LOS ALAMOS

INCORPORATED COUNTY OF LOS ALAMOS
SERVICES AGREEMENT

This **SERVICES AGREEMENT** (this "Agreement") is entered into by and between the **Incorporated County of Los Alamos**, an incorporated county of the State of New Mexico ("County"), and **Blue Cross and Blue Shield of New Mexico, A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association,**("Contractor" or BCBSNM"), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association"), permitting BCBSNM to use the Blue Cross and Blue Shield Service Marks in the State of New Mexico, and that BCBSNM is not contracting as the agent of the Association, to be effective for all purposes, January 1, 2018.

WHEREAS, the County Purchasing Agent determined in writing that the use of competitive sealed bidding was either not practical or not advantageous to County for procurement of the Services and County issued Request for Proposals No. 17-39 (the "RFP") on March 12, 2017, requesting proposals for **Medical Insurance Benefits for Los Alamos County Employees**, as described in the RFP; and

WHEREAS, Contractor timely responded to the RFP by submitting a response dated April 13, 2017 ("Contractor's Response") incorporated herein by reference for all purposes;

WHEREAS, based on the evaluation factors set out in the RFP, Contractor was the successful Offeror for the services listed in the RFP;

WHEREAS, the County Council approved this Agreement at a public meeting held on September 26, 2017;

WHEREAS, Contractor will provide the Services, as described below, to County.

NOW, THEREFORE, for and in consideration of the premises and the covenants contained herein, County and Contractor agree as follows:

SECTION A. SERVICES:

Contractor shall provide County with Administrative Services for Group Medical Insurance Benefits pursuant to the terms of the Administrative Services Agreement ("ASA"), including all Exhibits and Addenda attached thereto and the Sample Benefits Booklet. The final Benefits Booklet shall be provided by the Contractor within 60 days of the effective date of this Services Agreement. The ASA (Exhibit "A") and Sample Benefits Booklet (Exhibit "B"), are incorporated herein by reference for all purposes. Contractor is solely responsible for providing services and benefit determinations under Exhibits A and B above.

SECTION B. TERM: The term of this Agreement, for Administrative Services, shall commence January 1, 2018 and shall continue through December 31, 2019, unless sooner terminated, as provided herein. *At County's sole option the Agreement may be renewed for up to five (5) consecutive one-year periods, unless sooner terminated, as provided therein.*

The term of this Agreement, for Stop Loss Insurance Coverage, as defined in the Stop Loss Agreement (Exhibit 7 of the ASA), shall commence January 1, 2018 and shall continue through December 31, 2018,

unless sooner terminated, as provided herein. *At County's sole option the Agreement may be renewed for up to six (6) consecutive one-year periods, unless sooner terminated, as provided therein.*

SECTION C. COMPENSATION:

1. **Amount of Compensation**. County shall pay compensation for performance of the Services for the term of this Agreement, not to include any subsequent renewal periods, in an amount not to exceed ONE MILLION THREE HUNDRED THOUSAND DOLLARS ($1,300,000.00), in accordance with the rate schedule as set forth in the Administrative Services Agreement (Exhibit A), which amount shall include applicable New Mexico gross receipts taxes ("NMGRT"). For any subsequent renewal periods, compensation will be strictly based upon rate negotiations with contractor and Council approval of said negotiations as set forth in Section B, "Term," above.

2. **Invoices**. Contractor shall submit weekly invoices to County's Human Resources Division showing claims paid for covered employees, as well as monthly invoices for administrative services, showing amount of compensation due, amount of any NMGRT, and total amount payable. Payment of undisputed amounts shall be due and payable ten (10) calendar days after County's receipt of the invoice.

SECTION D. TAXES: Contractor shall be solely responsible for timely and correctly billing, collecting and remitting all NMGRT levied on the amounts payable under this Agreement.

SECTION E. STATUS OF CONTRACTOR, STAFF, AND PERSONNEL: This Agreement calls for the performance of services by Contractor as an independent contractor. Contractor is not an agent or employee of County and will not be considered an employee of County for any purpose. Contractor, its agents or employees shall make no representation that they are County employees, nor shall they create the appearance of being employees by using a job or position title on a name plate, business cards, or in any other manner, bearing the County's name or logo. Neither Contractor nor any employee of Contractor shall be entitled to any benefits or compensation other than the compensation specified herein. Contractor shall have no authority to bind County to any agreement, contract, duty or obligation. Contractor shall make no representations that are intended to, or create the appearance of, binding County to any agreement, contract, duty, or obligation. Contractor shall have full power to continue any outside employment or business, to employ and discharge its employees or associates as it deems appropriate without interference from County; provided, however, that Contractor shall at all times during the term of this Agreement maintain the ability to perform the obligations in a professional, timely and reliable manner.

SECTION F. STANDARD OF PERFORMANCE: Contractor agrees and represents that it has and will maintain the personnel, experience and knowledge necessary to qualify it for the particular duties to be performed under this Agreement. Contractor shall perform the Services described herein in accordance with a standard that exceeds the industry standard of care for performance of the Services.

SECTION G. DELIVERABLES AND USE OF DOCUMENTS: All deliverables required under this Agreement, including material, products, reports, policies, procedures, software improvements, databases, and any other products and processes, whether in written or electronic form, shall remain the exclusive property of and shall inure to the benefit of County as works for hire; Contractor shall not use, sell, disclose, or obtain any other compensation for such works for hire. In addition, Contractor may not, with regard to all work, work product, deliverables or works for hire required by this Agreement, apply for, in its name or otherwise, any copyright, patent or other property right and acknowledges that any such property right created or developed remains the exclusive right of County. Contractor shall not use deliverables in any manner for any other purpose without the express written consent of the County.

SECTION H. EMPLOYEES AND SUB-CONTRACTORS: Contractor shall be solely responsible for payment of wages, salary or benefits to any and all employees or contractors retained by Contractor in the performance of the Services. Contractor agrees to indemnify, defend and hold harmless County for any and all claims that may arise from Contractor's relationship to its employees and subcontractors.

SECTION I. INSURANCE: Contractor shall obtain and maintain insurance of the types and in the amounts set out below throughout the term of this Agreement with an insurer acceptable to County. Compliance with the terms and conditions of this Section is a condition precedent to County's obligation to pay compensation for the Services and Contractor shall not provide any Services under this Agreement unless and until Contractor has met the requirements of this Section. County requires Certificates of Insurance or other evidence acceptable to County that Contractor has met its obligation to obtain and maintain insurance. Should any of the policies described below be cancelled before the expiration date thereof, notice will be delivered in accordance with the policy provisions. General Liability Insurance and Automobile Liability Insurance shall name County as an additional insured.

1. **General Liability Insurance:** ONE MILLION DOLLARS ($1,000,000.00) per occurrence; TWO MILLION DOLLARS ($2,000,000.00) annual aggregate.
2. **Workers' Compensation:** In an amount as may be required by law. County may immediately terminate this Agreement if Contractor fails to comply with the Worker's Compensation Act and applicable rules when required to do so.
3. **Automobile Liability Insurance for Contractor and its Employees:** ONE MILLION DOLLARS ($1,000,000.00) combined single limit on any owned, and/or non-owned motor vehicles used in performing Services under this Agreement.
4. **Professional Liability Insurance:** A limit of at least ONE MILLION DOLLARS ($1,000,000.00) per claim, and with at least TWO MILLION DOLLARS annual aggregate limit. The coverage must be written without any restrictive "negligent act, negligent error, or negligent omission" clause, and the coverage must be sufficient to protect the contractor for a five (5) year period from the completion of this contract, against any and all claims which may arise from the contractor's negligent performance of the work described herein.

SECTION J. RECORDS: Contractor shall maintain, throughout the term of this Agreement and for a period of six (6) years thereafter, records that indicate the date, and nature of the services rendered. Contractor shall make available, for inspection by County, all records, books of account, memoranda, and other documents pertaining to Contractor's services for the County under Section 13 of the ASA at any reasonable time upon request.

SECTION K. APPLICABLE LAW: Contractor shall abide by all applicable federal, state and local laws, regulations, and Contractor's policies applicable to the Services and shall perform the Services in accordance with all applicable laws, regulations, and policies during the term of this Agreement. In any lawsuit or legal dispute arising from the operation of this Agreement, Contractor agrees that the laws of the State of New Mexico shall govern. Venue shall be in the First Judicial District Court of New Mexico in Los Alamos County, New Mexico.

SECTION L. NON-DISCRIMINATION: During the term of this Agreement, Contractor shall not discriminate against any employee or applicant for an employment position to be used in the performance of the obligations of Contractor under this Agreement, with regard to race, color, religion, sex, age, ethnicity, national origin, sexual orientation or gender identity, disability or veteran status.

SECTION M. INDEMNITY: The parties acknowledge and agree that (a) Contractor does not insure or underwrite the liability of County under the Plan and has no responsibility for designing the terms of the Plan or the benefits to be provided thereunder, and (b) County retains the ultimate responsibility for claims under or related to the Plan and all expenses incident to the Plan, except as specifically undertaken in this Agreement by Contractor. Contractor shall indemnify and hold harmless County and its directors, its Council members, officers and employees against any and all loss, liability, damages, penalties and expenses, including reasonable attorneys' fees, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, settlements or judgments with respect to this Agreement resulting from or arising out of any acts or omissions of Contractor or its directors, officers or employees (other than acts or omissions of Contractor done at County's direction) which have been adjudged to be (i) negligent and outside reasonable care undertaken in the ordinary course of business, dishonest, fraudulent or criminal or (ii) in material breach of the terms of this Agreement.

SECTION N. FORCE MAJEURE: Neither County nor Contractor shall be liable for any delay in the performance of this Agreement, nor for any other breach, nor for any loss or damage arising from uncontrollable forces such as fire, theft, storm, war, or any other force majeure that could not have been reasonably avoided by exercise of due diligence.

SECTION O. NON-ASSIGNMENT: Contractor may not assign this Agreement or any privileges or obligations herein without the prior written consent of County.

SECTION P. LICENSES: Contractor shall maintain all required licenses including, without limitation, all necessary professional and business licenses, throughout the term of this Agreement. Contractor shall require and shall assure that all of Contractor's employees and subcontractors maintain all required licenses including, without limitation, all necessary professional and business licenses.

SECTION Q. PROHIBITED INTERESTS: Contractor agrees that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. Contractor further agrees that it will not employ any person having such an interest to perform services under this Agreement. No County Council member or other elected official of County, or manager or employee of County shall solicit, demand, accept or agree to accept a gratuity or offer of employment contrary to Section 31-282 of the Los Alamos County Code.

SECTION R. TERMINATION:

Subject to the terms identified in this Agreement may be terminated as follows:

- **a.** County may terminate this Agreement with or without cause upon thirty (30) days prior written notice to Contractor. Upon such termination, Contractor shall be paid for Services actually completed to the satisfaction of County at the rate set out in Section C of the Service Agreement. Contractor shall render a final report of the Services performed to the date of termination and shall turn over to County originals of all materials prepared pursuant to this Agreement.
- **b.** By both parties on any date mutually agreed to in writing; or
- **c.** By either party, in the event of conduct by the other party constituting fraud, misrepresentation of material fact or material breach of the terms of this Agreement, upon written notice and following expiration of the cure period as provided under Section 16 of the ASA; or
- **d.** By Contractor, if County fails to pay Timely all amounts due under this Agreement including, but not limited to, all amounts pursuant to and in accordance with the specifications of the Fee Schedule of the most current ASO BPA, upon the County's failure to cure the non-payment within ten (10) days of written notice of the nonpayment to County as provided in Section 7.1 of Exhibit 2 "FEE SCHEDULE, FINANCIAL RESPONSIBILITIES & REQUIRED DISCLOSURES" of the ASA.
- **e.** This Agreement shall terminate without further action by County on the first day of any County fiscal year for which funds to pay compensation hereunder are not appropriated by the County Council. County shall make reasonable efforts to give Contractor at least ninety (90) days advance notice that funds have not been and are not expected to be appropriated for that purpose. Upon such termination, Contractor shall be paid for Services actually completed to the satisfaction of Contractor at the rate set out in Section C of the Service Agreement.
- **f.** No such termination will take place without a reasonable attempt to contact the County pursuant to Section 16 in the ASA, and allow the Contractor to make corrective action. No termination will occur without written notification indicated in Section 8.2 of the ASA..

SECTION S. NOTICE: Any notices required under this Agreement shall be made in writing, postage prepaid to the following addresses, and shall be deemed given upon hand delivery, verified delivery by telecopy (followed by copy sent by United States Mail), or three (3) days after deposit in the United States Mail:

County:
Kat Brophy
Incorporated County of Los Alamos
1000 Central Avenue, Suite 230
Los Alamos, New Mexico 87544

Contractor:
James Bloom, Account Executive
Blue Cross and Blue Shield of NM
PO Box 27630
Albuquerque, NM 87125

SECTION T. INVALIDITY OF PRIOR AGREEMENTS: This Agreement supersedes all prior contracts or agreements, either oral or written, that may exist between the parties with reference to the services described herein and expresses the entire agreement and understanding between the parties with reference to said services. It cannot be modified or changed by any oral promise made by any person, officer, or employee, nor shall any written modification of it be binding on County until approved in writing by both County and Contractor.

SECTION U. CAMPAIGN CONTRIBUTION DISCLOSURE FORM: A Campaign Contribution Disclosure Form was submitted as part of the Contractor's Response and is incorporated herein by reference for all purposes. This Section acknowledges compliance with Chapter 81 of the Laws of 2006 of the State of New Mexico.

IN WITNESS WHEREOF, the parties have executed this Agreement on the date(s) set forth opposite the signatures of their authorized representatives to be effective for all purposes on the date first written above.

ATTEST

_____
NAOMI D. MAESTAS
COUNTY CLERK

Approved as to form:

_____
J. ALVIN LEAPHART
COUNTY ATTORNEY

INCORPORATED COUNTY OF LOS ALAMOS

BY: _____
HARRY BURGESS **DATE**
COUNTY MANAGER

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO, A DIVISION OF HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY, AN INDEPENDENT LICENSEE OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION

BY: _____
NAME: _____ **DATE**
TITLE: _____

BlueCross BlueShield of New Mexico

ADMINISTRATIVE SERVICES AGREEMENT

The Effective Date of this Agreement is January 1, 2018.

For Employer Group Number(s): As specified on the most current ASO BPA (as defined below).

Account Number: 251305

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date and year specified below.

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company	**INCORPORATED COUNTY OF LOS ALAMOS**
By: _____	By: _____
Title: _____	Title: _____
Date: _____	Date: _____

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This Administrative Services Agreement ("ASA") made as of the Effective Date specified on page one (1) of this Agreement, by and between **Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company** (“Claim Administrator”), and Employer specified on page one (1) of this Agreement (“Employer”), for Employer Group Number(s) set forth on page one (1) of this Agreement, WITNESSETH AS FOLLOWS:

RECITALS

WHEREAS, as part of the Employer's benefit plan offered to its employees and their eligible dependents, Employer has established and adopted a separate self-insured group health plan component as defined by Section 160.103 of HIPAA ("the Plan"); and

WHEREAS, Employer on behalf of the Plan has executed an ASO BPA and Claim Administrator has accepted such ASO BPA attached hereto as Exhibit 4, with such ASO BPA, Service Agreement AGR18-XX704, this Agreement and all Exhibits and Addenda described in Section 1, below, collectively referred to hereinafter as the “Agreement”, unless specified otherwise; and

WHEREAS, Employer on behalf of the Plan desires to retain Claim Administrator to provide certain administrative services with respect to the Plan; and

WHEREAS, the parties agree that it is desirable to set forth more fully the obligations, duties, rights and liabilities of Claim Administrator and Employer, as sponsor of the Plan, with respect to the Plan;

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Employer and Claim Administrator hereby agree as follows:

SECTION 1: DEFINITIONS, EXHIBITS AND ADDENDA

Capitalized terms used in this Agreement shall have the meanings set forth in Section 24 **"DEFINITIONS"**, unless otherwise provided in the Agreement. All Exhibits and addenda attached hereto and referenced herein are hereby adopted and incorporated by reference as if set out in full in the body of this Agreement.

SECTION 2: APPOINTMENT AND SERVICES

2.1 ***Appointment.*** Employer hereby retains and appoints Claim Administrator to provide Services as hereinafter defined in connection with the administration of the Plan.

2.2 ***Administrative Services.*** Claim Administrator will perform the Services set forth in Exhibit 1 **"CLAIMS ADMINISTRATOR SERVICES"**. Claim Administrator, at its sole discretion, may contract with or delegate to other entities for performance of any of the Services; provided, however, Claim Administrator shall remain fully responsible and liable for performance of any such Services to be performed by Claim Administrator but contracted or delegated to other entities. Further, any of the Services may be performed by Claim Administrator, or any of its subsidiaries or affiliates, including any successor corporation(s), whether by merger, consolidation, or reorganization, without prior written approval by Employer.

SECTION 3: RESPONSIBILITIES OF EMPLOYER AND CLAIM ADMINISTRATOR

3.1 ***Employer responsibility.*** Employer retains full and final authority and responsibility for the Plan and its operation. Claim Administrator is empowered to act on behalf of Employer in connection with the Plan only as expressly stated in this Agreement or as otherwise mutually agreed to in writing by the parties hereto.

3.2 ***Claim Administrator responsibility.*** Claim Administrator shall have no responsibility for or liability with respect to the compliance or non–compliance of the Plan with any applicable federal, state and local rules, laws and regulations; and Employer shall have the sole responsibility for and shall bear the entire cost of compliance with all federal, state and local rules, laws and regulations, including, but not limited to, any licensing, filing, reporting, modification requirements and disclosure requirements as may apply to the Plan, and all costs, expenses and fees relating thereto, including, but not limited to, local, state or federal taxes, penalties, Surcharges or other fees or amounts regardless of whether payable directly by Employer or by or

through Claim Administrator. The Claims Administrator agrees to undertake reasonable efforts to advise the Employer when it knows the Employer's Plan, as administered by the Claims Administrator, may fail to comply with federal, state or local laws as may apply to the Plan. The Employer however shall retain the ultimate responsibility for Plan compliance and to make any determination relative to Plan compliance except as specifically set forth herein. Claim Administrator shall have the responsibility for and bear the cost of compliance with any federal, state or local laws as may apply to Claim Administrator's performance of its Services except as otherwise provided in this Agreement.

3.3 ***Litigation.*** Each party shall, to the extent practical, advise the other party of any legal actions against it or the other party that specifically or directly concern (a) the terms of or administration of the Plan, or (b) the obligations of either party under the Plan and this Agreement. The Employer shall undertake the defense of any such claim or such action only to the extent that it alleges breach or wrongdoing, action or failure to act on the part of the Employer. The Claim Administrator shall, with respect to claims or allegations of its breach or wrongdoing or action or failure to act, employ attorneys selected by it to defend any such action, the costs and expenses of which shall be the responsibility of the Claim Administrator. It is further agreed that each party (provided no conflicts of interest exist) shall fully cooperate with the other party in the defense of any action arising out of matters related to the Plan or this Agreement. The Claim Administrator does not insure or underwrite the liability of the Employer under the Plan and has no responsibility for designing the terms of the Plan or the benefits to be provided thereunder. The Employer retains the ultimate responsibility for claims under the Plan and all expenses incident to the Plan, except as specifically undertaken in this Agreement by the Claim Administrator. For purposes of this Section, Claim Administrator's "cooperation" includes, but is not limited to, providing reasonable levels of documentation and affidavits, when necessary, but only to the extent (i) Employer is entitled to such information under this Agreement, (ii) Employer would be entitled to the information in litigation, including but not limited to information directly relevant to such action, (iii) such information is not otherwise subject to restrictions on disclosures, including but not limited to privilege or contractual restrictions, and (iv) such documentation is within Claim Administrator's possession in the ordinary course of business. Some defense support, such as from an external reviewer, may require an additional fee.

3.4 ***Claim overpayments.*** Employer acknowledges that unintentional administrative errors may occur. When Claim Administrator becomes aware of a Claim overpayment to a Provider or Covered Person, Claim Administrator will follow its recovery processes, including, but not necessarily limited to, those items described below ("Recovery Process(es)"). Claim Administrator, however, will not be required to enter into litigation to obtain a recovery, unless specifically provided for elsewhere in this Agreement, nor will Claim Administrator be required to reimburse the Plan, except for when negligence that is outside reasonable care undertaken in the ordinary course of business or intentional misconduct by Claim Administrator caused the Overpayment.

For purposes of this Section 3.4, an "Overpayment" is defined as a payment to a Provider or a Covered Person which was more than it should have been, or a payment that was made in error.

Recovery Process. Claim Administrator, on behalf of Employer, has the right to obtain a refund of an Overpayment from a Provider or a Covered Person. Unless otherwise agreed upon between Claim Administrator and the Provider, when a Provider fails to return an Overpayment to Claim Administrator, Claim Administrator has the right to utilize the following mechanisms to recover the Overpayment:

For purposes of Sections (a) – (e) below, "Other Plan(s)" or "Another Plan" means any health benefit plan, including, but not limited to, individual and group plans or policies administered or insured by Claim Administrator.

(a) Reductions From Future Payments. Claim Administrator has the right to offset future payments owed to the Provider: (i) from the Plan, or, (ii) from Other Plans, up to an amount equal to the Overpayment ("Off-Set").

(b) Cross-Plan Offsets. Claim Administrator has the right to reduce Another Plan's payment to a Provider by the amount necessary to recover the Plan's Overpayment to the same Provider and to remit the recovered amount to Employer (net of fees, if any). Likewise, Claim Administrator has the right to reduce the Plan's

payment to a Provider by the amount necessary to recover Another Plan's Overpayment to the same Provider and to remit the recovered amount to the Other Plan (each, a "Cross-Plan Offset").

(c) Division of Recovery for Multiple Plans. If Claim Administrator has made Overpayments to a Provider for more than one (1) Other Plan, Claim Administrator has the right to Offset two (2) or more of the Overpayments collectively, against future payments owed to Another Plan as part of a single transaction, resulting in an Overpayment recovery amount equally divided between the Other Plans that overpaid the Provider.

(d) Employer Authorization for Cross-Plan Offsets. Employer authorizes and directs Claim Administrator to perform any Cross-Plan Offsets.

(e) No Independent Right of Recovery. Subject to the exception(s) set forth in this Section 3.4, Employer agrees that Claim Administrator will recover Overpayments in accordance with its Recovery Process and that Employer has no separate or independent right to recover any Provider Overpayment from Claim Administrator, Providers, or Another Plan.

3.5 ***Required Plan information.*** Employer shall furnish on a Timely basis to Claim Administrator certain information concerning the Plan and Covered Persons as may from time to time be required by Claim Administrator for the performance of its duties including, but not limited to, the following:

- **a.** All documents by which the Plan is established and any amendments or changes to the Plan.
- **b.** All data as may be required by Claim Administrator regarding Covered Persons who are to be covered under this Agreement.

It is Employer's obligation to Timely notify Claim Administrator of any change in a Covered Person's status under this Agreement. All such notifications by Employer to Claim Administrator (including, but not limited to, forms and tapes) must be furnished in a format mutually agreed to by the parties and must include all information reasonably required by Claim Administrator to effect such changes. It is also Employer's obligation to obtain any consent(s) from Covered Persons necessary for Claim Administrator to contact Covered Persons by telephone or text, including by pre-recorded message, artificial voice, or by use of an automatic telephone dialing system. Employer is responsible for ensuring that the terms of its health benefit plan are consistent with the terms of this Agreement.

3.6 ***Grandfathered Health Plans.*** Employer shall provide Claim Administrator with written notice prior to renewal (and during the plan year, at least 60 days advance written notice) of any changes that would cause any benefit package of its Plan(s) to lose its status as a "grandfathered health plan" under the Affordable Care Act and applicable regulations.

3.7 ***Excepted Benefits and/or Self-Insured Nonfederal Governmental Plans.*** If Claim Administrator provides Services for excepted benefits and/or self-insured nonfederal governmental plans (with an exemption election), then Employer represents and warrants that one or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a Plan does not have exempt plan status can result in retroactive and/or prospective changes by Claim Administrator to the terms and conditions of administrative services. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any plan's exempt plan status or any representation regarding any plan's exempt plan status.

3.8 ***Plan eligibility errors.*** Clerical errors in keeping or reporting data relative to benefits described in this Agreement will not invalidate coverage that would otherwise be validly in force or continue coverage which would otherwise validly terminate. Such errors will be corrected by Claim Administrator subject to the terms and conditions of this Agreement and Claim Administrator's reasonable administrative practices in the administration of the Plan including, but not limited to, those related to Timely notification of a change in a Covered Person's status. Employer is liable for any benefits paid for a terminated Covered Person until Employer has notified Claim Administrator of such Covered Person's termination.

3.9 ***Summary of Benefits and Coverage ("SBC").*** Unless otherwise provided in the applicable ASO BPA, Employer acknowledges and agrees that Employer will be responsible for the creation and distribution of the SBC as required by Section 2715 of the Public Health Service Act (42 USC 300gg-15) and SBC regulations (45 CFR 147.200), as supplemented and amended from time to time, and that in no event will Claim Administrator have any responsibility or obligation with respect to the SBC and Claim Administrator will not be obligated to respond to or forward misrouted calls, but may, at its option, provide participants and beneficiaries with Employer's contact information.

3.10 ***Massachusetts Health Care Reform Act.*** The Massachusetts Health Care Reform Act requires certain employers to provide, or contract with another entity to provide, a written statement to individuals residing in Massachusetts who had "creditable coverage" at any time during the prior calendar year through Employer's Plan(s) and to file a separate electronic report to the Massachusetts Department of Revenue verifying information in the individual written statements. If elected on the applicable ASO BPA, Claim Administrator will provide such written statements and electronic reporting, based on information provided to Claim Administrator by Employer and coverage under the Plan(s) during the term of this Agreement. Employer hereby certifies that, to the best of its knowledge, such coverage under the Plan(s) is "creditable coverage" in accordance with the Massachusetts Health Care Reform Act. Employer acknowledges that Claim Administrator is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this Service. Employer or its Covered Persons should seek advice from their legal or tax advisors as necessary. If not elected on the applicable ASO BPA, Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

3.11 ***Use and disclosure of Protected Health Information.*** The parties acknowledge and agree that they have entered into a Business Associate Agreement in accordance with HIPAA. The terms and conditions of the Business Associate Agreement shall govern the use and disclosure of Protected Health Information by the parties, except as otherwise provided in this Agreement.

3.12 ***Electronic exchange of information.*** In the event Employer and Claim Administrator exchange various data and information electronically, Employer agrees to transfer on a Timely basis all required data to Claim Administrator via secure electronic transmission on the intranet and/or internet or otherwise, in a format mutually agreed to by the parties. Further, Employer is responsible for maintaining any enrollment applications and enrollment documentation, including any changes completed by Covered Persons and to allow Claim Administrator reasonable access to this information as needed for administrative purposes.

Employer authorizes Claim Administrator to submit reports, data and other information to Employer in the electronic format mutually agreed to by the parties. In the event Employer is unable or unwilling to transfer data in the electronic format mutually agreed to by the parties, Claim Administrator is under no obligation to receive or transmit data in any other format unless required by law to do so. In the event garbled or intercepted transmissions occur, the parties agree to redirect the information via another mutually agreeable means.

SECTION 4: THIRD PARTY DATA RELEASE

4.1 ***Types of data.*** In the event Employer directs Claim Administrator to provide data directly to its third party consultant and/or vendor (the "Employer's Vendor"), and Claim Administrator agrees in its sole discretion, then Employer acknowledges and agrees, and will cause Employer's Vendor to acknowledge and agree:

- **a.** That the requested documents, records and other information (for purposes of this Section 4, "Confidential Information") are proprietary and confidential in nature and that the release of the Confidential Information may reveal Claim Administrator's Business Confidential Information.
- **b**. To maintain the confidentiality of the Confidential Information and any Business Confidential Information (for purposes of this Section 4, collectively, "Information") and to prevent unauthorized use or disclosure by Employer's Vendor(s) or unauthorized third parties, including those of its employees not directly involved in the performance of duties under its contract with Employer, to the same extent that it protects its own confidential information.
- **c.** To maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information.

d. To use, and require its employees to use, at least the same degree of care to protect the Information as is used with its own proprietary and confidential information.

e. To not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except as necessary to fulfill the purposes of this Agreement or as required by law.

f. To return or destroy the Information at the direction of Claim Administrator or within a reasonable time after the termination of this Agreement, not to exceed 60 days thereafter.

4.2 ***Third party obligations.*** Employer's Vendor(s) shall execute Claim Administrator's then-current data exchange agreement as required by Claim Administrator.

4.3 ***Employer obligations.*** Employer shall:

a. Provide Claim Administrator in writing the names of any Employer's Vendor(s) with whom Claim Administrator is authorized to release, disclose or exchange data. If Employer's Vendor(s) is under contract to perform services that involve the use, access or disclosure of Protected Health Information as defined by HIPAA, the identity of Employer Vendor(s) shall be documented within the Business Associate Agreement between Claim Administrator and Employer.

b. Provide Claim Administrator in writing, the appropriate authorization and specific directions with respect to the release, disclosure or exchange of data with Employer's Vendor(s) identified under 4.3.a. If Employer's Vendor(s) perform services that involve the use, access or disclosure of Protected Health Information as defined by HIPAA, the information required in this Section will be documented in the Business Associate Agreement between Claim Administrator and Employer.

c. Recognize that Claim Administrator will not be responsible for claims or damages for personal injury or property to the extent that they result in or arise from claims, lawsuits, demands, governmental inquiries or actions, settlements or judgments brought against Claim Administrator in connection with any claim based upon Claim Administrator's directed disclosure, including but not limited to disclosure of Protected Health Information, to the designated Employer Vendor(s) of any information and/or documentation or breach by Employer's Vendor(s) of any obligation described in this Agreement, only if such directed disclosure was consistent with Employer's directions. The Parties specifically recognize that the liability of the County of Los Alamos shall be subject in all cases to immunities and limitations of the New Mexico Tort Claims Act (Act), Section 41-4-1 et seq., NMSA 1978, as amended. Claim Administrator recognizes that the Act prohibits Employer from indemnifying Claim Administrator. In lieu of defense by Employer, Claim Administrator shall have the option, at its sole discretion, to employ attorneys selected by it to defend any such action, the costs and expenses of which shall be the responsibility of Claim Administrator.

SECTION 5: CLAIMS/INQUIRIES

5.1 ***Claim Administrator's responsibilities.*** As provided in this Agreement, Claim Administrator will receive eligibility information, review and process properly filed Claims, respond to Covered Person's inquiries and conduct Claim reviews and appeals; however, Claim Administrator does not have final authority to determine Covered Persons' eligibility or to establish the terms and conditions of the Plan.

5.2 ***Internal Claim Administrator reviews and final internal appeal determinations.*** On occasion Claim Administrator may deny all or part of submitted Claims. Upon request of the Covered Person or the Covered Person's authorized representative, Claim Administrator will provide a review of any adverse determination of a Claim or any adverse determination of a pre-service Claim when the Covered Person would have an adverse financial impact for failing to pre-authorize the service. Certain Claims, pre-service requests for review, appeals or inquiries where there is a question as to eligibility, rescission or clarity of Employer's Plan language will be referred to Employer for review and final determination. In addition, Claim Administrator may provide other types of reviews related to the Plan.

5.3 ***External Review Coordination*****.** Claim Administrator may coordinate, and Employer shall pay for, external reviews by Independent Review Organizations ("IROs") as described in Exhibit 1, "CLAIMS ADMINISTRATOR SERVICES", and/or the most current ASO BPA, but in no event shall IROs be considered subcontractors of Claim Administrator under this Agreement.

SECTION 6: INDEMNIFICATION

6.1 The parties acknowledge and agree that (a) Claim Administrator does not insure or underwrite the liability of Employer under the Plan and has no responsibility for designing the terms of the Plan or the benefits to be provided thereunder, and (b) Employer retains the ultimate responsibility for claims under or related to the Plan and all expenses incident to the Plan, except as specifically undertaken in this Agreement by Claim Administrator.

6.2 Claim Administrator hereby agrees to indemnify and hold harmless Employer and its directors, officers and employees against any and all loss, liability, damages, penalties and expenses, including reasonable attorneys' fees, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, settlements or judgments with respect to this Agreement resulting from or arising out of any acts or omissions of Claim Administrator or its directors, officers or employees (other than acts or omissions of Claim Administrator done at Employer's direction) which have been adjudged to be (i) negligent and outside reasonable care undertaken in the ordinary course of business, dishonest, fraudulent or criminal or (ii) in material breach of the terms of this Agreement.

SECTION 7: AUDIT RIGHTS

7.1 ***Employer audits Claim Administrator.***

a. During the term of this Agreement and within one hundred eighty (180) days after its termination, Employer or an authorized agent of Employer (subject to Claim Administrator's approval which shall not be unreasonably withheld) may, upon at least ninety (90) days prior written notice to Claim Administrator, conduct reasonable audits of records related to Claim Payments and to verify that Claim Administrator's administration of the covered health care benefits is performed according to the terms of this Agreement. The audit must be free of bias, influence or conflict of interest. Contingency fee based audits are deemed to have an inherent conflict of interest and will not be supported by Claim Administrator. Audit samples will be limited to no more than three hundred (300) Claims. If a pattern of errors is identified in an audit sample, Claim Administrator shall also identify Claims with the same errors and will reprocess such identified Claims in accordance with Claim Administrator policies and procedures. Notwithstanding anything in this Agreement to the contrary, after reasonable review of such errors, in no event will Claim Administrator be obligated to reprocess Claims or reimburse Employer for alleged errors based upon audit sample extrapolation methodologies or inferred errors in a population of Claim Payments. Employer will be responsible for all costs associated with the audit. Employer will reimburse Claim Administrator for any reasonable personnel time in excess of eighty (80) person-hours required to support audits conducted during the term of this Agreement. Employer will reimburse Claim Administrator for all reasonable expenditures necessary to support audits conducted after termination of this Agreement. All such audits shall be subject to Claim Administrator's then current external audit policy and procedures, a copy of which shall be furnished to Employer upon request to Claim Administrator. The audit period will be limited to the current Agreement year and the immediately preceding Agreement year. No more than one (1) audit shall be conducted during a twelve (12) consecutive-month period, except as required by state or federal government agency or regulation. Employer and such agent that have access to the information and files maintained by Claim Administrator will agree not to disclose any proprietary information.

b. If Employer is required to conduct an audit outside of the audit period note in paragraph a. above by a state or federal government agency, Claim Administrator will allow such audit as required by state or federal government agency or regulation.

7.2 ***Claim Administrator audits Employer.*** During the term of this Agreement and within one hundred eighty (180) days after its termination, Claim Administrator may, upon at least ninety (90) days prior written notice to Employer, conduct reasonable audits of Employer's membership records with respect to eligibility. Claims Administrator acknowledges Employer has the final authority to determine Covered Persons' eligibility in accordance with section 5.1 above.

SECTION 8: TERM AND TERMINATION OF AGREEMENT

8.1 ***Term.*** The term of this Agreement, for Administrative Services, shall commence January 1, 2018 and shall continue through December 31, 2019, unless sooner terminated, as provided herein. *At Employer's sole option the Agreement may be renewed for up to five (5) consecutive one-year periods, unless sooner terminated, as provided therein.*

The term of this Agreement, for Stop Loss Insurance Coverage, as defined in the Stop Loss Agreement (Exhibit 7 of the ASA), shall commence January 1, 2018 and shall continue through December 31, 2018, unless sooner terminated, as provided herein. *At Employer's sole option the Agreement may be renewed for up to six (6) consecutive one-year periods, unless sooner terminated, as provided therein.*

8.2 ***Termination.*** Subject to the terms identified in this Agreement may be terminated as follows:

- **a.** Employer may terminate this Agreement with or without cause upon thirty (30) days prior written notice to Claim Administrator. Upon such termination, Claim Administrator shall be paid for Services actually completed to the satisfaction of Employer at the rate set out in Section C of the Service Agreement. Claim Administrator shall render a final report of the Services performed to the date of termination and shall turn over to Employer originals of all materials prepared pursuant to this Agreement.
- **b.** By both parties on any date mutually agreed to in writing; or
- **c.** By either party, in the event of conduct by the other party constituting fraud, misrepresentation of material fact or material breach of the terms of this Agreement, upon written notice and following expiration of the cure period as provided under Section 16 below; or
- **d.** By Claim Administrator, if Employer fails to pay Timely all amounts due under this Agreement including, but not limited to, all amounts pursuant to and in accordance with the specifications of the Fee Schedule of the most current ASO BPA, upon the Employer's failure to cure the non-payment within ten (10) days of written notice of the nonpayment to Employer as provided in Section 7.1 of Exhibit 2 "FEE SCHEDULE, FINANCIAL RESPONSIBILITIES & REQUIRED DISCLOSURES" of this Agreement.
- **e.** This Agreement shall terminate without further action by Employer on the first day of any County fiscal year for which funds to pay compensation hereunder are not appropriated by the County Council. Employer shall make reasonable efforts to give Claim Administrator at least ninety (90) days advance notice that funds have not been and are not expected to be appropriated for that purpose. Upon such termination, Claim Administrator shall be paid for Services actually completed to the satisfaction of Claim Administrator at the rate set out in Section C of the Service Agreement.
- **f.** No such termination will take place without a reasonable attempt to contact the Employer pursuant to Section 16 herein. and allow the Employer to make corrective action. No termination will occur without written notification indicated in Section 8.2, above.

8.3 ***Notice of termination to Covered Employees.*** If this Agreement is terminated pursuant to this Section 8, Employer agrees to notify all Covered Employees. The parties agree that Employer will give such notice because Employer maintains direct and ongoing communication with, and maintains current addresses for, all such Covered Employees.

SECTION 9: RELATIONSHIP OF PARTIES

9.1 ***Regarding the parties.*** Claim Administrator is an independent contractor with respect to Employer. Neither party shall be construed, represented or held to be an agent, partner, associate, joint venturer nor employee of the other.

Further, nothing in this Agreement shall create or be construed to create the relationship of employer and employee between Claim Administrator and Employer; nor shall Employer's agents, officers or employees be considered or construed to be employees of Claim Administrator for any purpose whatsoever.

9.2 ***Regarding non–parties.*** It is understood and agreed that nothing contained in this Agreement shall confer or be construed to confer any benefit on persons who are not parties to this Agreement including, but not limited to, employees of Employer and their dependents.

9.3 ***Exclusivity.*** Employer agrees not to perform or engage any other party to perform the same services as Claim Administrator's Services while this Agreement is in effect, unless Employer terminates this Agreement pursuant to its terms.

9.4 ***Assignment.*** Except as otherwise permitted by Section 2 of this Agreement, no part of this Agreement, or any rights, duties or obligations described herein, shall be assigned, transferred, or delegated, directly or indirectly, without the prior express written consent of both parties. Any such attempted assignment in the absence of the prior written consent of the parties shall be null and void. Claim Administrator's contractual arrangements for the acquisition and use of facilities, services, supplies, equipment and personnel shall not constitute an assignment or delegation under this Agreement. This Agreement shall, however, be binding on any permitted assignees, delegates or successors to the parties to the Agreement.

SECTION 10: NON ERISA GOVERNMENT REGULATIONS

10.1 ***In relation to the Plan.*** Although Employer has advised Claim Administrator that Employer's Plan is currently not covered by ERISA, Employer hereby acknowledges (i) its employee benefit plan is established and maintained through a plan document, and (ii) its employee benefit plan document may provide for the allocation and delegation of responsibilities thereunder. However, notwithstanding anything contained in the Plan or any other employee benefit plan document of Employer, Employer agrees that Claim Administrator does not and will not accept any allocation or delegation of any fiduciary or non–fiduciary responsibilities under the Plan or any other plan document of Employer and no such allocation or delegation is effective with respect to or accepted by Claim Administrator except as set forth in this Agreement. Employer will promptly notify Claim Administrator in the event Employer's Plan is no longer exempt from ERISA.

10.2 ***In relation to the Plan Administrator/Named Fiduciary(ies).*** Claim Administrator is not the plan administrator of Employer's employee benefit plan and is not a fiduciary of Employer, the plan administrator or of the Plan, except as set forth in this Agreement.

10.3 ***Claim Administrator's limited fiduciary responsibility.*** Although Employer is exempt from ERISA, Employer hereby delegates to Claim Administrator the discretionary authority to administer claims in accordance with the terms of Employer's self-funded health care benefit plan and to make initial claim determinations concerning the availability of Plan benefits and final internal review and benefit determinations for appealed Claims. Claim Administrator hereby acknowledges and agrees that it shall act as a limited fiduciary to the Plan solely with respect to its performance of such claims processing and payment services and Employer acknowledges and agrees that Claim Administrator shall not have any other fiduciary duties or responsibilities under the Plan. In particular, but not in limitation of the foregoing, Employer acknowledges and agrees that Claim Administrator shall have no discretionary authority under its agreement with Employer except as otherwise set forth in this Agreement, and no fiduciary duty to the Plan, with respect to services performed by Employer, Employer's other vendors and Claim Administrator's separate financial arrangements with providers, pharmacy benefit managers, vendors, independent contractors and subcontractors of any type. Employer further agrees and acknowledges that Claim Administrator shall have no authority or obligation to act on behalf of the Plan or Plan participants or beneficiaries as a fiduciary or otherwise with respect to any litigation, including litigation by participants or beneficiaries for benefits under the Plan, except as may be required under Claim Administrator's indemnification obligations under this Agreement or its obligations to act as a fiduciary in its claims processing and payment services function as herein set forth or as may specifically be provided for elsewhere in this Agreement.

