that is either free-standing or associated with a hospital or Physician's office that is permanently equipped to perform surgery without requiring an overnight stay.
Partial Hospitalization	A program that provides covered 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.
Physician	Any of the following licensed practitioners who perform a service payable under this Program Summary: • A doctor of medicine (MD), osteopathy (DO), podiatry (DPM), or chiropractic (DC) • A licensed doctoral, clinical psychologist • A master's-level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral, clinical psychologist • A licensed Physician's assistant (PA) • A licensed nurse practitioner Where required to cover by law, any other licensed practitioner who: • Is acting within the scope of his or her license • Performs a service that is payable under this Program Summary. A Physician eligible for reimbursement by the In-Network Program does not include a person who lives with you or is part of your family (you, your spouse, or a child, brother, sister, or parent of you or your spouse).

Preauthorization	The process whereby you call BCBSNM to obtain prior approval for medical necessity and length of any hospital confinement. Certain services require Preauthorization from the Health Services department at BCBSNM. Preauthorization is based upon clinical findings supporting medical necessity and benefit determination. The clinical information provided to the Health Services department aids in the medical review throughout the treatment.
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 Terminee or the individual who is purchasing temporary continued coverage.
Primary Care Physician	The Physician who coordinates and manages your total health care for routine physicals to hospitalizations, ensuring that you receive the most appropriate care for your medical needs. Your PCP may practice in Family Practice or Internal Medicine. Pediatrician and OB/GYN Physicians are also considered those patients' PCP.
Residential Treatment Facility	A Residential Treatment Facility provides acute overnight services for the care of Chemical Dependency disorder or overnight mental health services for Members 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	A Physician who provides specialty services such as a dermatologist, podiatrist, cardiologist, etc.
Substance Abuse	Abuse by the individual of drugs, alcohol, or other chemicals to the point of addiction, which has been diagnosed as an Illness by a licensed Physician. See "Chemical Dependency."
Urgent Care	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.
Urgent Care Facility	Can be attached to a hospital or be free-standing, staffed by licensed Physicians and nurses, and providing health care services.

Section 13. 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

BlueExtras gives Members and covered family members 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.

- **Seattle Sutton's Healthy Eating** (800-442-3438). Seattle Sutton's Healthy Eating is a weight loss and healthy weight management program.
- **Jenny Craig** (877-536-6970). Jenny Craig is a weight loss and healthy weight management program.
- **Complementary Alternative Medicine** (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** (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/sandia. Click the **My Health** tab, and then the BlueExtras Discount Program link.

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