SECTION 11: PROPRIETARY MATERIALS

11.1 ***Business Confidential Information and Proprietary Marks.*** The parties acknowledge that Claim Administrator has developed acquired or owns certain Business Confidential Information. "Business Confidential Information" includes, but is not limited to, intellectual property, trade secrets, inventions, applications, tools, methodologies, software, operating manuals, technology, technical documentation, techniques, product or services specifications or strategies, operational plans and methods, automated claims processing systems, payment systems, membership systems, privacy and security measures, cost or pricing

information (including but not limited to provider discounts and rates), business plans and strategies, company financial planning and financial data, prospect and customer lists, contracts, vendor and supplier lists and information, symbols, trademarks, service marks, designs, copyrights, know-how, data, databases, processes, plans, procedures, and any other information that reasonably should be understood to be confidential, whether developed or acquired before or after the Effective Date of this Agreement. "Business Confidential Information" also includes modifications, enhancements, derivatives and improvements of the Business Confidential Information described in the preceding sentence. Employer shall not use or disclose Business Confidential Information to any third party without prior written consent of Claim Administrator.

Neither party shall use the name, symbols, copyrights, trademarks or service marks ("Proprietary Marks") of the other party or the other party's respective clients in advertising or promotional materials without prior written consent of the other party; provided, however, that Claim Administrator may include Employer in its list of clients.

11.2 ***Claim Administrator/Association ownership.*** Employer acknowledges that certain of Claim Administrator's Proprietary Marks and Business Confidential Information are utilized under a license from the Blue Cross and Blue Shield Association. Employer agrees not to contest (i) the Blue Cross and Blue Shield Association's ownership of, or the license granted by the Blue Cross and Blue Shield Association to Claim Administrator for use of, such Proprietary Marks and (ii) Claim Administrator's ownership of its Proprietary Marks or Business Confidential Information.

11.3 ***Infringement.*** Claim Administrator agrees not to infringe upon, dilute or harm Employer's rights in its Proprietary Marks. Employer agrees not to infringe upon, dilute or harm Claim Administrator's rights in its Proprietary Marks, including those Proprietary Marks owned by the Blue Cross and Blue Shield Association and utilized by Claim Administrator under a license with the Blue Cross and Blue Shield Association.

11.4 Employer is a governmental entity and subject to certain public disclosure laws including, but not limited to, the New Mexico Inspection of Public Records Act, Sections 14-2-2, et seq., NMSA 1979. The Parties intend to preserve, and prevent waiver of all rights and privileges that protect against disclosure or inspection of otherwise public records or of attorney work product and attorney-client communications. This Agreement is not intended to create privileged status for documents or information where it would not otherwise exist, or to obstruct legitimate discovery. Nothing in this Agreement is intended to diminish or expand the application of any applicable disclosure or inspection laws. The Parties shall execute the Non-Disclosure Agreement attached hereto as Exhibit "IV", the terms and conditions of which shall govern the disclosure of information, including information deemed or identified by Claim Administrator to be confidential.

11.5 ***Disclosures in Account Contracts***. Employer on behalf of itself and its Covered Persons hereby expressly acknowledges its understanding this Agreement constitutes a contract solely between Employer and Claim Administrator, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Claim Administrator to use the Blue Cross and Blue Shield Service Mark, and that Claim Administrator is not contracting as the agent of the Association. Employer on behalf of itself and its Covered Persons further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Claim Administrator and that no person, entity, or organization other than Claim Administrator shall be held accountable or liable to Employer for any of Claim Administrator's obligations to Employer created under this Agreement. This subsection shall not create any additional obligations whatsoever on the part of Claim Administrator other than those obligations created under other provisions of this Agreement.

11.6 ***Administrative Services Only, Network Only.*** Claim Administrator must disclose that it does not underwrite or assume any financial risk with respect to claims liability; and disclose the nature of the services and/or network access Claim Administrator is providing. Such disclosures must be made to Employer, Employer's Covered Persons, and Providers and must include, at a minimum, disclosure on identification cards, benefit booklets, Employer contracts and explanation of benefits documentation.

SECTION 12: ELECTRONIC DOCUMENTS

Employer's consent/responsibilities. Employer consents that any documents exchanged between the parties that describe the benefits under, or the administration of, the Plan (including but not limited to benefit booklets) may

be in the format of an electronic file or access to an electronic file. Employer further acknowledges and agrees that if Claim Administrator provides Employer, at Employer's request, an electronic file that describes the benefits under, or the administration of, the Plan, Employer will provide Covered Persons access, via the intranet, internet, or otherwise, to only the most current version of that electronic file. Employer also acknowledges and agrees that, in all instances, Claim Administrator may rely on the fact that the most current version of the electronic file Claim Administrator provides to Employer is the authorized document that governs administration of Employer's Plan under this Agreement and will prevail in the event of any conflict between such electronic file and any other electronic or paper file. Employer is solely responsible for any and all claims for loss, liability or damages, arising either directly or indirectly from Employer's use or posting of the electronic file on the intranet and/or internet.

SECTION 13: RECORDS

All Claim determination records, excluding any and all of the Business Confidential Information of Claim Administrator, other Blue Cross and/or Blue Shield companies, or Claim Administrator's subsidiaries, affiliates, and vendors, in the possession of Claim Administrator are and shall remain the property of Employer upon termination of this Agreement. Claim Administrator shall return a copy of such property upon request in a form as agreed upon by the parties with the cost of preparing such property for transmittal to be borne by Employer. All such Claim records shall be retained by Claim Administrator until Claim Administrator receives a request from Employer for transmittal or for a period of eleven (11) years from the date of a Claim's adjudication, whichever occurs first.

SECTION 14: APPLICABLE LAW

This Agreement shall be governed by, and shall be construed in accordance with, the laws of the state of New Mexico without regard to any state choice–of–law statutes, and any applicable federal law. All disputes between Employer and Claim Administrator arising out of or related to this Agreement will be resolved in Los Alamos, New Mexico**.** Venue shall be in the First Judicial District Court of New Mexico in Los Alamos County, New Mexico. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of the Services in accordance with section 15.3 below.

SECTION 15: ENTIRE AGREEMENT

15.1 ***Definition.*** Service Agreement AGR18-704 and this Agreement, including all Exhibits and Addenda of this Agreement, represents the entire agreement and understandings of the parties with respect to the subject matter of this Agreement. All prior or contemporaneous agreements, understandings, representations, promises, or warranties, whether written or oral, in regard to the subject matter of this Agreement (collectively, the "Prior Communications") are superseded, except as otherwise expressly incorporated into this Agreement. The provisions of this Agreement, and any written amendments made pursuant to Section 15.3 (Amending) of this Agreement, shall prevail in the event of a conflict with any Prior Communications that either party or a third party asserts to be a component of the Agreement between the parties.

15.2 ***Components.*** The Exhibits and Addenda of this Agreement are:

- **a.** Exhibit 1 - Claim Administrator Services
- **b.** Exhibit 2 - Fee Schedule, Financial Responsibilities & Required Disclosures
- **c.** Exhibit 3 - ASO BPA
- **d.** Exhibit 4 - Pharmacy Benefit Management (PBM) Addendum
- **e.** Exhibit 5 - Performance Guarantee (PG) Addendum
- **g.** Exhibit 6 - Stop Loss Agreement
- **f**. Exhibit 7 - Business Associate Agreement ("BAA")

15.3 ***Amending.*** This Agreement shall be amended by mutual written agreement of the parties. Any amendments required by law, regulation or order ("Law"), or by Claim Administrator or the Blue Cross and Blue Shield Association if the change(s) relates to Section 16 herein and/or conditions of Claim Administrator's license agreement with the Blue Cross and Blue Shield Association. may be implemented by Claim Administrator upon sixty (60) calendar days' prior notice to Employer or such time period as may be required by

law. Amendments required by Law shall be effective retroactively, if applicable, as of the date required by such Law. If Employer objects to such amendment within thirty (30) days of receipt of notice of such amendment, the parties shall then engage in good faith negotiations to amend the amendment, to the extent reasonably possible. If the parties cannot agree on terms of the amendment in a satisfactory manner, either party shall be allowed to proceed to a mutually agreed upon dispute resolution process or other remedy provided by law.

SECTION 16: NOTICE AND SATISFACTION

Unless specifically stated otherwise in this Agreement or in any written Exhibit or Addenda thereto, Employer and Claim Administrator agree to give one another written notice (pursuant to Section 19 Notices below) of any complaint or concern the other party may have about the performance of obligations under this Agreement and to allow the notified party thirty (30) days in which to make necessary adjustments or corrections to satisfy the complaint or concern prior to taking any further action with regard to such. The written notice shall provide a description of the complaint or concern in such reasonable detail as to allow the notified party the opportunity to make the necessary modifications within the agreed upon term.

SECTION 17: LIMITATIONS; LIMITATION OF LIABILITY

No action or dispute shall be brought to recover under this Agreement after the expiration of six (6) years from the date the cause of action accrued.

As part of the consideration for services provided by Claim Administrator and for the fees paid by Employer under this Agreement, except as otherwise agreed below or otherwise prohibited by Law, liability (whether in contract, tort, or under any other form of liability) for any errors or omissions by Claim Administrator (or its officers, directors, employees, agents or independent contractors) in the administration of this Agreement, or in the performance of any duty or responsibility contemplated by this Agreement, shall be limited to the Employer's actual, direct damages, not to exceed the total fees set forth in Exhibit "A.". The foregoing limitation of liability shall not apply to claims that arise out of Claim Administrator's gross negligence, fraud, criminal actions, willful, reckless or wanton misconduct or Claim Administrator's bad faith conduct.

SECTION 18: RESERVED

SECTION 19: NOTICES

All notices given under this Agreement must be in writing and shall be deemed to have been given for all purposes when personally delivered and received or when deposited in the United States mail, first–class postage prepaid, and addressed to the parties' respective contact names at their respective addresses or when transmitted by facsimile via their respective facsimile numbers as indicated on the most current ASO BPA. Each party may change such notice mailing and/or transmission information upon Timely prior written notification to the other party. Claim Administrator may also provide such notices electronically, to the extent permitted by applicable law.

SECTION 20: SEVERABILITY; ENFORCEMENT; FORCE MAJEURE; SURVIVAL

Should any provision(s) contained in this Agreement be held to be invalid, illegal, or otherwise unenforceable, the remaining provisions of the Agreement shall be construed in their entirety as if separate and apart from the invalid, illegal or unenforceable provision(s) unless such construction were to materially change the terms and conditions of this Agreement.

Any delay or inconsistency by either party in the enforcement of any part of this Agreement shall not constitute a waiver by that party of any rights with respect to the enforcement of any part of this Agreement at any future date nor shall it limit any remedies which may be sought in any action to enforce any provision of this Agreement.

Neither party shall be liable for any failure to Timely perform its obligations under this Agreement if prevented from doing so by a cause or causes beyond its commercially reasonable control including, but not limited to, acts of God or nature, fires, floods, storms, earthquakes, riots, strikes, wars, terrorism, cybersecurity crimes or restraints of government.

Certain provisions of this Agreement survive expiration or termination of the Agreement, whether expressly or by their nature. These include, but are not limited to, the following: Section 3.3 "Responsibilities of Employer and Claim Administrator: Litigation"; Section 4 "Third Party Data Release"; Section 6 "Indemnification" (for acts or omissions occurring during the term of the Agreement or under Section 8 of Exhibit 2); Section 11 "Proprietary Materials"; Section 13 "Records"; Section 17 "Limitation; Limitation of Liability"; and Section 8 of Exhibit 2 "Financial Obligation Upon Agreement Termination".

SECTION 21: INDUSTRY IMPROVEMENT, RESEARCH AND SAFETY

Notwithstanding any other provision of this Agreement, Claim Administrator may use and or disclose a limited data set or de-identified data for purposes of providing the services under this Agreement and for other purposes required or permitted by applicable law (the “Permitted Purposes” as defined herein). For purposes of this paragraph, “Permitted Purposes” means the studies, analyses or other activities that are designed to promote quality health care outcomes, manage health care and administrative costs, and enhance business and performance, including, but not limited to, utilization studies, cost analyses, benchmarking, modeling, outcomes studies, medical protocol development, normative studies, quality assurance, credentialing, network management, network development, fraud and abuse monitoring or investigation, administrative or process improvement, cost comparison studies, or reports for actuarial analyses. For purposes of this paragraph, a “limited data set” has the meaning set forth in HIPAA and “de-identified” means both member de-identification (as defined by HIPAA) and Employer de-identification (unless the work is being done in connection with Employer’s Plan). Solely for the Permitted Purposes, Claim Administrator may release, or authorize the release of, a limited data set or de-identified data to a third party data aggregation service or data warehouse and its customers. Such data warehouse and data aggregation service providers may charge their customers a fee for access to such data. Nothing in the paragraph is intended to expand or limit the terms and conditions of the Business Associate Agreement with respect to the permitted use or disclosure of PHI (other than with respect to limited data sets). The foregoing notwithstanding, the Blue Cross and Blue Shield Association and its support vendors are permitted to have internal access to Claim Administrator-assigned Employer Group and Identification number.

SECTION 22: THIRD PARTY RECOVERY VENDORS AND OUTSIDE ATTORNEYS

To assist in the recovery of payments, Claim Administrator may engage a third party to assist in identification or collection of recovery amounts related to Claim Payments made under the Agreement. In such event, the recovered amounts will be applied according to Claim Administrator's refund recovery policies. Claim Administrator may also engage a third party to assist in the review of healthcare Providers’ Claim coding or billing to identify discrepancies prior to Claim Payments. Third parties' fees associated with such assistance and Claim Administrator's fee for its related administrative expenses to support such third party recovery identification and collection will be paid by Employer, in an amount not to exceed 25% of any recovered amount made by Claim Administrator and identified by Third Party Recovery Vendor or, no more than 35% of any recovered amount made by Claim Administrator's third party law firm, as identified in Exhibit 4 ASO BPA, and are separate from and in addition to the Reimbursement Fees set forth in the ASO BPA.

SECTION 23: NOTICE OF ANNUAL MEETING

Employer is hereby notified that it is a Member of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative, or by proxy at all meetings of Members of said Company, consistent with HCSC bylaws. The annual meeting is held at its principal office at 300 East Randolph Street, Chicago, Illinois each year on the last Tuesday in October at 12:30 P.M.

For purposes of this Section, the term “Member” means the group, trust, association or other entity with which this Agreement has been entered. It does not include Covered Employees or Covered Persons under the Plan.

From time to time, Claim Administrator pays indemnification or advances expenses to a director, officer, employee or agent consistent with HCSC’s bylaws then in force and as otherwise required by applicable law.

SECTION 24: DEFINITIONS

24.1 "Accountable Care Organization" means a group of healthcare Providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.

24.2 "Administrative Charge" means the monthly service charge that is required by Claim Administrator for the administrative services performed under this Agreement. The Administrative Charge(s) is set forth in the Fee Schedule.

24.3 "Allowable Charge" means the charge that Claim Administrator will use as the basis for benefit determination for Covered Services a Covered Person receives under the Plan. Claim Administrator will use the following criteria to establish the Allowable Charge for Covered Services:

a. ***For Medical Network Providers -*** The Provider's usual charge, not to exceed the amount the Provider has agreed to accept as payment for Covered Services in accordance with the terms of the Provider contract.

b. ***For Medical Providers other than Medical Network Providers ("Non-Contracting Providers") -*** The Allowable Charge will be the lesser of: **(i)** the Provider's billed charges, or; **(ii)** Claim Administrator's Non-Contracting Allowable Charge. Except as otherwise provided in this Section, the Non-Contracting Allowable Charge is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by Claim Administrator. Such factor will not be less than 100% of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, the Allowable Charge for Non-Contracting Providers will represent an average contract rate for Network Providers adjusted by a predetermined factor established by Claim Administrator and updated on a periodic basis. Such factor shall not be less than 100% of the average contract rate and will be updated not less than every two years. Claim Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by Non-Contracting Providers which may also alter the Allowable Charge for a particular service. In the event Claim Administrator does not have any claim edits or rules, Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Allowable Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by Claim Administrator within one hundred forty-five (145) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

In the event the Non-Contracting Allowable Charge does not equate to the Non-Contracting Provider's billed charges, the Covered Person will be responsible for the difference, along with any applicable Copayment, Coinsurance and deductible amount. This difference may be considerable. To find out an estimate of Claim Administrator's Non-Contracting Allowable Charge for a particular service, the Covered Person may call the customer service number shown on the back of the Covered Person's Identification Card.

Notwithstanding anything to the contrary in the Group Health Plan, for Out-of-Network Emergency Care Services rendered by Non-Contracting Providers, the Allowable Charge shall be equal to the greatest of the following three possible amounts – not to exceed billed charges:

(i) the median amount negotiated with Network or Contracting Providers for Emergency Care Services furnished;

(ii) the amount for the Emergency Care Services calculated using the same method the Plan generally uses to determine payments for Out-of-Network Provider services, but substituting the In-Network or contracting cost-sharing provisions for the Out-of-Network or Non-Contracting Provider cost-sharing provisions; or

(iii) the amount that would be paid under Medicare for the Emergency Care Services.

Each of these three amounts is calculated excluding any Network or Contracting Provider (Copayment) (or) (Coinsurance) imposed with respect to the Covered Person.

c. When Covered Services are received outside the state of New Mexico from a Provider who does not have a written agreement with Blue Cross and Blue Shield of New Mexico or with the local Blue Cross and Blue Shield Plan, the Allowable Charge will be determined by the Blue Cross and Blue Shield Plan (Host Plan) servicing the area. This Allowable Charge will be the amount the Host Plan uses for their own local members that obtain services from local Non-Contracting Providers.

d. ***For Prescription Drug Benefits,*** the Allowable Charge is determined as follows:

(i) Participating Pharmacy, Employer – For a Provider which has a written agreement with Claim Administrator, a Blue Cross and/or Blue Shield Plan or the entity chosen by Claim Administrator to administer its prescription drug program, to provide prescription drug services to a Covered Person at the time Covered Services under the prescription drug benefit are rendered ("Participating Prescription Drug Provider"), the Allowable Charge, for purposes of calculating the Employer Payment, shall be the cost mutually agreed upon by the Employer and Claim Administrator within the PBM Fee Schedule Addendum to the BPA attached and incorporated herein by this reference.

(ii) Participating Pharmacy, Covered Person – For Participating Prescription Drug Providers, the Allowable Charge, for purposes of calculating the Covered Persons' required deductible and Coinsurance for Covered Services received from a Participating Prescription Drug Provider, is the cost agreed to by the Participating Prescription Drug Provider and Claim Administrator, a Blue Cross and/or Blue Shield Plan or the entity chosen by Claim Administrator to administer its prescription drug program, as applicable.

(iii) Out-of-Network Pharmacy – For a Provider which does not have a written agreement with Claim Administrator, a Blue Cross and/or Blue Shield Plan or the entity chosen by Claim Administrator to administer its prescription drug program, to provide prescription drug services to a Covered Person at the time Covered Services under the prescription drug benefit are rendered, the Allowable Charge for purposes of calculating both the Employer Payment and the Covered Persons' required deductible and Coinsurance shall be the lesser of the charge which the particular Out-of-Network Pharmacy usually charges for Covered Services, or the amount Claim Administrator would reimburse Participating Prescription Drug Providers for the same service, minus 25% unless otherwise agreed upon by Claim Administrator and Employer.

e. ***For Covered Dental Services,*** if dental benefits coverage is elected on the most current ASO BPA, the Allowable Charge is determined in accordance with the type of dental benefits coverage elected:

(i) Participating Dentist – the amount the Dentist has agreed to accept as full payment for Covered Services.

(ii) Out-of-Network Dentist – Please refer to Plan Summary/Summary Plan Description for criteria used to establish the Out-of-Network Allowable Charge.

24.4 "Alternative Provider Compensation Arrangements" means the arrangements described in the definition of "Alternative Provider Compensation Arrangement Payments."

24.5 "Alternative Provider Compensation Arrangement Payments" means a payment Claim Administrator makes to Network Providers for any services, including but not limited to, any capitation payments, performance-based payments, Care Coordination payments, Value-Based Program payments, Accountable Care Organization payments, Global Payments/Total Cost of Care payments, Patient-Centered Medical Homes payments, Provider Incentives or other incentives or bonus payments, Shared Savings payments and any other alternative funding arrangement payments as described in Claim Administrator's arrangement with the Network Provider, all as further described in Section 15.4 of Exhibit 2.

If the actual amount of an Alternative Provider Compensation Arrangement Payment (for purposes of this Section 24.5, a "Payment") is not known at the time Claim Administrator bills Employer under this Agreement, then Claim Administrator may bill Employer in advance for Expected Payments to Network Providers (the "Expected Payments"). Such Expected Payments will be calculated for each member in each specific Alternative Provider Compensation Arrangement on a per member per month ("PMPM") basis or on another agreed upon compensation mechanism between Participating Healthcare Provider and Claim Administrator, in the same manner as methodologies described in Section 15.4 of Exhibit 2. Where such Alternative Provider

Compensation Arrangements include a PMPM Payment structure, the calculation of the Expected Payments will be made using (i) the estimated number of members involved in a particular Arrangement (as of the end of the month preceding the calculation), and (ii) the estimated Payments for all such Members, unless an alternate calculation method is used (in the same manner as described in Section 15.4 of Exhibit 2. Expected Payment may vary from Member to Member. For the purposes of this Section 24.5, a "Member" means all of the members in a health benefit plan insured or administered by Claim Administrator, including but not limited to Employer's Covered Persons.

Employer will be billed for its share of the Expected Payment, calculated based on (i) the number of Employer's Covered Persons participating (or expected to participate) in an Alternative Provider Compensation Arrangement per month and/or (ii) the number and/or cost of the Covered Services received (or expected to be received) by the Employer's Covered Persons per month.

Any difference (surplus or deficit) between the Expected Payments and actual Payments will be factored into Claim Administrator's calculation of future Expected Payments. Interest on such difference (surplus or deficit) will be credited (or charged) to Employer and included in the calculation of future Expected Payments. Claim Administrator may recalculate the PMPM amounts and any other applicable Expected Payments or charges from time to time in a manner consistent with this Agreement. In the case of any modification to the PMPM or Expected Payments, Claim Administrator shall inform Employer of such modifications. Thereafter, Employer will be deemed to have approved the modifications, which will become part of this Agreement.

24.6 "Blue Cross Blue Shield Global Core Access Vendor Fees" means the charges to Claim Administrator for the transaction fees through Blue Cross Blue Shield Global Core which are payable to the medical assistance vendor for assisting Covered Persons traveling or living outside of the United States, Puerto Rico, and U.S. Virgin Islands to obtain medical services.

24.7 "Care Coordination" means organized, information-driven patient care activities intended to facilitate the appropriate responses to Covered Person's healthcare needs across the continuum of care.

24.8 "Care Coordinator" means an individual within a Provider organization who facilitates Care Coordination for patients.

24.9 "Care Coordinator Fee" means a fixed amount paid by a BlueCross and/or Blue Shield Plan to Providers periodically for Care Coordination under a Value-Based Program.

24.10 "Claim" means a properly completed notification in a form acceptable to Claim Administrator, including but not limited to, form and content required by applicable law, that service has been rendered or furnished to a Covered Person. This notification must set forth in full the details of such service including, but not limited to, the Covered Person's name, age, sex and identification number, the name and address of the Provider, a specific itemized statement of the service rendered or furnished (including appropriate codes), the date of service, applicable diagnosis (including appropriate codes), the Claim Charge, and any other information which Claim Administrator may request in connection for such service.

24.11 "Claim Charge" means the amount which appears on a Claim as the Provider's regular charge for service rendered to a patient, without further adjustment or reduction**.**

24.12 "Claim Payment" means Claim Administrator's payments under this Agreement based on the benefit calculated by Claim Administrator, plus any related Surcharges, upon submission of a Claim, in accordance with the benefits specified in the Plan for which Claim Administrator has agreed to provide administrative services. All Claim Payments shall be calculated on the basis of the Provider's Allowable Charge**,** in accordance with the benefit coverage(s) elected on the most current ASO BPA, for Covered Services rendered to the Covered Person. The term "Claim Payment" also includes Employer's share of Alternative Provider Compensation Arrangement Payments, whether billed to Employer as part of a Claim or billed separately, as described in the definition of "Alternative Provider Compensation Arrangement Payments."

24.13 "Coinsurance" means a percentage of an eligible expense that a Covered Person is required to pay toward a Covered Service.

24.14 "Copayment" means a specified dollar amount that a Covered Person is required to pay toward a Covered Service.

24.15 "Covered Employee" shall have the same meaning as defined in Employer's Plan to the extent consistent with the ASO BPA.

24.16 "Covered Person" shall have the same meaning as defined in Employer's Plan to the extent consistent with the applicable ASO BPA.

24.17 "Covered Service" means a service or supply specified in the Plan for which benefits will be provided and for which Claim Administrator has agreed to provide administrative services under this Agreement.

24.18 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

24.19 "Fee Schedule" means the fees and charges specified in the initial ASO BPA, including but not limited to, the Administrative Charge and other service charges; or subsequent fees and charges set forth in a subsequent ASO BPA as replacement or supplement to the initial ASO BPA. The Fee Schedule shall be applicable to the Fee Schedule Period therein, except that any item of the Fee Schedule may be changed in accordance with Exhibit 2.

24.20 "Fee Schedule Period" means the period of time indicated in the Fee Schedule and, if applicable, the PBM Fee Schedule Addendum of the most current ASO BPA.

24.21 "Global Payment/Total Cost of Care" means a payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as Outpatient, Physician, ancillary, Hospital services, and prescription drugs.

24.22 "HIPAA" means the Health Insurance Portability and Accountability Act and its implementing regulations (45 C.F.R. Parts 160-164) and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, and its implementing regulations, each as amended, and their respective implementing regulations, as issued and amended by the Secretary of Health and Human Services (all the foregoing, collectively "HIPAA").

24.23 "Hospital" means a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

24.24 "Host Blue" means a local Blue Cross and/or Blue Shield licensee outside the geographic area that Claim Administrator serves.

24.25 "Inpatient" means the Covered Person is a registered bed patient and treated as such in a health care facility.

24.26 "Negotiated Arrangement" means an agreement negotiated between one or more Blue Cross and/or Blue Shield Plans for any national account that is not delivered through the BlueCard Program.

24.27 "Network" means identified Providers, including Physicians, other professional health care Providers, Hospitals, ancillary Providers, and other health care facilities, that have entered into agreements with Claim Administrator (and, in some instances, with other participating Blue Cross and/or Blue Shield Plans) for participation in a participating provider option and/or point–of–service managed care health benefits coverage program(s), if applicable to the Plan under this Agreement.

24.28 "Non-Participating Healthcare Provider" means a healthcare Provider that does not have a contractual agreement with a Host Blue.

24.29 "Outpatient" means a Covered Person's receiving of treatment while not an Inpatient. Services considered Outpatient include, but are not limited to, services in an emergency room regardless of whether the Covered Person is subsequently registered as an Inpatient in a health care facility.

24.30 "Participating Healthcare Provider" means a healthcare Provider that has a contractual agreement with a Host Blue.

24.31 "Patient-Centered Medical Home" means a model of care in which each patient has an ongoing relationship with a Primary Care Physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified Physicians.

24.32 "Physician" means a physician duly licensed to practice medicine in all of its branches.

24.33 "Plan" means, as applied to this Agreement, the separate self-insured group health plan as defined by Section 160.103 of HIPAA.

24.34 "Primary Care Physician" means a Physician who is a Network Provider at the time Covered Services are rendered who is selected by or assigned to a Covered Person to coordinate and arrange for the Covered Person's medical care and who provides medical care within the scope of a license permitting him/her to

legally practice medicine in the recognized areas of pediatrics, obstetrics and gynecology, internal medicine and family practice.

24.35 "Provider" means any Hospital, health care facility, laboratory, person or entity duly licensed to render Covered Services to a Covered Person or any other provider of medical or dental services, products or supplies which are Covered Services.

24.36 "Provider Incentive" means an additional amount of compensation paid to a healthcare Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with, or participation in, agreed-upon procedural and/or outcome measures, joint-initiatives, including but not limited to, any measures or initiatives related to a particular population of Covered Persons.

24.37 "Services" means the services listed in Exhibit 1.

24.38 "Shared Savings" means a payment mechanism in which the Provider and the Blue Cross and/or Blue Shield Plan share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

24.39 "Supplemental Charge" means a fee or charge payable to Claim Administrator by Employer in addition to the fees and charges set forth in the Fee Schedule. A Supplemental Charge may be applied for any customized reports, forms or other materials or for any additional services or supplies not documented in the applicable Fee Schedule. Such services and/or supplies and any applicable Supplemental Charge(s) are to be agreed upon by the parties in advance.

24.40 "Surcharges" means local, state or federal taxes, surcharges or other fees or amounts, including, but not limited to, Blue Cross Blue Shield Global Core Access Vendor Fees and amounts due in connection with the Affordable Care Act Transitional Reinsurance Programs (or successor or alternate program amounts) (the "Reinsurance Contribution"), paid by Claim Administrator which are imposed upon or resulting from this Agreement, or are otherwise payable by or through Claim Administrator. Upon request, Employer shall furnish to Claim Administrator in a Timely manner all information necessary for the calculation or administration of any Surcharges. Surcharges may or may not be related to a particular claim for benefits. In no event will Claim Administrator be responsible for the Reinsurance Contribution.

24.41 "Timely" means the following, unless an alternative standard is specified in this Agreement or is mutually agreed to by the parties in writing:

a. With respect to all payments due Claim Administrator by Employer under this Agreement, weekly claim invoices are due within ten (10) calendar days of notification to Employer by Claim Administrator, monthly fees (e.g. administrative) are due by the fifteenth (15th) of the month with a thirty-one (31) day grace period; or

b. With respect to all information due Claim Administrator by Employer concerning Covered Persons, within thirty–one (31) calendar days of a Covered Person's effective date of coverage or change in coverage status under the Plan; or

c. With respect to all Plan information due Claim Administrator by Employer, upon the effective date of this Agreement and at least ninety (90) calendar days prior to the effective date of change or amendment to the Plan thereafter.

24.42 "Value-Based Program" means a payment arrangement and/or a Care Coordination model facilitated through one or more Providers that may utilize one (1) or more of the following metrics: (i) Covered Person health outcomes; (ii) Covered Person Care Coordination; (iii) quality of Covered Services; (iv) cost of Covered Services; (v) Covered Person access; (vi) Covered Person experience with a Provider; or (vii) joint initiatives to increase collaboration in the provision of Covered Services to Covered Persons, and which payment arrangement is reflected in one (1) or more Provider payments, including but not limited to Alternative Provider Compensation Arrangement Payments.

EXHIBIT 1
CLAIM ADMINISTRATOR SERVICES

- **ALTERNATIVE PROVIDER COMPENSATION ARRANGEMENTS**

  Employer agrees to participate in Alternative Provider Compensation Arrangements as applicable based on Covered Person criteria established by Claim Administrator.

- **CLAIMS ADJUDICATION**

  Determination of payment levels of Claims according to Employer's directions. Employer agrees that Claim Administrator will apply Claim Administrator's standard medical and utilization management criteria and policies and Coordination of Benefits (COB) processes for self-funded customers, unless otherwise provided on the ASO BPA.

- **EXPLANATION OF BENEFITS (EOB)**

  Preparation of EOBs.

- **CLAIMS/MEMBERSHIP INQUIRIES**

  Providing responses to inquiries –– written, phone or in–person – related to membership, benefits, and Claim Payment or Claim denial.

- **ENROLLMENT SERVICE**

  Upon Employer request, assist Employer, in accordance with Claim Administrator's standard procedures, in initial enrollment activities, including education of Covered Persons about benefits, the enrollment process, selection of health care Providers and how to file a Claim for benefits; issue Claim submission instructions on behalf of Employer to health care Providers who render services to Covered Persons.

- **CLIENT SERVICES AND MATERIALS**

  Provision of those items as elected by Employer from listing below:

  a. ***Enrollment Materials.*** Implementation materials to be provided by Claim Administrator's Marketing Administration Division during the enrollment process; any custom designed materials may be subject to Supplemental Charge.

  b. ***Standard Identification Cards.*** Provision of identification cards appropriate to health benefit Plan coverage(s) selected.

  c. ***Standard Provider Directories.*** Access to Network Provider directories and periodic updates to such, if applicable to the health benefit Plan coverage(s) under the Agreement.

  d. ***Customer Service.*** Access to a toll–free customer service telephone number.

  e. ***Medical Pre–notification Helpline.*** For those services determined by Employer and provided in writing to Claim Administrator that require pre–notification, advance Claim Administrator review of medical necessity, based on Claim Administrator's standard medical and utilization management criteria and policies, of such services covered under the Plan; access to toll–free medical pre–notification helpline for Covered Persons and their health care Providers to call for assistance.

- **INTERNAL APPEALS**

  Determination of properly filed internal appeal requests received by Claim Administrator from a Covered Person or a Covered Person's authorized representative.

- **EXTERNAL REVIEW COORDINATION (if applicable)**

  Claim Administrator will coordinate external reviews of certain adverse benefit determinations for Employer as described and for the fee set forth in the most current ASO BPA and/or this Agreement. If elected on the ASO BPA, Claim Administrator's coordination includes reviewing external review requests to assess whether they meet eligibility requirements, referring requests to IROs, and reversing the Plan's determinations if so indicated by the IRO. External reviews shall be performed by an IRO and not Claim Administrator. Amounts received by Claim Administrator and IROs may be revised from time to time and may be paid each time an external review is undertaken.

- **MEMBERSHIP**

  Using membership information provided to Claim Administrator by Employer to make claim and appeal determinations and for other purposes as described in the Agreement.

- **STANDARD REPORTS**

  Make available Claim data, Claim settlement statements (as outlined in Exhibit 2, Section 6) and periodic reports in Claim Administrator's standard format(s) in accordance with Claim Administrator's standard reporting policy at no additional charge. Any additional reports required by Employer must be mutually agreed upon by the parties in writing prior to their development and may be subject to a Supplemental Charge.

- **STOP LOSS COORDINATION**

  Coordinate all necessary reporting, tracking, notification and other similar financial and/or administrative services pursuant to settlements under stop loss policy(ies) purchased (or proposed to be purchased) from Claim Administrator in conjunction with the Agreement. For stop loss coverage purchased from entity(ies) other than Claim Administrator, such coordination is limited to this Exhibit's STANDARD REPORTS to be made available to Employer subject to the Agreement's disclosure requirements.

- **REPORTING SERVICES**

  Preparation and filing of annual Internal Revenue Service (IRS) 1099 forms for the reporting of payments to health care Providers who render services to Covered Persons and who are reimbursed under the Plan for those services.

- **ACTUARIAL AND STATISTICAL**

  Determination of Claims projections and pricing of administrative services and stop–loss coverage.

- **FRAUD DETECTION AND PREVENTION**

  Identify and investigate suspected fraudulent activity by Providers and/or Covered Persons and inform Employer of findings and proof of fraud applying Claim Administrator's standard processes; address any related recovery litigation as set forth in Exhibit 3.

- **EMPLOYER PORTAL (currently called BLUE ACCESS® FOR EMPLOYERS)**

  Provide Employer with an on-line resource that allows employer the ability to perform a variety of plan administrative functions, currently managing membership and enrollment, inquiring about claims status, generating reports, and receiving billing information. Functions may be changed or added as they become available.

- **MEMBER PORTAL (currently called BLUE ACCESS® FOR MEMBERS)**

  Provide Member with an on-line resource that allows individuals access to information about their healthcare coverage and benefits, currently verifying claims status, receiving email notifications, accessing health and wellness information, verifying dependents coverage, and taking a health risk assessment. Information may be changed or added as it becomes available.

- **PROVIDER NETWORK(S)**

  If applicable to the health benefit Plan coverage(s) under the Agreement, establish, arrange and maintain a Network(s) through contractual arrangements with Providers including, if also applicable, Primary Care Physicians within the designated service area.

- **BLUE CARE CONNECTION® PROGRAM (*If elected on the most current ASO BPA)***

  Provide a program that may include utilization management, case management, condition management, lifestyle management, predictive modeling, Well on Target, 24/7 nurseline and access to a personal health manager or such other features as determined by Employer and agreed to by Claim Administrator.

- **MASSACHUSETTS STATEMENTS OF CREDITABLE COVERAGE AND ELECTRONIC REPORTING (*If elected on the most current ASO BPA)***

  At the written direction of Employer, issuance of written statements of creditable coverage and related electronic reporting to the Massachusetts Department of Revenue with respect to Covered Persons under the Agreement subject to the Massachusetts Health Care Reform Act.

- **REFERENCE BASED PRICING (RBP) (*If elected on the most current ASO BPA)***

Assist Employer with establishing a maximum coverage amount for specified imaging, inpatient, and outpatient procedures derived from a pricing method based on either the Employee's or Provider's location, as elected by Employer in the most current ASO BPA.

- **VIRTUAL VISITS PROGRAM MANAGEMENT *(if elected on the most current ASO BPA)***
  Provide or arrange for a program that allows Covered Persons to access benefits for certain Covered Services remotely from virtual visit participating Providers via i) interactive audio communication (via telephone or similar technology) and/or ii) interactive audio/video examination and communication (via online portal, mobile app or similar technology), where available.
- **SUMMARY OF BENEFITS AND COVERAGE (SBC) *(if elected on the most current ASO BPA)***
  Create SBCs for benefits Claim Administrator administers under this Agreement and provide SBCs to Employer and Covered Persons as described in the ASO BPA.
- **MSP INFORMATION REPORTING**
  Pursuant to Exhibit 2, Section 17 entitled "MEDICARE SECONDARY PAYER INFORMATION REPORTING", reporting preparation and filing as required of Claim Administrator as Responsible Reporting Entity ("RRE") for the Plan as that term is defined in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.
- **UNCASHED FUNDS**
  Regarding outstanding funds that are or become "stale" (over 365 days old), issue notification letters to payees and upon completion of notification process, reissue such funds to payees based upon payee response, if any. When fund reissuance is not possible, escheat such funds to state of payee's last known address on behalf of Employer, in accordance with Claim Administrator's established procedures and/or the applicable state's unclaimed property law.
- **ADDITIONAL SERVICES NOT SPECIFIED**
  Claim Administrator may provide additional services not specified in the Agreement; such services will be mutually agreed upon between the parties in writing prior to their performance and may be subject to Supplemental Charge in accordance with Los Alamos County Procurement Code.
- **ACTIVITIES THAT ARE NOT CONSIDERED SERVICES**
  Claim Administrator does not provide Employer with software, facilities, phone systems, computers, database or information management, quality or security services, and the term "Services" does not include backroom operations.
- **HEALTH ADVOCACY SOLUTIONS (*If elected on the most current ASO BPA*)**
  Provide a program that may include Holistic Health Management, Member Rewards, utilization management, access to clinical and non-clinical Health Advocates, or such other features as determined by Employer and agreed to by Claim Administrator.

EXHIBIT 2
FEE SCHEDULE, FINANCIAL RESPONSIBILITIES & REQUIRED DISCLOSURES

SECTION 1: FEE SCHEDULE

Service charges and other service specifications applicable to the Agreement are set forth in the Fee Schedule section of the most current ASO BPA and the PBM Exhibit. They are to apply for the period(s) of time indicated therein and shall continue in full force and effect until the earlier of: i) the end of the Fee Schedule Period noted on such ASO BPA and the PBM Exhibit; ii) the date a Fee Schedule is amended or replaced in its entirety by the execution of a subsequent ASO BPA or PBM Exhibit; or iii) the date the Agreement is terminated (or in the case of the PBM Exhibit, the date such Exhibit is terminated).

Inter-Plan Arrangement Fees:

i. **BlueCard® Program/Network access fees* (as applicable):** Additional information is available upon request; included in the Claim Charge, if applicable;

ii. **Negotiated Arrangement/Custom fees (as applicable):** Additional information is available upon request; included in the medical Administrative Charge(s) noted in the ASO BPA and in any Termination Administrative Charge(s) noted in the ASO BPA calculated on the basis of such medical Administrative Charge(s);

iii. **For Non-Participating Healthcare Providers Outside Claim Administrator's Service Area/processing fees (as applicable):** Additional information is available upon request; included in the medical Administrative Charge(s) noted in the ASO BPA and in any Termination Administrative Charge(s) noted in the ASO BPA calculated on the basis of such medical Administrative Charge(s).

**Such fees may not exceed the lesser of the applicable annual percentage of the discount (dependent upon group size) permitted under the BlueCard Program or $2,000 per Claim.*

SECTION 2: EXHIBIT DEFINITIONS

Other definitions applicable to this Exhibit are contained in Section 24 AGREEMENT DEFINITIONS of the Agreement.

2.1 "Employer Payment" means the amount owed or payable to Claim Administrator by Employer for a given Employer Payment Period in accordance with Section 5 of this Exhibit which is the sum of Claim Payments made plus applicable service charges incurred during that Employer Payment Period.

2.2 "Employer Payment Method" means the method elected in the Fee Schedule specifications of the most current ASO BPA by which Employer Payments will be made.

2.3 "Employer Payment Period" means the time period indicated in the Fee Schedule specifications of the most current ASO BPA.

2.4 "Medicare Secondary Payer ("MSP")" means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare–eligible employees, their spouses and, in some cases, dependent children. (See Section 17 of this Exhibit titled "MEDICARE SECONDARY PAYER INFORMATION REPORTING.")

2.5 "Run–Off Claim" means a Claim incurred prior to the termination of the Agreement that is submitted for payment during the Run–Off Period.

2.6 "Run–Off Period" means the time period immediately following termination of the Agreement, indicated in the Fee Schedule specifications of the most current ASO BPA, during which Claim Administrator will accept Run-Off Claims submitted for payment.

2.7 "Termination Administrative Charge" means the consideration indicated in the Fee Schedule specifications of the most current ASO BPA that is required by Claim Administrator upon termination of the Agreement or partial termination of Covered Employees, including any services that may be performed by Claim Administrator during the Run–Off Period indicated on such ASO BPA.

SECTION 3: COMPENSATION TO CLAIM ADMINISTRATOR

3.1 ***Intent of service charges.*** Employer will pay service charges to Claim Administrator, in accordance with the Fee Schedule specifications of the most current ASO BPA and PBM Exhibit, as compensation for the processing of Claims and administrative and other services provided to Employer.

3.2 ***Determining service charges.*** The service charges, which are for the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA and PBM Exhibit, have been determined in accordance with Claim Administrator's current regulatory status and Employer's existing benefit program.

3.3 ***Changing service charges.*** Such service charges shall be subject to change by Claim Administrator as follows:

- **a.** At the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA, provided that ninety (90) days prior written notice is given by Claim Administrator;
- **b.** On the effective date of any changes or benefit variances in the Plan, its administration, or the level of benefit valuation which would increase Claim Administrator's cost of administration;
- **c.** On any date changes imposed by governmental entities increase expenses incurred by Claim Administrator, provided that such increases shall be limited to an amount sufficient to recover such increase in expenses;
- **d.** On any date that the actual number of Covered Employees (in total, by product or by benefit plan), the single/family mix, or the Medicare/Non-Medicare mix varies +/- 10% from Claim Administrator's projections;
- **e.** The information upon which Claim Administrator's projections were based (benefit levels, census/demographics, producer/broker fees, etc.) becomes outdated or inaccurate; or
- **f.** On any date an affiliate, subsidiary, or other business entity is added or dropped by Employer.

3.4 ***Service charges upon termination.*** In the event the Agreement is terminated in accordance with the "TERM AND TERMINATION" provisions of the Agreement, Employer will Timely pay Claim Administrator the Termination Administrative Charge indicated in the Fee Schedule specifications of the most current ASO BPA. Termination Administrative Charges assume the continuation of the Plan benefit program(s) and the administrative services in effect prior to termination. Should such Plan benefit program(s) and/or administrative services change, or in the event the average Plan enrollment during the three (3) months immediately preceding termination varies by ten percent (10%) or more from the enrollment used to determine the service charges in effect at the time of termination, Claim Administrator reserves the right to adjust the fees for service charges (including, but not limited to, access fees) to be used to compute the Termination Administrative Charge. In the event of a partial termination by Employer of more than 10% of Claim Administrator's projections of Covered Employees, Employer will pay the Termination Administrative Charge as specified in the current ASO BPA for such terminated Covered Employees.

3.5 ***Additional service charges.*** In addition to the amounts due and payable each month in accordance with the Fee Schedule specifications of the most current ASO BPA, Claim Administrator may charge Employer for:

- **a.** Any applicable Supplemental Charge(s);
- **b.** Reasonable fees for the reproduction or return of Claim records requested by Employer, a governmental agency or pursuant to a court order; and/or
- **c.** Any other fees that may be assessed by third parties for services rendered to Employer and/or any other fees for services mutually agreed upon by the parties in writing.

3.6 ***Effect of Plan enrollment.*** Administrative Charges will be paid based upon information Claim Administrator receives regarding current Plan enrollment as of the first day of each month. Appropriate adjustments will be made for enrollment variances or corrections.

3.7 ***Timely payment.*** Performance of all duties and obligations of Claim Administrator under the Agreement are contingent upon the Timely payment of any amount owed Claim Administrator by Employer.

SECTION 4: CLAIM PAYMENTS

4.1 ***Claim Administrator's payment.*** Upon receipt of a Claim, Claim Administrator will make a Claim Payment provided that all payments due Claim Administrator under the terms of the Agreement are paid when due.

4.2 ***Employer's liability.*** Any reasonable determination by Claim Administrator in adjudicating a Claim under the Agreement that a Covered Person is entitled to a Claim Payment is conclusive evidence of the liability of Employer to Claim Administrator for such Claim Payment pursuant to Section 6 below titled "CLAIM SETTLEMENTS."

4.3 ***Covered Person's certain liability.*** Under certain circumstances, if Claim Administrator pays the healthcare Provider amounts that are the responsibility of the Covered Person under this Agreement, Claim Administrator may collect such amounts from the Covered Person.

4.4 ***Cessation of Claim Payments.*** If Employer has failed to pay when due any amount owed Claim Administrator, Claim Administrator shall be under no obligation to make any further Claim Payments until such default is cured.

SECTION 5: EMPLOYER PAYMENT

5.1 ***Intent.*** In consideration of Claim Administrator's obligations as set forth in the Agreement and at the end of each Employer Payment Period, Employer shall pay to Claim Administrator or shall provide access for Claim Administrator to obtain, Employer Payment amount due for that Employer Payment Period**.**

5.2 ***Confirmation or notification of amount due and payment due date.*** Employer shall confirm with Claim Administrator or Claim Administrator shall notify Employer's financial division, of Employer Payment for each Employer Payment Period and when such payment is due. Confirmation or notification shall be in accordance with Employer Payment Method elected in the Fee Schedule specifications of the most current ASO BPA and the following:

- **a.** ***If Employer Payment Method is by check,*** Claim Administrator shall issue Employer a settlement statement which will include Claim Administrator's mailing address for check remittance and the date payment is due.
- **b.** ***If Employer Payment Method is other than check,*** Employer shall confirm on-line the amount due by accessing Claim Administrator's "Blue Access for Employers" (as provided in Exhibit 1); or Claim Administrator shall advise Employer by email or facsimile (at an email address or facsimile number to be furnished by Employer prior to the effective date of the Agreement) or by such other method mutually agreed to by the parties, of the amount due. Employer Payment must be made or obtained within ten (10) calendar days of confirmation by Employer or Employer's notification by Claim Administrator. If any day on which an Employer Payment is due is a holiday, such payment will be made or obtained on the next business day.

5.3 ***Federal Regulation of Employer.*** Employer will be responsible for payment of any applicable contributions to the funding of the Transitional Reinsurance Programs established by the Affordable Care Act. Under no condition will Claim Administrator be responsible for payment of Reinsurance Contributions.

5.4 ***Late Payments.*** Late payments are subject to the penalties outlined in Section 7.3 of this Exhibit.

SECTION 6: CLAIM SETTLEMENTS

6.1 ***Determining What Employer Owes.*** A Claim settlement shall be determined for each Claim settlement period indicated in the Fee Schedule specifications of the most current ASO BPA. The Claim settlement shall reflect the sum of the following:

- **a.** Claim Payments paid by Claim Administrator in the particular Claim settlement period.
- **b.** Claim Payments paid by Claim Administrator in prior Claim settlement periods that have not been included in a prior Claim settlement.

c. The Administrative Charges and credits, Surcharges, and other applicable service charges as indicated in the Fee Schedule specifications of the most current ASO BPA of the Agreement and any applicable Supplemental Charge(s).

The sum of a., b., and c. above shall be referred to as the "Claim Settlement Total."

6.2 ***Employer underpayment.*** If, within the Claim settlement period, the Claim Settlement Total exceeds Employer Payments, Employer will pay the difference to Claim Administrator. The Claim settlement will be determined within sixty (60) days from the last day of the Claim settlement period. Claim Administrator will notify Employer in writing of the results of the Claim settlement. Any sums due Claim Administrator will be paid Timely by Employer.

6.3 ***Employer overpayment.*** If, within the Claim settlement period, Employer Payments exceed the Claim Settlement Total, Claim Administrator may, at its option, pay such difference to Employer, apply the difference against amounts then owed Claim Administrator by Employer or authorize a reduction equal to such difference from the next Claim Settlement Total due Claim Administrator from Employer.

SECTION 7: LATE PAYMENTS AND REMEDIES

7.1 ***When Employer fails to Pay.*** If Employer fails to pay when due any amount required to be paid to Claim Administrator under the Agreement, and such default is not cured within ten (10) days of written notice to Employer, Claim Administrator may, at its option:

a. Suspend Claim Payments; or

b. Terminate the Agreement as of the effective date specified in such notice in accordance with Section 8 of the Agreement.

No such termination will take place without a reasonable attempt to contact the Employer pursuant to Section 16 herein and allow the Employer to make corrective action. No termination will occur without written notification indicated in 8.2, above.

7.2 ***When Claim Administrator fails to Timely notify.*** Pursuant to Section 20 "SEVERABILITY; ENFORCEMENT; FORCE MAJEURE; SURVIVAL" of the Agreement, Claim Administrator's failure to provide Employer with Timely notice of any amount due hereunder shall not be considered a waiver of payment of any amount which may otherwise be due hereunder from Employer.

7.3 ***Late charge.*** If Employer fails to make any payment required by the Agreement on a Timely basis, Claim Administrator, at its option, may assess a daily charge for the late remittance from the due date of any amount(s) payable to Claim Administrator by Employer. This daily charge shall be an amount equal to the amount resulting from multiplying the amount due times the lesser of:

a. The rate of .0329% per day which equates to an amount of twelve percent (12%) per annum; or

b. The maximum rate permitted by state law.

7.4 ***Insolvency.*** In addition, if Employer becomes insolvent, however evidenced, or is in default of its obligation to make any Employer Payment as provided hereunder, or if any other default hereunder has occurred and is continuing, then any indebtedness of Claim Administrator to Employer (including any and all contractual obligations of Claim Administrator to Employer) may be offset and/or recouped and applied toward the payment of Employer's obligations hereunder, whether or not such obligations, or any part thereof, shall then be due Employer.

SECTION 8: FINANCIAL OBLIGATIONS UPON AGREEMENT TERMINATION

8.1 ***Run–Off Claims.*** Employer hereby acknowledges that on the date of termination of the Agreement in accordance with the provisions of either Section 7 of this Exhibit or Section 8 of the Agreement, or on the date of a partial termination by Employer of more than 10% of Claim Administrator's projections of Covered Employees, there may be an undetermined but substantial number of Claims for services rendered or furnished prior to that date which have not been submitted to Claim Administrator for reimbursement and also an undetermined but substantial number of Claims submitted for reimbursement which have not been paid by Claim Administrator ("Run–Off Claims"). Employer shall be responsible for the reimbursement of all Run–Off Claims, whether or not such Claims have been submitted, or whether or not Claim Payments for such Claims

have been made by Claim Administrator, as of the date of termination or partial termination, including, but not limited to, Claim Payments made in accordance with MSP laws, and for the payment of the Termination Administrative Charge and any other applicable service charges indicated in the Fee Schedule specifications of the most current ASO BPA and any applicable Supplemental Charge(s) pursuant to the processing of such Claims after the Agreement's termination date or date of partial termination. Further, if a Covered Person is an Inpatient at the time his or her coverage under the Plan terminates, the Plan shall provide benefits for Covered Services which are provided by and regularly charged for by a Hospital or other facility Provider until the Covered Person is discharged or until the end of the Covered Person's benefit period, whichever occurs first ("Extended Benefits"). Employer shall be liable to Claim Administrator for all Claim Payments and the applicable service charges for such Extended Benefits.

8.2 ***Corresponding Employer Payments.*** In consideration of Claim Administrator's continuing to make Claim Payments in accordance with Section 4 of this Exhibit for Run–Off Claims, Employer shall continue to make Employer Payments for all such Claims paid by Claim Administrator up to the final settlement outlined below.

8.3 ***Final Settlement.*** A final settlement shall be made within sixty (60) days after the last day of the Run–Off Period. This final settlement shall compare Employer Payments against the Claim Settlement Totals for all Run–Off Claims paid up to the date of the final settlement. The difference shall be paid or applied as set forth in Section 6 of this Exhibit. However, if Employer Payments exceed the Claim Settlement Totals for all Run–Off Claims paid up to the final settlement, Claim Administrator shall pay such difference to Employer after applying the difference against amounts, if any, then owed to Claim Administrator by Employer. After the final settlement, Claim Administrator shall be released from any further liability for Claim Payments and Claim adjustments under this Agreement, and as of the date Employer shall assume full liability and responsibility for all further administration of Claim Payments. Further, after the final settlement, any refunds resulting from Claim adjustments for overpayments, regardless of when such adjustments occurred shall be retained by Claim Administrator and Employer shall have no liability for any charges associated with any adjustments.

8.4 ***Uncashed funds.*** As of the date of termination of the Agreement, any outstanding funds that are or become "stale" (over 365 days old) will be escheated by Claim Administrator, on Employer's behalf, in accordance with the applicable state's unclaimed property law.

SECTION 9: REQUIRED DISCLOSURE PROVISIONS

Employer represents that it acknowledges and has communicated the substance of the provisions stated in each of the following sections of this Exhibit 2 (Sections 10 and after) to its Covered Persons, with modifications appropriate for communications with Covered Persons.

SECTION 10: PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

10.1 ***Claim Payment.*** All payments by Claim Administrator for the benefit of any Covered Person may be made directly to any Provider furnishing Covered Services for which such payments are due, and Claim Administrator is authorized by such Covered Person to make such payments directly to such Providers. However, Claim Administrator reserves the right to pay any benefits that are payable under the terms of the Plan directly to the Covered Person or to the Provider furnishing Covered Services at Claim Administrator's option and in its sole discretion. Claim Administrator's decision to pay a Provider directly is not intended to waive and shall not constitute a waiver of the prohibition on assignment described in 10.3, below. All benefits payable to the Covered Person which remain unpaid at the time of the death of the Covered Person will be paid to the estate of the Covered Person.

10.2 ***Claim dispute.*** Once Covered Services are rendered by a Provider, the Covered Person has no right to request Claim Administrator not to pay the Claim submitted by such Provider and no such request by a Covered Person or his agent will be given effect. Furthermore, Claim Administrator will have no liability to the Covered Person or any other person because of its rejection of such request.

10.3 ***Invalidity of assignments.*** Neither coverage under the Plan nor a Covered Person's claims or rights under the Plan, including but not limited to claims for payment of benefits, are assignable in whole or in part to any person or entity at any time, and any such assignments shall be considered void. Coverage under the Plan is expressly non–assignable and non–transferable and will be forfeited if a Covered Person attempts to assign

or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under the Plan. However, if Claim Administrator makes payment because of a person's wrongful use of the identification card of a Covered Person, such payment will be considered a proper payment and Claim Administrator will have no obligation to pursue recovery of such payment.

SECTION 11: COVERED PERSON/PROVIDER RELATIONSHIP

11.1 ***Choosing a Provider.*** The choice of a Provider is solely the choice of the Covered Person and Claim Administrator will not interfere with the Covered Person's relationship with any Provider.

11.2 ***Claim Administrator's role.*** It is expressly understood that Claim Administrator does not itself undertake to furnish Hospital, medical or dental service, but acts solely to make Claim Payments to a Provider for the Covered Services received by Covered Persons. Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to a Covered Person. Professional services which can only be legally performed by a Provider are not provided by Claim Administrator. Any contractual relationship between a Provider and Claim Administrator shall not be construed to mean that Claim Administrator is providing professional service.

11.3 ***If point–of–service coverage applies.*** If coverage under a Network point–of–service managed care health benefits program is applicable to the Plan under the Agreement, the following apply:

a. ***Physician Selection.***

A Covered Person shall be entitled to select a Primary Care Physician through the Plan to act as the Covered Person's principal care giver and to provide or arrange for the provision of medical care.

b. ***Changing Physician Selection.***

Both the Covered Person and the Primary Care Physician may request a change from one Primary Care Physician to another by notifying Claim Administrator of the desire to change; provided, however, such a request by a Primary Care Physician shall not be based upon the type, amount or cost of services required by the Covered Person or the physical condition of the Covered Person except where reasonably necessary to provide optimal medical care.

11.4 ***Intent of terminology.*** The use of an adjective such as but not limited to, 'Approved,' 'Administrator,' 'Participating,' 'In–Network' or 'Network' in modifying the term 'Provider' shall in no way be construed as a recommendation, referral or statement as to the ability or quality of such Provider. Conversely, the omission, non-use or non-designation of the foregoing adjectives, or, alternatively, any similar modifier, or, alternatively, the use of a term such as 'Non-Approved,' 'Non-Administrator,' 'Non-Participating,' 'Out-of-Network,' or 'Non-Network' should not be construed as carrying any statement or inference, whether negative or positive, as to the ability or quality of such Provider.

11.5 ***Provider's role.*** Each Provider provides Covered Services only to Covered Persons and does not otherwise interact with or provide any services to Employer (other than as an individual Covered Person) or the Plan.

SECTION 12: LIMITED BENEFITS FOR NON–NETWORK PROVIDERS

Regarding any comprehensive major medical coverage with access to Network Providers elected on the most current ASO BPA. Employer acknowledges that when Covered Persons elect to utilize the services of a non–Network professional Provider for a Covered Service in non–emergency situations, benefit payments to such non–Network professional Provider are not based upon the amount billed. The basis of the benefit payment will be determined according to the Plan's Fee Schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined under the Plan. Non–Network Providers may bill the Plan's Covered Person for any amount up to the billed charge after Claim Administrator has paid the Plan's portion of the bill. Network Providers have agreed to accept discounted payments for services with no additional billing to the Covered Person other than Coinsurance and deductible amounts. A Covered Person may obtain further information about the Network status of professional Providers and information on out–of–pocket expenses by calling the toll–free number on their identification card.

SECTION 13: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

13.1 For Covered Services provided by Participating Prescription Drug Providers under the prescription drug benefit, all amounts payable to Claim Administrator by Employer for Claim Payments provided by Claim Administrator and applicable service charges pursuant to the terms of the Agreement shall be calculated on the basis of an amount mutually agreed upon by Employer and Claim Administrator. For Covered Services provided by the Participating Prescription Drug Providers under the prescription drug benefit, required deductible and Coinsurance amounts under the Agreement shall be calculated on the basis of the Allowable Charge, Section 24.3, subsection (d)(ii). All (a) amounts payable to Claim Administrator by Employer for Claim Payments provided by Claim Administrator for Covered Services provided by Non-Participating Prescription Drug Providers under the prescription drug benefit, and (b) required deductible and Coinsurance amounts under the Agreement shall be calculated on the basis of the Allowable Charge, Section 24.3, subsection (d)(iii).

13.2 Claim Administrator hereby informs Employer and all Covered Persons that it has contracts, either directly or indirectly, with prescription drug Providers ("Participating Prescription Drug Providers)" for the provision of, and payment for, prescription drug services to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which Claim Administrator is a party, including the Covered Persons under the Agreement, and that pursuant to Claim Administrator's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, Claim Administrator may receive discounts for prescription drugs dispensed to Covered Persons under the Agreement. Actual Network savings achieved for Covered Persons will vary. Some rates are currently based on benchmark prices including, but not limited to, Wholesale Acquisition Cost ("WAC"), Average Sales Price ("ASP") and Average Wholesale Price ("AWP"), which are determined by third parties and are subject to change.

13.3 Employer understands that Claim Administrator may receive such discounts during the term of the Agreement. Neither Employer nor Covered Persons hereunder are entitled to receive any portion of any such discounts except as such items may be indirectly or directly reflected in the service charges specified in the Agreement. The drug fees/discounts that Claim Administrator has negotiated with Prime Therapeutics LLC ("Prime") through the Pharmacy Benefit Management (PBM) Agreement, will be used to calculate Covered Persons deductibles and Coinsurance for both retail and mail/specialty drugs, except as otherwise mutually agreed to by the parties. Except for mail/specialty drugs, the PBM Agreement requires that the fees/discounts that Prime has negotiated with pharmacies (or other suppliers) are passed-through to Claim Administrator. For the mail-order pharmacy and specialty pharmacy program, which as of the Effective Date are partially owned by Prime and administered through Prime affiliates, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail-order pharmacy and/or specialty pharmacy program. Claim Administrator pays a fee to Prime for pharmacy benefit services, which may be included in the Administrative Charge charged by Claim Administrator to Employer. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, Claims processing, customer service response, and mail-order processing.

13.4 "Weighted Paid Claim" refers to the methodology of counting claims for purposes of determining Claim Administrator's fee payment to Prime. Each retail (including claims dispensed through PBM's specialty pharmacy program) paid claim will be weighted according to the days' supply dispensed. A paid claim is weighted in 34 day supply increments so a 1-34 days' supply is considered 1 weighted claim, a 35-68 days' supply is considered 2 weighted claims, and the pattern continues up to 6 weighted claims for 171 or more days' supply. Claim Administrator pays Prime a Program Management Fee ("PMF") on a per weighted claim basis.

13.5 The amounts received by Prime from Claim Administrator, pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to Claim Administrator (as described above), administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to Employer as expenses, or accrue to the benefit of Employer, unless otherwise specifically set forth in the Agreement. Additional information about these types of fees or the amount of these fees is available upon request.

SECTION 14: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

14.1 Claim Administrator hereby informs Employer and all Covered Persons that it owns a significant portion of the equity of Prime and that Claim Administrator has entered into one or more agreements with Prime or other entities (collectively referred to as "Pharmacy Benefit Managers"), for the provision of, and payment for, prescription drug benefits to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which Claim Administrator is a party, including the Covered Persons under the Agreement. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. In addition, Prime's mail order pharmacy and other PBM services operate through the same entity, Prime Therapeutics LLC. In addition, the mail-order pharmacy and specialty pharmacy operate through an affiliate partially owned by Prime Therapeutics, LLC.

14.2 The Pharmacy Benefit Manager(s) ("PBM") negotiates rebate contracts with pharmaceutical manufacturers and has agreed to provide rebates made available pursuant to such contracts to the Claim Administrator under the PBM's agreement with Claim Administrator. This negotiation is conducted by the PBM for the benefit of Claim Administrator and not for the benefit of the Employer or Covered Persons. The PBM collects the rebates from the pharmaceutical manufacturers, for drugs covered under both the prescription drug program and medical benefit, and forwards the entire amount collected to Claim Administrator (other than any interest or late fees earned on rebates received from manufacturers, which the PBM retains). Each year, Claim Administrator will calculate a projection of the amount of rebates it expects to receive from the PBM. Such projections are referred to as the "Expected Rebates". Expected Rebates are calculated based on a number of factors and projections for the Fee Schedule Period, which may include Employer-specific demographics, retail, mail-order pharmacy and specialty pharmacy utilization, cost of prescription drugs, the Employer's benefit design, and rebate arrangements entered into by the PBM, none of which Claim Administrator directly controls. Claim Administrator's estimate of the Expected Rebates is set forth in the proposal or renewal packet, as appropriate, which is hereby incorporated into this Agreement. Rebates, like all Claim Administrator assets and revenue sources, are utilized by Claim Administrator in various ways to enable Claim Administrator to provide cost-effective products and services. Additional information about rebates, the PBM and the Rebate Credit will be available upon request. The Claim Administrator may provide the Employer with a Rebate Credit, the amount of which is set forth in the ASO BPA. The Rebate Credit provided to Employer will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates provided to Claim Administrator by the PBM. The Employer acknowledges that it has negotiated for the specific Rebate Credit included as part of this Agreement and that it and its group health plan have no right to, or legal interest in, any portion of the rebates provided by the PBM to Claim Administrator and consents to Claim Administrator's retention of all such rebates. Rebate Credits shall not continue after termination of the prescription drug program.

14.3 As of the Effective Date, the maximum that a Pharmacy Benefit Manager will receive from any pharmaceutical manufacturer for manufacturer administrative fees is four and one quarter percent (4.25%) of the Wholesale Acquisition Cost ("WAC") for all products of such manufacturer dispensed during any given calendar year to members of Claim Administrator and to members of the other Blue Cross and/or Blue Shield operating divisions of Health Care Service Corporation or for which Claims are submitted to Pharmacy Benefit Manager at Claim Administrator's Request; provided, however, that Claim Administrator will advise Employer if such maximum has changed..

SECTION 15: INTER-PLAN ARRANGEMENTS

15.1 ***Out-of-Area Services***

Claim Administrator has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Association. Whenever Covered Persons access healthcare services outside the geographic area Claim Administrator serves, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below. Claim Administrator's services under this Agreement are governed by and subject to the Inter-Plan Arrangements

rules in effect during the term of this Agreement, and a Host Blue is neither the agent nor the subcontractor of Claim Administrator.

Typically, when accessing care outside the geographic area Claim Administrator serves, Covered Persons obtain care from Participating Healthcare Providers. In some instances, Covered Persons may obtain care from Non-Participating Healthcare Providers. Claim Administrator remains responsible for fulfilling its contractual obligations to Employer. Claim Administrator's payment practices in both instances are described below.

This disclosure describes how Claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with the Inter-Plan Arrangements. Dental care benefits, when paid as stand-alone benefits, and prescription drug benefits or vision care benefits that may be administered by a third party contracted by Claim Administrator to provide the specific service or services, are not processed through Inter-Plan Arrangements.

15.2 *BlueCard® Program*

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Covered Persons access Covered Services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its Participating Healthcare Providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, Claim Administrator's action will be consistent with the spirit of this description.

a. *Liability Calculation Method – In General*

(1) Covered Person Liability Calculation.

Unless subject to a fixed dollar Copayment, the calculation of the Covered Person's liability on Claims for Covered Services will be based on the lower of the Participating Healthcare Provider's billed charges for Covered Services or the negotiated price made available to Claim Administrator by the Host Blue.

(2) Employer's Liability Calculation.

The calculation of Employer's liability on Claims for Covered Services processed through the BlueCard Program will be based on the negotiated price made available to Claim Administrator by the Host Blue. Sometimes, this negotiated price may, for a particular service or services, exceed the billed charge in accordance with how the Host Blue has negotiated with its Participating Healthcare Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, Employer may be liable for the excess amount even when the Covered Person's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the Provider's participation in the Network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the Provider, even when the contracted price is greater than the billed charge.

b. *Claims Pricing*

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's Provider contracts. The negotiated price made available to Claim Administrator by the Host Blue may be represented by one of the following:

(1) An actual price. An actual price is a negotiated rate of payment in effect at the time a Claim is processed without any other increases or decreases; or

(2) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a Claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other Claim- and non-Claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a Claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

(3) An average price. An average price is a percentage of billed charges for Covered Services in effect at the time a Claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare Providers or a similar classification of its Providers and other Claim- and

non-Claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether it will use an actual, estimated or an average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price Employer pays on a specific Claim and the actual amount the Host Blue pays to the Provider. However, the BlueCard Program requires that the amount paid by the Covered Person and Employer is a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims.

Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future Claim prices. As a result, the amounts charged to Employer will be adjusted in a following year, as necessary, to account for over- or under-estimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from Employer. If Employer terminates, Employer will not receive a refund or charge from the variance account.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated/drawn down over time. The timeframe for the liquidation depends on variables, including, but not limited to, overall volume/number of Claims processed and variance account balance. Variance account balances may earn interest at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

c. *BlueCard Program Fees and Compensation*

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under the BlueCard Program to pay to the Host Blues, to the Association, and/or to vendors of the BlueCard Program-related services. The specific BlueCard Program fees and compensation that are charged to Employer are set forth in the most current ASO BPA. The specific BlueCard Program fees and compensation may be revised from time to time as described in Section 15.9 below.

Claim Administrator will charge these fees as follows:

(1) BlueCard Program Access Fees

The access fee is charged by the Host Blue to Claim Administrator for making its applicable Provider Network available to Employer.

A BlueCard Program access fee may be charged only if the Host Blue's arrangement with its healthcare provider prohibits billing Covered Persons for amounts in excess of the negotiated payment. However, a healthcare provider may bill for non-covered healthcare services and for Covered Person cost sharing (for example, deductibles, Copayments, and/or Coinsurance) related to a particular Claim.

(2) How the BlueCard Program Access Fee Affects Employer

When Claim Administrator is charged a BlueCard Program access fee, Claim Administrator may pass the charge along to Employer as a Claim expense or as a separate amount. The access fee will not exceed $2,000 for any Claim. If Claim Administrator receives an access fee credit, Claim Administrator will give Employer a Claim expense credit or a separate credit. Instances may occur in which the Claim payment is zero or Claim Administrator pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, Claim Administrator will pay the Host Blue's access fee and pass it along to Employer as stated above even though Employer paid little or had no Claim liability.

15.3 *Negotiated Arrangements*

With respect to one or more Host Plans, instead of using the BlueCard Program, Claim Administrator may process Employer's Covered Persons' Claims for Covered Services through a Negotiated Arrangement. Pursuant to such a Negotiated Arrangements, the Host Blue(s) has/have agreed to provide, on Claim Administrator's behalf, Claim Payments and certain administrative services for those Covered Persons of

Employer receiving Covered Services in the state and/or service area of the Host Blue(s). Pursuant to the agreement between Claim Administrator and the Host Blue(s), Claim Administrator has agreed to reimburse each Host Blue for all Claim Payments made on Claim Administrator's behalf for those Covered Persons of Employer receiving Covered Services in the state and/or service area of such Host Blue.

In addition, if Claim Administrator and Employer have agreed that (a) Host Blue(s) shall make available (a) custom healthcare Provider Network(s) in connection with this Agreement, then the terms and conditions set forth in Claim Administrator's Negotiated Arrangement(s) for national accounts with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of claims when Covered Persons access such networks. In negotiating such arrangement(s), Claim Administrator is not acting on behalf of or as an agent for Employer, Employer's Plan or Employer's Covered Persons.

a. ***Covered Person and Employer Liability Calculation***

Covered Person liability calculation will be based on the lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under 16.2.a., BlueCard Program) that the Host Blue makes available to Claim Administrator and that allows Employer's Covered Persons access to negotiated participation agreement Networks of specified Participating Healthcare Providers outside of Claim Administrator's service area.

Employer's liability calculation will be based on the negotiated price (refer to the description of negotiated price under 15.2.a, BlueCard Program).

Employer acknowledges that pursuant to the Host Blue's contracts with Host Blues' Participating Healthcare Providers, under certain circumstances described therein, the Host Blue (i) may receive substantial payment from Host Blues' Participating Healthcare Providers with respect to services rendered to such Covered Persons for which the Host Blue was initially obligated to pay the Host Blues' Participating Healthcare Providers, (ii) may pay Host Blues' Participating Healthcare Providers more or less than their billed charges for services, by discounts or otherwise, or (iii) may receive from Host Blues' Participating Healthcare Providers other allowances under the Host Blue's contracts with them. One example of this is quality improvement programs/payments.

If charged by the Host Blue to Claim Administrator, Employer shall reimburse Claim Administrator for any payments made to the Host Blue, unless otherwise set forth in the Agreement's Fee Schedule, including "Claim-like" charges, which are those charges for payments to Host Blues' Participating Healthcare Providers on other than a fee for services basis which include, but are not limited to, incentive payments.

Employer acknowledges that, in negotiating the Administrative Charge set forth in the Agreement's Fee Schedule, it has taken into consideration that, among other things, the Host Blue may receive such payments, discounts and/or other allowances during the term of its agreement with Claim Administrator. Further, all amounts payable by Covered Person and Employer shall be calculated on the basis described in this subsection, irrespective of any separate financial arrangement between the Host Blue's Participating Healthcare Provider that rendered the applicable Covered Service and the Host Blue other than the negotiated price as described in this subsection.

b. ***Fees and Compensation***

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association, and/or to vendors of Inter-Plan Arrangement-related services. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as described in Section 15.9 below.

In addition, the participation agreement with the Host Blue may provide that Claim Administrator must pay an administrative and/or a network access fee to the Host Blue, and Employer further agrees to reimburse Claim Administrator for any such applicable administrative and/or network access fees. The specific fees and compensation that are charged to Employer under Negotiated Arrangements are set forth in the most current ASO BPA.

15.4 ***Special Cases: Value-Based Programs***

a. ***Value-Based Programs Overview***

Employer's Covered Persons may access Covered Services from Providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

b. ***Value-Based Programs under the BlueCard Program***

(1) ***Value-Based Programs Administration***

Under Value-Based Programs, a Host Blue may pay Providers for reaching agreed-upon cost/quality goals in the following ways: retrospective settlements, Provider Incentives, a share of target savings, Care Coordinator Fees and/or other allowed amounts. The Host Blue may pass these Provider payments to Claim Administrator, which Claim Administrator will pass on to Employer in the form of either an amount included in the price of the Claim or an amount charged separately in addition to the Claim.

When such amounts are included in the price of the Claim, the Claim may be billed using one of the following pricing methods, as determined by a Host Blue:

a) ***Actual Pricing:*** The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the Claim. These charges are passed to Employer via an enhanced Provider fee schedule.

b) ***Supplemental Factor:*** The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the Claim as an amount based on a specified supplemental factor (e.g. a small percentage increase in the claim amount). The supplemental factor may be adjusted from time to time. This pricing method may be used only for non-attributed Value-Based Programs.

When such amounts are billed separately from the price of the Claim, they may be billed as Per Member Per Month ("PMPM") billings for Value-Based Programs incentives/Shared Savings settlements to accounts outside of the Claim system. Claim Administrator will pass these Host Blue charges directly through to Employer as a separately identified amount on the group billings.

The amounts used to calculate either the supplemental factors for estimated pricing or PMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard Claim pricing section above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:

a) Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.

b) Address any deficit in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period.

The Host Blue will not receive compensation resulting from how estimated average or PMPM price methods, described above, are calculated. If Employer terminates, Employer will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-

Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of this Agreement.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated/drawn down over time. The timeframe for the liquidation depends on variables, including, but not limited to, overall volume/number of Claims processed and variance account balance. Variance account balances may earn interest, and interest is earned at the federal funds or similar rate. Host Blues may retain interest earned on funds in variance accounts.

Note: Covered Persons will not bear any portion of the cost of Value-Based Programs except when a Host Blue uses either average pricing or actual pricing to pay Providers under Value-Based Programs.

(2) ***Care Coordinator Fees***

Host Blues may also bill Claim Administrator for Care Coordinator Fees for Provider services which Claim Administrator will pass onto Employer as follows:

a) PMPM billings; or

b) Individual Claim billings through applicable Care Coordination codes from the most current editions of either *Current Procedural Terminology* (CPT) published by the American Medical Association (AMA) or *Healthcare Common Procedure Coding System* (HCPCS) published by the US Centers for Medicare and Medicaid Services (CMS).

As part of this Agreement, Claim Administrator and Employer will not impose Covered Person cost sharing for Care Coordinator Fees.

c. ***Value-Based Programs under Negotiated Arrangements***

If Claim Administrator has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Employer's Covered Persons, Claim Administrator will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted in BlueCard Program section.

15.5 ***Return of Overpayments***

Recoveries from a Host Blue or its Participating Healthcare Providers and Non-Participating Healthcare Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare Provider/Hospital bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. Recoveries will be applied, in general, on either a claim-by-claim or prospective basis. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to Employer.

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, Claim Administrator may request the Host Blue to provide full refunds from Participating Healthcare Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original Claim. For Care Coordinator Fees associated with Value-Based Programs, Claim Administrator may request such refunds for a period of only up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of Claim Payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare Provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements, or (c) would jeopardize the Host Blue's relationship with its Participating Healthcare Providers, notwithstanding to the contrary any other provision of this Agreement.

15.6 ***Inter-Plan Arrangements: Federal/State Taxes/Surcharges/Fees***

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to self-funded accounts. If applicable, Claim Administrator will include any such surcharge, tax or other fee to Employer, which will be Employer's liability.

15.7 ***Non-Participating Healthcare Providers Outside Claim Administrator's Service Area***

a. ***Covered Person Liability Calculation***

(1) In General

When Covered Services are provided outside of Claim Administrator's service area by Non-Participating Health Care Providers, the amount(s) a Covered Person pays for such services will be based on either the Host Blue's Non-Participating Healthcare Provider local payment or the pricing requirements required by applicable law. The Covered Person may be responsible for the difference between the amount that the Non-Participating Health Care Provider bills and the payment Claim Administrator will make for the Covered Services as set forth in this paragraph.

(2) Exceptions

a. In certain situations, Claim Administrator may use other payment bases to determine the amount Claim Administrator will pay for services rendered by Non-Participating Health Care Providers, such as:

i. Billed charges for Covered Services;

ii. The payment Claim Administrator would make if the healthcare services had been obtained within Claim Administrator's service area;

iii. A special negotiated payment, as permitted under Inter-Plan Arrangements; or

iv. The lessor of

1. the amount described in (1), above; or

2. for professional Providers, a payment based on publicly available data and historic reimbursement to Providers for the same or similar professional services, adjusted for geographical differences where applicable; or for hospital or facility Providers, a payment based on publicly available data reflecting the approximate costs that hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the hospital or facility.

In these situations, a Covered Person may be liable for the difference between the amount that the Non-Participating Health Care Provider bills and the payment Claim Administrator will make for the Covered Services as set forth in this paragraph.

b. ***Fees and Compensation***

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Arrangements requirements to pay to the Host Blues, to the Association, and/or to vendors of Inter-Plan Arrangements related services. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided in Section 15.9 below.

15.8 ***Blue Cross Blue Shield Global Core®***

a. ***General Information***

If Covered Persons are outside the United States, the Commonwealth of Puerto Rice and the U.S. Virgin Islands (hereinafter: "BlueCard Service Area"), the Covered Persons may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard Service Area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists Covered Persons with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such, when Covered Persons receive care from Providers outside the BlueCard Service Area, the Covered Persons will typically have to pay the Providers and submit the Claims themselves to obtain reimbursement for these services.

(1) Inpatient Services

In most cases, if Covered Persons contact the Blue Cross Blue Shield Global Core Service Center for assistance, Hospitals will not require Covered Persons to pay for covered Inpatient services, except for their cost-share amounts/deductibles, Coinsurance, etc. In such cases, the Hospital will submit the Covered Person's Claims to the Blue Cross Blue Shield Global Core

Service Center to initiate Claims processing. However, if the Covered Person paid in full at the time of service, the Covered Person must submit a Claim to obtain reimbursement for Covered Services. Covered Persons must contact Claim Administrator to obtain preauthorization/precertification for non-emergency Inpatient services, if Employer's Plan requires preauthorization or precertification for such services.

(2) Outpatient Services

Physicians, urgent care centers and other Outpatient Providers located outside the BlueCard Service Area will typically require Covered Persons to pay in full at the time of service. Covered Persons must submit a Claim to obtain reimbursement for Covered Services.

(3) Submitting a Blue Cross Blue Shield Global Core Claim

When Covered Persons pay for Covered Services outside the BlueCard Service Area, they must submit a Claim to obtain reimbursement. For institutional and professional Claims, Covered Persons should complete a Blue Cross Blue Shield Global Core International Claim form and send the Claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center address on the form to initiate Claims processing. The Claim form is available from Claim Administrator, the Blue Cross Blue Shield Global Core Service Center or online at www.bluecardworldwide.com. If Covered Persons need assistance with their Claim submissions, they should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (253) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

b. ***Blue Cross Blue Shield Global Core Program-Related Fees***

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Employer under Blue Cross Blue Shield Global Core Program are available upon request. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in Section 15.9 below.

15.9 ***Modifications or Changes to Inter-Plan Arrangement Fees or Compensation***

Modifications or changes to Inter-Plan Arrangement fees are generally made effective Jan. 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes, Claim Administrator shall provide Employer with at least thirty (30) days' advance written notice of any modification or change to such Inter-Plan Arrangement fees or compensation describing the change and the effective date thereof and Employer's right to terminate this Agreement without penalty by giving written notice of termination before the effective date of the change, which notice will be effective after ninety (90) days in accordance with Section 8.2(a) of the Agreement. If Employer fails to respond to the notice and does not terminate this Agreement during the notice period, Employer will be deemed to have approved the proposed changes, and Claim Administrator will then allow such modifications to become part of this Agreement.

SECTION 16: MEDICARE SECONDARY PAYER INFORMATION REPORTING

16.1 Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110-173) adds new mandatory reporting requirements for group health plan ("GHP") arrangements. The parties agree that Claim Administrator as the Responsible Reporting Entity ("RRE") under Section 111 requirements is required to report information to the Centers for Medicare & Medicaid Services ("CMS") about individuals enrolled in the GHP who are also covered by Medicare so that CMS and Claim Administrator can effectively coordinate health care payments consistent with the MSP rules.

16.2 Employer hereby authorizes and directs Claim Administrator to disclose to CMS, periodically, information pertaining to Medicare–eligible Covered Persons under the Plan.

16.3 Employer agrees that Claim Administrator's ability to make accurate primary/secondary MSP determinations depends on the breadth and accuracy of Claim Administrator's files concerning Covered Persons and the

number of individuals employed by Employer. Employer agrees to use its best efforts in responding promptly and accurately to Claim Administrator's requests for information.

16.4 Further, to assure the continuing accuracy of Claim Administrator's files, Employer agrees that it is Employer's responsibility to notify Claim Administrator promptly as may be required for such continuing accuracy, of any change in the number of individuals employed by Employer or status of its employees that might affect the order of payment under the MSP statute, such as information regarding working–aged persons who retire and changes in the number of individuals employed by Employer that place it in, or take it out of, the scope of the MSP statute. Employer acknowledges and agrees that Claim Administrator will be using the information provided by Employer and Covered Persons to update Claim Administrator's files, and will also forward this information to CMS so that CMS can revise its file to reflect relevant changes in primary/secondary status.

16.5 Disclosure Statement: Employer acknowledges that Claim Administrator has furnished it with a copy of a pamphlet entitled "Information Regarding the Medicare Secondary Payer Statute" (also referred to as the "Disclosure Statement"), prepared by the Blue Cross and Blue Shield Association and reviewed by CMS, which administers Medicare.

SECTION 17: REIMBURSEMENT PROVISION

Applicable only if this service is elected in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA

17.1 If a Covered Person incurs expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for Covered Services described in the Plan, the following provisions will apply:

- **a.** Claim Administrator on behalf of Employer has the right to reimbursement for all benefits Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Covered Person, the Covered Person's parents, if the Covered Person is a minor, or the Covered Person's legal representative as a result of that sickness or injury, in the amount of the Provider's Allowable Charge for Covered Services for which Claim Administrator has provided benefits to the Covered Person.
- **b.** Claim Administrator is assigned the right to recover from the third party, or the third party's insurer, to the extent of the benefits Claim Administrator provided for that sickness or injury.

17.2 Claim Administrator shall have the right to first reimbursement out of all funds the Covered Person, the Covered Person's parents, if the Covered Person is a minor, or the Covered Person's legal representative is or was able to obtain for the same expenses for which Claim Administrator has provided benefits as a result of that sickness or injury. The Covered Person is required to furnish any information or assistance or provide any documents that Claim Administrator may reasonably require in order to obtain its rights under this provision. This provision applies whether or not the third party admits liability.

SECTION 18: MEMBER DATA SHARING

A Covered Person may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Claim Administrator, or, if Covered Person does not reside in Claim Administrator's service area, by the Host Blue(s) whose service area covers the geographic area in which the Covered Person resides. The circumstances mentioned above may arise from involuntary termination of Covered Person's health coverage sponsored by Employer but solely as a result of a reduction in force, plan/office closing(s) or group health plan termination (in whole or in part). As part of the overall plan of benefits that Employer offers to a Covered Person, if the Covered Person does not reside in Claim Administrator's service area, Claim Administrator may facilitate a Covered Person's right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which the Covered Person resides. To do this, Claim Administrator may (1) communicate directly with the Covered Persons and/or (2) provide the Host Blues whose service area covers the geographic area in which a Covered Person resides, with a Covered Person's personal information and may also provide other general information relating to Covered Person's coverage under the Plan and which Employer has with Claim Administrator to the extent reasonably necessary to enable the relevant Host Blues to offer a Covered Person coverage continuity through replacement coverage.

EXHIBIT 3
ASO BENEFIT PROGRAM APPLICATION ("ASO BPA")

Benefit Program Application ("ASO BPA")

Applicable to Administrative Services Only (ASO) Group Accounts

administered by Blue Cross and Blue Shield of New Mexico, a Division of Health Care Services Corporation, a Mutual Legal Reserve Company, hereinafter referred to as the "Claim Administrator" or "HCSC"

Group Status: Renewing ASO Account

Employer Account Number (6-digits): 251305 Group Number(s): 251307 Section Number(s): All

Legal Employer Name: Incorporated County of Los Alamos

(Specify the Employer or the employee trust applying for coverage. Names of subsidiary or affiliated companies to be covered must also be named below. AN EMPLOYEE BENEFIT PLAN *MAY NOT* BE NAMED.)

ERISA Regulated Group Health Plan*: ☐ Yes ☒ No

Is your ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☐ Yes
If not, please specify your ERISA Plan Year*: Beginning Date __/__/__ End Date __/__/__ (month/day/year)

ERISA Plan* Administrator*: _____ Plan Administrator's Address: _____

If you maintain that ERISA is not applicable to your group health plan, give legal reason for exemption:
Non-Federal Governmental Plan (Public Entity) ; if applicable, specify other: _____

Is your Non-ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☒ Yes
If not, please specify your Non-ERISA Plan Year*: Beginning Date __/__/__ End Date __/__/__ (month/day/year)

For more information regarding ERISA, contact your Legal Advisor.

*All as defined by ERISA and/or other applicable law/regulations

Effective Date of Coverage: (Month/Day/Year) 01 / 01 / 2018

Anniversary Date: (Month/Day/Year) 01 / 01 / 2018

Account Information NO CHANGES SEE ADDITIONAL PROVISIONS

Standard Industry Code (SIC): 9111 Employer Identification Number (EIN): 856000679

Address: 1000 Central Avenue Suite 230

City: Los Alamos State: NM ZIP: 87544

Administrative Contact: Kat Brophy Title: Benefits & Pension Manager

Email Address: kat.brophy@lacnm.us Phone Number: 505-662-8045 Fax Number: 505-662-8000

Wholly Owned Subsidiaries:

Affiliated Companies:

(If Subsidiaries or Affiliated Companies listed above are to be covered, Employer hereby confirms that Employer and the listed Subsidiaries and/or Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), (c) or (m).)

Blue Access for Employers (BAE) Contact: Kat Brophy

(The BAE Contact is the Employee authorized by the Employer to access and maintain the Employer's account in BAE.)

Email Address: kat.brophy@lacnm.us Phone Number: 505-662-8045 Fax Number: 505-662-8000

☒ The Employer or other company listed in this BPA is a is a public entity or governmental agency/contractor

Producer of Record Information NO CHANGES SEE ADDITIONAL PROVISIONS

Effective: _____

If applicable, the below-named producer(s) or agency(ies) is/are recognized as Employer's Producer of Record (POR) to act as representative in negotiations with and to receive commissions from Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, and HCSC subsidiaries for the Employer's employee benefit programs. This statement rescinds any and all previous POR appointments for the Employer. The POR is authorized to perform membership transactions on behalf of the Employer. This appointment will remain in effect until withdrawn or superseded in writing by the Employer.

Producer or Agency to whom commissions are to be paid*: _____

Tax ID Number (TIN) of ☐ Producer or ☐ Agency: _____ Producer #: _____

NPN: _____

Address:_____

City: _____ State:_____ ZIP: _____

Phone: _____ Fax: _____ Email:

Is Producer/Agency appointed with HCSC in New Mexico? ☐Yes ☐ No

*****The Producer or agency name(s) above to whom commissions are to be paid must exactly match the name(s) on the appointment application(s).

Schedule of Eligibility NO CHANGES SEE ADDITIONAL PROVISIONS

Employer has made the following eligibility decisions

1. Eligible Person means**:**
   - ☒ A full-time employee of the Employer.
   - ☐ A full-time employee of the Employer who is a member of: _____ *(name of union)*
   - ☐ Other: _____

   Are any classes of employees to be excluded from coverage? ☐ Yes ☐ No
   If yes, please identify the classes and describe the exclusion:_____

2. Employee Definition

   Full-Time Employee means:
   - ☒ A person who is regularly scheduled to work a minimum of 20 hours per week and who is on the permanent payroll of the Employer.
   - ☐ Other:

3. The Effective Date of termination for a person who ceases to meet the definition of Eligible Person:
   - ☐ The date such person ceases to meet the definition of Eligible Person.
   - ☒ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
   - ☐ Other: _____

4. Select an effective date rule for person who becomes an Eligible Person after the Effective Date of the Employer's health care plan **(**The effective date must not be later than the 91st calendar day after the date that a newly eligible person becomes eligible for coverage, unless otherwise permitted by applicable law).
   - ☐ The date of employment.
   - ☐ The _____ day of employment.
   - ☐ The _____ day of the month following _____ month(s) of employment.
   - ☐ The _____ day of the month following _____days of employment.
   - ☒ The 1st day of the month following the date of employment.
   - ☐ Other: _____

   Is the waiting period requirement to be waived on initial group enrollment? ☐ Yes ☐ No
   Are there multiple new hire waiting periods? ☐ Yes ☐ No
   If yes, please attach eligibility and contribution details for each section.

5. Domestic Partners covered: ☐ Yes ☒ No

   If yes: *a Domestic Partner, is eligible to enroll for coverage*.

   If yes, are Domestic Partners eligible for continuation of coverage? ☐ Yes ☐ No

   If yes, are dependents of Domestic Partners eligible to enroll for coverage? ☐ Yes ☐ No

   If yes, are dependents of Domestic Partners eligible for continuation of coverage? ☐ Yes ☐ No

   The Employer is responsible for providing notice of possible tax implications to those Covered Employees with coverage for Domestic Partners.

6. Limiting Age for covered children**:** Twenty-six (26) years, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. Other:

7. Are unmarried step-children under the limiting age eligible for coverage? ☒ Yes ☐ No
   If yes, is residency with the employee required? ☐ Yes ☒ No

8. Are unmarried grandchildren eligible for coverage?
   ☒ No ☐ Yes (answer the question below)

   Must the grandchild be dependent on the employee for federal income tax purposes at the time application is made? ☐ Yes ☐ No

9. Termination of coverage upon reaching the Limiting Age:
   ☐ The last day of coverage is the day prior to the birthday.
   ☒ The last day of coverage is the last day of the month in which the limiting age is reached.
   ☐ The last day of coverage is the last day of the billing month.
   ☐ The last day of coverage is the last day of the year (12/31) in which the limiting age is reached.
   ☐ The last day of coverage is the day prior to the Employer's Anniversary Date.

   Automatically cancel dependents when they reach the day their coverage terminates

   ☒ Yes ☐ No

   Will coverage for a child who is medically certified as disabled and dependent on the employee terminate upon reaching the Limiting Age even if the child continues to be both disabled and dependent on the employee?
   ☐ Yes ☒ No

   However, such coverage shall be extended in accordance with any applicable federal or state law. *The Employer will notify HCSC of such requirements*.

10. Will extension of benefits due to temporary layoff, disability or leave of absence apply?

    ☐ Yes (specify number of days below) ☒ No
    Temporary Layoff: _____ days Disability: _____ days Leave of Absence: _____ days

    However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with any applicable federal or state law. The Employer will notify HCSC of such requirements.

11. Enrollment:

    Special Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a Special Enrollment qualifying event if he/she did not previously apply prior to his/her Eligibility Date or when otherwise eligible to do so. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be the effective date of the qualifying event or, in the event of Special Enrollment due to marriage or termination of previous coverage, then no later than the first day of the Plan Month following the date of receipt of the person's application of coverage.

    An Eligible Person may apply for coverage within sixty (60) days of a Special Enrollment qualifying event in the case either of a loss of coverage under Medicaid or a state Children's Health Insurance program, or eligibility for group coverage where the Eligible Person is deemed qualified for assistance under a state Medicaid or CHIP premium assistance program.

    Special Enrollment: ☒ Yes ☐ No

    Late Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer.

    ☐ Annual open enrollment – late applicant may apply during open enrollment and be subject to the late applicant provisions.
    ☒ Annual open enrollment

☐ Late applicants may apply at any time – coverage is effective first of the month following receipt of the application.

Open Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Employer's Open Enrollment Period. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer. Such date shall be subsequent to the Open Enrollment Period.

Specify Open Enrollment Period: November 8 - December 15

☐ Annual/open enrollment – late applicant may apply during open enrollment.

☒ Annual/open enrollment

12. ***** Does COBRA Auto Cancel apply? ☒ Yes ☐ No

Member's COBRA/Continuation of Coverage will be automatically cancelled at the end of the member's eligibility period.

**Not recommended for accounts with automated eligibility.*

CURRENT EMPLOYEE ELIGIBILITY INFORMATION

☐ **NO CHANGES** ☒ **Current number of Employees enrolled** 514 ☐ **SEE ADDITIONAL PROVISIONS**

1. Current Employee Eligibility Information only applies to new accounts. If your account is renewing, please just indicate the current number of enrolled employees (above). **Total number of employees** presently eligible for coverage: _____
2. Total number of employees serving new hire eligibility period: _____
3. Total number of employees with other coverage (i.e., other group coverage, Medicare, Medicaid, TRICARE/Champus): _____
4. Total number of individuals currently covered under COBRA: _____

Lines of Business (Check all applicable services)	**NO CHANGES**	***See Additional Comments***

Medical Plan Services:

☒ PPO: Plan Name Blue PPO Options

☒ Dual Option
Plan Name: Blue PPO 35
Plan Name: Blue PPO 45

☐ EPO ☐ POS

Consortium Pricing (National Groups) ☐ Yes ☐ No

Additional Services:

☒ Blue Care Connection®

☐ Wellness Incentives

☒ Well onTarget®

☐ Blue Directions (Private Exchange) *(If selected, the Blue Directions Addendum is attached and made a part of the Agreement.)*

☐ Other Select Product

☐ Other Select Product

☐ Other Select Product

☐ Other Select Product

Consumer Driven Health Plan:

☐ Health Care Account (HCA) Administrative Services *(if purchased, complete separate HCA BPA)*

☐ FSA (Vendor: ConnectYourCare)

☐ HSA: (Vendor:)

Traditional Coverage:

☐ Out-of-Area (Indemnity)

Prescription Drugs:

☒ Covered under a pharmacy benefit *(If selected, the PBM Fee Schedule Addendum must be attached and is part of this BPA)*

☐ Covered under the medical benefit

Pharmacy Network (Select one):

☒ Traditional Select Network

☐ Advantage Network

☐ Preferred Network

☐ Elite Network

☐ Other ☐ Other	☐ Network on PBM Fee Schedule Addendum Drug List**:** Basic Drug List Other (please specify): _____ **Ancillary Services:** ☐ Dental Plan Services ☐ Vision Plan Services ☒ Stop Loss *(if selected, complete separate Exhibit to the Stop Loss Coverage Policy)* ☐ Dearborn National Life Insurance *(if selected, complete separate application)* ☐ COBRA Administrative Services *(if selected, complete separate COBRA Administrative Services Addendum)*

FEE SCHEDULE

Payment Specifications **NO CHANGES** **SEE ADDITIONAL PROVISIONS**

Employer Payment Method: ☐ **Online Bill Pay** ☒ **Electronic** ☐ **Auto Debit** ☐ **Check**

Employer Payment Period: ☒ **Weekly** (cannot be selected if Check is selected as payment method above)
☐ **Semi-Monthly** ☐ **Monthly**

Claim Settlement Period: ☒ **Monthly**

Run-Off Period: Employer Payments are to be made for 12 months following end of Fee Schedule Period.
Standard is twelve (12) months.

Fee Schedule Period: To begin on Effective Date of Coverage and continue for 12 months. If other than 12 months, please specify: 12 Months.

Administrative Per Employee Per Month (PEPM) Charges **NO CHANGES** **SEE ADDITIONAL PROVISIONS**

	Medical			
Administrative Fee	**$57.03**	**$**_____	**$**_____	**$**_____
Dental	**$**_____	**$**_____	**$**_____	**$**_____
Claims Fiduciary	**$Included**	**$**_____	**$**_____	**$**_____
Management of the Virtual Visits Program	**$Included**	**$**_____	**$**_____	**$**_____
*Rebate Credit for the medical benefit	**$**_____	**$**_____	**$**_____	**$**_____
*Rebate Credit for the Prescription Drug Program	**$(20.03)**	**$**_____	**$**_____	**$**_____
Commissions	**$**_____	**$**_____	**$**_____	**$**_____
Other: Select Service Category List Service: _____	**$**_____	**$**_____	**$**_____	**$**_____
Other: Select Service Category List Service: _____	**$**_____	**$**_____	**$**_____	**$**_____

Other: Select Service Category List Service: _____	**$**_____	**$**_____	**$**_____	**$**_____
Miscellaneous: Enhanced BCC	**$Included**	**$**_____	**$**_____	**$**_____
Miscellaneous: _____	**$**_____	**$**_____	**$**_____	**$**_____
Total	**$37.00**	**$**_____	**$**_____	**$**_____

*The Rebate Credit is a per Covered Employee per month credit applied to the monthly billing statement. The Employer and Claim Administrator have agreed to the Rebate Credit and Employer agrees that it and its group health plan have no right to, or legal interest in, any portion of the rebates actually provided by the Pharmacy Benefit Manager (PBM) to Claim Administrator and consents to Claim Administrator's retention of all such rebates. The Rebate Credit will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates actually provided to Claim Administrator by the PBM or expected to be provided. Rebate Credits shall not continue after termination of the Prescription Drug Program. Employer agrees that any provision in the governing Administrative Services Agreement to the contrary is hereby superseded.

Administrative Line Item Charges	Frequency	Amount
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	**$**_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	**$**_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	**$**_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	**$**_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	**$**_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	**$**_____
	Total:	**$**_____

Other Service and/or Program Fee(s) **NO CHANGES** **SEE ADDITIONAL PROVISIONS**

Not applicable to Grandfathered Plans

External Review Coordination: ☒ Yes ☐ No If yes coordination fee: $700 for each external review requested by a Covered Person that the Claim Administrator coordinates for the Employer in relation to the Employer's Plan. Employer elects the following process:

☒ Federal Affordable Care Act Process

☐ Employer has selected outside External Review alternatives. Name of outside ERO vendor:

Reimbursement Service: ☒ Yes ☐ No

If yes*:* The Employer has elected to utilize the reimbursement service offered by the Claim Administrator, the Corporate Reimbursement Subrogation department. It is understood and agreed that in the event the Claim Administrator makes a recovery on a third-party liability claim, the Claim Administrator will retain 25% of any recovered amounts other than recovered amounts received as a result of or associated with any Workers' Compensation Law.

Claim Administrator's Third Party Recovery Vendors and Law Firms (other than Reimbursement Services):

Employer will pay no more than 25% of any recovered amount made by Claim Administrator's Third Party Recovery Vendor. Employer will pay no more than 35% of any recovered amount made by Claim Administrator's third party law firm.

Alternative Compensation Arrangements: Employer acknowledges and agrees that Claim Administrator has Alternative Compensation Arrangements with contracted Providers, including but not limited to Accountable Care Organizations and other Value Based Programs. Further information concerning Employer's payment for Covered

Services under such Arrangements is described in the Administrative Services Agreement.

Virtual Visits Program: ☒ Yes ☐ No If yes, Covered Persons would be able to obtain certain Covered Services remotely via video or audio only (where available) capability from Providers participating in the Virtual Visit program.

Termination Administrative Charge

As applies to the Run-Off Period indicated in the Payment Specifications section above:

i. ***For service charges (including, but not limited to, access fees) billed on a per Covered Employee basis at the time of termination of the Agreement or partial termination of Covered Employees***, the Termination Administrative Charge will be the amount equal to ten percent (10%) of the annualized charges based on the service charges in effect as of the termination date or date of partial termination and the Plan participation of the two (2) months immediately preceding the termination date or date of partial termination. Such aggregate amount will be due the Claim Administrator within ten (10) days of the Claim Administrator's notification to the Employer of the Termination Administrative Charge described herein

ii. ***For service charges (including, but not limited to, access fees) billed on a basis other than per Covered Employee at the time of termination of the Agreement or partial termination of Covered Employees***, the Termination Administrative Charge will be such service charges in effect at the time of termination of the Agreement or partial termination of Covered Employees to be applied and billed by the Claim Administrator, and paid by the Employer, in the same manner as prior to termination of the Agreement or partial termination of Covered Employees.

The Termination Administrative Charge applicable to the Run-Off Period shall be equal to the sum of the amounts obtained by multiplying the total number of Covered Employees by category (*per Covered Employee per individual or family composite)* during the three (3) months immediately preceding the date of termination by the appropriate factor shown below.

Service	**Medical**			
Medical Run-off Administration Charge:	**$23.00**	**$_____**	**$_____**	**$_____**
Dental Run-off Administration Charge	**$_____**	**$_____**	**$_____**	**$_____**
Miscellaneous	**$_____**	**$_____**	**$_____**	**$_____**
Miscellaneous	**$_____**	**$_____**	**$_____**	**$_____**
Total:	**$23.00**	**$_____**	**$_____**	**$_____**

Other Provisions

NO CHANGES **SEE ADDITIONAL PROVISIONS**

1. Summary of Benefits & Coverage:

   a. Will Claim Administrator create Summary of Benefits & Coverage (SBC)?

   ☒ Yes. Please answer question b. The SBC Addendum is attached.
   ☐ No. If No, then skip question b and refer to the Administrative Services Agreement for further information.

   b. Will Claim Administrator distribute Summary of Benefits & Coverage (SBC) to participants and beneficiaries?

   ☒ No. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to participants and beneficiaries (or hire a third party to distribute) as required by law.

   ☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute to participants and beneficiaries as required by law, except that Claim Administrator will send the SBC in response to the occasional request received directly from individuals.

   ☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and distribute SBC to participants and beneficiaries via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is $1.50 per package. The distribution fee will not apply

to SBCs that Claim Administrator sends in response to the occasional request received directly from individuals.

2. Does the Employer direct Claim Administrator to provide written statements of creditable coverage to its Covered Employees who reside, or have enrolled dependents who reside, in Massachusetts and file electronic reports to the Massachusetts Department of Revenue in a manner consistent with the requirements under the Massachusetts Health Care Reform Act? ☒ Yes ☐ No

   If no: The Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

3. Case Management Program: ☒ Yes ☐ No *The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons for Utilization Management, Case Management, and other health care management programs.*

4. Employer acknowledges and agrees to utilize Claim Administrator's standard list of services and supplies for which pre-notification or preauthorization is required: ☒ Yes ☐ No If no, Employer authorizes Claim Administrator to post Employer's pre-notification or preauthorization requirements on Claim Administrator's Website: ☐ Yes ☐ No

5. Essential Health Benefits ("EHB") Election:

   Employer elects EHBs based on the following:

   ☒ 1. EHBs based on a HCSC state benchmark: ☐ Illinois ☐ Oklahoma ☐ Montana ☐ Texas ☒ New Mexico
   ☐ 2. EHBs based on benchmark of a state other than IL, MT, NM, OK and TX
   If so, indicate the state's benchmark that Employer elects: ___

   ☐ 3. Other EHB, as determined by Employer

   In the absence of an affirmative selection by Employer of its EHBs, then Employer is deemed to have elected the EHBs based on the New Mexico benchmark plan.

6. This ASO BPA is binding on both parties and is incorporated into and made a part of the Administrative Services Agreement with both such documents to be referred to collectively as the "Agreement" unless specified otherwise.

7. Producer/Consultant Compensation

   The Employer acknowledges that if any producer/consultant acts on its behalf for purposes of purchasing services in connection with the Employer's Plan under the Administrative Services Agreement to which this ASO BPA is attached, the Claim Administrator may pay the Employer's producer/consultant a commission and/or other compensation in connection with such services under the Agreement. If the Employer desires additional information regarding commissions and/or other compensation paid the producer/consultant by the Claim Administrator in connection with services under the Agreement, the Employer should contact its producer/consultant.

Additional Provisions: 1. Claim payments are settled within 10 days. 2. Blue Card Program/Network Access fees are the lesser of up to 10% of the discount or $2000 per claim. 3. Admin fee includes Claims Fiduciary, Enhanced Blue Care Connection and Virtual Visits(MD Live). 4. The medical admin fee is guaranteed at $57.03 for 2018 and 2019; the medical admin fee is capped at $59.03 for 2020 and $61.09 for 2021. 5. The rebate credit of $20.03 is guaranteed as the minimum rebate credit for 2018, 2019 and 2020. 6. Administrative services include performance guarantees for services and discounts. The PG Exhibit, Network Discount Exhibit and PG Addendum are made part of this BPA.

I UNDERSTAND AND AGREE THAT:

1. HCSC will report the value of all remuneration by HCSC to ERISA plans with 100 or more participants for use in preparation of ERISA Form 5500 schedules. Reporting will also be provided upon request to non-ERISA plans or plans with fewer than 100 participants. Reporting will include base commissions, bonuses, incentives, or other forms of remuneration for which your agent/consultant is eligible for the sale or renewal of self-funded and/or insured products.

Signature

Sales Representative

District Phone & FAX Numbers

Producer Representative

Producer Firm

Producer Address

Producer Phone & FAX Numbers

Producer Email Address

Tax I.D. No.

Signature of Authorized Purchaser

Print Name

Title

Date

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than thirty (30) nor more than sixty (60) days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least twenty (20) days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

From time to time, HCSC pays indemnification or advances expenses to directors, officers, employees or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

Group No.: _____ By: _____
Print Signer's Name Here

➡ _____
Signature and Title

Group Name: _____

Address: _____

City: _____ State: _____ ZIP _____

Dated this _____ day of _____
Month Year

EXHIBIT 4
PHARMACY BENEFIT MANAGEMENT (PBM) ADDENDUM
PHARMACY BENEFIT MANAGEMENT SERVICES
(TRADITIONAL PRICING)
(FOR USE ONLY FOR 151+ EMPLOYEES)

EFFECTIVE DATE OF THIS EXHIBIT:

1. **Pharmacy Management:** Claim Administrator has contracted with Prime Therapeutics LLC (Prime) and/or other pharmacy benefit manager(s), mail order pharmacies, specialty pharmacies or other pharmacies to furnish certain pharmacy benefit management and other prescription drug benefit programs, including Rebate management and fee schedule management, including but not limited to MAC List management. Other services Prime will provide may include certain account management, clinical management, Drug List management, and Utilization Management services as set forth in the agreement between Prime and Claim Administrator. Claim Administrator reserves the right to contract with other Pharmacy Benefit Managers and pharmacies for such services. Please see the Agreement for additional information regarding Claim Administrator's use of Pharmacy Benefit Managers.

The Employer acknowledges that Claim Administrator currently owns a significant portion of the equity of Prime. The Employer further understands and agrees that fees and compensation that Prime receives related to the pharmacy benefit management program and/or the provision of pharmaceutical products and services by pharmacies may be revised. Some of these fees and compensation may be charged each time a Claim is processed (or requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to Claim Administrator, administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to Manufacturers. Currently, none of these fees are passed on to the Employer as expenses or accrue to the benefit of Employer, unless otherwise specifically set forth in the Agreement or this Exhibit.

2. **Services:** Services to be provided include Drug List/Rebate Management Services; management of the pharmacy networks for Members; Claims processing (electronic and paper); management of clinical management programs; reporting and account support services. Claim Administrator pays a fee to Prime for pharmacy benefit management services, which may be factored into the pricing set forth in the ASO BPA and the PBM Fee Schedule Addendum to the ASO BPA (the "BPA Addendum") .

3. **Drug List Services:** Claim Administrator utilizes its own Drug List and Prime supports Claim Administrator in the development, maintenance and updating of such Drug List. Prime performs Drug List exception reviews in accordance with the agreement between Prime and Claim Administrator. Prime provides Drug List management services, in accordance with NCQA and URAC standards, to Claim Administrator in supporting the Claim Administrator Pharmacy and Therapeutics ("P&T") and Business Committees. Employer acknowledges and agrees that Claim Administrator may, in a manner consistent with the Benefit Plan, promote the dispensing of pharmaceuticals in a manner consistent with the designated Drug List.

4. **Rebate Management**

a. **Negotiating Manager and Rebate Conditions:** In Claim Administrator's agreement with Prime, Prime has agreed to negotiate with Manufacturers to obtain Rebates for Covered Prescription Drug Products and Services. Prime has advised Claim Administrator that Rebate arrangements are based on volume purchase discounts or other similar arrangements with Manufacturers.

b. **Rebate and Fee Disclosures:** In addition, Prime has advised Claim Administrator that Prime receives Manufacturer Administrative Fees as compensation for bona fide administrative services performed by Prime for the Manufacturer. Prime may retain these Manufacturers Administrative Fees or pass them along, in whole or in part, to Claim Administrator in accordance with Prime's

agreement with Claims Administrator. As of the Effective Date, the maximum that Prime will receive from any Manufacturer for Manufacturer Administrative Fees is four and one quarter percent (4.25%) of the Wholesale Acquisition Cost ("WAC") for all products of such Manufacturer dispensed during any given calendar year to members of Claim Administrator; provided, however, Claim Administrator will advise Employer if such maximum has changed.

.

5. **Disclosures:** All other disclosures set forth in the Agreement will apply to pharmacy benefit management services.

6. **Pharmacy Network**

a. **Network Establishment and Maintenance:** In Prime's agreement with Claim Administrator, Prime has agreed to provide and maintain a network of Network Participants for use by Members to obtain Covered Prescription Drug Products and Services. The Employer acknowledges that in negotiating the Agreement and this Exhibit, it has taken into consideration that Claim Administrator and/or Prime will keep a portion of the discounts and/or other allowances that Claims Administrator or its pharmacy benefits manager has negotiated with the Network Participant. Prime will implement the methodology described in the Allowable Charge when calculating the Network Participant reimbursement, Copayment/Deductible, and Coinsurance amounts. Prime requires its Network Participants to not switch Covered Prescription Drug Products to a higher cost product unless requested to by the Member.

b. **Non-Payment to Excluded Providers:** Prime will use commercially reasonable efforts not to make payments to providers that are not licensed as required by law or that have been debarred, suspended or otherwise excluded from a federal or state program.

c. **Prime Maximum Allowable Cost ("MAC") Lists:** Prime owns and will maintain proprietary database listings of multi-source pharmaceutical drug products and supplies that also identifies a recommended maximum allowable cost for drugs or supplies within specified categories, commonly referred to as Prime's MAC Lists.

d. **Pharmacy Locator:** Prime will provide a means, either toll-free telephone line or electronic, to enable Members to identify Network Participants in a particular area.

e. **Mail Service:** Prime will provide or cause to be provided a mail order prescription drug service through which Members may receive Covered Prescription Drug Products and Services through the mail ("Mail Service"). Upon termination of the Agreement between Claim Administrator and Employer, Prime agrees to provide or cause to be provided mail order open refill and prior authorization files for purposes of transition to any new vendor selected by Employer at Prime's standard rate. Mail service and specialty pharmacy operates through an affiliate partially owned by Prime Therapeutics LLC.

f. **Pharmacy Network Audit Services:** Prime will perform or cause to be performed pharmacy Claims audits to promote Network Participant contract integrity.

g. **Audits:** In addition to the audit rights available elsewhere in the Agreement, Employer may request that Claim Administrator inspect and/or audit Prime's records, pursuant to the terms and conditions of the agreement between Claim Administrator and Prime, as they relate to the Claims under the Agreement. Employer may also audit Prime's records as they relate to the aforementioned Claims by coordinating such audit through Claim Administrator and executing an audit agreement with Prime as a party. Audits will be performed during normal business hours and are subject to providing Claim Administrator and Prime with reasonable advance written notice. Prime will make available records, as they relate to the Claims, unless Prime is legally or otherwise contractually prohibited from doing so. No material shall be copied or removed from

Claim Administrator or Prime without prior written approval by Prime. Employer will bear its own cost and expenses for all such audits.

h. **Specialty Pharmacy:** Claim Administrator and Prime have contracted with specialty pharmacies and/or vendors to provide Members with access to in-network benefits for covered Specialty Drugs.

7. Claims Processing

a. **Adjudication of Prescription Drug Claims from Network Participants:** Prime will process Claims for Prescription Drugs Products and Services electronically submitted by Network Participants through the Claims Adjudication System, according to Benefit Plan benefit and eligibility information submitted by Claim Administrator to Prime and will pay eligible Claims and provide to the submitting entity electronic notification of declined or ineligible Claims. Prime will also process and pay Paper Claims received from a Member at the benefit level set forth in the Benefit Plan, and based on the Allowable Charge, in accordance with the terms of the Benefit Plan, provided that the Benefit Plan allows such reimbursement.

b. **Material Change to AWP:** If after the Effective Date: (i) changes to the formula, methodology or manner in which AWP is calculated or reported by Medi-Span take effect or (ii) Medi-Span ceases to publish AWP for the Covered Prescription Drug Services under this Exhibit, then the financial terms of this Exhibit shall be automatically adjusted at the time of such change to return the parties to their respective economic positions as they existed under the Agreement immediately prior to such change. If the event described in item (ii) above occurs, the AWP pricing under this Exhibit shall immediately and automatically be converted to an alternative pricing benchmark determined by Prime.

c. **Statement of Account:** Prime will furnish to Claim Administrator, at least weekly, a statement of account of the amount of payments that have become due for Claims processed by Prime.

d. **NDC File:** Prime will maintain a National Drug Code (NDC) File for prescription drugs and required elements for each NDC.

e. **Help Desk Service:** Prime will provide help desk service for pharmacist Claim and Benefit Plan inquiries.

8. Benefit Plan Design:

In the event the Employer wishes to implement Benefit Plan design changes including, but not limited to, implementation of Coinsurance or increase of Copayment/Deductible, the pricing in the ASO BPA Addendum will no longer be applicable and new ASO BPA Addendum pricing will need to be negotiated.

9. Term This PBM Exhibit will be in effect for the term of the Agreement or the Term as stated in the ASO BPA Addendum, whichever is shorter (the “Term”).

10. Termination

This Exhibit may be terminated as follows:

a. By either party at the end of any twelve-month period of the Prescription Drug Program under this PBM Exhibit upon ninety (90) days prior written notice to the other party; or

b. By both parties on any date mutually agreed to in writing; or

c. By termination of the entire Agreement by either party at the end of any month after the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA upon ninety (90) days prior written notice to the other party; or

d. By either party, in the event of fraud, misrepresentation of a material fact or not complying with the terms of this Exhibit, upon written notice as provided in the "Notices" section of the Agreement; or

e. By Claim Administrator, upon the Employer's failure to pay all amounts due under the Agreement or this Exhibit including, but not limited to, all amounts pursuant to and in accordance with the specifications of the Fee Schedule of the most current ASO BPA and ASO BPA Addendum.

11. Program Pricing Terms

The pricing terms for Pharmacy Benefit Management services are as follows:

a. **Retail Pharmacy Program Claims**

1. (a) Employer will reimburse Claim Administrator for Claims submitted under the retail pharmacy program at the pricing set forth in the ASO BPA Addendum.

(b) Payment by Employer is subject to applicable Copayment/Deductible and/or Coinsurance or other coverage features set forth in the Benefit Plan designated by Employer under the retail pharmacy program.

In each case, if applicable, Employer will pay Claim Administrator the price set forth in subsection (a) above, plus any Provider Taxes and any federal, state, or local sales, use or other tax or assessment related to any Prescription Drug Products and Services less the Member's cost share as established by Employer.

In no event will Employer be charged if the Member Copayment/Deductible or Coinsurance covers 100% of the Covered Prescription Drug Products and Services. Member will pay the lower of the discounted AWP plus Dispensing Fee and applicable taxes, U&C, or Member Copayment/Deductible or Coinsurance. Zero balance logic is not employed.

2. **Direct Claims:** The Member reimbursement terms applicable to direct reimbursement of Paper Claims submitted by Members are determined by the benefit design.

b. **Mail Service Pharmacy Program Claims**

1. (a) Employer will reimburse Claim Administrator for Claims submitted under the mail pharmacy program at the pricing set forth in the ASO BPA Addendum.

(b) Payment by Employer is subject to applicable Copayment/Deductible, Coinsurance or other coverage features set forth in the Benefit Plan designated by Employer under the mail order pharmacy program.

In each case, if applicable, Employer will pay Claim Administrator the price set forth in subsection (a) above, plus any Provider Taxes and any federal, state, or local sales, use or other tax or assessment related to any Prescription Drug Products and Services less the Member's cost share as established by Employer.

In no event will Employer be charged if the Member Copayment/Deductible or Coinsurance covers 100% of the Covered Prescription Drug Products and Services.

Member will pay the lower of the discounted AWP, U&C, or Member Copayment/Deductible or Coinsurance. Zero balance logic is not employed.

2. **Direct Claims:** The Member reimbursement terms applicable to direct reimbursement of Paper Claims submitted by Members are determined by the benefit design.

c. **Specialty Drug Claims**

If covered under Employer Benefit Plan, notwithstanding anything to the contrary in Sections a and b above and elsewhere in the Agreement, Employer will reimburse Claim Administrator for Covered Prescription Drug Products and Services designated as Specialty Drugs under the Specialty Drug program, at the lesser of (i) the pricing set forth in the BPA Addendum or (ii) the U&C price on the date the prescription transaction is processed, subject to the Copayment/Deductible and Coinsurance in the applicable Benefit Plan. Specialty Drugs may be provided by Prime, an affiliate of Prime, or other specialty pharmacy that has a written arrangement with Prime or Claim Administrator. Pricing for Specialty Drug Claims are not included in the retail and mail pharmacy pricing described above. Members will pay the lesser of the contracted rate, U&C, or Member Copayment/Deductible or Coinsurance.

d. **Copayments/Deductibles/Coinsurance**

The Brand Drug Copayment/Deductible and Coinsurance will apply to all Brand Drugs as indicated in the applicable Drug List for the Employer group. The Generic Drug Copayment/Deductible and Coinsurance will apply to all generic drugs as indicated in the applicable Drug List and Benefit Plan for Employer.

e. **Rebates**

Rebate credits are paid prospectively to the Employer as a credit on the monthly billing statement and shall not continue after termination of the Prescription Drug Program or the PBM Exhibit. Additional information about rebates and rebate credits are included in the Agreement and the ASO BPA.

12. DEFINITIONS

Certain terms are defined in the Administrative Services Agreement, but the following terms and phrases will have the meaning set forth below, for purposes of the services described in this Exhibit.

1. “Average Wholesale Price” or “AWP” means the average wholesale price of a prescription drug as set forth in the Prime price file at the time a Claim is processed. The price file will be updated no less frequently than weekly through the Pricing Source. The applicable AWP used for retail and mail will be based on the NDC-11 of the package size submitted.

2. “Benefit Plan” means the benefit plan document that describes the Covered Prescription Drug Products and Services reimbursement for which an applicable Member of that Benefit Plan is entitled.

3. “Brand Drugs” means a drug that may be protected by a patent and/or marketed under a trade name which the Pricing Source designates as a Brand Drug. The Pricing Source used on the effective date of this Exhibit, Medi-Span, typically designates Brand Drugs as M, N or O in their multi-source code indicator.

4. “Claim” or “Claims” means requests for payment submitted by Network Participants or Members for Prescription Drug Products and Services.

5. “Claim Administrator” has the meaning set forth in the Agreement.

6. “Claims Adjudication” means the determination of whether a given Claim is entitled to reimbursement pursuant to the terms and conditions of a Benefit Plan and the amount payable to or by a Network Participant or Member pursuant to such Benefit Plan, the applicable Network Contract and any other applicable factors, including any Copayment/Deductible or Coinsurance payable by a Member, as well as drug utilization review. Claims Adjudication shall accommodate any e-prescribing procedures that may be adopted after the date hereof.

7. “Coinsurance” means that portion of the amount claimed for Covered Prescription Drug Products and Services, calculated as a percentage of the Allowable Charge (or its substitute) for such services, which is to be paid by Members pursuant to Member’s Benefit Plan.

8. “Copayment/Deductible” means a fixed dollar portion of the amount claimed for Covered Prescription Drug Products and Services that is to be paid by Members pursuant to Member’s Benefit Plan.

9. “Covered Prescription Drug Products and Services” means the pharmaceuticals and associated services available to Members and eligible for reimbursement pursuant to the Member’s Benefit Plan, subject to any Copayment/Deductible or Coinsurance.

10. “Dispensing Fee” means the fee required to be paid to the Network Participant for the professional service of filling a prescription and is added to the Ingredient Cost for the prescription.

11. “Drug Utilization Review” or “DUR” means the process whereby the therapeutic effects and cost effectiveness of various drug therapies are reviewed, monitored and acted upon consistent with the Member’s Benefit Plan. DUR can be prospective, concurrent or retrospective.

12. “Drug List” means a list of pharmaceutical products which is available to Network Participants, Members, physicians or other health care providers for purposes of providing information about the coverage and tier status of individual pharmaceutical products.

13. “Generic Drug” means a drug that is not protected by a patent nor marketed under a trade name which the Pricing Source designates as a Generic Drug. The Pricing Source used on the effective date of this Exhibit, Medi-Span, typically designates Generic Drugs as Y in their multi-source code indicator.

14. “Ingredient Cost” means the amount required to be paid to a Network Participant for a prescription drug and which, when combined with the applicable Dispensing Fee, constitutes the full amount payable to such Network Participant for the given prescription drug and the professional service of dispensing such drug.

15. "MAC List" means the list of unit prices established by PBM for multi-source Covered Drugs, each such unit price specified by Generic Product Identifier ("GPI") and including the dates for which such price was in effect. The MAC List is maintained by PBM and updated from time to time at PBM's sole discretion.

16. “Mail Service” means the service through which Members may receive Covered Prescription Drug Products and Services through the mail.

17. “Manufacturer” means a company that manufactures, and/or distributes pharmaceutical drug products.

18. “Manufacturer Administration Fee” means all fixed fees received by Prime from any given Manufacturer relating to administration of Rebates under a Manufacturer Agreement.

19. “Maximum Allowable Cost” or “MAC” means the highest Ingredient Cost at which a Benefit Plan will reimburse any Network Participant or Member for a specific drug for products present on the MAC List at the time of service.

20. “Member” or “Members” means an individual who is eligible to receive Covered Prescription Drug Products and Services as a beneficiary at the time of service under a Benefit Plan.

21. “Network Contract” has the meaning set forth in the definition of “Network Participant.”

22. “Network Participant” means each individual pharmacy, chain or Pharmacy Services Administrative Organizations (PSAO) that has entered into an agreement with Prime or Claim Administrator (“Network Contract”) to provide Covered Prescription Drug Products and Services to Members, as may be amended.

23. “Paper Claims” means Claims for prescription drug services that are submitted to Prime for Claim Adjudication through the use of a paper claim form, generally by a Member, subsequent to the point of sale.

24. “Pricing Source” means Medi-Span, or other such national drug database or alternate pricing benchmark as Prime and Claim Administrator may designate, which established and provides updates to Prime no less frequently than weekly or as otherwise required by law, regarding AWP or other alternative pricing benchmark for Covered Prescription Drug Products and Services. Claim Administrator will only use a single nationally recognized pricing source at any given time.

25. “Provider Tax” means any tax on a Covered Prescription Drug Product and Service required to be collected or paid by a pharmacy provider for a Covered Prescription Drug Product and Service.

26. “Rebate(s)” means compensation or remuneration of any kind received or recovered by Prime from any Manufacturer which is directly or indirectly attributable to purchase or utilization of Covered Prescription Drug Products and Services by Members. Rebates do not include Manufacturer Administration Fees which Prime is entitled to retain pursuant to the Agreement and this Exhibit unless otherwise required by law.

27. “Rebate Management Services” means the services which Prime is obligated to provide pursuant to Section 4.

28. “Specialty Drugs” means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected, but may also include drugs that are for serious or chronic conditions, oral medications and/or that have special handling or storage requirements. In addition, patient support and/or education may be required for these drugs. The list of Specialty Drugs is determined by Prime and subject to change.

29. “Usual and Customary” or “U&C” means the price, including any Dispensing Fee, that a Network Participant would charge a particular customer if such customer were paying cash for the identical prescription drug service on the date dispensed. This includes any applicable discounts including but not limited to senior discounts, frequent shopper discounts, and other special discounts offered to attract customers.

30. “Utilization Management” means clinical management services designed to encourage proper utilization of prescription drugs in order to enhance (or not diminish) Member outcomes while managing drug benefit costs, directly and/or indirectly, for Benefit Plan and Members. Such

services include, but are not limited to the following: drug list exception, prior authorization, step therapy, quantity limits and DUR.

31. “Zero Balance Due Claim” means any Claim where the Member cost share covers 100% of the Allowable Charge for such Claim.

EXHIBIT 5
PG ADDENDUM
PERFORMANCE GUARANTEES

The Performance Guarantees described herein shall apply to the Administrative Services Agreement (the "Agreement") to which this Addendum is attached and have the same force and effect as the Agreement's most current Fee Schedule, unless amended, replaced, or terminated by the parties to the Agreement in writing.

All obligations, definitions, terms, conditions, promises, agreements, and language in the Agreement and its most current Fee Schedule apply equally to the obligations, terms, conditions, promises, agreements, and language in this Addendum PG and its most current Exhibit-PG.

SECTION I
TIMING

A. The period for which the Claim Administrator's performance will be measured and for which Employer may receive a refund is referred to as the Settlement Period and is indicated on the most current Exhibit-PG.

B. The measurement of Performance Guarantees will begin on the date indicated on the most current Exhibit-PG provided all of the requirements listed below are completed. The requirements are as follows:

1. Benefit information and claims administrative procedures have been provided by Employer to the Claim Administrator,

2. All accumulation totals, if applicable, have been received from the prior carrier and have been loaded onto the Claim Administrator's claims processing system,

3. Accurate and complete membership information has been received and loaded onto the Claim Administrator's claims processing system, and

4. Transfer Payment procedures have been established in accordance with the Agreement.

SECTION II
DETERMINATION

A. The Claim Administrator agrees to guarantee performance levels as indicated on the most current Exhibit-PG. In the event that the Claim Administrator's level of performance is determined to be less than any of the standards described in the most current Exhibit-PG during a Settlement Period for which the Claim Administrator's performance shall be evaluated for any reason, except any disaster or epidemic which substantially disrupts the Claim Administrator's normal business operation, the Claim Administrator will be responsible for reimbursing Employer a portion of the Administrative Charge.

B. The Claim Administrator will measure Performance Guarantees and report the measurement results to Employer, and any refund amounts due in accordance with this Addendum PG within

120 days following the close of all measurement periods necessary to finalize Performance Guarantee results for the Settlement Period.

C. The Claim Administrator will not be obligated to measure Performance Guarantees and will not be obligated to refund Employer based thereon until the Administrative Services Agreement (including the most current Exhibit-PG) has been executed and is on file with the Claim Administrator by the close of the applicable Settlement Period.

D. The Claim Administrator will not be obligated to measure Performance Guarantees and will not be obligated to refund Employer based thereon for any portion of the Settlement Period in which the Employer:

1. Fails to provide the Claim Administrator with Timely changes in enrollment or membership information or any other reports or information as may be necessary for the Claim Administrator to perform its administrative duties, including but not limited to identification or certification of claimants eligible for benefits, dates of eligibility, number of employees and dependents covered under the Plan; or

2. Fails to pay Administrative Charges in accordance with the terms of the Agreement or comply with all established Transfer Payment procedures.

E. The Claim Administrator will not be obligated to measure any Performance Guarantee impacted by changes requested in writing by Employer during the time period required to modify the Claim Administrator's system and to complete all other tasks necessary to achieve the same qualitative standard of execution that existed before the change was requested. All changes or amendments to the Plan must be submitted to the Claim Administrator in accordance with the Agreement.

F. If for any reason there is a significant change in the benefit structure or the administrative procedures of the benefit coverage administered by the Claim Administrator, Medicare payment systems, or if the enrollment of the Plan's benefit coverage administered by the Claim Administrator varies in number of enrolled Covered Employees as indicated in the most current Exhibit-PG attached to and made a part of this Addendum during any Settlement Period, the Claim Administrator reserves the right to re-evaluate and renegotiate the level of performance and/or the Administrative Charges at risk in this Addendum PG and the attached Exhibit-PG..

G. If for any reason the Agreement is terminated prior to the end of any Settlement Period, the Performance Guarantees will not be measured and Employer will not receive any refund, based on that part of the Settlement Period in which the Administrative Services Agreement was in effect.

H. If (i) changes to the formula, methodology or manner in which a third-party benchmark (such as AWP) is calculated or reported take effect, or (ii) such third party ceases to publish such benchmark, then the performance guarantees and/or standards based on such benchmark in this Agreement, if any, shall be re-evaluated and adjusted or converted to an alternative benchmark by Claim Administrator or its designee at the time of such change to return the parties to their respective economic positions with respect to such guarantees and/or standards as they existed under the Agreement immediately prior to such change.

EXHIBIT 6
STOP LOSS AGREEMENT

BlueCross BlueShield of New Mexico

STOP LOSS COVERAGE AGREEMENT

between

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO
A DIVISION OF HEALTH CARE SERVICE CORPORATION,
a Mutual Legal Reserve Company

Herein called "the Company"
and

The EMPLOYER

The Application for Stop Loss Coverage (herein called the "Application") attached hereto and made a part of this Agreement shall establish the Employer's Group Name, Employer Group Number, the Effective Date of Agreement, and the Policy Period.

In consideration of the Application attached hereto and in consideration of the payment made by the Employer of all premiums when due as hereinafter provided, the Company agrees to make the payments herein specified, subject to the provisions and conditions of this Agreement.

All obligations, terms, definitions, conditions, promises, agreements and provisions of the Administrative Services Agreement between the Employer and the Company shall apply equally to this Agreement unless otherwise specified in this Agreement or the Application.

ATTEST:

Kurt Shipley

Executive Director

SECTION I
DEFINITIONS

Additional definitions applicable to this Agreement are contained in the Administrative Services Agreement.

"Application" means the attached **APPLICATION FOR STOP LOSS COVERAGE** specifying the particulars of this Agreement or any subsequent replacement Application supplied by the Company. The specifications or items of the Application shall be applicable for the Policy Period indicated on the Application, except that any item of the Application may be changed in accordance with the provisions described in this Agreement.

"Continuous Stay" means an Inpatient stay spanning consecutive calendar days, beginning on the date of admission to the facility and ending on the date of discharge from the facility, even if the Provider submits claims in increments.

"Covered Person" means an individual Employee, dependent(s) of an Employee, a retired Employee, dependent(s) of a retired Employee, and certain continued persons and their dependents covered under a continuation of coverage provision, whose coverage has become effective in accordance with the terms of the Employer's Plan and whose Paid Claims are eligible for Stop Loss Coverage as indicated on the most current Application to this Agreement.

"**Claim Liability"** means the total amount of Paid Claims that the Employer is responsible for paying each Policy Period. Claim Liability will be calculated for each Policy Period in accordance with the formula indicated in Item A.5. of the most current Application to this Agreement.

"Effective Date of Agreement" means the date specified on the Application.

"Employee" means an individual employee, retired employee, or continued person, whose coverage has become effective under the Employer's Plan and whose Paid Claims are eligible for Stop Loss Coverage as indicated on the most current Application to this Agreement.

"Final Policy Period" means the period of time beginning on the first day of the Policy Period specified on the most current Application and ending on the date the Agreement is terminated.

"Month" means each succeeding calendar Month period beginning on the first day of the Policy Period.

"Paid Claims" shall mean:

(a) The total amount of Claim Payments under and pursuant to the Administrative Agreement; and

(b) If applicable, the claim payments made by the Employer's prior claim administrator, as specified on the Application;

for the types of claims specified on the Application and in settlement of claims for any benefits under the Plan which are:

(c) In the case of new coverage (i.) Incurred and paid during the Policy Period or (ii.) Incurred during the Stop Loss Coverage Period and paid during the Policy Period, as specified on the Application;

(d) In the case of a renewal of existing coverage, incurred on or after the original Effective Date of the Agreement and paid during the most current Policy Period, as specified on the Application.

(e) Paid Claims may also include Run-Off Paid Claims in accordance with the provisions of this Agreement.

An Inpatient facility claim for a Continuous Stay is considered "incurred" on the first date of admission to such facility. All other claims, including but not limited to professional services claims for a Continuous Stay, are considered "incurred" on the date the service or supply is furnished. An Inter-Plan Program claim is considered "paid" on the date the Company receives notification from the Host Plan that payment has been sent to the Provider. All other claims are considered "paid" when the claim is both adjudicated and processed for payment.

"Paid Claims" shall not include:

(a) Claims incurred prior to the original Effective Date of Agreement, except as specified on the Application; or

(b) Claims incurred after the termination date of this Agreement; or

(c) Extra contractual damages of any nature, compensatory damages, or any similar damages however assessed, or any payments made as an exception to the Plan or as settlement of a lawsuit; or

(d) Any payments made at the specific written request of the Employer when not provided for as benefits under the Plan or which are limited or excluded under such document; or

(e) Any payments of benefits which are interpreted by the Employer as coming within the terms of the Plan if the Company notifies the Employer that it does not agree with that interpretation.

"Plan" shall mean the self-funded Group Health Plan of the Employer.

"Point of Attachment" means the dollar amount above which Stop Loss Insurance will apply as indicated in Items A.7. and/or B.4. of the most current Application to this Agreement provided, however, that the Point of Attachment for Aggregate Stop Loss Insurance shall never be less than the minimum specified in Item A.7. of the most current Application.

"Agreement" as used herein means this Stop Loss Coverage Agreement.

"Policy Period" means the period of time beginning and ending on the dates shown on the most current Application.

"Run-In Period" means the period immediately prior to the initial Policy Period, if any, as specified in Items A.2. and/or B.2 of the Application.

"Run-Off Paid Claims" means those Paid Claims incurred on or after the original Effective Date of this Agreement but prior to termination, which are paid in accordance with the Administrative Services Agreement during the Run-Off Period.

"Run-Off Claims Liability" means the amount to fund anticipated Run-Off Paid Claims. Settlements for Run-Off Paid Claims will be in accordance with the section entitled SETTLEMENTS, Run-Off Period Settlement subsection of this Agreement.

"Run-Off Period" means the twelve-Month period immediately following the termination of this Agreement.

"Stop-Loss Claims" means the amount of Paid Claims for which the Company assumes responsibility and risk.

(a) If the amount of Paid Claims that have accumulated during the Policy Period for any Covered Person exceeds the amount indicated in Item B.4. of the most current Application to this Agreement, such excess, up to the maximum amounts indicated, if any, shall be referred to in this Agreement as **Individual (Specific) Stop-Loss Claims.** A monthly review and reimbursement if applicable will occur to determine if such excess exists.

(b) Individual (Specific) Stop-Loss Insurance does not extend beyond the termination date of this Agreement.

(c) If, during the current Policy Period, Paid Claims less Individual (Specific) Stop-Loss Claims, if any, exceed the Aggregate Point of Attachment indicated in Item A.7. of the most current Application to this Agreement, such excess, if any, shall be referred to in this Agreement as **Aggregate Stop-Loss Claims.**

(d) Stop Loss Claims may also include claims paid by the Employer's prior claim administrator as specified on the Application.

"Stop Loss Coverage Period" means the period specified in Items A.2. and/or B.2. of the most current Application.

"Stop-Loss Premium" means the Monthly or annual premium, calculated in accordance with the formulas indicated in Items A.8. and/or B.5. of the most current Application, that is required by the Company for the risk assumed for the Stop Loss Coverage indicated in Item A.7. and/or B.4. of the most current Application. The Employer shall pay to the Company the Stop Loss Premium within the agreed upon calendar days of receipt following the billing as reflected in the most current Application.

The Stop-Loss Premium shall be subject to change by the Company as follows:

(a) At the end of the Policy Period shown in the most current Application, provided that sixty (60) days prior written notice is given by the Company;

(b) On the implementation date of any changes or benefit variances in the Employer's Plan, its administration, or the level of benefit valuation which would increase the Company's risk;

(c) On any date changes imposed by governmental entities increase expenses incurred by the Company provided that such increases shall be limited to an amount sufficient to recover such increase in expenses; or

(d) On any date that the number of Covered Persons enrolled changes by an amount equal to 10% or more of total enrollment over a one-Month period or 25% or more of total enrollment over a three-Month period.

SECTION II
AGREEMENT PROVISIONS

INDEMNIFICATION OF RISK. The Company hereby agrees to indemnify the Employer as specified in the section of this Agreement entitled SETTLEMENTS against the amount paid pursuant to the Plan during the Policy Period which is in excess of the Point of Attachment specified in Items A.7. and/or B.4. of the most current Application. The Company shall not be liable for, nor shall the indemnification be extended to, any claim or liability for extra contractual or punitive damages, including interest, statutory penalties and attorney fees.

ENTIRETY. This Agreement, the most current Application and any attachments shall constitute the entire Agreement between the parties for the purposes of this Agreement and shall supersede any and all prior or contemporaneous Agreements or understandings, either oral or in writing, between the parties with respect to the subject matter herein. This Agreement shall not create any right or legal obligation between the Company and the Covered Person under the Plan.

MODIFICATION. Except for the Application to this Agreement, which may be changed at any time in accordance with the provisions of this Agreement by notifying the Policyholder in writing of such change, no modification, amendment, change, or waiver of any provision of this Agreement shall be valid unless agreed to by an officer of Company and an authorized representative of the Employer.

SECTION III
PREMIUM PROVISIONS

PREMIUM PAYMENT. The premium(s) to be paid to the Company as consideration for the insurance provided hereunder and the method of premium payment (monthly or annual) shall be as specified on the Application. Monthly premium is due on the first day of each Month beginning on the first day of the Policy Period through the end of the Policy Period. Annual Premium is due on the first day of the Policy Period. Premium is based on the current membership specified on the Application.

REMITTANCE. The Company shall bill the Employer for the Stop-Loss Premium amount due and the Employer shall remit payment within the agreed upon time frame in the most current Application. A remittance will be considered received when actually delivered into the possession or control of the Company.

DAILY CHARGE. A daily charge shall be assessed for the late remittance of any amount(s) due and payable to the Company by the Employer. This charge shall be an amount equal to the amount resulting from multiplying the amount due times the lesser of:

(a) The rate of .0329% per day (which equates to an amount of 12.0% per annum); or

(b) The maximum rate permitted by state law**.**

NOTICE AND PROOF OF LOSS. The Company shall reimburse the Employer as specified in the section of this Agreement entitled SETTLEMENTS*.* Payment to the Employer in settlement of claims hereunder shall not be construed as a waiver of, or prohibition against, the Company's right to adjudicate or make further adjustments to such settlements.

Any amount which the Employer recovers from a third party, whether by subrogation, reimbursement or otherwise, in connection with a claim under the Employer's Plan shall not be eligible to satisfy the Point(s) of Attachment applicable to the Employer as specified on the Application nor will the Company pay any benefit hereunder with respect to any such recovered amount. Any such recovery shall be applied first to refund to the Company any benefit paid hereunder with respect to such claim and the Employer shall pay such refund to the Company within thirty-one (31) days after its receipt of such recovery, whether or not this Agreement is still in force at that time.

No action at law or in equity shall be brought to recover on this Agreement more than three (3) years from expiration of this Agreement.

The books and records of the Employer which pertain to the Plan shall be open to the Company and its representatives at all times during the usual business hours for inspection.

SECTION IV.
DISPUTE RESOLUTION

Any dispute arising out of or relating to this Agreement shall be resolved in accordance with mutually agreed process and procedures. All negotiations pursuant to this Section IV. are confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence. Except as provided otherwise in this Agreement, each party is required to continue to perform its obligations under this Agreement pending final resolution of any dispute arising out of or relating to this Agreement.

SECTION V
SETTLEMENTS

INDIVIDUAL (SPECIFIC) STOP LOSS SETTLEMENT. For any Individual (Specific) Stop Loss Claims, the claim settlement shall be provided to the Employer by the Company within ninety (90) days after the end of each Policy Period during which this Agreement is in effect. The Company reserves the right to deduct any amount(s) owed the Company by the Employer from any payment due the Employer as a result of the claim settlement**.**

If this Agreement is terminated prior to the expiration of the Policy Period, claim settlements for Individual (Specific) Stop Loss Claims will be made, as specified herein, for only those full Months of the Policy Period immediately preceding Agreement termination. Individual Stop-Loss Coverage shall not extend beyond the termination date of this Agreement.

AGGREGATE STOP LOSS SETTLEMENT OR ACCOUNTING.

For any Aggregate Stop Loss Claims, the claim settlement shall be provided to the Employer by the Company within ninety (90) days after the end of each Policy Period during which this Agreement is in effect. The Company reserves the right to deduct any amount(s) owed the Company by the Employer from any payment due the Employer as a result of the claim settlement**.** Aggregate Stop Loss Insurance shall not exceed the maximum indicated in Item

A.7. of the most current Application to this Agreement in any Policy Period or any Final Policy Period.

If the settlement reflects that Paid Claims for the Policy Period exceed the Point of Attachment for that Policy Period, then Aggregate Stop Loss Claims, minus any Individual (Specific) Stop Loss Claims, to the extent funded by the Employer, shall be the responsibility of the Company. If the Aggregate Point of Attachment exceeds the Paid Claims, then no Aggregate Stop-Loss benefit shall be payable to the Employer.

RUN-OFF PERIOD SETTLEMENT. In the event of termination of this Agreement on the last day of the Policy Period, the Run-Off Period immediately following termination will be combined with the Final Policy Period and this shall be termed a **Final Settlement Period.** Within ninety (90) days following the end of the Run-Off Period, a final settlement will reflect the following:

(a) **Final Settlement Paid Claims:**

(1) The sum of the Paid Claims during the Final Policy Period and the Run-Off Paid Claims, minus
(2) Any Individual (Specific) Stop-Loss Claims during the Final Policy Period, if applicable.

(b) **Final Settlement Point of Attachment:**

(1) The sum of the Employer's Claims Liability for the Final Policy Period, plus
(2) The Employer's Run-Off Claim Liability

If the Final Settlement Paid Claims exceed the Final Settlement Point of Attachment, then Aggregate Stop-Loss benefits shall be payable to the Employer to the extent funded by the Employer.

If the Final Settlement Point of Attachment exceeds the Final Settlement Paid Claims, then no Aggregate Stop-Loss benefits shall be payable to the Employer.

SECTION VI
GENERAL PROVISIONS

LIMITATION OF LIABILITY. Liability for any errors or omissions by the Company (or its officers, directors, employees, agents, or independent contractors) in the administration of this Agreement, or in the performance of any duty of responsibility contemplated by this Agreement, shall be limited to the maximum benefits which should have been paid under the Agreement had the errors or omissions not occurred (including the Company's share of any arbitration expenses incurred under the Agreement), unless any such errors or omissions are adjudged to be the result of intentional misconduct, gross negligence, or intentional breach of a duty under this Agreement by the Company.

TERM AND TERMINATION. This Agreement shall continue in full force and effect from year to year unless terminated as provided herein.

This Agreement may be terminated as follows:

(a) By either party at the end of any Policy Period following thirty (30) days prior written notice to the other;

(a) By both parties on any date mutually agreed to in writing.

(b) This Agreement will terminate automatically:

(1) On the date the most current Application terminates as specified on the Application, unless a replacement Application for the period immediately following is executed by the Company and the Employer;

(2) Upon failure of the Employer to pay Stop Loss Premium in accordance with the provisions of this Agreement;

(3) On the date the Plan terminates; or

(4) On the date the Administrative Services Agreement terminates. The Employer shall notify the Company in writing of a change in claim administrator from the Company to another carrier or administrator no later than thirty (30) days in advance of the date of change.

In the event of termination of this Agreement for any reason prior to the expiration of a Policy Period, no Aggregate Stop Loss Insurance will exist for the Final Policy Period or Run-Off Period. The Employer will be required to fund all claims during the Final Policy Period and Run-

Off Period. The Company shall have no obligation to determine a claim settlement for the period during which coverage was in effect nor shall the Company refund any portion of the premium(s) to the Employer.

ASSIGNMENT. No part of this Agreement, or any rights, duties, or obligations described herein, shall be assigned or delegated without the prior express written consent of both parties. Any such attempted assignment shall be null and void. The Company's standing contractual arrangements for the acquisition and use of facilities, services, supplies, equipment, and personnel from other parties shall not constitute an assignment under this Agreement.

GOVERNING LAW. This Agreement shall be governed by, and shall be construed in accordance with, the laws of the State of New Mexico without regard to any state choice-of-law statutes, and any applicable federal law. All obligations created hereunder are performable in Albuquerque, New Mexico and all disputes arising out of this Agreement will be resolved in Albuquerque, New Mexico.

NO WAIVER. The failure of either the Employer or the Company to insist upon strict performance of any of the terms of this Agreement shall not be construed as a waiver of its respective rights to remedies with respect to any subsequent breach or default in any of the terms of this Agreement.

SEVERABILITY. In case any one or more of the provisions contained in this Agreement shall, for any reason, be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provisions of this Agreement, but this Agreement shall be construed as if such invalid, illegal, or unenforceable provision had never been contained herein.

TAXES. Any premium amounts due under this Agreement will automatically be increased by the amount of any taxes imposed, increased, or adjudged due by any lawful authority on or after the Effective Date of this Agreement, which directly pertain to this Agreement and which the Company is required to pay or remit, whether relating to fees, services, benefits, payments, or any other aspect of this Agreement or the Plan.

INSOLVENCY. The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Employer or its Claim Administrator will not impose on the Company any liability other than the liability defined this Agreement. The insolvency of the Employer will not make the Company liable to the creditors of the Employer, particularly the Covered Persons under the Plan.

RIGHT OF RECOVERY. The Company will not seek recovery of any excess or erroneous payment made under this Agreement more than twenty-four (24) months after the payment is made, unless:

(a) The payment was made because of fraud committed by the Employer, the Covered Person or the provider; or

(b) The Employer, Covered Person or provider has otherwise agreed to make a refund to the Company for overpayment of a claim.

EXHIBIT 7
BUSINESS ASSOCIATE AGREEMENT

CLAIM ADMINISTRATOR BUSINESS ASSOCIATE AGREEMENT

This Claim Administrator Business Associate Agreement ("Agreement") by and between Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("Claim Administrator") and County of Los Alamos ("Employer") and the Employer on behalf of its Group Health Plan ("GHP"), collectively the "Parties," is effective on January 1, 2013.

The purpose of this Agreement is to set forth the Parties' mutual agreement on the terms for their compliance with the Health Insurance Portability and Accountability Act ("HIPAA" or "Privacy Rule" or "Security Rule" or "Electronic Transactions Rule") and its implementing regulations (45 C.F.R. Parts 160-164) and the requirements of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), as incorporated in the American Recovery and Reinvestment Act of 2009 and the implementing regulations, as issued and amended by the Secretary, that are applicable to Business Associates. Capitalized terms used in this Agreement and not otherwise defined herein shall have the meanings set forth in HIPAA and/or HITECH which definitions are hereby incorporated by reference.

The Parties acknowledge and agree that Claim Administrator is a Business Associate and that the Group Health Plan ("GHP") established and maintained by the Employer is a Covered Entity as those terms are defined by HIPAA. Employer acknowledges that its employee welfare benefit plan meets the definition of Health Plan in 45 CFR 160.103.

1. **Obligations and Activities of Claim Administrator as Business Associate.**

(a) Claim Administrator agrees to use or disclose Protected Health Information (PHI) it creates or receives for or from Employer and GHP only as permitted or required by this Agreement or as Required by Law.

(i) Claim Administrator is permitted to use or disclose PHI to perform the functions, activities and services as the claim administrator for Employer's GHP. In addition, the Parties may enter into other agreements from time to time that include additional functions, activities, and services provided by the Claim Administrator, and to the extent that such agreements include the Use or Disclosure of PHI, the Parties agree that the terms of this Agreement shall also apply.

(ii) Claim Administrator is permitted to use or disclose PHI to perform functions, activities, or services for, or on behalf of, the GHP as Covered Entity, provided that such Use or Disclosure would not violate the Privacy Rule or HITECH if done by Covered Entity, including the minimum necessary and/or Limited Data Set requirements of the Privacy Rule and HITECH.

(iii) Except as otherwise limited in this Agreement, Claim Administrator may use PHI for the proper management and administration of the Agreement or to carry out the legal responsibilities of the Claim Administrator.

(iv) Except as otherwise limited in this Agreement, Claim Administrator may disclose PHI to carry out Claim Administrator's proper management, administration or legal responsibilities, provided that the Disclosures are: Required by Law; or Claim Administrator obtains reasonable assurances from the person/entity to whom the information is disclosed, that it will remain confidential and used or further disclosed only as Required by Law. An executed Business Associate Agreement or other applicable Confidentiality Agreement would be used as evidence to support this. Furthermore, the information disclosed will only be used for its intended purpose and if the confidentiality of the information has been breached, the person/entity will notify the Claim Administrator in all instances.

(v) Except as otherwise limited in this Agreement, Claim Administrator may use PHI to provide Data Aggregation services relating to the Health Care Operations of the GHP and as permitted by 45 CFR 164.504(e)(2)(i)(B).

(vi) Claim Administrator may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502(j) (1) and HITECH.

(b) Claim Administrator agrees to use appropriate safeguards to prevent Use or Disclosure of PHI other than as provided for by this Agreement. Claim Administrator agrees to implement administrative, technical, and physical measures that reasonably and appropriately protect the confidentiality, integrity, and availability of the

Electronic PHI that Claim Administrator creates, receives, maintains, or transmits on Covered Entity's behalf as required by the Security Rule, 45 C.F.R. Part 164, Subpart C and/or as required by Section 13401 of HITECH.

(c) Claim Administrator agrees to report to Covered Entity any Use or Disclosure of PHI not provided for by this Agreement of which it becomes aware. Claim Administrator will make such report to Covered Entity's Privacy Office within a reasonable time after Claim Administrator learns of such Use or Disclosure not provided for by this Agreement.

(d) Claim Administrator agrees to report to Covered Entity any successful Security Incident of which Claim Administrator becomes aware. Claim Administrator will make such report to Covered Entity's Privacy Office within a reasonable time after Claim Administrator learns of any successful Security Incidents. To avoid unnecessary burden on either Party, Claim Administrator will only be required to report, upon the Covered Entity's request, attempted, but unsuccessful Security Incidents which Claim Administrator becomes aware; provided that the Covered Entity's request shall be made no more often than is reasonably based upon the relevant facts, circumstances and industry practices.

(e) Claim Administrator will report to Covered Entity, in writing without unreasonable delay after a determination is made that an incident has occurred that affects plan members, but no later than five (5) business in the case of electronic unsecured PHI and ten (10) business days in the case of breaches of hardcopy Unsecured PHI or as required by law of any "Breach" of "Unsecured Protected Health Information" as these terms are defined by HITECH. Claim Administrator shall cooperate with Covered Entity in investigating the Breach and in meeting the Covered Entity's obligations under HITECH and any other security breach notification laws. Any such report shall include the identification (if known) of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by Claim Administrator to have been accessed, acquired, or disclosed during such Breach as required by law.

Covered Entity shall check "YES", below, if Covered Entity is electing to delegate to Claim Administrator the provision of the HITECH Act Security Breach services described in Attachment 1 of this Agreement ("Attachment 1"), Covered Entity shall check "NO", below, if Covered Entity is electing to retain the provision of the HITECH Act Security Breach services described in Attachment 1. If Covered Entity does not check "YES" or "NO" below, Claim Administrator will NOT provide the HITECH Act Security Breach services described in Attachment 1 and these services will become the responsibility of the Covered Entity.

☒ Yes ☐ No

(f) Claim Administrator agrees to ensure that any of its agents, including a subcontractor, to whom Claim Administrator provides PHI received from, or created or received by Claim Administrator on behalf of Covered Entity, agree in writing to substantially the same restrictions, conditions, and security measures that apply through this Agreement to Claim Administrator with respect to such information.

(g) Claim Administrator agrees to make internal practices, books, and records, including policies and procedures and PHI, relating to the Use and Disclosure of PHI received from, or created or received by Claim Administrator on behalf of Covered Entity, available to the Secretary, in a time and manner as reasonably requested by or designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

(h) Claim Administrator agrees to document such Disclosures of PHI and information related to such Disclosures as would be required for Covered Entity to respond to a request by an Individual for an Accounting of Disclosures of PHI in accordance with 45 CFR 164.528 and HITECH.

(i) The Party identified on Attachment 2 of this Agreement ("Attachment 2") agrees to provide to an Individual, and in the time and manner mutually agreed by the Parties, information collected in accordance with Section 1(h) of this Agreement, to permit Covered Entity to respond to a request by an Individual for an Accounting of Disclosures of PHI in accordance with 45 CFR 164.528. Upon termination of this Agreement, Claim Administrator will respond to the Individual for a period of up to six years.

(j) The Party identified on Attachment 2 agrees to provide access, at the request of an Individual, and in the time and manner mutually agreed by the Parties, to PHI for an Individual in order to meet the requirements under

45 CFR 164.524 and HITECH. Upon termination of this Agreement, Claim Administrator will respond to an Individual's request during such time that Claim Administrator maintains the data.

(k) Prior to responding to an Individual's request for an amendment pursuant to 45 CFR 164.526, Covered Entity shall ask Claim Administrator if Claim Administrator created the PHI maintained in the designated record set. Claim Administrator will notify Covered Entity of its recommendation to deny or grant the individual's request. The Party identified on Attachment 2 will respond to Individual's request for an amendment. Upon termination of this Agreement, Claim Administrator will respond to an Individual's request during such time that Claim Administrator maintains the data.

(l) In those instances when Claim Administrator may conduct Standard Transactions on behalf of the Covered Entity, Claim Administrator will comply with the HIPAA requirements for Standard Transactions and Data Code Sets.

2. Obligations of GHP as Covered Entity.

(a) Covered Entity shall notify Claim Administrator of any limitation(s) in the Notice of Privacy Practices of Covered Entity on Attachment 2 in accordance with 45 CFR 164.520, to the extent that such limitation may affect Claim Administrator's Use or Disclosure of PHI. Employer or Covered Entity will notify Claim Administrator of any material change in privacy policies, procedures or practices.

(b) Covered Entity shall notify Claim Administrator of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect Claim Administrator's Use or Disclosure of PHI.

(c) Prior to responding to an Individual's restriction request on the Use or Disclosure of PHI in accordance with 45 CFR 164.522, Covered Entity shall ask Claim Administrator if the proposed restriction will affect its functions, activities, or services under the Agreement. If such restriction would affect Claim Administrator's Use or Disclosure of PHI, Covered Entity will deny the Individual's request. Upon termination of this Agreement, Claim Administrator will respond to an Individual's request during such time that Claim Administrator maintains the data.

(d) If Covered Entity or Claim Administrator receives a request from an Individual for confidential communication of PHI by alternative means or at alternative locations in accordance with 45 CFR 164.522(b), Covered Entity, prior to responding to such a request, shall ask Claim Administrator for information on the feasibility of implementing or accommodating the request and on whether there may be an additional cost. Covered Entity shall promptly notify Claim Administrator of its decision on the request for confidential communication of PHI. Upon termination of this Agreement, Claim Administrator will respond to an Individual's request during such time that Claim Administrator maintains the data.

(e) Covered Entity shall provide Claim Administrator the necessary information to fulfill Claim Administrator's obligations under this Agreement, including but not limited to, a written statement of the restrictions for the Disclosure of PHI by Claim Administrator to the Employer. Employer certifies that the Employer's benefit Plan Documents have been amended in compliance with 45 CFR 164.314(b) and 45 CFR 164.504(f) and that information from the applicable amendments shall be included in the written statement provided to Claim Administrator.

(f) Covered Entity shall identify its Business Associates and Group Health Plan employees on Attachment 2 to whom Claim Administrator is permitted to directly Disclose PHI. Covered Entity shall provide information on any limitations or restrictions on Claim Administrator's Disclosure to a specific Business Associate or Group Health Plan employees of Covered Entity.

3. Permissible Requests by Covered Entity.

Covered Entity shall not request Claim Administrator to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity, unless otherwise noted in this Agreement.

4. Term and Termination.

(a) **Term**. The Term of this Agreement shall be effective on the date stated on the first page of this Agreement and shall terminate without notice upon termination of any agreement or arrangement between the

Parties for Claim Administrator to provide administrative services to Employer's self-insured health benefit welfare plan.

(b) **Termination for Cause**. Upon Covered Entity's knowledge of a material breach by Claim Administrator, Covered Entity shall either:

(i) Provide an opportunity for Claim Administrator to cure the breach or end the violation and terminate this Agreement if Claim Administrator does not cure the breach or end the violation within the time specified by Covered Entity;

(ii) Immediately terminate this Agreement if Claim Administrator has breached a material term of this Agreement and cure is not possible; or

(iii) If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(c) **Effect of Termination**. The Parties agree that returning or destroying the PHI is not feasible due to: (1) state or federal regulatory requirements applicable to Claim Administrator and Covered Entity, or (2) Claim Administrator's record retention policies. Therefore, Claim Administrator shall extend the protections of this Agreement to such PHI, limiting further Uses and Disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Claim Administrator maintains such PHI.

(d) **Cure of Non-material Breach.** Covered Entity shall provide an opportunity for Claim Administrator to cure a non-material breach within the time specified by Covered Entity.

5. Miscellaneous.

(a) **Regulatory References**. A reference in this Agreement to a section in the HIPAA Rules (45 C.F.R. Parts 160-64) and HITECH means the section as in effect and the implementing regulations, as issued and amended by the Secretary.

(b) **Amendment**. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of HIPAA and HITECH and as the HIPAA Privacy, Security, and Electronic Transactions Rule may be amended from time to time.

(c) **Survival**. The respective rights and obligations of Covered Entity and Claim Administrator under Section 4(c) of this Agreement shall survive the termination of this Agreement.

(d) **Interpretation.**

(i) Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy, Security, Electronic Transactions Rule and HITECH.

(ii) Any conflict between terms of this Agreement and any other agreement between the Parties concerning the Employer's health welfare benefits plan shall be resolved so that the terms of this Agreement supersede and replace the relevant terms of any such other agreement concerning the confidentiality of GHP data, medical records information, and other records containing PHI.

(e) **Counterparts**. This Agreement may be executed in counterparts, each of which shall be deemed an original, and all of which shall constitute one binding agreement.

(f) **Severability**. The provisions of this Agreement shall be severable, and if any provision of this Agreement shall be held or declared to be illegal, invalid or unenforceable, the remainder of this Agreement shall continue in full force and effect as though such illegal, invalid or unenforceable provision had not been contained.

(g) **Identifying Information**. Employer's and Claim Administrator's respective Privacy Office information is provided in Attachment 2.

IN WITNESS WHEREOF, the Parties hereto have authorized this Agreement to be executed by their respective authorized officers as of December 28, 2012.

County of Los Alamos, Employer [*or Plan Sponsor*] and Employer on behalf of its Group Health Plan, the Covered Entity:	Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company Claim Administrator:
Signature: _____	Signature: Kurt Shipley
Printed Name: Enter the Name of the Person Signing Harry Burgess	Printed Name: Kurt Shipley
Title: Enter the Title of the Person Signing County Administrator	Title: President New Mexico Division

Attachments:
ATTACHMENT 1 - DELEGATION of HITECH BREACH NOTIFICATION
ATTACHMENT 2 - ADDITIONAL INFORMATION FORM

ATTACHMENT 1 – DELEGATION OF HITECH BREACH NOTIFICATION
Claim Administrator Business Associate Agreement

The following Health Information Technology for Economic and Clinical Health Act ("HITECH") Security Breach services will be provided as indicated by Covered Entity on the Claim Administrator Business Associate Agreement, as allowed by the HITECH Act and any subsequent regulation or guidance from the United States Department of Health and Human Services (DHHS):

- Investigate any unauthorized access, use, or disclosure of Group Health Plan member protected health information (PHI).
- Determine whether there is a significant risk of financial, reputational or other harm to any Group Health Plan member as provided for in the HITECH Act.
- Determine whether the incident falls under any of the HITECH Act Security Breach notification exceptions.
- Document and retain each HITECH Security Breach risk assessment and exception analyses, and make this information available to Group Health Plan members upon request.
- Provide Group Health Plan with written notification that describes the HITECH Security Breach incident in detail including a list of the impacted members and/or a copy of a member notification.
- Notify each Group Health Plan member impacted by the HITECH Security Breach by first class mail within the applicable statutory notification period, and provide toll-free numbers to the impacted members in order to handle any member questions regarding the incident. The notification will include the following:
    - A brief description of the incident, including the date of the Security Breach and the date it was discovered;
    - A description of the types of PHI involved in the Security Breach (i.e., name, birth date, home address, account number, Social Security Number, etc.);
    - The steps that individuals might take to protect themselves from potential harm; and
    - A brief description of what the Claim Administrator is doing to mitigate the harm and to avoid further incidents.
- Provide a substitute notice, as described in the HITECH Act, to impacted members if there is insufficient mailing address information.
- Maintain a log and submit to DHHS an annual report of Security Breaches that impact fewer than 500 members.
- Notify DHHS immediately, in the event the Security Breach impacts more than 500 individuals.
- Notify media when required under the HITECH Act and alert Group Health Plan if any such notifications are needed.

NOTE: If Covered Entity does not designate on the Business Associate Agreement which Party will provide the Security Breach services listed above, these services will NOT be provided by Claim Administrator and will be the responsibility of the Covered Entity.

The above listed HITECH Act Security Breach services may be changed from time to time by Claim Administrator as necessary, and as required by the HITECH Act, DHHS regulation and DHHS guidance.

ATTACHMENT 2 – ADDITIONAL INFORMATION FORM
Self Funded Accounts
(Please Print or Type this form)

This document replaces any previous Attachment 2 – Business Associate Agreement Additional Information Documents.

Employer or Plan Sponsor:	**County of Los Alamos**
BCBSNM Account number:	**251305; 288516**
BCBSNM group number(s):	**251306; 288517**

Claim Administrator's Privacy Officer: Thomas C. Lubben
Address: HCSC Privacy Office; PO Box 804836; 300 E. Randolph St., Chicago, IL 60680-4110

Primary Privacy Officer Contact		Alternate Privacy Officer Contact	
Name:	**Kat Brophy**	Name:	**Denise Cassel**
Title:	**Benefits and Pension Manager**	Title:	**Human Resources Manager**
Phone #:	**505-662-8045**	Phone #:	**505-662-8047**
FAX #:	**505-662-8000**	FAX #:	**505-662-8000**
Mailing Address:	**2451 Central Avenue, Suite B**	Mailing Address:	**2451 Central Avenue, Suite B**
City, State, Zip:	**Los Alamos, NM 87544**	City, State, Zip:	**Los Alamos, NM 87544**
e-Mail Address:	**kat.brophy@lacnm.us**	e-Mail Address:	**denise.cassel@lacnm.us**

Authorized Signatory (Form should only be signed by authorized employee of the account)

Name of individual completing this form: **Kat Brophy**

Title of individual completing this form: **Benefits and Pension Manager**

Signature: Kat Brophy Date: 1/17/13

Limitations

Please identify any limitations in any of the following documents that may affect BCBSNM's use or disclosure of protected health information (PHI) in the Group Health Plan's:

(List the limitation or indicate "none")

a. Notice of Privacy Practices (NoPP) None
b. GHP Plan Document None
c. Other: None

HIPAA Individual Rights Requests

Employer or Plan Sponsor:	**County of Los Alamos**
BCBSNM Account number:	**251305; 288516**
BCBSNM group number(s):	**251306; 288517**

Upon receiving a request from a member to exercise one of the following HIPAA Individual Rights requests, should BCBSNM respond directly to the member or direct the member back to the Employer/Group Health Plan (GHP)?

Please select Employer/GHP OR BCBSNM (not Both).

1) Request to Access PHI:	☐ - Employer/GHP	☒ - BCBSNM
2) Request for Disclosure Accounting:	☐ - Employer/GHP	☒ - BCBSNM
3) Request to Amend PHI:	☐ - Employer/GHP	☒ - BCBSNM

Group Health Plan Authorizations

Please identify employees within your organization with whom BCBSNM is authorized to release PHI for Plan Administration functions. Please list by name or job title and indicate any limitations or restrictions on BCBSNM's disclosure of PHI to such employee.

Please list: JOB TITLE, NAME (optional), RESTRICTIONS
enter each position or person on a different line

Benefits and Pension Manager - Kat Brophy

HR Technician - Bernadette Martinez

Payroll Specialist - Kacie Caster

Business Associate Authorizations

Please identify your Business Associates and employees within that organization with whom BCBSNM is authorized to release PHI for HIPAA purposes. Please list company name, employee name or title, and indicate any limitations or restrictions on BCBSNM's disclosure of PHI to such Business Associate.

Please list: COMPANY NAME, JOB TITLE, NAME (optional), RESTRICTIONS
enter each position or person on a different line

Note: It is the Employer's/GHP's responsibility to notify HCSC of any updates to the information provided in this document.

Administered by:

BlueCross BlueShield of New Mexico

County of Los Alamos

Account #: 251305

BluePPO Evolution®

A Guide To Your Group Preferred Provider (PPO) Health Care Plan - Plan 35 & 45

Exhibit B

CUSTOMER ASSISTANCE

Customer Service: Medical/Surgical Claims and Prescription Drugs—The 24/7 Nurseline can help when you have a **health** problem or concern. The 24/7 Nurseline is staffed by registered nurses who are available 24 hours a day, 7 days a week.

24/7 Nurseline toll- free telephone number: 1- 800- 973- 6329

When you have a **non-medical** benefit question or concern, call BCBSNM Monday through Friday from 6 A.M. - 8 P.M. and 8 A.M. - 5 P.M. on Saturdays and most holidays or visit the BCBSNM Customer Service department in Albuquerque. (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 P.M. the next business day.) You may either call toll- free or visit the BCBSNM office in Albuquerque at:

Street address: 4373 Alexander Blvd. NE
Toll- free telephone number: 1- 800- 432- 0750

Send all **written inquiries/preauthorization requests** and submit **medical/surgical claims*** to:

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

Preauthorizations: Medical/Surgical Services and Prescription Drugs—For preauthorization requests, call a Health Services representative, Monday through Friday 8 A.M. - 5 P.M., Mountain Time. Written requests should be sent to the address given above. **Note:** If you need preauthorization assistance between 5 P.M. and 8 A.M. or on weekends, call Customer Service. If you call after normal Customer Service hours, you will be asked to leave a message.

1- 505- 291- 3585 or 1- 800- 325- 8334

Mental Health and Chemical Dependency—For inquiries or preauthorizations related to mental health or chemical dependency services, call the Behavioral Health Unit (BHU):

24 hours/day, 7 days/week: 1-888-898-0070

Send claims* to:

Claims, Behavioral Health Unit
P.O. Box 27630
Albuquerque, New Mexico 87125-7630

Website—For provider network information, BCBSNM Drug List, claim forms, and other information, or to e- mail your question to BCBSNM, visit the BCBSNM website at:

www.bcbsnm.com

*__Exceptions to Claim Submission Procedures__—Claims for health care services received from providers that do not contract **directly** with BCBSNM, should be sent to the Blue Cross and Blue Shield Plan in the state where services were received. **Note: Do not submit drug plan claims to BCBSNM.** See *Section 8: Claim Payments and Appeals* for details on submitting claims.

Be sure to read this benefit booklet carefully and refer to the *Summary of Benefits*.

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

Attachment A

Exhibit B

A message from

County of Los Alamos

Welcome to the Preferred Provider (In-Network-Only) health care benefit plan for eligible employees of **County of Los Alamos** and their eligible family members. Blue Cross and Blue Shield of New Mexico (BCBSNM), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, and an Independent Licensee of the Blue Cross and Blue Shield Association is pleased to serve as the Claims Administrator for the **County of Los Alamos** self-funded health care benefit plan. You will be accessing the worldwide BCBS Preferred Provider network as if you were insured by BCBSNM.

Please take some time to get to know your health care benefit plan coverage, including its benefit limits and exclusions, by reviewing this important document and any enclosures. Learning how this plan works can help make the best use of your health care benefits.

Note: The Plan's benefit administrator (BCBSNM) and **County of Los Alamos** (your group) may change the benefits described in this benefit booklet. If that happens, BCBSNM or **County of Los Alamos** will notify you of those mutually agreed upon changes.

If you have any questions once you have read this benefit booklet, talk to your benefits administrator or call us at the number listed on the back of your ID card, or as listed in *Customer Assistance* on the inside front cover. It is important to all of us that you understand the protection this coverage gives you.

Thank you for selecting BCBSNM for your health care coverage. We look forward to working with you to provide personalized and affordable health care now and in the future.

Note: Under this Plan, you will receive benefits for non-emergency services only if you use a BCBSNM preferred provider. (This network is one of the largest in the state of New Mexico and you will be able to take advantage of the many preferred provider contracts that other Blue Cross Blue Shield Plans have throughout the United States.)

Sincerely,

County of Los Alamos

Revision History: renewing ASO plan with change in plans Jan 2018 with all applicable changes

Attachment A

TABLE OF CONTENTS

SECTION 1: HOW TO USE THIS BENEFIT BOOKLET

This benefit booklet describes the medical/surgical, prescription drug, and mental health/chemical dependency coverage available to members of this health care plan and the Plan's benefit limitations and exclusions.

- Always carry your current Plan ID card issued by BCBSNM. When you arrive at the provider's office or at the hospital, show the receptionist your Plan ID card.
- To find doctors and hospitals nearby, you may use the Internet, make a phone call, or request a hard copy of a directory from BCBSNM. See details in *Section 3: How Your Plan Works.*
- Call BCBSNM (or the Behavioral Health Unit) for preauthorization, if necessary. The phone numbers are on your Plan ID card. See *Section 4: Preauthorizations* for details about the preauthorization process.
- Please read this benefit booklet and familiarize yourself with the details of your Plan *before* you need services. Doing so could save you time and money.
- **In an emergency, call 911 or go directly to the nearest hospital.**

DEFINITIONS

Throughout this benefit booklet, many words are used that have a specific meaning when applied to your health care coverage. When you come across these terms while reading this benefit booklet, please refer to *Section 10: Definitions,* for an explanation of the limitations or special conditions that may apply to your benefits.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

The Summary of Benefits and Coverage is referred to as the *Summary of Benefits* throughout this benefit booklet. The *Summary of Benefits* that shows specific member cost-sharing amounts and coverage limitations of your Medical Program. If you do not have a *Summary of Benefits*, please contact a BCBSNM Customer Service Advocate (the phone number is at the bottom of each page of this benefit booklet). You will receive a new *Summary of Benefits* if changes are made to your health care plan.

IDENTIFICATION (ID) CARD

You will receive a BCBSNM identification (ID) card. The ID card contains your "group" number and your identification number (including an alpha prefix) and tells providers that you are entitled to benefits under this health care plan with BCBSNM.

Carry it with you. Do not let anyone who is not named in your coverage use your card to receive benefits. If you need an additional card or need to replace a lost card, contact a BCBSNM Customer Service Advocate.

PROVIDER NETWORK DIRECTORY

The provider network directory is available through the BCBSNM website at www.bcbsnm.com. It lists all providers in the BCBSNM preferred provider (PPO) network and participating pharmacies. It also provides links to the listings of preferred providers in other states. (If you want a paper copy of a directory, you may request one from Customer Service. It will be mailed to you free of charge.) **Note:** Although provider directories are current as of the date shown at the bottom of each page, they can change without notice. To verify a provider's status or if you have any questions about the directory, contact a Customer Service Advocate or visit the BCBSNM website.

DRUG PLAN BENEFITS

BCBSNM has contracted with a separate pharmacy benefit manager to administer your outpatient drug plan benefits. In addition to your benefit booklet, you will be sent important information about your drug plan benefits. For information specific to your drug plan coverage, see "Prescription Drugs and Other Items" in *Section 5: Covered Services*.

BLUECARD® BROCHURE

As a member of a health plan administered by BCBSNM, you take your health plan benefits with you – across the country and around the world. The BlueCard Program gives you access to preferred providers almost everywhere you travel or live. Almost 90 percent of physicians in the United States contract with Blue Cross and Blue Shield (BCBS) Plans. You and your eligible family members can receive the Preferred Provider level of benefits – even when traveling or living outside New Mexico – by using health care providers that contract as preferred providers with their local BCBS Plan. You should have received a brochure describing this program in more detail. It's a valuable addition to your health care plan coverage. Instructions for locating a preferred provider outside New Mexico are in the brochure or can be found on the BCBSNM website at www.bcbsnm.com.

LIMITATIONS AND EXCLUSIONS

Each provision in *Section 5: Covered Services* not only describes what is covered, but may list some limitations and exclusions that specifically relate to a particular type of service. *Section 6: General Limitations and Exclusions* lists limitations and exclusions that apply to *all* services.

PREAUTHORIZATION REQUIRED

To receive full benefits for some nonemergency admissions and certain medical/surgical services, you or your provider must call the BCBSNM Health Services department **before** you receive treatment. Call Monday through Friday, 8 A.M. to 5 P.M., Mountain Standard Time. See *Section 4: Preauthorization* for details. **Note:** Call Customer Service if you need preauthorization assistance after 5 P.M.

Emergency/Maternity Admission Notification

To receive full benefits for emergency hospital admissions, you or your provider should notify BCBSNM **within 48 hours** of admission, or as soon as reasonably possible following admission. Call BCBSNM's Health Services department, Monday through Friday, 8 A.M. to 5 P.M., Mountain Standard Time. Also, if you have a routine delivery and stay in the hospital **more than 48 hours**, or if you have a C- section delivery and stay in the hospital **more than 96 hours**, you must call BCBSNM for preauthorization before you are discharged.

Written Request Required

If a **written request** for preauthorization is required in order for a service to be covered, you or your provider should send the request, along with appropriate documentation, to:

Blue Cross and Blue Shield of New Mexico
Attn: Health Services Department
P.O. Box 27630
Albuquerque, NM 87125-7630

Please ask your health care provider to submit your request early enough to ensure that there is time to process the request before the date you are planning to receive services.

PREAUTHORIZATION OF BEHAVIORAL HEALTH CARE

All inpatient and specified outpatient mental health and chemical dependency services must be preauthorized by the Behavioral Health Unit (BHU) at the phone number below (also listed on the back of your ID card). For services requiring preauthorization, you or your physician should call the BHU before you schedule treatment. The BHU will coordinate covered services with an in-network provider near you. **If you do not call and receive preauthorization before receiving nonemergency services, benefits for services may be denied**. Call 7 days a week, 24 hours a day:

Toll-Free Phone Number: 1-888-898-0070

PREAUTHORIZATION AND COMPLAINT/APPEAL PROCEDURES

In addition to the summary of complaint and appeal procedures presented in this booklet, you should have a special notice that provides all of the details of the BCBSNM complaint and appeals procedures, including independent external review and other actions that may be available under your health plan. If you do not have the special notice, please call a Customer Service Advocate.

HEALTH AND WELLNESS MAINTENANCE AND IMPROVEMENT PROGRAMS

BCBSNM and your employer have the right to offer programs for the purposes of medical management programs, quality improvement programs, and health behavior wellness, maintenance or improvement over and above the standard benefits provided by this plan. These programs may allow for a reward, a contribution, a disincentive, a differential in premiums or a differential in medical, prescription drug or equipment, copayment, coinsurance, deductibles or costs, or a combination of incentives and/or disincentives for participating in any program offered or administered by BCBSNM or any retailer, provider, or manufacturer chosen by BCBSNM to administer such program. Discounted programs for various health behavior wellness or insurance-related items and services may also be available from time to time. For details of current discounts or other programs available, please contact a customer services representative by calling the phone number on the back of your ID card. Such programs may be discontinued with or without notice. Contact your employer for additional information regarding any value based programs offered by your employer.

For individuals in wellness programs who are unable to participate in these incentives or disincentives due to an adverse health factor shall not be penalized based upon an adverse status and unless otherwise permitted by law. Blue Cross Blue Shield will allow a reasonable alternative to any individual for whom it is unreasonably difficult, due to a medical condition, to satisfy otherwise applicable wellness program standards.

Contact Blue Cross Blue shield for additional information regarding any value based programs offered by Blue Cross Blue Shield.

IDENTITY THEFT PROTECTION SERVICES

As a member, BCBSNM makes available at no additional cost to you identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by BCBSNM's designated outside vendor and acceptance or declination of these services is optional to members. Members who wish to accept such identify theft protection services will need to individually enroll in the program online at www.bcbsnm.com or telephonically by calling the toll free telephone number on your identification card. Services will automatically end when the person is no longer an eligible member. Services may change or be discontinued at any time with or without notice and BCBSNM does not have guarantee that a particular vendor or service will be available given time. The services are provided as a convenience and are not considered covered benefits under this benefit program.

CUSTOMER SERVICE

If you have any questions about your coverage, call or e-mail BCBSNM's Customer Service department. Customer Service Advocates are available Monday through Friday from 6 A.M. - 8 P.M. and 8 A.M. - 5 P.M., Mountain Standard Time on Saturdays and most holidays. 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 P.M. the next business day.

Customer Service representatives can help with the following:

- answer questions about your benefits
- assist with preauthorization requests
- check on a claim's status
- order a replacement ID card, provider directory, benefit booklet, or forms

For your convenience, the toll-free customer service number is printed at the bottom of every page in this benefit booklet. Refer to Customer Assistance on the inside cover of this booklet for important phone numbers, website, and mailing information. You can also e-mail the Customer Service unit via the BCBSNM website noted below:

In addition to accepting e-mail inquiries, the BCBSNM website contains valuable information about BCBSNM provider networks, the BCBSNM Drug List, and other Plan benefits. It also has various forms you can print off that could save you time when you need to file a claim.

Website: www.bcbsnm.com

Behavioral Health Customer Service

When you have questions about your behavioral health benefits, call the BCBSNM Behavioral Health Unit (BHU) for assistance.

Toll-free: 1-888-898-0070

Deaf and Speech Disabled Assistance

Deaf, hard-of-hearing, and speech disabled callers may use the New Mexico Relay Network. Dialing **711** connects the caller to the state transfer relay service for TTY and voice calls.

Translation Assistance

If you need help communicating with BCBSNM, BCBSNM offers Spanish bilingual interpreters for members who call Customer Service. If you need multi-lingual services, call the Customer Service phone number on the back of your ID card.

After Hours Help

If you need or want help to file a complaint outside normal business hours, you may call Customer Service. Your call will be answered by an automatic phone system. You can use the system to:

- leave a message for BCBSNM to call you back on the next business day
- leave a message saying you have a complaint or appeal
- talk to a nurse at the 24/7 Nurseline right away if you have a health problem

24/7 Nurseline

If you can't reach your doctor, the free 24/7 Nurseline will connect you with a nurse who can help you decide if you need to go to the emergency room or urgent care center, or if you should make an appointment with your doctor. The Nurseline will also give you advice if you cannot reach your doctor and he or she can't see you right away when you think you might have an urgent problem. To learn more, call:

Toll-free: 1-800-973-6329

BCBSNM also has a phone library of more than 1000 health topics available through the Nurseline, including over 600 topics available in Spanish.

Special Beginnings®

This is a maternity program that helps you better understand and manage your pregnancy. You should enroll in the program within three months of becoming pregnant, by calling:

Toll-free: 1-888-421-7781

BLUE ACCESS FOR MEMBERS℠

To help members track claim payments, make health care choices, and reduce health care costs, BCBSNM maintains a flexible array of online programs and tools for health care plan members. The online "Blue Access for Members" (BAM) tool provides convenient and secure access to claim information and account management features and the Cost Estimator tool. While online, members can also access a wide range of health and wellness programs and tools, including a health assessment and personalized health updates. To access these online programs, go to www.bcbsnm.com, log into Blue Access for Members and create a user ID and password for instant and secure access.

If you need help accessing the BAM site, call:

BAM Help Desk (toll-free): 1- 888- 706- 0583
Help Desk Hours: Monday through Friday 6 A.M. - 9 P.M., Mountain Standard Time
Saturday 6 A.M. - 2:30 P.M. Mountain Standard Time.

Note: Depending on your group's coverage, you may not have access to all online features. Check with your benefits administrator or call Customer Service at the number on the back of your ID card. BCBSNM uses data about program usage and member feedback to make changes to online tools as needed. Therefore, programs and their rules are updated, added, or terminated, and may change without notice as new programs are designed and/or as our members' needs change. We encourage you to enroll in BAM and check the online features available to you - and check back in as frequently as you like. BCBSNM is always looking for ways to add value to your health care plan and hope you will find the website helpful.

HEALTH CARE FRAUD INFORMATION

Health care and insurance fraud results in cost increases for health care plans. You can help; always:

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

If you suspect fraud, contact the BCBSNM Fraud Hotline at 1- 888- 841- 7998.

SECTION 2: ENROLLMENT AND TERMINATION INFORMATION

WHO IS ELIGIBLE

Unless otherwise specified in the Administrative Services Agreement, all active employees who have completed the employee probationary period and who are regularly working the minimum number of hours specified in the Administrative Services Agreement and their eligible family members are eligible for coverage. (No such probationary period may exceed 90 days unless permitted by applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations. If BCBSNM records show that your group has a probationary period that exceeds the time period permitted by applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations, then BCBSNM reserves the right to begin your coverage on a date that BCBSNM believes is within the required period. Regardless of whether BCBSNM exercises that right, your group is responsible for your probationary period. If you have questions about your probationary period or the number of hours you must work per week or to learn of any other eligibility criteria specified by your group, contact your benefits administrator.)

BCBSNM may request proof that a valid employer-employee relationship exists, if applicable, and/or that the applicant meets the eligibility requirements stated in the Administrative Services Agreement and the member's application.

No eligibility rules or variations in premium will be imposed on you based on your specific health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status-related factor. You will not be discriminated against for coverage under this Plan on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes, or benefits of this policy that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives, and/or other programs do not constitute discrimination.

See "Re- Enrollment" in this section for important information if you or an eligible family member were previously enrolled in a health care plan administered by BCBSNM.

ELIGIBLE FAMILY MEMBERS

Covered family member, covered spouse, covered child - An eligible spouse or eligible child (as defined below) who has applied for and been granted coverage under the subscriber's policy based on his/her family relationship to the subscriber.

Eligible family members - Family members of the subscriber, limited to the following persons:

- the subscriber's legal **spouse**
- the subscriber's eligible **child** through the end of the month in which the child reaches **age 26** (Once a covered child reaches age 26, the child is automatically removed from coverage and rates adjusted accordingly - unless the child is an eligible family member under this Plan due to a disability as described below.)
- the subscriber's **unmarried** child age 26 or older who was enrolled as the subscriber's covered child in this health plan at the time of reaching the age limit, and who is medically certified as **disabled,** chiefly dependent upon the subscriber for support and maintenance, and incapable of self-sustaining employment by reason of his/her disability. Such condition must be certified by a physician and BCBSNM. Also, a child may continue to be eligible for coverage age 26 or older only if the condition began before or during the month in which the child would lose coverage due to his/her age. BCBSNM must receive written notice of the disabling condition within 31 days of the child's attainment of the limiting age and subsequently, as may be required by BCBSNM, but not more frequently than annually after the two-year period following the Child's attainment of the limiting age of 26.

Eligible child - The following family members of the subscriber through the end of the month during which the child turns age 26:

- natural or legally adopted child of the subscriber

- child placed in the subscriber's home for purposes of adoption (including a child for whom the subscriber is a party in a suit in which the adoption of the child by the subscriber is being sought)
- stepchild of the subscriber
- child for whom the subscriber must provide coverage because of a court order or administrative order pursuant to state law

A child meeting the criteria above is an "eligible child" whether or not the subscriber is the custodial or noncustodial parent, and whether or not the eligible child is claimed on income tax, employed, married, attending school or residing in the subscriber's home, **except** that:

- once the subscriber is no longer a legal guardian of a child or there is no longer a court order to provide coverage to a child, the child must be eligible as a natural child, legally adopted child, or stepchild of the subscriber in order to retain eligibility as a family member under this health plan.

County of Los Alamos may require acceptable proof (such as copies of income tax forms, legal adoption or legal guardianship papers, or court orders) that an individual qualifies as an eligible family member under this coverage. Unless listed as an eligible family member, no other family member, relative or person is eligible for coverage as a family member.

Information for Noncustodial Parents

When a child is covered by the Plan through the child's noncustodial parent, the **County of Los Alamos** will:

- provide such information to the custodial parent as may be necessary for the child to obtain benefits through the Plan;
- permit the custodial parent or the provider (with the custodial parent's approval) to submit claims for covered services with the approval of the noncustodial parent; and
- make payments on claims submitted in accordance with the above provision directly to the custodial parent, the provider, or the state Medicaid agency, if applicable.

MEDICARE- ELIGIBLE MEMBERS

Shortly before you turn age 65 or qualify for Medicare benefits for other reasons, you are responsible for contacting the local Social Security office to establish Medicare eligibility. You should then contact your benefits administrator to discuss coverage options.

If an active employee qualifies under the provisions of federal law for the working aged (TEFRA), then the working employee age 65 or older and/or his/her eligible spouse age 65 or older who is covered by Medicare may continue this Plan coverage as primary over Medicare until the eligible employee retires.

A member under age 65 receiving Medicare benefits due to disability or end- stage renal disease (ESRD) also has primary benefits under this Plan coverage, but for only a limited period of time. (For ESRD patients, this Plan coverage is primary only during the CMS- defined ESRD coordination time period - usually 30 months after the start of dialysis. Medicare becomes primary when the Medicare ESRD coordination time period expires.)

In any case, if you are a Medicare beneficiary and you actively *select* Medicare as your primary coverage, this Plan is **not** available to you, and your employer may not offer you any other employer- sponsored health care plan.

Refer to a Medicare Handbook or contact the Social Security Administration for more information and eligibility guidelines that apply to you.

APPLYING FOR COVERAGE

An eligible person can apply for coverage, including for his/her eligible family members, by submitting an enrollment/change form to **County of Los Alamos within 31 days** after becoming eligible according to the terms of the Administrative Services Agreement**. Note: County of Los Alamos** cannot use genetic information or require genetic testing in order to determine or to limit or deny coverage.

WHEN COVERAGE BEGINS

County of Los Alamos will determine your effective date of coverage according to the provisions of the Administrative Services Agreement.

This Plan does not cover any service received before your effective date of coverage (which, for eligible family members, may be later than the subscriber's effective date). Also, if your prior coverage has an extension of benefits provision, this Plan will not cover those charges incurred after your effective date that are covered under the prior benefit plan.

CHANGES TO COVERAGE

After initial enrollment, you may need to add eligible family members to, or remove them from your coverage, update your address, or switch from Individual to Family coverage, or vice versa.

Your ability to change coverage types (e.g., from Family to Individual coverage, etc.) will depend on the rules and regulations set forth by your employer. Please contact your employer to find out when you can change your coverage type or remove a person from your coverage.

ADDING A FAMILY MEMBER TO COVERAGE

A subscriber may apply for coverage of an eligible family member (such as a new spouse or a newborn child). **Within 31 days** of acquiring the newly eligible family member, the subscriber must:

- request that the employer notify BCBSNM of the change,
- complete and submit all necessary enrollment/change forms and legal documentation of proof of dependency, and
- pay any additional premium or other employee contribution for coverage, which may mean changing, for example, from Individual to Family coverage.

Adding a Spouse

If a subscriber adds coverage for a spouse **within 31 days** of marriage, the effective date of the new eligible family member's coverage will be no later than the first of the month following the date your group received the completed and signed enrollment/change application form. If the subscriber does not submit a completed and signed enrollment/change application form to his/her benefits administrator or to BCBSNM (or to the COBRA administrator), along with necessary documentation and, if required, change from Individual (or Employee + Child(ren) coverage, if applicable) to Family coverage **within 31 days** of marriage, the spouse may not be added to coverage except as a late applicant (unless specified under "Special Enrollment" later in this section). You may also have the option of applying for a Two-Person (Employee + Spouse) coverage type. Ask your employer which coverage types are available to you. For example, if you are applying for coverage for a new spouse and his/her eligible child(ren), you will have to change to Family coverage. See "Adding an Eligible Child," below.

Adding an Eligible Child

If you do not submit an application for an eligible child or add additional coverage, if required, within the time frames below, the child will be considered a **late applicant**, except as specified under "Special Enrollment."

Newborn Children

If Family coverage (or Employee/Children coverage, if available) is in effect, a newborn, natural child is covered from birth. (You should, however, submit an application to add the newborn as an eligible child as soon as possible after birth.) If, for example, Family coverage is not in effect, you must add coverage for the newborn **within 31** days of the birth in order for newborn care to be covered beyond day 31, (e.g., If an Employee + Children coverage type is not available to your group, you would need to switch to Family coverage.). In any case, if the application is not received **within 31** days and additional premium or other employee contributions for coverage, if any, are not paid, the newborn is considered a late applicant.

Note: If the parent of the newborn is an eligible child of the subscriber (i.e., the newborn is the subscriber's grandchild), benefits are **not** available for the newborn.

Adopted Children

A child placed in the subscriber's home for the purposes of adoption may be added to coverage as soon as the child is placed in the home. However, application for coverage can be made as late as **31 days** following legal adoption without being considered late. (Although a child over the age of 18 is not eligible for adoption, an adopted child is covered as any other child, subject to the same eligible child age limitations and restrictions.) **Note:** An adopted child who is not enrolled within 31 days of adoption or placement in the home will be considered a late applicant unless the child was previously enrolled in a group health plan or other creditable coverage within 30 days of his/her adoption or placement for adoption and has had prior creditable coverage since that date with no significant lapse (i.e., 63 or more days).

Legal Guardianship

Application for coverage must be made for a child for whom the subscriber or the subscriber's spouse becomes the legal guardian **within 31 days** of the court or administrative order granting guardianship.

Stepchild

Application for coverage must be made for a stepchild **within 31 days** of the marriage to the stepchild's biological parent.

Court Ordered Coverage for Children

When an employee or employer is required by a court or administrative order to provide coverage for an eligible child, the eligible child may be enrolled in the subscriber's Family coverage, or Employee/Children coverage, if available and will **not** be considered a late applicant. (If the subscriber has Individual or Two- Person coverage, he/she may be required to pay additional premium in order for the eligible child to be added.) If not specified in the court or administrative order, the eligible child's effective date of coverage will be the date the order has been filed as public record with the State or the effective date of Family coverage, or Employee/Children coverage, if available, whichever is later. **County of Los Alamos** must receive a copy of the court or administrative order.

LATE APPLICANT

Unless eligible for a special enrollment, applications from the following enrollees will be considered late:

- anyone not enrolled **within 31 days** of becoming eligible for coverage under this Plan (e.g., a newborn child added to coverage more than 31 days after birth when, for example, Family coverage (or Employee/Children coverage, if available) is not already in effect, a child added more than 31 days after legal adoption, or a new spouse or stepchild added more than 31 days after marriage)
- anyone enrolling on the group's initial BCBSNM enrollment date who was not covered under the group's prior plan (but who was eligible for such coverage)
- anyone eligible but not enrolled during the group's initial enrollment
- anyone who voluntarily terminates his/her coverage and applies for reinstatement of such coverage at a later date (except as provided under USERRA of 1994)

Application for coverage from late applicants will be accepted only during your group's annual open enrollment period, except as described under "Special Enrollment for Active Employees and Their Eligible Family Members" and under "Switch Enrollment and Changes in Plan," provision of this plan.

OPEN ENROLLMENT

Open enrollment is the period prior to the group's anniversary date (ask your employer when your group's open enrollment period is held). During the annual open enrollment period, any eligible employee and his/her eligible family members may enroll as members under this Plan.

Late applicants may not enroll until the next annual open enrollment period.

SWITCH ENROLLMENT AND CHANGES IN PLAN

If your employer offers employees more than one choice of health plan, your Plan choice can only be changed outside open enrollment if you, as an active employee or eligible family member of an active employee, are eligible for a special enrollment. (See "Special Enrollment for Active Employees and Their Eligible Family Members" for details.)

During an Open Enrollment Period

During an open enrollment period, the subscriber and his/her eligible family members may change coverage to one of the other health care plans for which the subscriber meets eligibility requirements. This is the only period of time during which a member may "voluntarily" change from one health care plan to another for which he/she is eligible.

Outside the Open Enrollment Period

If you or your covered family member must change to another health care plan being offered by the employer because of a change in the subscriber's residency (i.e., moving outside an HMO service area) or family status (i.e., a special enrollment qualifying event), an enrollment/change form must be submitted to County of Los Alamos as soon as possible (or, for continuation members, the COBRA administrator). Your effective date under the new health plan will be the first of the month following your change in eligibility status. If you are switching to another health plan due to a special enrollment, the effective date of change is explained below.

SPECIAL ENROLLMENT FOR ACTIVE EMPLOYEES AND THEIR COVERED FAMILY MEMBERS

There are four instances ("qualifying events") in which an eligible person can obtain a "special enrollment" right (see definition in *Section 10: Definitions.* You have a limited amount of time during which you may request a special enrollment. If you do not request special enrollment **within the time period specified below,** you will be considered a late applicant.

Note: There are no special enrollments for persons applying for any continuation or conversion coverage if offered under your Plan. You must enroll in these coverages timely.

Qualifying Events

The four instances of special enrollment are:

Loss of Prior Coverage

An eligible employee who declined coverage when initially eligible because of having other comprehensive medical coverage and who later *involuntarily* loses the other coverage (or who reaches a lifetime maximum under the prior benefit plan), may apply for coverage for himself/herself and eligible family members. (The eligible family members need not have been covered under the prior benefit plan when the employee has been granted a special enrollment under this provision.) Currently enrolled employees may also add eligible family members to coverage under this provision if the eligible family member had prior creditable coverage that was involuntarily lost or had reached a lifetime benefit maximum under the other carrier's benefit plan. (See definition of "involuntary loss of coverage" in *Section 10: Definitions.")*

If a completed and signed enrollment/change form is received by the employer **within 31 days** of losing the other coverage (or **within 31 days** of receiving the first denial notice informing the employee or eligible family member that he/she had reached a lifetime limit), the applicant(s) will **not** be considered late.

Documentation from the prior carrier - supporting the fact that the person had prior creditable coverage that was lost involuntarily - may be submitted at a later date with the employer's approval, but the employee must submit the completed and signed enrollment/change form **within 31 days** of the loss of coverage (or denial notice). **Note:** Enrollment changes cannot be processed until **all documentation** is provided to the employer.

If the employee lost prior coverage, special enrollment is available to the current employee and any eligible family members of the employee (including spouse). If an eligible family member of the current employee lost prior coverage, special enrollment is available for the affected eligible family member and the employee (not other eligible family members). The choice to quit paying premiums, for example, because the subscriber or one family member under the other carrier's benefit plan reaches a lifetime benefit maximum in **not** an example of involuntary loss of coverage for the entire family. However, in the case of one eligible

family member losing prior coverage, although all family members may not be eligible for a "special" enrollment, eligible family members may be enrolled at the same time as the special enrollee, subject to late applicant provisions. Also, in order to be eligible for a special enrollment due to loss of prior coverage, the declining person must have completed a waiver of coverage statement when first eligible to enroll, and the reason stated for declining coverage must have been due to having other coverage. If an employee requests a special enrollment for self only, eligible family member(s) only, or both, BCBSNM requires proof of loss of coverage or proof of the date of the event.

Change in Family Status

An employee who acquires a new eligible family member due to marriage, birth, adoption, or placement for adoption may apply for a special enrollment in this Plan for himself/herself **and other family members** who are eligible for coverage under this Plan. Application for special enrollment of the employee and his/her eligible family members will **not** be considered late if submitted **within 31 days** of the marriage, birth, adoption, or placement of the eligible child in the subscriber's home. If submitted more than 31 days following the change in family status, special enrollment is not available.

- **Newborn or Adopted Child:** For a change in family status due to birth of an eligible newborn or adoption of a child, coverage begins on the date of birth or adoption (or, if earlier, on the date of placement in the subscriber's home).
- **Marriage:** The effective date of coverage for all persons granted a special enrollment due to marriage will be the same as the new spouse's effective date of coverage as described under "Adding An Eligible Family Member to Coverage."

This right to special enrollment upon a change in family status applies to the employee and to all eligible family members.

Loss of Medicaid/SCHIP Eligibility

If an eligible employee or his/her eligible family member is not currently enrolled in the Plan and loses eligibility under Medicaid or under a state child health plan (SCHIP), the person losing such coverage may enroll in the Plan without being considered a late applicant. To be eligible for special enrollment, the person must apply for coverage under the group health plan no later than **60 days** after the date of termination of Medicaid or SCHIP coverage. (In order for an eligible family member to be eligible for special enrollment, the employee must be covered under the employer group health plan. If the employee is not enrolled in the Plan when the eligible family member becomes eligible for assistance, the employee must enroll into the Plan at the same time as the eligible family member.) Documentation from the state - supporting the fact that the person had Medicaid/SCHIP coverage that was lost involuntarily - may be submitted at a later date with the employer's approval, but the employee must submit the completed and signed enrollment/change form within **60 days** of the loss of coverage. **Note:** Enrollment changes cannot be processed until **all documentation** is provided to the employer.

If the employee lost Medicaid/SCHIP coverage, special enrollment is available to the current employee and any eligible family members of the employee (including spouse). If an eligible family member of the current employee lost Medicaid/SCHIP coverage, special enrollment is available for the affected eligible family member and the employee (not other eligible family members).

Medicaid/SCHIP Group Health Plan Premium Assistance Eligibility

A state may offer premium subsidies through Medicaid or a state child health plan (SCHIP) to low-income children and their families for qualified employer-sponsored coverage. This includes premium assistance for continuation coverage under federal or state law. Therefore, if an eligible employee or an eligible family member is not enrolled in the Plan and later becomes eligible for group health plan premium assistance under Medicaid or under SCHIP, the eligible person may enroll in the Plan without being considered a late applicant. To be eligible for special enrollment, the affected person must apply for coverage through the employer no later than **60 days** after becoming eligible for premium assistance. (In order for a family member to be eligible for special enrollment, the employee must be covered under the employer's health plan. If the employee is not enrolled in the Plan when the eligible family member becomes eligible for assistance, the employee must enroll in to the Plan at the same time as the eligible family member.)

Documentation from the state - supporting the fact that the person is eligible for premium assistance from Medicaid or SCHIP - may be submitted at a later date with the employer's approval, but the employee must submit the completed and signed enrollment/change form **within 60 days** of the affected person's premium assistance eligibility date. **Note**: Enrollment changes cannot be processed until **all documentation** is provided to the employer.

The current employee who is eligible but not enrolled for coverage under the terms of the group health plan (or a dependant of such an employee who is eligible but not enrolled for group health plan coverage under such terms) may enroll in the group health plan upon becoming eligible for a state premium assistance subsidy under Medicaid or SCHIP if special enrollment is requested in a timely manner.

Applying for Special Enrollment

Application for special enrollment must be made **within the time period specified for each of the qualifying events above** in order to qualify you and/or your eligible family member(s) for a special enrollment right (switch enrollment may be available to members who are offered more than one Plan option). Please contact your benefits administrator for details about special enrollment privileges that apply to you and your eligible family members.

Waiving Coverage

If an employee declines to enroll in this group health plan when initially eligible to do so, the employee must sign a waiver of coverage statement and submit it to the employer. **It is very important that the employee indicate the reason for declining coverage.** If the employee declined coverage due to having other health care coverage and later involuntarily loses the other coverage, the employee and his/her eligible family members may be eligible to enroll in the employer's group plan as "special enrollees." An employee waiver of coverage statement, indicating that coverage is being declined due to having coverage, must be submitted to the employer **within 31 days** of becoming eligible for coverage under the employer's health care plan. If you later lose the other coverage and wish to enroll in the Plan as a result, you will also need to submit proof that you had the required creditable coverage.

If you do not enroll an eligible family member when he/she is initially eligible, you do not need to sign a waiver of coverage statement. However, if the affected family member later loses the other coverage and requests a special enrollment, you *will* need to submit proof that the family member had the required creditable coverage.

If the person declining coverage later requests a special enrollment, but no such proof of loss or prior coverage is provided, or if the reason for declining coverage is *not* due to having other coverage, he/she will be ineligible for special enrollment. If the person chooses to enroll anyway, the person will be considered a late applicant.

Coverage Effective Date

If a member is granted a special enrollment due to involuntary loss of coverage, due to premium assistance eligibility, or due to marriage, and the required documentation is received timely by the employer, coverage will begin no later than the first day of the month after the employer received the request for special enrollment. However, for a change in family status due to birth of an eligible newborn or adoption of a child, coverage begins on the date of birth or adoption.

If a completed and signed enrollment/change form is **not** received within the time periods set forth in this section, the employee and /or his/her eligible family members will be considered late applicants and no special enrollment right will be available.

RE- ENROLLMENT

If a previously covered employee and/or eligible family member is re- enrolled in this group Plan, he/she will usually be considered a late applicant. See "Leave of Absence or Military Service" and "Special Enrollment" for exceptions and details.

Any individual whose previous BCBSNM contract was terminated for good cause is not eligible to re- enroll in this Plan, unless approved in writing by BCBSNM. (Members currently enrolled in continuation coverage may not re- enroll once coverage is terminated, unless eligibility under this Plan is re- established.)

If coverage is voluntarily discontinued by a COBRA member, the terminated member may not re-enroll at any time.

NOTIFICATION OF ELIGIBILITY AND ADDRESS CHANGES

The subscriber must notify **County of Los Alamos within 31 days** following any changes that may affect his/her or a family member's eligibility, including a change to a covered family member's name or address, by indicating such changes on an enrollment/change form and submitting it to **County of Los Alamos.** You can obtain this form at BCBSNM's website at www.bcbsnm.com, from your benefits administrator, or by calling the BCBSNM Customer Service department. (Members covered under federal continuation must submit enrollment/change forms directly to the COBRA administrator.)

Employees and Their Eligible Family Members

Employees covered under the group Plan are responsible for completing and submitting signed enrollment/change forms to your employer.

State Continuation Coverage

Employees covered under the group Plan are responsible for completing and submitting signed enrollment/change forms to BCBSNM.

COBRA Continuation Policy Members

If you are covered under a COBRA continuation policy, you must contact the COBRA administrator. The name, address, and phone number of the administrator will be provided to you should you elect COBRA coverage.

COVERAGE TERMINATION

Unless stated otherwise, if you do not elect or do not qualify for continuation coverage (see "How to Continue Coverage"), coverage ends at the end of the month following the earliest of the date:

- The employee **terminates employment** or **otherwise loses eligibility** according to the terms of the Administrative Services Agreement. If the group or subscriber fails to notify BCBSNM **within 30 days** to remove an ineligible person from coverage, BCBSNM may recover any payment made on the ineligible person's behalf.
- When the **premium payment** or other employee contribution for coverage is not received on time. (Coverage will be suspended if premium is not paid when it is due. If premium is not received **within 30 days** after its due date, the group or affected member(s) will be terminated at the end of the last- paid billing period. Any claims received and paid for during the 30- day grace period will be billed both to the subscriber and to the group or, in the case of continuation coverage, to the subscriber.)
- When the member begins a **leave of absence** or enters the **armed forces** for **more than 30 days** or as provided by law. (See "Leave of Absence or Military Service.")
- When the **member materially fails to abide by the rules,** policies, or procedures of this Plan or fraudulently provides or materially misrepresents information affecting coverage. If a member knowingly gave false material information in connection with the eligibility or enrollment of the subscriber or any of his/her eligible family members, **County of Los Alamos** may terminate the coverage of the subscriber and his/her eligible family members retroactively to the date of initial enrollment. The subscriber is liable for any benefit payments made as a result of such improper actions.
- When the subscriber **dies**. (Surviving eligible family members remain covered through the last- paid billing period.)
- If this Plan is primary over **Medicare** due to federal laws and regulations, when the Medicare- eligible member *chooses* Medicare as his/her primary coverage. (See "Medicare- Eligible Members" for information on coverage options for members who are entitled to Medicare.)
- When the member acts in a **disruptive** manner that prevents the orderly business operation of any network provider or dishonestly attempts to gain a financial or material advantage.
- When **group coverage is discontinued** for the entire group or for the employee's enrollment classification.
- When **County of Los Alamos** gives BCBSNM or BCBSNM gives **County of Los Alamos** a minimum **30 days' advance written notice**.

Additional Family Member Termination Reasons

In addition, coverage will end for any family member on the earliest of the above dates or the earliest of the following dates:

- at the end of the **last- paid billing period** for Family coverage;
- at the end of the month when a child **no longer qualifies as an eligible child** under the Plan (e.g., a child is removed from placement in the home or reaches the eligible child age limit);
- at the end of the month following the date of a final **divorce** decree or **legal separation** for a spouse;
- at the end of the month when the subscriber gives a minimum **30 days' advance notice** in writing to end coverage for a covered family member(s), according to the rules of your Plan as established by your employer.

If a family member is being removed from coverage because of losing his/her eligibility under the Plan (for reasons other than reaching the eligible child age limit), the enrollment/change form must be received by BCBSNM **within 31 days** following the effective date of the change. In these cases, the member will be removed from coverage as of the end of the month following the change in his/her eligibility status and payroll deductions will be properly adjusted, if necessary. BCBSNM and the providers of care may recover benefits erroneously paid on behalf of the removed member.

Voluntary Termination of Coverage

To remove a family member from coverage before loss of eligibility or to voluntarily terminate his/her own coverage, the subscriber must submit a completed enrollment/change form to his/her benefits administrator. If voluntary termination is allowed under your Plan outside the annual renewal period, coverage will end the first of the month following receipt of the enrollment/change form. Voluntarily terminated members may re- enroll under the Plan only as late applicants (except as provided under "Special Enrollment"). Also, these members are **not** eligible for any extension of benefits or federal or state continuation or conversion coverage. Voluntarily terminated members may apply for individual coverage offered by BCBSNM; a health statement will be required and the application may be denied.

Termination of Continuation Coverage

See "How to Continue Coverage" for more information.

Leave of Absence or Military Service

Coverage will end for a subscriber and his/her eligible family members at the end of the month during which the leave began. During a leave of absence covered by the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), coverage will continue as provided by law. Contact your benefits administrator for information.

HOW TO CONTINUE COVERAGE

If you lose coverage under this Plan, you may be able to continue coverage for a limited period of time. **Note:** There is no special enrollment under these provisions. You must enroll timely to qualify for continued coverage.

Continuation Coverage

Your group may be subject to the provisions for continuation of plan coverage under federal law (COBRA or USERRA). If so, employees and their covered family members who lose eligibility under this group health care plan may be able to continue as members, without a health statement, for a limited period of time by purchasing the continuation coverage described below. You must pay premiums from the date of loss of group coverage.

You are not eligible to enroll for continuation coverage if:

- the employer stops offering this coverage to its employees, *or*
- you do not elect continuation coverage in a timely fashion.

In addition, if you elect state continuation coverage, you may not later enroll in federal continuation coverage. Refer to *Appendix A: Continuation Coverage Rights under COBRA* or contact your benefits administrator for details about enrolling in continuation coverage.

Continuation Benefits

Continuation coverage is identical to the coverage a similarly situated regular member has. If the coverage for regular members changes, your continuation coverage will reflect the same change. For example, if the Plan's deductible or other cost- sharing amounts change for regular members, yours will change by the same amount.

Federal Continuation (COBRA)

Unless approved in writing by BCBSNM, the following persons may **not** enroll in this continued coverage option:

- one who **voluntarily** terminated coverage while still eligible (*Involuntary termination* includes loss of coverage under the following situations only: legal separation, divorce, loss of eligible child eligibility status, death of the subscriber, termination of employment, reduction in hours, or termination of employer contributions. Any other reason is considered voluntary.)
- a covered family member who was removed from coverage by the subscriber while the family member was still eligible
- any member whose BCBSNM health care coverage was terminated for good cause

Continuation coverage under federal law ends on the **earliest** of the following dates or any of the applicable dates listed under "Coverage Termination" earlier in this section:

- the first of the month when you become entitled to Medicare
- when the employer discontinues offering this Plan to employees (If this Plan is replaced by another health care plan, continuation coverage will also be replaced by the new Plan.)
- when you become covered under another group health care plan
- when the continuation period expires (If this employer's Plan is still being administered by BCBSNM, you will have the option of changing to the conversion coverage provided by BCBSNM and described under "Conversion to Individual Coverage.")

State Continuation Coverage

A subscriber and his/her covered family members may continue Plan coverage for six months after losing coverage for any reason other than nonpayment of premiums or termination of the entire group, if your group is eligible for such coverage. (See your Benefits Administrator for more information.) BCBSNM must receive the application for state continuation coverage **within 30 days** after group coverage is lost. (A health statement is not required.)

State continuation coverage ends on the **earliest** of the following dates or of the applicable dates listed under "Coverage Termination" earlier in this section:

- when the employer discontinues offering this Plan to employees (If this Plan is replaced by another health care plan, continuation coverage will also be replaced by the new Plan.)
- when the continuation period expires (If this employer's Plan is still being administered by BCBSNM, you will have the option of changing to the conversion coverage provided by BCBSNM and described under "Conversion to Individual Coverage.")

If you are entitled to both Parts A and B of Medicare, your state continuation coverage option is limited to a Medicare Supplement Plan administered by BCBSNM. (The options for members under age 65 are limited.) Call a Customer Service Advocate for more information.

Premium Payments

Subscribers under federal COBRA continuation coverage must pay premiums to the COBRA administrator. Subscribers under state continuation coverage pay premiums to BCBSNM. Contact your benefits administrator for an application for coverage and details.

USERRA Continuation Coverage

Employees and their covered family members who lose group coverage because the employee is absent from work due to military service may be able to continue coverage for **up to 24 months** after the absence begins. Contact your benefits administrator for details about the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

CONVERSION TO INDIVIDUAL COVERAGE

Involuntarily terminating members may change to individual conversion coverage if this employer group health plan is still in effect and coverage is lost due to one of the following circumstances:

- termination of employment
- a member no longer meets the eligibility requirements of the Administrative Services Agreement
- the period of continuation coverage expires
- a covered family member loses coverage for one of the following reasons:
  - — divorce or legal separation from the subscriber
  - — disqualification of the member under the definition of an eligible family member
  - — death of the subscriber
  - — an employee becomes primary under Medicare — leaving eligible family members without coverage

The subscriber and any eligible family members *who were covered* at the time that group coverage was lost are eligible to apply for conversion coverage without a health statement.

BCBSNM must receive your application for conversion coverage **within 31 days** after you lose eligibility under the group/continuation Plan. **You must pay conversion coverage premiums from the date of such termination.**

Conversion coverage is **not** available in the following situations:

- when group coverage under this Plan was discontinued for the entire group or the employee's enrollment classification
- when you reside outside of or move out of New Mexico. (Call BCBSNM for details on transferring coverage to the Blue Cross Blue Shield Plan in the state where you are living.)

If you are entitled to Medicare, your conversion coverage option is limited to a Medicare Supplement Plan administered by BCBSNM. (The options for members under age 65 are limited.) Call a Customer Service Advocate for the enrollment options available to you.

The benefits and premiums for conversion coverage will be those available to terminated health care plan members on your coverage termination date. You will receive a new benefit booklet if you change to conversion coverage. (Some benefits of this Plan are not available under conversion coverage.) Contact a Customer Service Advocate for details.

SECTION 3: HOW YOUR PLAN WORKS

BENEFIT CHOICES

This is a health care plan that provides benefits under agreement with an exclusive network of preferred providers. When you need nonemergency health care that is covered under this Plan, **you must choose a provider from the Blue Cross and Blue Shield "Preferred Provider Organization (PPO)" network in order to receive benefits.**

At A Glance

Preferred Provider Services
•You must use preferred providers except in an emergency and specified situations described under "Exceptions for Nonpreferred Providers" later in this Section.
•You pay an annual deductible or, in some cases, a fixed-dollar amount (copayment) for a covered service.
•You have an annual out-of-pocket limit.
•The preferred provider is responsible for filing claims for you directly to the local Blue Cross and Blue Shield Plan.
•The preferred provider will not bill you for amounts above the covered charge, which may be less than the billed charge. The "covered charge" is the amount that BCBSNM determines is fair and reasonable allowance for a particular covered service. After your share of a covered charge (e.g., deductible, copayment, and/or penalty amount) has been calculated, BCBSNM pays the remaining amount of the covered charge, up to maximum benefit limits, if any.
•Preferred providers that contract **directly** with BCBSNM are responsible for requesting all necessary preauthorizations for you. (Providers that contract with another BCBS Plan usually call for preauthorization on your behalf, but you will be responsible for making sure that preauthorization is obtained when required. If you do not obtain preauthorization, benefits may be reduced or denied.)

PREFERRED PROVIDERS VERSUS NONPREFERRED PROVIDERS

Preferred Providers are health care professionals and facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, or another BCBS Plan as "preferred" or "PPO" providers. These providers have agreed to provide health care for preferred providers' members and accept the Plan's payment for a covered service plus the member's share of the covered charge (i.e., deductible, copayment and/or penalty amount, if any) as payment in full.

Nonpreferred Providers are providers that have not contracted with BCBSNM, either directly or indirectly, to be part of the "preferred" or "PPO" provider network. (These providers may have "participating" provider agreements, but are **not** considered preferred. See "Filing Claims" in *Section 8: Claim Payments and Appeals* for more information.) **Unless listed as an exception under "Exceptions for Nonpreferred Providers," services of nonpreferred providers are not covered.**

When you receive treatment, schedule a surgery or admission, ask each of your providers if he/she is a preferred provider. (A physician's or other provider's contract may be separate from the facility's contract.)

Unless listed under "Exceptions for Nonpreferred Providers," benefits are not available for nonemergency services received from a nonpreferred provider.

Covered Charges
*For covered charges related to claims from providers that contract directly with BCBSNM, see "Covered Charges" in *Section 8: Claims Payments and Appeals.*
*For covered charges related to claims from out-of-network providers, see "Exceptions for Nonpreferred Providers" later in this *Section 3: How Your Plan Works.*
*For covered charges related to claims from providers outside New Mexico, see "BlueCard" in *Section 8: Claims Payments and Appeals.*

PROVIDER DIRECTORY AND ONLINE PROVIDER FINDER®

When you need medical care, there are a variety of ways you can choose a Primary Preferred Provider (PPP) or other preferred provider in your area. You can also access mental health providers (including those specializing in chemical dependency) and participating pharmacies. **Note:** Only those providers listed under Family Practice, General Practice, Internal Medicine, Gynecology, Obstetrics/Gynecology and Pediatrics are considered Primary Preferred Providers (PPPs). See "Cost- Sharing Features," later in this section for details.

Whichever method you choose, the provider directory gives each provider's specialty, the language spoken in the office, the office hours, and other information such as whether the office is handicapped accessible. (To find this information on the website directory, click on the doctor's name once you have found one you want to know more about.) The website directory also gives you a map to the provider's office.

Although provider directories are current as of the date shown at the bottom of each page of a printed directory or as of the date an Internet site was last updated, the network and/or a particular provider's status can change without notice. To verify a provider's current status, request a current directory, request a paper copy of a directory (free of charge), or if you have any questions about the directory, contact a BCBSNM Customer Service Advocate. It is also 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.

Web-Based BCBSNM Provider Finder

To find a Preferred Provider in New Mexico or along the border of neighboring states, please visit the *Provider Finder* section of the BCBSNM website for a list of network providers:

www.bcbsnm.com

The website is the most up-to-date resource for finding providers and also has an Internet link to the national Blue Cross and Blue Shield Association website for service outside New Mexico. Website directories also include maps and directions to provider locations.

Paper Provider Network Directory

If you want a paper copy of a *BCBSNM Preferred Provider Network Directory*, you may request one from BCBSNM Customer Service and it will be mailed to you free of charge. You may also call BCBSNM and request a paper copy of a BCBS provider directory from another state.

Finding a Pharmacy

To find a participating pharmacy, visit the Prime Therapeutics website at:

www.MyPrime.com

Click on *Find a Pharmacy*. You will then be asked to select from a list of BCBS Plans. **You must select "Blue Cross and Blue Shield of New Mexico"** and then select **"Other BCBSNM Plans"** in order to get the correct list of participating pharmacies for this health plan. After you have selected "Blue Cross and Blue Shield of New Mexico" as your health plan administrator, you will be able to locate participating pharmacies throughout the United States based on zip code or state name. You may also request a paper copy of the list of participating pharmacies by calling a Customer Service Advocate at BCBSNM.

Providers Outside New Mexico

Out- of- state providers that contract with their local Blue Cross and/or Blue Shield Plan and international providers that contract with the Blue Cross and Blue Shield Association as **Preferred Providers** are also eligible for the "Preferred Provider" level of benefits for covered services, including fixed-dollar copayment amounts listed on the *Summary of Benefits.* **Note:** Providers who have a "participating- only" contract are **not** preferred providers and you will not receive benefits when receiving services from participating- only providers. You must use **preferred providers** in order to obtain the higher benefit (unless listed under **"Exceptions for Nonpreferred Providers,"** later in this section).

You have a number of ways to locate a Preferred Provider in the United States or around the world:

BCBSNM Website

If you have an Internet connection, go to the BCBSNM website at www.bcbsnm.com, click on "Provider Finder→" and then select the line entitled "Providers located outside New Mexico." You will then be linked to
the Blue Cross Blue Shield Association's BlueCard Doctor and Hospital Finder.

BCBSNM website: www.bcbsnm.com

National Website

Visit the Blue Cross and Blue Shield Association website at www.bcbs.com and click on the national "BlueCard Doctor and Hospital Finder," then select "Find a Doctor or Hospital." Follow the instructions.

Blue Cross and Blue Shield Association website:

www.bcbs.com (or www.bluecares.com)

National Phone Number

Call BlueCard Access→ at the phone number below for the names and addresses of doctors and hospitals in the area where you or an eligible family member need care. When you call, a BlueCard representative will give you the name and telephone number of a local provider (you will be asked for the zip code in the area of your search) who will be able to call Customer Service for eligibility information and will submit a claim for the services provided to the local BCBS Plan. Call:

1-800-810-BLUE (2583)

International Assistance

Call the BlueCard Worldwide Service Center at one of the phone numbers **below**, 24 hours a day, 7 days a week, for information on doctors, hospitals, and other health care professionals or to receive 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. If you need to be hospitalized, call BCBSNM for preauthorization. You can find the preauthorization phone number on your ID card. **Note:** The phone number for preauthorization is different from the following phone numbers, which are strictly for locating a Preferred Provider while outside the United States:

1-800-810-BLUE (2583) or call collect: 1-804-673-1177

Exceptions for Nonpreferred Providers

There are four instances in which the services of a nonpreferred provider may be eligible for coverage:

Emergency Care

If you visit a nonpreferred provider for emergency care services, you will receive benefits for the initial treatment, which includes emergency room services and, if you are hospitalized **within 48 hours** of an emergency, the related inpatient hospitalization. (Office/urgent care facility services are not considered "emergency care" for purposes of this provision.)

For follow- up care (which is no longer considered emergency care)and for all other nonemergency care, you will receive no benefit for the services of a nonpreferred provider, except as specified below. (See "Emergency and Urgent Care" in *Section 5: Covered Services* for more information.)

Ancillary Providers

Once you have obtained preauthorization for an inpatient admission to a preferred hospital or treatment facility, your preferred physician or hospital will make every effort to ensure that you receive ancillary services from other preferred providers. If you receive covered services from a **preferred** physician for outpatient surgery or inpatient medical/surgical care in a preferred hospital or treatment facility, services of a nonpreferred radiologist, anesthesiologist or pathologist will be paid at the preferred provider level and you will not be responsible for any amounts over the covered charge (these are the only three specialties covered under this provision).

If a **nonpreferred** surgeon provides your care or you are admitted to a nonpreferred hospital or other treatment facility, you **will** be responsible for any services received from other nonpreferred providers during the admission or procedure.

Unsolicited Providers

In some states, the local BCBS Plan does not offer preferred provider contracts to certain types of providers (e.g., home health care agencies, chiropractors, ambulance providers). These provider types are referred to as "unsolicited providers." The types of providers that are unsolicited varies from state to state. If you receive covered services from an "unsolicited provider" outside New Mexico, you will receive benefits for those services. **However, the unsolicited provider may still bill you for amounts that are in excess of covered charges. You will be responsible for these amounts, in addition to your deductible and/or copayment.**

Transition of Care

This provision applied to both continuity of care and transition of care. 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 provider 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 30 days. (If necessary and ordered by the treating provider, BCBSNM may also authorize transitional care from other out-of-network providers.) An ongoing course of treatment will include, but is not limited to: (1) Treatment for a life-threatening condition, defined as a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted; (2) Treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, radiation therapy or post-operative visits; (3) The second or third trimester of pregnancy, through the postpartum period; or (4) An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes. 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 30 days. Call the BCBSNM Customer Service department for details.

If medically necessary covered services are not available through network professional providers, BCBSNM and the network professional will refer you to an out-of-network professional. However, the payment for the out-of-network provider will **not** exceed the payment that would have been made in the absence of any referral.

Members who extend coverage under an extension of benefits due to disability after the group contract is terminated are not eligible to receive prior authorization for services of an out-of-network provider. Services of an out-of-network provider are not covered in such instances of extended coverage.

These are the only instances in which services of a nonpreferred provider will be covered.

CALENDAR YEAR

A calendar year is a period of one year which begins on January 1 and ends on December 31 of the same year. The initial calendar year is from a member's effective date of coverage through December 31 of the same year, which may be less than 12 months.

BENEFIT LIMITS

There is no general lifetime maximum benefit under this Plan. However, certain services have separate benefit limits per admission or per calendar year. (See the *Summary of Benefits* for details.)

Benefits are determined based upon the coverage in effect on the day a service is received, an item is purchased, or a health care expense is incurred. For inpatient services, benefits are based upon the coverage in effect on the date of admission, except that if you are an inpatient at the time your coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date.

COST- SHARING FEATURES

For some services, you will pay only a fixed-dollar amount copayment for covered charges and/or you will have to meet a deductible (preferred providers will not bill you for amounts in excess of the covered charge). When you receive

a number of services during a single visit or procedure, you may have to pay both a copayment and a deductible (if applicable) of the covered charges that are not included in the copayment. Refer to your *Summary of Benefits* for details.

YOUR DEDUCTIBLE

Your deductible (if applicable) is the amount of covered charges that you must pay in a calendar year before this Plan begins to pay its share of the covered charges you incur during the same calendar year. If the deductible amount remains the same during the calendar year, you pay it only once each calendar year, and it applies to covered services subject to the deductible and applicable copayment you receive during that calendar year.

Individual Deductible

The individual deductible (if applicable) is listed on the *Summary of Benefits*. Once a member's deductible payments for covered services reach the individual deductible amount, this Plan will begin paying its share of that member's covered charges for the rest of the calendar year.

Family Deductible

An entire family meets the annual deductible, if applicable, when the total deductible amount for all family members reaches the amount specified on your separately issued *Summary of Benefits*. (The deductible amounts for three or more family members are combined to satisfy the family deductible.) **Note:** If a member's Individual deductible is met, no more charges incurred by that member may be used to satisfy the Family deductible.

What Is Not Subject to the Deductible

Drug plan copayments are not applied to the annual deductible.

Admissions Spanning Two Calendar Years

If a deductible has been met while you are an inpatient and the admission continues into a new calendar year, no additional deductible is applied to that admission for covered services. However, all other services received during the new calendar year are subject to the deductible for the new calendar year.

Timely Filing Reminder

Most benefits are payable only after BCBSNM's records show that the applicable deductible has been met. Preferred providers and providers that have "participating- only" provider agreements with BCBSNM will file claims for you and must submit them within a specified amount of time (usually 180 days). If you file your own claims for covered services from nonparticipating providers (see "Exceptions for Nonpreferred Providers," earlier in this section), you must file them **within 12 months** of the date of service. If a claim is returned for further information, resubmit it **within 45 days.** See *Section 8: Claim Payments and Appeals* for details.

COPAYMENTS

Copayments are the fixed-dollar amount of a covered charge that you pay for certain services as specified on the separately issued *Summary of Benefits*.

Office Visit Copayment

When you receive **office services** from a preferred provider, you pay only a fixed- dollar amount (or copayment), for his/her covered **office visit charge**. The copayments for "Primary Preferred Provider" (PPP) and PPO Specialist office visits are listed on the *Summary of Benefits.* However, all other services received during the office visit (such as physical therapy or chemotherapy) will be subject to regular deductible requirements and/or to an additional copayment as listed on the *Summary of Benefits.*

Besides office visits, other services are also subject to a copayment amount. See the *Summary of Benefits.*

Primary Preferred Provider (PPP) is a preferred provider in one of the following medical specialties **only**: Family Practice; General Practice; Internal Medicine; Obstetrics/Gynecology; Gynecology; or Pediatrics. PPPs do **not** include physicians specializing in any other fields such as Obstetrics only, Geriatrics, Pediatric Surgery or Pediatric Allergy.

Preferred (PPO) Specialist is a practitioner of the healing arts who is in the Preferred Provider Network – but does not belong to one of the specialties defined above as being for a "Primary Preferred Provider" (or "PPP"). A PPO Specialist does not include hospitals or other treatment facilities, urgent care facilities, pharmacies, equipment suppliers, ambulance companies, or similar ancillary health care providers.

Drug Plan Copayment

When you purchase covered prescription drugs and other items through the drug plan, your responsibility may be either a fixed- dollar amount or a percentage of the covered charge. (You may also have to pay the difference between the cost of a brand- name drug and its generic equivalent.) In either case, drug plan copayments are **not** subject to the deductible or out-of-pocket limit provisions. See "Prescription Drugs and Other Items" for more information about the drug plan.

OUT- OF- POCKET LIMIT

For **Nongrandfathered** plans, the out- of- pocket limit is the maximum amount of deductible and copayments that you pay for most covered services in a calendar year. After the out- of- pocket limit is reached, this Plan pays 100 percent of most of your covered charges for the rest of the calendar year, not to exceed any benefit limits.

Individual Limits

Once your deductible and copayment amounts reach the individual amount indicated on the *Summary of Benefits,* this Plan pays 100 percent of most of your covered charges for the rest of the calendar year.

Family Limits

An entire family meets the out- of- pocket limit during a calendar year when the total deductible and copayments for all family members reaches the amount specified in the *Summary of Benefits*. (When a member meets the Individual out- of- pocket limit, no more charges incurred by that member may be used to satisfy the Family out- of- pocket limit.)

What Is Not Included in the Out- of- Pocket Limits

The following amounts are **not** applied to the out- of- pocket limits and are **not** eligible for 100 percent payment under this provision:

- penalty amounts
- amounts in excess of covered charges (including amounts in excess of annual or lifetime benefit limits, if applicable)
- noncovered expenses (including services in excess of annual or lifetime day/visit limits)

See the Summary of Benefits for your deductible amounts, copayments and out- of- pocket limit amounts.

CHANGES TO THE COST- SHARING AMOUNTS

Copayments, coinsurance, deductibles, and out- of- pocket limits may change during a calendar year. If changes are made, the change applies only to services received after the change goes into effect (for inpatient services, benefits are determined based on the date you are admitted to the facility). You will be notified if changes are made to this Plan.

If your group increases the deductible or out- of- pocket limit amounts during a calendar year, the new amounts must be met during the same calendar year. For example, if you have met your deductible and your group changes to a higher deductible, you will not receive benefit payments for services received after the change went into effect until the increased deductible is met.

If your group decreases the deductible or out- of- pocket limit amounts, you will not receive a refund for amounts applied to the higher deductible or out- of- pocket limit.

SECTION 4: PREAUTHORIZATIONS

You or your provider must obtain preauthorization from BCBSNM *before* you are admitted as an inpatient or receive certain types of services.

In order to receive benefits:

- services must be covered and medically necessary;
- services must not be excluded; and
- the procedures described in this section must be followed regardless of where services are rendered or by whom.

Preauthorization determines only the medical necessity of a specific service and/or an admission and an allowable length of stay. **Preauthorization does not guarantee your eligibility for coverage, that benefit payment will be made, or that you will receive 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 Plan, and services that are not medically necessary will be denied.

Medically Necessary/Medical Necessity is defined as health care services determined by a provider, in consultation with BCBSNM, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by BCBSNM consistent with such federal, national and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease.

Please note:

Preauthorization is a requirement that you or your provider must obtain authorization from BCBSNM before you are admitted as an inpatient and *before* you receive certain types of services.

Even when this Plan is not your primary coverage, these preauthorization procedures must be followed. **Failure to do so may result in a reduction or in a denial of benefits.**

Most preauthorization requests will be evaluated and you and/or the provider notified of BCBSNM's decision **within 15 days** of receiving the request (**within 24 hours** for urgent care requests). If requested services are not approved, the notice will include: 1) the reasons for denial; 2) a reference to the health care plan provisions on which the denial is based; and 3) an explanation of how you may appeal the decision if you do not agree with the denial (see *Section 8: Claims Payments and Appeals*).

Retroactive approvals will not be given, except for emergency and maternity-related admissions, and you may be responsible for the charges if preauthorization is not obtained **before** the service is received.

How the Preauthorization Procedure Works

When you or your provider call, BCBSNM's Health Services representative 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 representative will evaluate the information and notify the requesting provider (usually at the time of the call) if benefits for the proposed hospitalization or other services are preauthorized. If the admission or other services are not preauthorized, you may appeal the decision as explained in *Section 8: Claims Payments and Appeals*.

BCBSNM PREFERRED PROVIDERS

If the attending physician is a preferred provider that contracts **directly** with BCBSNM, obtaining preauthorization is not your responsibility — it is the provider's. Preferred providers contracting with BCBSNM must obtain **preauthorization** from BCBSNM (or from the Behavioral Health Unit (BHU), when applicable) in the following circumstances:

- when recommending any nonemergency admission, readmission, or transfer

- when a covered newborn stays in the hospital longer than the mother
- before providing or recommending a service listed under "Other Preauthorizations," later in this section
- before recommending that you go to a nonpreferred provider for whose services you expect to receive benefits (Such requests may be denied.)

Note: Providers that contract with other Blue Cross and Blue Shield Plans are not familiar with the preauthorization requirements of BCBSNM. Unless a provider contracts directly with BCBSNM as a preferred provider, the provider is not responsible for being aware of this Plan's preauthorization requirements.

NONPREFERRED PROVIDERS OR PROVIDERS OUTSIDE NEW MEXICO

If any provider outside New Mexico (except for those contracting as preferred providers directly with BCBSNM) or any Nonpreferred Provider recommends an admission or a service that requires preauthorization, the provider is **not** obligated to obtain the preauthorization for you. In such cases, it is **your** responsibility to ensure that preauthorization is obtained. If authorization is **not** obtained **before** services are received, **your benefits for covered services will be reduced for some services or you will be entirely responsible for the charges.** The provider may call on your behalf, but it is **your responsibility** to ensure that BCBSNM is called. **Remember:** Nonpreferred providers are covered only for emergency care and in those specific circumstances described in *Section 3: How Your Plan Works.*

INPATIENT PREAUTHORIZATION

Preauthorization is required for all admissions **before** you are admitted to the hospital or other inpatient treatment facility (e.g., skilled nursing facility, residential treatment center, physical rehabilitation facility, long-term acute care (LTAC). If you are receiving services at an out-of-network facility (or from an in-network facility outside New Mexico) and you do not obtain authorization within the time limits indicated in the table below, benefits for covered facility services will be **reduced or denied** as explained under "Penalty for Not Obtaining Inpatient Preauthorization," in this section.

Type of inpatient admission, readmission, or transfer:	When to obtain inpatient admission preauthorization:
Nonemergency	**Before** the patient is admitted.
Emergency, nonmaternity	**Within 48 hours** of the admission. If the patient's condition makes it impossible to call within 48 hours, call as soon as possible.
Maternity-related (including eligible newborns when the mother is not covered)	**Before the mother's maternity due date**, soon after pregnancy is confirmed. BCBSNM must be notified as soon as possible if the mother's stay is greater than 48 hours for a routine delivery or greater than 96 hours for a C-section delivery.
Extended stay, newborn (an eligible newborn stays in the hospital longer than the mother)	**Before the newborn's mother is discharged.**

Penalty for Not Obtaining Inpatient Preauthorization

If you or your provider **do not receive preauthorization** for inpatient benefits, but you choose to be hospitalized anyway, **no** benefits may be paid or partial payment may be made, as indicated in the table below:

If, based on a review of the claim:	Then:
The admission was **not for a covered service**.	Benefits for the facility and all related services will be **denied.***
The admission was for an item listed under **"Other Preauthorizations,"** (e.g., air ambulance).	Benefits for the facility and all related services will be **denied.***
The admission was for any other covered service but hospitalization was **not medically necessary**.	Benefits will be **denied** for **room, board,** and **other charges** that are not medically necessary.*
The admission was for a **medically necessary covered service.**	Benefits for the facility's covered services will be reduced by $400.*

*The admission review penalty of $400 and charges for noncovered and denied services are **not applied** to any deductible or out- of- pocket limit. You are responsible for paying this amount for out-of-network services.

Inpatient preauthorization requirements may affect the amounts that this Plan pays for inpatient services, but they do not deny your right to be admitted to any facility and to choose your services.

OTHER PREAUTHORIZATIONS

In addition to preauthorization review for all nonemergency inpatient services, preauthorization is required for the services listed below. Most preauthorizations may be requested over the telephone. If a *written* request is needed, have your provider call a Health Services representative for instructions for filing a written request for preauthorization. An out-of-network provider, or an out-of-state network provider may call on your behalf, but it is **your responsibility** to ensure that BCBSNM is called. Preferred providers that contract **directly** with BCBSNM are responsible for requesting all necessary preauthorizations for you. (See "Inpatient Preauthorization" for further information regarding inpatient preauthorization requirements.)

If preauthorization is not obtained for the following services and all related services, the service will be reviewed for medical necessity and subject to one of the following actions in the chart below:

No Preauthorization Received	Claim Disposition: In-Network	Claim Disposition: Out-of-Network
Service is medically necessary	Claim is paid based on member's benefit plan	Claim is paid based on member's benefit plan
Service is **not** medically necessary	**Claim is denied; member held harmless**	**Claim is denied; member responsible for payment**

- **air ambulance** services (unless during a medical emergency)
- **Applied Behavioral Analysis (ABA)**
- **PET scans**; **cardiac CT scans**; **MRIs**
- **enteral nutritional products, special medical foods,** and **certain drugs** covered under "Prescription Drugs and Other Items;"
- **home infusion therapy (HIT),** excluding antibiotics
- **hospice**
- certain **injections,** including but not limited to **intravenous immunoglobulin** (**IVIG**)
- nonemergency or **elective hospital** or other facility admissions
- **psychological testing; neuropsychological testing; electroconvulsive therapy (ECT); intensive outpatient program (IOP)** treatment and repetitive transcranial magnetic stimulation
- **molecular genetic testing**
- **diagnostic sleep studies for obstructive sleep apnea**
- **radiation therapy**
- **transplant procedures** including pretransplant evaluations

All services, including those for which preauthorization is required, must meet the standards of medical necessity criteria described in *Section 5: Covered Services,* "Medically Necessary Services," and will not be covered, if excluded, for any reason. **Some services requiring preauthorization may not be approved for payment** (for example, due to being experimental, investigational, unproven, or not medically necessary). The complete list of services requiring preauthorization is subject to review and change by BCBSNM.

The preauthorization requirements noted above do not apply to mandated benefits, unless permitted by law and stated in the provisions of a specific mandated benefit. The medical necessity requirements noted above do not apply to mandated benefits, unless permitted by law.

It is strongly recommended that you request a predetermination for benefits for high-cost services in order to reduce the likelihood of benefits being denied *after* charges are incurred. See "Advance Benefit Information/Predetermination" later in this section for further information.

Preauthorization of Mental Health/Chemical Dependency Services

All inpatient mental health and chemical dependency services must be preauthorized by the BCBSNM Behavioral Health Unit (BHU) at the phone number listed on the back of your ID card. Preauthorization is also required for applied behavior analysis (ABA) therapies, outpatient psychological testing, neuropsychological testing, intensive outpatient program (IOP) treatment, and electroconvulsive therapy (ECT) for treatment of mental disorder and/or chemical dependency. Preauthorization is **not** required for outpatient/office group, individual, or family therapy visits to a physician or other professional provider licensed to perform covered services under this health plan.

For services needing preauthorization, you or your health care provider should call the BHU **before** you schedule treatment. **NOTE:** Your provider may be asked to submit clinical information in order to obtain preauthorization for the services you are planning to receive. Services may be authorized or may be denied based on the clinical information received. (*Clinical information* is information based on actual observation and treatment of a particular patient.)

If you or your provider do not call for preauthorization of nonemergency **inpatient** services, benefits for covered, medically necessary inpatient facility care may be reduced by an amount that is equal to the preauthorization (or admission review) penalty, if any, indicated for medical/surgical admissions. If inpatient services received without preauthorization are determined to be not medically necessary or not eligible for coverage under your Plan for any other reason, the admission and all related services will be denied. In such cases, **you may be responsible for all charges.**

If preauthorization is **not** obtained before you receive psychological testing, IOP treatment, neuropsychological testing, or electroconvulsive therapy, repetitive transcranial magnetic stimulation, or applied behavior analysis (ABA) therapies, your claims may be denied as being **not medically necessary.** In such cases, **you may be responsible for all charges.** Therefore, you should make sure that you (or your provider) have obtained preauthorization for outpatient services *before* you start treatment.

Use the chart below to determine the appropriate contact for your situation.

Summary of Contact Information for Preauthorization, Customer Service, Claim Submission, and Appeal (or Reconsideration) Processes for Medical/Surgical and Behavioral Health Services:			
Process:	**Type of service:**	**Phone:**	**Send to:**
Request preauthorization	Medical/surgical	1-800-325-8334	Send to P.O. number listed on inside cover.
	Mental health/chemical dependency	1-888-898-0070	BH Unit P.O. Box 27630, Albuquerque, NM 87125-7630
Customer Service inquiry	Medical/surgical	1-800-432-0750	Send to P.O. number listed on inside cover.
	Mental health/chemical dependency	1-888-898-0070	BH Unit P.O. Box 27630 Albuquerque, NM 87125-7630
Submit claim (post-service)	Medical/surgical		Send claim to P.O. number listed on inside cover.
	Mental health/chemical dependency		BH Unit P.O. Box 27630 Albuquerque, NM 87125-7630

Request **appeal** or reconsideration of **claim** or **preauthorization** decision	Medical/surgical	1-800-205-9926	BCBSNM Appeals Unit P.O. Box 27630 Albuquerque, NM 87125-9815
	Mental health/chemical dependency	1-888-898-0070	BCBSNM Appeals Unit P.O. Box 27630 Albuquerque, NM 87125-9815
Grievance Assistance - Office of Superintendent of Insurance (OSI), Managed Health Care Bureau	Medical/surgical; Mental health/ chemical dependency	1-855-427-5674	OSI P.O. Box 1689 Santa Fe, NM 87504-1689

ADVANCE BENEFIT INFORMATION/PREDETERMINATION

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

UTILIZATION REVIEW/QUALITY MANAGEMENT

Medical records, claims, and requests for covered services may be reviewed to establish that the services are/were medically necessary, delivered in the appropriate setting, are consistent with the condition reported and with generally accepted standards of medical and surgical practice in the area where performed and according to the findings and opinions of BCBSNM's professional consultants. Utilization management decisions are based only on appropriateness of care and service. BCBSNM does not reward providers or other individuals conducting utilization review for denying coverage or services and does not offer incentives to utilization review decision- makers to encourage underutilization.

SECTION 5: COVERED SERVICES

This section describes the services and supplies covered by this group health care plan, subject to the limitations and exclusions in *Section 3: How Your Plan Works* and *Section 6: General Limitations and Exclusions*. All payments are based on covered charges as determined by BCBSNM.

Reminder: It is to your financial advantage to receive care from preferred providers.

MEDICALLY NECESSARY SERVICES

A service or supply is medically necessary when it is provided to diagnose or treat a covered medical condition, is a service or supply that is covered under this Plan, and is determined by BCBSNM's medical director (in consultation with your provider) to meet all of the following conditions:

- it is medical in nature;
- it is recommended by the treating physician;
- it is the most appropriate supply or level of service, taking into consideration:
  - potential benefits;
  - potential harms;
  - cost, when choosing between alternatives that are equally effective; and
  - cost effectiveness, when compared to the alternative services or supplies.
- it is known to be effective in improving health outcomes as determined by credible scientific evidence published in the peer- reviewed medical literature (for established services and supplies, professional standards and expert opinion may also be taken into account); and
- it is not for the convenience of the member, the treating physician, the hospital, or any other health care provider.

All services must be eligible for benefits as described in this section, not listed as an exclusion and must meet all of the conditions of "medically necessary" as defined above in order to be covered.

Note: Because a health care provider prescribes, orders, recommends, or approves a service does not make it medically necessary or make it a covered service, even if it is not specifically listed as an exclusion. BCBSNM, at its sole discretion, will determine medical necessity based on the criteria above.

AMBULANCE SERVICES

This Plan covers ambulance services in an emergency (e.g., cardiac arrest, stroke). When you cannot be safely transported by any other means in a nonemergency situation, this Plan also covers medically necessary ambulance transportation to a hospital with appropriate facilities, or from one hospital to another.

Air Ambulance

Ground ambulance is usually the approved method of transportation. This Plan covers air ambulance only when terrain, distance, or your medical condition requires the use of air ambulance services or for high- risk maternity and newborn transport to tertiary care facilities. To be covered, nonemergency air ambulance services require **preauthorization** from BCBSNM.

BCBSNM determines on a case- by- case basis when air ambulance is covered. If BCBSNM determines that ground ambulance services could have been used, benefits are limited to the cost of ground ambulance services.

Exclusions

This Plan does **not** cover:

- commercial transport, private aviation, or air taxi services
- services not specifically listed as covered, such as private automobile, public transportation, or wheelchair ambulance
- services ordered only because other transportation was not available, or for your convenience

AUTISM SPECTRUM DISORDERS

For a member **19 years old or younger** (or, if enrolled in high school, 22 years old or younger), this Plan covers the habilitative and rehabilitative service of autism spectrum disorder through speech therapy, occupational therapy, physical therapy, and applied behavioral analysis (ABA). Providers must be credentialed to provide such therapy.

Treatment must be prescribed by the member's treating physician in accordance with a treatment plan. Treatment must be **preauthorized** by BCBSNM to determine that the services are to be performed in accordance with such a treatment plan; if services are received but were not approved as part of the treatment plan, benefits for services will be denied. Services not preauthorized by BCBSNM must be performed in accordance with a treatment plan and must be medically necessary or benefits for such services will be denied. **Note:** Habilitative services are defined as occupational therapy, physical therapy, speech therapy and other health care services that help you keep, learn, or improve skills and functioning for daily living, as prescribed by your physician pursuant to a treatment plan. Examples include therapy for a child who isn't walking or talking at the expected age and includes therapy to enhance the ability of a child to function with a congenital, genetic or early acquired disorder. There services may include physical therapy and occupational therapy, speech language pathology, or other services for people with disabilities in a variety of inpatient and/or outpatient settings, with coverage as described in this booklet.

Services are subject to usual member cost-sharing features such as deductible, coinsurance, copayments, and out-of-pocket limits - based on place of treatment, type of service, and whether preauthorization was obtained from BCBSNM. All services are subject to the *General Limitations and Exclusions* except where explicitly mentioned as being an exception. For example, certain autism spectrum disorder services are excepted from the "Medical Policy Determinations" exclusion, but such services are **not** excepted from exclusions such as the "Pre-Existing Conditions" exclusions (for children over age **19**). This benefit is subject to the other general provisions of the health plan, including but not limited to: coordination of benefits, participating provider agreements, restrictions on health care services, including review of medical necessity, case management, and other managed care provisions.

Regardless of the type of therapy received, claims for services related to autism spectrum disorder should be mailed to BCBSNM - **not** to the behavioral health services administrator.

Exclusions

This Plan does **not** cover:

- any experimental, long-term, or maintenance treatments unless listed above
- medically unnecessary or nonhabilitative services under any circumstance
- any services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children 3 to 22 years old who have autism spectrum disorder
- services not in accordance with a treatment plan
- respite services or care
- Sensory Integration Therapy (SIT) or Auditory Integration Therapy (AIT)
- music therapy, vision therapy, or touch or massage therapy
- floor time
- facilitated communication
- elimination diets; nutritional supplements; intravenous immune globulin infusion; secretin infusion
- chelation therapy
- hippotherapy, animal therapy, or art therapy

DENTAL- RELATED SERVICES AND ORAL SURGERY

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

Dental and Facial Accidents

Benefits for covered services for the treatment of accidental injuries to the jaw, mouth, face or sound natural teeth are generally subject to the same limitations, exclusions and member cost- sharing provisions that would apply to similar services when not dental- related (e.g., x- rays, medical supplies, surgical services).

To be covered, *initial* treatment for the accidental injury must be sought **within 72 hours** of the accident and any services required after the initial treatment must be associated with the initial accident in order to be covered. (For treatment of TMJ or CMJ injuries, see "TMJ/CMJ Services.")

Facility Charges

This Plan covers inpatient and outpatient hospital expenses for dental-related services **only** if the patient is under age six or has a nondental, hazardous physical condition (e.g., heart disease or hemophilia) that makes hospitalization medically necessary. All hospital services for dental-related and oral surgery services must be **preauthorized** by BCBSNM. **Note:** The dentist's services for the procedure will not be covered unless listed as eligible for coverage in this section.

Reminder: If hospital covered services are recommended by a nonpreferred (out-of-network) provider, you are responsible for assuring that your provider obtains preauthorization for outpatient covered services or benefits may be reduced or denied. (See *Section 4: Preauthorizations*.)

Oral Surgery

This Plan covers the following oral surgical procedures only:

- medically necessary orthognathic surgery
- external or intraoral cutting and draining of cellulitis (not including treatment of dental- related abscesses)
- incision of accessory sinuses, salivary glands or ducts
- lingual frenectomy
- removal or biopsy of tumors or cysts of the jaws, cheeks, lips, tongue, roof or floor of mouth when pathological examination is required

TMJ/CMJ Services

This Plan covers standard diagnostic, therapeutic, surgical and nonsurgical treatments of temporomandibular joint (TMJ) and craniomandibular joint (CMJ) disorders or accidental injuries. Treatment may include orthodontic appliances and treatment, crowns, bridges or dentures **only if** required because of an accidental injury to sound natural teeth involving the temporomandibular or craniomandibular joint.

Exclusions

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

- surgeon's or dentist's charges for noncovered dental services
- hospitalization or general anesthesia for the patient's or provider's convenience
- any service related to a dental procedure that is not medically necessary
- any service related to a dental procedure that is excluded under this Plan for reasons other than being dental- related, even if hospitalization and/or general anesthesia is medically necessary for the procedure being received (e.g., cosmetic procedures, experimental procedures, services received after coverage termination, work- related injuries, etc.)
- nonstandard services (diagnostic, therapeutic, or surgical)
- removal of tori, exostoses, or impacted teeth
- procedures involving orthodontic care, the teeth, dental implants, periodontal disease, noncovered services, or preparing the mouth for dentures
- duplicate or "spare" appliances

- personalized restorations, cosmetic replacement of serviceable restorations, or materials (such as precious metals) that are more expensive than necessary to restore damaged teeth
- dental treatment or surgery, such as extraction of teeth or application or cost of devices or splints, unless required due to an accidental injury and covered under "Dental and Facial Accidents" or "TMJ/CMJ Services"
- dentures, artificial devices and/or bone grafts for denture wear, including implants

DIABETIC SERVICES

Diabetic persons are entitled to the same benefits for medically necessary covered services as are other members under the health care plan. For special coverage details, such as for insulin, glucose monitors and educational services, refer to the applicable provisions as noted below. **Note:** This Plan will also cover items not specifically listed as covered when new and improved equipment, appliances and prescription drugs for the treatment and management of diabetes are approved by the U.S. Food and Drug Administration.

For insulin and over- the- counter diabetic supplies, including glucose meters, see "Prescription Drugs and Other Items."

For durable medical equipment, see "Supplies, Equipment and Prosthetics."

For educational services and diabetes management services, see "Physician Visits/Medical Care."

EMERGENCY CARE AND URGENT CARE

Emergency Care

This Plan covers medical or surgical procedures, treatment or services delivered after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to his/her health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part, or disfigurement. (In addition, services must be received in an emergency room, trauma center, or ambulance to qualify as an emergency.) Examples of emergency conditions include, but are not limited to: heart attack or suspected heart attack, coma, loss of respiration, stroke, acute appendicitis, severe allergic reaction, or poisoning.

Emergency Room Services

Use of an emergency center for nonemergency care is NOT covered. However, services will not be denied if you, in good faith and assessing average knowledge of health and medicine, seek care for what reasonably appears to be an emergency — even if your condition is later determined to be nonemergency.

Acute emergency care is available 24 hours per day, 7 days a week. If services are received in an emergency room or other trauma center, the condition and treatment must meet the definition of emergency care in order to be covered. Services received in an emergency room that do not meet the definition of emergency care may be reviewed for appropriateness and may be denied.

If you visit a nonpreferred provider for emergency care, the preferred provider benefit is applied only to the initial treatment, which includes emergency room services and, if you are hospitalized **within 48 hours** of an emergency, the related inpatient hospitalization. Once you are discharged, covered follow- up care from a nonpreferred provider is paid at the nonpreferred provider benefit level. (Services received in an office or urgent care facility are not considered emergency care for purposes of this provision.)

Emergency Admission Notification

To ensure that benefits are correctly paid and that an admission you believe is emergency-related will be covered, you or your physician or hospital should notify BCBSNM as soon as reasonably possible following admission.

Follow-Up Care

For all follow- up care (which is no longer considered emergency care) and for all other nonemergency care, you will receive the nonpreferred provider benefit for the covered services of a nonpreferred provider, even if a preferred provider is **not** available to perform the service.

Urgent Care

This Plan covers urgent care services, which means medically necessary medical or surgical procedures, treatments, or services received for an unforeseen condition that is *not* life- threatening. The condition does, however, require prompt medical attention to prevent a serious deterioration in your health (e.g., high fever, cuts requiring stitches).

Urgent care is covered as any other type of service. However, if services are received in an emergency room or other trauma center, the condition and treatment must meet the definition of emergency care in order to be covered.

HEARING AIDS/RELATED SERVICES FOR CHILDREN UNDER AGE 21

This Plan covers the cost of hearing aids, the fitting and dispensing fees for hearing aids and ear molds, **limited to two hearing aids every 36 months** for members under 21 years old. This 36- month benefit period begins on the date the first covered hearing aid- related service is received and payable under this provision and ends 36 months later. The next benefit period begins 36 months after the first hearing aid- related service (e.g., fitting cost, ear mold, etc.) OR on the date the next hearing aid- related service, whichever length of time is greater.

Benefits for hearing aid- related services payable under this provision are not subject to any deductible, or copament amount. Benefits for hearing aid- related services will be provided at **100 percent** of the covered charges. (Other covered services, such as hearing examinations and audiometric testing related to a hearing aid need for members under 21 years old are subject to the usual plan deductible and copayment provisions for office services and diagnostic testing. Benefits for these additional services are not applied to the 36- month maximum benefit available for hearing aids.) **Routine hearing examinations and related services are not covered for members age 21 and older.**

HOME HEALTH CARE/HOME I.V. SERVICES

Conditions and Limitations of Coverage

If you are homebound (unable to receive medical care on an outpatient basis), this Plan covers home health care services and home I.V. services provided under the direction of a physician. Nursing management must be through a home health care agency approved by BCBSNM. A *visit* is one period of home health service of up to four hours.

Preauthorization Required

Before you receive home I.V. therapy, your physician or home health care agency must obtain **preauthorization** from BCBSNM. **This Plan does not cover home I.V. services without preauthorization.**

Covered Services

This Plan covers the following services subject to the limitations and conditions above, when provided by an approved home health care agency during a covered visit in your home:

- skilled nursing care provided on an intermittent basis by a registered nurse or licensed practical nurse
- physical, occupational, or respiratory therapy provided by licensed or certified physical, occupational, or respiratory therapists
- speech therapy provided by a speech pathologist or an American Speech and Hearing Association certified therapist
- intravenous medications and other prescription drugs ordinarily not available through a retail pharmacy if **preauthorization** is received from BCBSNM (If drugs are not provided by the home health care agency, see "Prescription Drugs and Other Items.")
- drugs, medicines, or laboratory services that would have been covered during an inpatient admission
- enteral nutritional supplies (e.g., bags, tubing) (For enteral nutritional formulas, see "Prescription Drugs and Other Items.")
- medical supplies
- skilled services by a qualified aide to do such things as change dressings and check blood pressure, pulse, and temperature

Exclusions

This Plan does **not** cover:

- care provided primarily for your or your family's convenience
- homemaking services or care that consists mostly of bathing, feeding, exercising, preparing meals for, moving, giving medications to, or acting as a sitter for the patient (See the "Custodial Care" exclusion in *Section 6: General Limitations and Exclusions*.)
- services provided by a nurse who ordinarily resides in your home or is a member of your immediate family
- private duty nursing

HOSPICE CARE SERVICES

Conditions and Limitations

This Plan covers inpatient and home hospice services for a terminally ill member received during a hospice benefit period when provided by a hospice program approved by BCBSNM. If you need an extension of the hospice benefit period, the hospice agency must provide a new treatment plan and the attending physician must recertify your condition to BCBSNM. (See definition of a hospice benefit period in *Section 10* for more information.)

Covered Services

This Plan covers the following services, subject to the conditions and limitations under the hospice care benefit:

- visits from hospice physicians
- skilled nursing care by a registered nurse or licensed practical nurse
- physical and occupational therapy by licensed or certified physical or occupational therapists
- speech therapy provided by an American Speech and Hearing Association certified therapist
- medical supplies (If supplies are *not* provided by the hospice agency, see "Supplies, Equipment and Prosthetics.")
- drugs and medications for the terminally ill patient. (If drugs are *not* provided by the hospice agency, see "Prescription Drugs and Other Items.")
- medical social services provided by a qualified individual with a degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training and experience (Such services must be recommended by a physician to help the member or his/her family deal with a specified medical condition.)
- services of a home health aide under the supervision of a registered nurse and in conjunction with skilled nursing care
- nutritional guidance and support, such as intravenous feeding and hyperalimentation
- respite care for a period **not to exceed five continuous days** for **every 60 days** of hospice care and **no more than two respite care periods** during each hospice benefit period (*Respite care* provides a brief break from total care- giving by the family.)

Exclusions

This Plan does **not** cover:

- food, housing, or delivered meals
- medical transportation
- homemaker and housekeeping services
- comfort items
- private duty nursing

- supportive services provided to the family of a terminally ill patient when the patient is not a member of this Plan
- care or services received after the member's coverage terminates

HOSPITAL/OTHER FACILITY SERVICES

Blood Services

This Plan covers the processing, transporting, handling, and administration of blood and blood components. This Plan covers directed donor or autologous blood storage fees only when the blood is used during a scheduled surgical procedure. This Plan does **not** cover blood replaced through donor credit.

Inpatient Services

Preauthorization Required

If hospitalization is recommended by a nonpreferred provider in an emergency or you are outside New Mexico, **you are responsible** for obtaining preauthorization. If you do not follow the inpatient preauthorization procedures, benefits for covered facility services will be **reduced** or **denied** as explained in *Section 4: Preauthorizations.*

Covered Services

For acute inpatient medical or surgical care received during a covered hospital admission, this Plan covers room and board and other medically necessary services provided by the facility.

Medical Detoxification

This Plan also covers medically necessary services related to medical detoxification from the effects of alcohol or drug abuse. Detoxification is the treatment in an acute care facility for withdrawal from the physiological effects of alcohol or drug abuse, which usually takes about three days in an acute care facility. Benefits for detoxification services are the same as for any other acute medical/surgical condition. Preauthorization is required for all inpatient hospitalizations. See "Psychotherapy (Mental Health and Chemical Dependency)" for information about benefits for chemical dependency rehabilitation. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Exclusions

This Plan does **not** cover:

- transplants or related services when the transplant received at a facility that does not contract directly with a BCBSNM participating provider or through a BCBS transplant network. (See "Transplant Services" for more information.)
- admissions related to elective services or procedures
- custodial care facility admissions

Outpatient or Observation Services

Coverage for outpatient or observation services and related physician or other professional provider services for the treatment of illness or accidental injury depends on the type of service received (for example, see "Lab, X- Ray, Other Diagnostic Services" or "Emergency and Urgent Care").

LAB, X- RAY, OTHER DIAGNOSTIC SERVICES

For invasive diagnostic procedures such as biopsies and endoscopies or any procedure that requires the use of an operating or recovery room, see "Surgery and Related Services."

This Plan covers diagnostic services, including but not limited to, preadmission testing, that are related to an illness or accidental injury. Covered services include:

- x- ray and radiology services, ultrasound, and imaging studies

- laboratory and pathology tests
- EKG, EEG, and other electronic diagnostic medical procedures
- genetic testing (Tests such as amniocentesis or ultrasound to determine the gender of an unborn child are not covered; see "Maternity/Reproductive Services and Newborn Care.")
- infertility- related testing (See "Maternity/Reproductive Services and Newborn Care.")
- PET (Positron Emission Tomography) scans, cardiac CT scans with **preauthorization** from BCBSNM
- MRIs
- psychological or neuropsychological testing with **preauthorization** from BCBSNM
- audiometric (hearing) and vision tests for the diagnosis and/or treatment of an accidental injury or an illness

Note: All services, including those for which preauthorization is required, must meet the standards of medical necessity criteria established by BCBSNM and will not be covered if excluded for any reason under this Plan. **Some services requiring preauthorization will not be approved for payment.**

MATERNITY/REPRODUCTIVE SERVICES AND NEWBORN CARE

Like benefits for other conditions, member cost- sharing amounts for pregnancy, family planning, infertility, and newborn care are based on the place of service and type of service received.

Family Planning and Infertility- Related Services

For preventive oral contraceptive coverage and contraceptive devices purchased from a pharmacy, see "Prescription Drugs and Other Items."

Family Planning for Nongrandfathered Plans

Covered family planning services include:

- health education
- the following categories of FDA-approved contraceptive drugs, devices, and services, subject to change as FDA guidelines are modified: progestin-only contraceptives, combination contraceptives, emergency contraceptives, extended-cycle/continuous oral contraceptives, cervical caps, diaphragms, implantable contraceptives, intra-uterine devices (IUDs), injectables, transdermal contraceptives, and vaginal contraceptive devices
- pregnancy testing and counseling
- vasectomies

For these following covered family planning services, no coinsurance, deductible, copayment, or benefit maximums will apply when received from a provider in the preferred or participating provider network.

- over-the-counter female contraceptive devices with a written prescription by a health care provider
- FDA-approved contraceptive drugs and devices from the following categories of FDA-approved contraceptive drugs, devices, and services, subject to change as FDA guidelines are modified: progestin-only contraceptives, combination contraceptives, emergency contraceptives, extended-cycle/continuous oral contraceptives, cervical caps, diaphragms, implantable contraceptives, intra-uterine devices (IUDs), injectables, transdermal contraceptives, and vaginal contraceptives devices. Covered FDA approved contraceptives drugs and devices are listed on the contraceptive drugs and devices list posted on the BCBSNM website (http://bcbsnm.com/affordable_care_act/provisions.html), or (http://www.bcbsnm.com/pdf/rx/contraceptive-list-nm.pdf) or available by contacting Customer Service at the toll-free number on your ID card
- outpatient contraceptive services such as consultations, examinations, procedures (including follow-up care for trouble you may have from using a birth control method that a family planning provider gave you) and medical services provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy
- female surgical sterilization procedures (other than hysterectomy), including tubal ligations

When obtaining the items noted above for **Nongrandfathered** plans, you may be required to pay the full cost and then submit a claim form with itemized receipts to BCBSNM for reimbursement. Please refer to *Section 8: Claims Payments and Appeals* of this Benefit Booklet for information regarding submitting claims.

Infertility- Related Services

This Plan covers the following infertility- related treatments (**Note:** the following procedures only *secondarily* treat infertility):

- surgical treatments such as opening an obstructed fallopian tube, epididymis, or vas deferens when the obstruction is **not** the result of a surgical sterilization
- replacement of deficient, naturally occurring hormones **if** there is documented evidence of a deficiency of the hormone being replaced

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

Diagnostic *testing* is covered only to diagnose the cause of infertility. Once the cause has been established and the treatment determined to be noncovered, no further testing is covered. For example, this Plan will cover lab tests to monitor hormone levels following the hormone replacement treatment listed as covered above. However, daily ultrasounds to monitor ova maturation are **not** covered since the testing is being used to monitor a noncovered infertility treatment.

Exclusions

In addition to services not listed as covered above, this Plan does **not** cover:

- male contraceptive devices, including over- the- counter contraceptive products such as condoms (for **Nongrandfathered** plans)
- sterilization reversal for males or females
- infertility treatments and related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization
- Gamete Intrafallopian Transfer (GIFT)
- Zygote Intrafallopian Transfer (ZIFT)
- cost of donor sperm
- artificial conception or insemination; fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such as in vivo or in vitro (test tube) fertilization, and embryo transfer; drugs for induced ovulation; or other artificial methods of conception

Pregnancy-Related/Maternity Services

If you are pregnant, you should call BCBSNM before your maternity due date, soon after your pregnancy is confirmed. BCBSNM must be notified as soon as possible if the mother's stay is greater than **48 hours** for a routine delivery or greater than **96 hours** for a C- section delivery. If not notified, benefits for covered facility services may be reduced by **$400.**

A covered daughter also has coverage for pregnancy-related services. However, if the parent of the newborn *is* a covered child of the subscriber (i.e., the newborn is the subscriber's grandchild), benefits are **not** available for the newborn except for the first 48 hours of routine newborn care (or 96 hours in the case of a C-section).

Covered Services

Covered pregnancy-related services include:

- hospital or other facility charges for room and board and ancillary services, including the use of labor, delivery, and recovery rooms (This Plan covers all medically necessary hospitalization, including at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a C- section delivery. **Note:** Newborns who are not eligible for coverage under this Plan will not be covered beyond the 48 or 96 hours required under federal law.)

- routine or complicated delivery, including prenatal and postnatal medical care of an obstetrician, certified nurse- midwife or licensed midwife (Expenses for prenatal and postnatal care are included in the total covered charge for the actual delivery or completion of pregnancy. The office visit during which a pregnancy is confirmed is subject to the member cost-sharing provisions that apply to any other office visit.) **Note:** Home births are not covered unless the provider has a preferred provider contract with his/her local BCBS Plan and is credentialed to provide the service.
- pregnancy- related diagnostic tests, including genetic testing or counseling (Services must be sought due to a family history of a gender- linked genetic disorder or to diagnose a possible congenital defect caused by a present, external factor that increases risk, such as advanced maternal age or alcohol abuse. For example, tests such as amniocentesis or ultrasound to determine the gender of an unborn child are **not** covered.)
- necessary anesthesia services by a provider qualified to perform such services, including acupuncture used as an anesthetic during a covered surgical procedure and administered by a physician, a licensed doctor of oriental medicine, or other practitioner as required by law
- when necessary to protect the life of the infant or mother, coverage for transportation, including air transport, for the medically high- risk pregnant woman with an impending delivery of a potentially viable infant to the nearest available tertiary care facility for newly born infants (See "Ambulance Services" for details.)
- services of a physician who actively assists the operating surgeon in performing a covered surgical procedure when the procedure requires an assistant
- elective, spontaneous, or therapeutic termination of pregnancy prior to full term

Special Beginnings

This is a maternity program for BCBSNM members that is available wherever you need it. It can help you better understand and manage your pregnancy. To take full advantage of the program, you should enroll within three months of becoming pregnant. When you enroll, you will 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 toll-free at:

1-888-421-7781

Newborn Care

If you do not have coverage for your newborn on the date of birth, **you must add coverage within 31 days of birth** in order for any newborn charges, routine or otherwise, to be covered beyond the first 48 hours of birth (or 96 hours in the case of a C-section).

Newborn Eligibility

If you do not enroll and add coverage for your newborn within 31 days, and wish to add the child to coverage later, the child is considered a late applicant unless eligible for a special enrollment. **Note:** If the parent of the newborn is a covered child of the subscriber (i.e., the newborn is the subscriber's grandchild), services for the newborn are **not** covered except for the first 48 hours of routine newborn care (or 96 hours in the case of a C-section).

Routine Newborn Care

If both the mother's charges and the baby's charges are eligible for coverage under this Plan, no additional deductible for the newborn is required for the facility's initial routine nursery care if the covered newborn is discharged on the same day as the mother.

Covered Services

Covered services for initial routine newborn care include:

- routine hospital nursery services, including alpha- fetoprotein IV screening
- routine medical care in the hospital after delivery

- pediatrician standby care at a C- section procedure
- services related to circumcision of a male newborn

For children who are covered from their date of birth, benefits include coverage of injury or sickness, including covered services related to the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Extended Stay Newborn Care

A newborn who is enrolled for coverage within the time limits specified in *Section 2: Enrollment and Termination Information* is also covered if he/she stays in the hospital longer than the mother. The baby's services will be subject to a separate deductible, coinsurance and out- of- pocket limit.

Note: If you are in a nonpreferred facility, 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 **$400**. The baby's services will be subject to a separate deductible, coinsurance and out- of- pocket limit.

PHYSICIAN VISITS/MEDICAL CARE

This section describes benefits for therapeutic injections, allergy care and testing, and other nonsurgical, nonroutine medical visits to a health care provider for evaluating your condition and planning a course of treatment. See specific topics referenced in this section for more information regarding a particular type of service (e.g., "Preventive Services," "Transplant Services," etc.).

This Plan covers medically necessary care provided by a physician or other professional provider for an illness or accidental injury.

Office Visits and Consultations

Services covered under this provision include allergy care, therapeutic injections, office visits, consultations (including second or third surgical opinions) and examinations and other nonroutine office medical procedures — when not related to hospice care or payable as part of a surgical procedure. (See "Hospice Care" or "Surgery and Related Services" if the medical visits are related to either of these services.)

Allergy Care

This Plan covers direct skin (percutaneous and intradermal) and patch allergy tests, radioallergosorbent testing (RAST), allergy serum, and appropriate FDA-approved allergy injections administered in a provider's office or in a facility.

Breastfeeding Support and Services

If you have a **Non-Grandfathered** plan, it covers counseling and support services rendered by a lactation consultant such as a certified nurse practitioner, certified nurse midwife or midwife, not subject to coinsurance, deductible, copayment, or benefit maximum, when received from a provider in the preferred or participating provider network.

Diabetes Self- Management Education

This Plan covers diabetes self- management training if you have diabetes or an elevated blood glucose due to pregnancy. Training must be prescribed by a health care provider and given by a certified, registered, or licensed health care professional with recent education in diabetes management. Covered services are limited to:

- medically necessary visits upon the diagnosis of diabetes
- visits following a physician diagnosis that represents a significant change in your symptoms or condition that warrants changes in your self- management
- visits when re- education or refresher training is prescribed by a health care provider
- medical nutrition therapy related to diabetes management

See "Prescription Drugs and Other Items" for benefits for insulin and oral agents to control blood glucose levels, glucose meters, needles, syringes, and test strips; see "Supplies, Equipment and Prosthetics" for other covered supplies and equipment required due to diabetes.

Genetic Inborn Errors of Metabolism

This Plan covers medically necessary expenses related to the diagnosis, monitoring and control of genetic inborn errors of metabolism as defined in *Section 10: Definitions.* Covered services include medical assessment, including clinical services, biochemical analysis, medical supplies, prescription drugs (see "Prescription Drugs and Other Items"), corrective lenses for conditions related to the genetic inborn error of metabolism, nutritional management and **preauthorized** special medical foods (as defined and described in "Prescription Drugs and Other Items"). In order to be covered, services cannot be excluded under any other provision of this benefit booklet and are paid according to the provisions of the Plan that apply to that particular type of service (e.g., special medical foods are covered under "Prescription Drugs and Other Items," medical assessments under "Physician Visits/Medical Care" and corrective lenses under "Supplies, Equipment and Prosthetics").

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

Injections and Injectable Drugs

This Plan covers most FDA- approved therapeutic injections administered in a provider's office. However, this Plan covers some injectable drugs only when **preauthorization** is received from BCBSNM. Your BCBSNM- contracted provider has a list of those injectable drugs that require preauthorization. If you need a copy of the list, call a BCBSNM Customer Service Advocate. (When you request preauthorization, you may be directed to purchase the self- injectable medication through your drug plan.)

The Claims Administrator and the Plan reserves the right to exclude any injectable drug currently being used by a member. Proposed new uses for injectable drugs previously approved by the FDA will be evaluated on a medication- by- medication basis. Call a BCBSNM Customer Service Advocate if you have any questions about this policy.

Mental Health Evaluation Services

This Plan covers medication checks and intake evaluations for mental disorders, alcohol, and drug abuse. See "Psychotherapy (Mental Health and Chemical Dependency)" for psychotherapy and other therapeutic service benefits.

Inpatient Medical Visits

With the exception of dental- related services, this Plan covers the following services when received on a covered inpatient hospital day:

- visits for a condition requiring **only** medical care, unless related to hospice care
- consultations (including second opinions) and, if surgery is performed, inpatient visits by a provider who is not the surgeon and who provides medical care **not** related to the surgery (For the surgeon's services, see "Surgery and Related Services" or "Transplant Services.")
- medical care requiring **two or more** physicians at the same time because of multiple illnesses
- initial routine newborn care for a newborn added to coverage within the time limits specified in *Section 2: Enrollment and Termination Information* (See "Maternity/Reproductive Services and Newborn Care" for details and for extended stay benefits.)

PRESCRIPTION DRUGS AND OTHER ITEMS

When you are being treated for an illness or accident, your doctor may prescribe certain drugs or other pharmacy items as part of your treatment. Your coverage includes benefits for drugs that are self-administered and other items listed below. This section explains which drugs and other items are covered and the benefits available for them. The benefits are subject to all of the terms and conditions of your health plan. For example, benefits will be provided only if drugs and supplies are medically necessary. Please see the *General Limitations and Exclusions* section of this benefit booklet for a full list of exclusions that apply to all health care services, including prescription drugs and other items.

All drugs listed on the drug list or specialty drug list are covered unless specifically excluded. (For example, if your Plan excludes weight management or obesity treatment, drugs for the treatment of obesity are also excluded.) Prescription drugs under your drug plan will not be excluded only because the drug has not been approved by the FDA for the treatment of your particular condition. Such a drug may be covered under the drug plan if it is recognized as safe and effective for the treatment of your condition in at least one standard medical reference compendium, including the "AMA Drug Evaluation," the "American Hospital Formulary Service Drug Information," and "Drug Information for the Healthcare Provider," OR is being provided during a covered cancer clinical trial as required under New Mexico state law. The drug will not be covered however, if it is excluded for another reason (such as being for weight loss, cosmetic, etc.).

Pharmacy-Related Definitions

Please see all pharmacy-related definitions under "Pharmacy-Related Definitions" in *Section 10: Definitions.*

Covered Medications and Other Items

This Plan covers the following drugs, supplies and other products through this drug plan provision only when dispensed by a **participating pharmacy** under the **Retail Pharmacy Program** or **Specialty Pharmacy Drug Program** (unless required as the result of an emergency) or ordered through the **Mail Order Service** vendor:

- prescription drugs, prenatal vitamins, and medicines, unless listed as an exclusion (covered drugs/items include insulin, glucagon, prescriptive oral agents for controlling blood sugar levels and prescription contraceptive devices and medications purchased from a participating pharmacy) **Note:** Prescription contraceptive devices fitted or inserted by, and purchased directly from a physician are payable under the "Family Planning" benefit, if any, of your medical/surgical Plan.
- specialty drugs such as, but not limited to, self-administered injectable drugs such as growth hormone, Copaxone, Avonex. (Most injectable drugs require **preauthorization** from BCBSNM. Some self- administered drugs, whether injectable or oral, are identified as specialty drugs and must be acquired through a participating specialty pharmacy provider in order to be covered.)
- vaccinations for flu or pneumonia or Zostavax→ vaccinations when received from certain participating pharmacies (For a list of pharmacies that are contracted with BCBSNM to provide this service, go to the BCBSNM website at www.bcbsnm.com.)
- insulin needles, syringes, glucose meters and other diabetic supplies (e.g., glucagon emergency kits, autolets, lancets, lancet devices, blood glucose and visual reading urine and ketone test strips). (A separate copayment amount applies for each item purchased.) These items are **not** covered as a medical supply or medical equipment expense under any medical or surgical provisions of this benefit booklet. See "Supplies, Equipment, and Prosthetics" later in this section for a list of diabetic equipment that *is* covered under the medical/surgical portion of your health plan.
- nonprescription enteral nutritional products and special medical foods only when **preauthorized** and either: 1) delivered through a medically necessary enteral access tube that has been surgically placed (e.g., gastrostomy, jejunostomy) or 2) meeting the definition of special medical foods (These products must be ordered by a physician and **preauthorization** received from BCBSNM in order to be covered.) See *Section 4: Preauthorizations* for more information about preauthorization requirements.
- treatment with FDA approved prescription drugs to assist you with quitting tobacco use or smoking. Note: For members covered under PPO medical plans only, certain of these items may also be purchased from an out-of-network pharmacy. For details, see "Retail Pharmacy Program" below. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Preauthorizations

Certain prescription drugs, injectable medications and specialty pharmacy drugs may require **preauthorization** from BCBSNM. A list of drugs requiring preauthorization is available on the BCBSNM website at www.bcbsnm.com. Your physician can request the necessary preauthorization. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Step Therapy

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

BENEFITS FOR ORALLY ADMINISTERED ANTICANCER MEDICATIONS

Benefits are available for medically necessary orally administered anticancer medication that is used to kill or slow the growth of cancerous cells. No coinsurance or copayment amount will apply to orally administered anticancer medications listed on the specialty drug list. To determine if a specific drug is on the specialty drug list, you may access the website at http://www.bcbsnm.com/members/specialty_rx.html or contact Customer Service at the toll-free number on your ID card.

Member Copayments and Coinsurance

For covered prescription drugs, insulin, diabetic supplies, and nutritional products, you pay the applicable tiered copayment or applicable coinsurance, not to exceed the actual retail price for each prescription filled or item purchased (not to exceed supply limitations described in this section). **See your Summary of Benefits for your copayment amount.** Any coinsurance amounts due for certain covered items are noted in this benefit booklet.

Each calendar year, the copayments and coinsurance percentage amounts, are applied to your or your family's applicable annual out-of-pocket limit for that calendar year. Any pricing difference between the cost of brand name drugs and their generic equivalents that you pay under this drug plan portion of your health care benefits plan are not applied to your or your family's applicable annual out-of-pocket limit for that calendar year under the medical portion of your health care benefits plan during a single calendar year, BCBSNM pays 100% of your covered prescription drugs, insulin, diabetic supplies, and nutritional products under this drug plan for the remainder of that calendar year. Noncovered charges may not be used to meet the out-of-pocket limit under the medical portion of your health care benefits plan.

Your drug plan offers several benefit design copayment option for when you purchase drugs or supplies from a participating pharmacy, or a BCBSNM-designated specialty pharmacy provider, or BCBSNM-designated mail order service vendor (see below for an example of a tiered copayment drug plan and how it works). When you need a prescription order filled, you should use a participating pharmacy. Each prescription or refill is subject to the copayment or coinsurance shown on your SBC. Any deductible shown in the SBC will also apply.

When you go to a participating pharmacy, you must pay any copayment, deductible (if any), and any applicable pricing difference. You may be required to pay for limited or noncovered services. No claim forms are required. If you are unsure whether a pharmacy is a participating pharmacy, you may access the website at www.bcbsnm.com or contact customer service at the toll-free number on your ID card.

See your Summary of Benefits for the drug plan copayment option that corresponds to the health benefits plan you have chosen. Except as may be specified elsewhere in this benefit book, drugs and supplies must be purchased from a participating pharmacy, or a BCBSNM-designated specialty pharmacy provider, or BCBSNM-designated mail order service in order to be covered under your drug plan.

Here is a sample of how the drug plan works under the "3-Tier Drug Plan" using the $15/$35/$55 option:

Type of Prescription	Sample of Copayment Amounts
Generic Drug*	**Tier-One copayment: $15***
Preferred Brand-Name Drug (no generic equivalent)*	**Tier-Two copayment: $35***
Nonpreferred Brand-Name Drug (no generic equivalent)*	**Tier-Three copayment: $55***
Specialty Drug (Note: Preferred Specialty drugs are subject to the lower Tier 3 copayment, above.)	**Tier- Three copayment: $55**

*For all Brand-Name Drugs **with** an FDA-approved generic equivalent, if you or your provider order the brand-name, you will pay the **Tier 2 or 3 Coinsurance,** PLUS the **difference in cost** between the Brand-Name Drug and its generic equivalent. The difference in cost is **not** applied to your Deductible or out-of-pocket limit under the medical portion of your health benefits plan, but is **your sole responsibility**.	
Vaccinations for flu or pneumonia, or zostavax vaccinations received from certain participating pharmacies (For a list of pharmacies that are contracted with BCBSNM to provide this service, go to the BCBSNM website at ww.bcbsnm.com.)	**No Copayment or Coinsurance**
Mail Order Service (available for Tiers 1, 2, and 3 only; specialty drugs are not covered through Mail Order Service)	**$30, $70, or $110** (copayment for Tier 1, 2, or 3 drug - depending on generic/brand and Drug List status)
Nonprescription Enteral Nutritional Products and Special Medical Foods (brand-name or generic; requires preauthorization)	**Coinsurance of 50% of Covered Charge**

Under the drug plan, drugs are available at "tiered" copayment levels. The benefits you receive and the amount you pay will differ depending upon the type of drugs, or diabetic supplies, or insulin and insulin syringes, or nutritional products obtained and whether they are obtained from a participating pharmacy or a BCBSNM-designated specialty pharmacy provider, or BCBSNM-designated mail order service vendor.

For covered non-specialty, generic drugs, you pay the lowest copayment tier only. (Commonly prescribed generic drugs are listed on the drug list but a full listing of all generic drugs are not available. A list of generic drugs is available on the BCBSNM web site at www.bcbsnm.com. You may also contact a customer service advocate for more information).

To determine your copayment for a brand-name drug, check the drug list. If your covered brand-name drug is on the preferred drug list, you will pay the tier 2 copayment for preferred brand-name drugs. If it is a nonpreferred brand-name drug, its is subject to a tier 3 copayment.

When the copayment or coinsurance for an item purchased under the drug plan is **greater** than the covered charge for the supply being purchased from a participating pharmacy, you pay the **least of**: 1) your copayment amount or 2) the pharmacy's or vendor's retail price or 3) the covered charge (i.e., the BCBSNM-contracted rate). For claim submitted to the pharmacy benefit manager for reimbursement, you are paid the **lesser of**: 1) the sum of the drug ingredient cost, the dispensing fee that would be payable to a participating pharmacy and any sales tax minus the applicable member share or 2) the pharmacy's retail price minus the applicable member share.

New-to-Market FDA Approved Drugs

New-to-market FDA approved drugs are subject to review by Prime Therapeutics Pharmacy & Therapeutics (P&T) Committees prior to coverage of the drug.

Retail Pharmacy Program

Your drug plan provides access to the pharmacy in the retail pharmacy network. All items covered under this provision must be purchased from a participating retail pharmacy unless there is an emergency (as defined in this benefit booklet). Also, for members covered under a PPO medical plan, you may purchase the following items from an out-of-network pharmacy and receive benefits as described later in this section: an orally administer anticancer medication, a prescription drug purchased for smoking cessation treatment, a diabetic drug or diabetic supply, or a drug covered as part of an approved in-state cancer clinical trial. (Claims for items purchased from a nonparticipating retail pharmacy must be submitted to the pharmacy benefit manager in order to be eligible for coverage under the drug plan.) Although you can go to the retail pharmacy of your choice, your benefits for covered drugs and other items will be greater when you obtain them from a participating pharmacy. Also, claims for items purchased from an out-of-network retail pharmacy must be submitted to the pharmacy benefit manager in order to be eligible for coverage.

For a list of participating pharmacies, call Customer Service at the phone number on the back of your ID card and request a provider directory - or visit the BCBSNM website at www.bcbsnm.com. The pharmacies that are

participating in the BCBSNM Retail Pharmacy Program may change from time to time. You should check with your pharmacy before obtaining drugs or supplies to make certain of its participating status.

You must present your BCBSNM identification (ID) card to the pharmacist at the time of purchase to receive your drug benefits. (You do not receive a separate prescription ID card; use your BCBSNM ID card to receive all your medical/surgical and prescription drug services covered under this Plan.) You are responsible for paying any deductibles, coinsurance amounts, copayments, any pricing differences when applicable, and limited or non-covered services. No claim forms are required when you purchase your prescriptions at a participating pharmacy.

NOTE: Specialty drugs must be purchased from the BCBSNM-designated specialty pharmacy provider in order to be covered.

You can use your ID card to purchase covered items only for yourself and covered family members. When coverage for you or a family member ends under this Plan, the ID card may not be used to purchase drugs or other items for the terminated family member(s).

If you do not have your ID card with you or if you purchase your drug or other item from a nonparticipating (out-of-network) pharmacy and it is eligible for coverage as indicated in the first paragraph above, such as in an **emergency**, you must pay for the purchase in full and then submit a claim directly to the BCBSNM pharmacy benefit manager, Prime Therapeutics, at the address below (do not send to BCBSNM). In such cases, you will pay the difference in cost between the pharmacy's billed amount and the covered charge, in addition to your deductible, coinsurance, and/or copayment amount. If not included in your enrollment materials, you can obtain the necessary claim forms from a Customer Service Advocate or on the BCBSNM website (www.bcbsnm.com).

Prime Therapeutics
P.O. Box 1466
Lexington, KY 40512-4624

If you are leaving the country or need an extended supply of medication, call Customer Service **at least two weeks** before you intend to leave. (Extended supplies for vacation overrides are not available through the Mail Order Service Program (see below) and may be approved only through the Retail Pharmacy Program. In some cases, you may be asked to provide proof of continued enrollment/eligibility under the Retail Pharmacy Program.)

Specialty Pharmacy Program

The specialty drug delivery service integrates specialty drug benefits with your overall medical and drug plan benefits. This program provides delivery of medications directly to your provider's office or to your home if you are undergoing treatment for a complex medical condition. The Specialty Pharmacy Program delivery service offers:

- coordination of coverage among you, your health care provider, and BCBSNM
- educational materials about your condition and information about managing possible medication side effects
- syringes, sharps containers, alcohol swabs, and other supplies with every shipment of FDA-approved self-injectable medications
- access to a pharmacist for urgent medication issues 24 hours a day, 7 days a week, 365 days a year

Except as provided elsewhere in this booklet for orally administered anticancer medications for members covered under a PPO medical plan or as otherwise required under applicable law or regulation, this drug plan covers only those specialty drugs that are listed on the specialty drug list. The list of specialty drugs, both preferred and nonpreferred, is on the BCBSNM website at www.bcbsnm.com, or can be obtained from a Customer Service Advocate by calling the number on the back of your ID card. Your cost for specialty drugs is indicated on your *Summary of Benefits* and you will be responsible for any deductibles, copayments, coinsurance, any pricing differences when applicable, and limited or non-covered services that may apply to your coverage.

Mail Order Service

Except for supply limitations and nutritional products, all items that are covered under the Mail Order Service are the same items that are covered under the Retail Pharmacy Program and are subject to the same limitations and exclusions. To use the Mail Order Service, follow the instructions outlined in the materials provided to you in your enrollment packet. (If you do not have this information, call a Customer Service Advocate.) **Note:** Prescription

drugs and other items may **not** be mailed outside the United States. Extended supplies or vacation overrides required when you are outside the country may be approved only through the Retail Pharmacy Program.

IMPORTANT: Specialty drugs are not covered through the Mail Order Service. You must use the specialty pharmacy provider designated by BCBSNM in order to receive benefits for specialty drugs.

Supply Limitations

For each copayment listed on the *Summary of Benefits,* you can obtain the following supply of a single covered prescription drug or other item (unless otherwise specified):

Program Type	Supply Maximum	Copay Requirement* (see note)
Nonprescription Nutritional Products	**30-day supply** during any 30-day period	**50 percent** of covered charges (includes prescriptions for enteral nutritional products and special medical foods as described under "Covered Drugs and Other Items")
Retail Pharmacy and Specialty Pharmacy Provider	During each one-month period, a **30-day supply or 120 units** (e.g., pills) whichever is less	**One copayment.** If more than 120 units are needed to reach a 30-day supply, another copayment will apply to each additional 120 units (or portion thereof) purchased. For oral contraceptives, the supply is limited to one menstrual cycle (normally 28 days).
Mail Order Service (Tiers 1, 2, and 3 only)	During each three-month period, a **90-day supply or 360 units** (e.g., pills) whichever is less	**Two copayments.** If less than a 90-day supply is ordered, one copayment will apply. If more than 360 units are needed to reach a 90-day supply, 2 copayments will apply to each additional 360 units (or portion thereof) purchased.

NOTE: For commercially packaged items (such as an inhaler, a tube of ointment or a blister pack of tablets or capsules), you will pay the applicable copayment for each package, **regardless of the number of days supply the package represents**. For example, if two inhalers are purchased under the Retail Pharmacy Program, 2 copayments will apply. Under Mail-Order, you can receive up to three times the number of packages obtainable from a retail pharmacy for the same copayment amount payable under the Retail Pharmacy Program.

Dispensing Limits

In addition to the supply limits listed above and regardless of the quantity of a covered drug prescribed by a physician, BCBSNM has the right to establish dispensing limits on covered drugs. These limits, which are based upon FDA dosing recommendations and nationally recognized clinical guidelines, identify gender or age restrictions, and/or the maximum quantity of a drug (or member of a drug class) that can be dispensed to you over a specific period of time. Such limits are in place to encourage appropriate drug use and patient safety, and to reduce waste and stockpiling of drugs. Benefits for a covered drug may also be denied if the drug is dispensed or delivered in a manner intended to avoid the BCBSNM-established dispensing limit. If you need a drug quantity that exceeds the dispensing limit, ask your doctor to submit a request for review to BCBSNM on your behalf. The preauthorization request will be approved or denied after the clinical information submitted by the prescribing doctor has been evaluated by BCBSNM.

Controlled Substances

If BCBSNM determines you may be receiving quantities of controlled substances medications not supported by FDA approved dosages or recognized treatment guidelines, benefits may be subject to a review to determine if they are medically necessary, appropriate and other coverage restrictions such as limiting coverage to services provided by a certain provider and/or participating pharmacy for the prescribing and dispensing of the controlled substance medication. For the purposes of this provision, controlled substance medications are medications restricted by state or federal laws because of their potential of addition or misuse.

Drug Plan Exclusions

In addition to services listed as not eligible for coverage in the *General Limitations and Exclusion* section of this booklet, this drug plan provision of your health plan does **not** cover:

- nonprescription and over- the- counter drugs unless specifically listed as covered, including herbal or homeopathic preparations and nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum, or prescription drugs that have over- the- counter equivalents This exclusion includes nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum.
- compound medications, regardless of whether or not one or more ingredients in the compound requires a prescription (Compounds are those made by mixing or reconstituting ingredients in a manner or ratio that is inconsistent with United States Food and Drug Administration-approved indications provided by the ingredients' manufacturers.)
- nonprescription and over- the- counter drugs unless specifically listed as covered, including herbal or homeopathic preparations and nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum, or prescription drugs that have over- the- counter equivalents This exclusion includes nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum.
- prescription drugs if there is an over-the-counter product available with the same active ingredient(s), in the same strength, unless otherwise determined by the Plan, at its sole discretion
- herbal or homeopathic preparations
- drugs which by law do not require a prescription order from an authorized health care practitioner (except insulin, insulin analogs, insulin pens, oral agents for controlling blood sugar levels, and vaccinations administered through certain participating pharmacies)
- legend drugs or covered devices for which no valid prescription order is obtained
- prescriptions or other covered items purchased from a nonparticipating pharmacy, nonparticipating specialty pharmacy provider or other provider unless eligible for benefits in an emergency situation (as defined in your benefit booklet) or for members covered under PPO medical plans, as listed under “Retail Pharmacy Program" and purchased from a non-participating retail pharmacy
- refills before the normal period of use has expired, in excess of the number specified by the physician or requested more than one year following the physician's original order date (Prescriptions cannot be refilled until at least 75 percent of the previously dispensed supply will have been exhausted according to the physician's instructions. Call Customer Service for instructions on obtaining a greater supply if you are leaving home for more than a 30- day period of time.)
- replacement of drugs or other items that have been lost, stolen, destroyed or misplaced
- infertility medications
- nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum, or prescription drugs that have over-the-counter equivalents
- drugs or other items for the treatment of sexual or erectile dysfunction
- therapeutic devices or appliances, including support garments and other nonmedicinal substances
- devices or durable medical equipment of any type (even though such devices may require a prescription order) such as, but not limited to therapeutic devices, including support garments and other non-medicinal substances, artificial appliances, or similar devices
- drugs that are repackaged by a company other than the original manufacturer
- medications or preparations used for cosmetic purposes (such as preparations to promote hair growth or medicated cosmetics), including tretinoin (sold under such brand names as Retin- A) for cosmetic purposes
- nonprescription enteral nutritional products that are taken by mouth or delivered through a temporary naso- enteric tube (e.g., nasogastric, nasoduodenal, or nasojejunal tube), unless the patient meets criteria for genetic inborn errors of metabolism and the product is **preauthorized** by BCBSNM); or nonprescription nutritional products that have not been preauthorized by BCBSNM (See *Section 4: Preauthorizations* for more information about preauthorization requirements.*)*

- shipping, handling or delivery charges
- prescription drugs required for international travel or work
- appetite suppressant or diet aids; weight reduction drugs food or diet supplements and medication prescribed for body building or similar purposes
- ordinary foodstuffs that might be part of an exclusionary diet; any product that does not have and/or require a physician's prescription; food items purchased at a health food, vitamin, or similar store; food purchased on the Internet
- any drug not listed on the formulary
- devices and pharmaceutical aids
- institutional packs
- surgical supplies
- ostomy products
- diagnostic agents, except diabetics test strips
- general anesthetics
- bulk powders

Note: Prescription contraceptive devices are payable under your medical/surgical plan benefit booklet in the "Family Planning" provision of the *Covered Services* section.

Drug Exclusions

Some equivalent drugs are manufactured under multiple brand names. In such cases, the health care Plan may limit benefits to only one of the brand equivalents available. If you do not accept the brand that is covered under the Plan, the brand-name drug purchased will not be covered under any benefit level.

Blue Cross and Blue Shield of New Mexico (BCBSNM) may inform you that it has contracts, either directly or indirectly, with participating prescription drug providers for the provision of, and payment for, prescription drug services all persons entitle to prescription drug benefits under individual certificates, group health insurance policies, and contracts to which BCBSNM is a party, including this contract. Pursuant to BCBSNM's contracts with participating prescription drug providers, and under certain circumstances described therein, BCBSNM may receive discounts for prescription drugs dispensed to you. Actual discounts used to calculate your share of the cost of prescriptions drugs will vary. Some discounts are currently based on average wholesale priced (AWP) which is determined by a third party and is subject to change.

BCBSNM may receive such discounts, although you are not entitled to receive any portion of any such discounts. The drug fees and/or discounts that BCBSNM has negotiated with Prime Therapeutics LLC (Prime) through the pharmacy benefit management (PBM) agreement will be used to calculate your share of the cost of prescription drugs for retail and mail specialty drugs. Except for mail and/or specialty drugs, the PBM agreement requires that the fees and/or discounts.

To help you understand how BCBSNM's separate financial agreements with participating prescription drug provides work, please consider the following example:

Assume you have a prescription dispensed and the undiscounted amount of the prescription drug is $100. How is the $100 bill paid?

- You will have to pay the coinsurance amount set out in this contract.
- For purposes of calculating your coinsurance amount, the full amount of the prescription drug would be reduced by the discount. In our example, if the applicable discount were 20%, the $100 prescription drug bill would be reduced by 20% to $80 for purposes of calculating your coinsurance amount.
- In our example, if your coinsurance obligation is 5%, you will have to pay 5% of $80, or $4. You should note that your 5% coinsurance amount is based upon the discounted amount of the prescription and not the full $100 bill.

For the mail and specialty pharmacy program owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail and/or specialty pharmacy program. BCBSNM pays a fee to Prime for pharmacy benefit services. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, claims processing, customer service response, and mail order processing.

“Weighted paid claim" refers to the methodology of counting claims for purposes of determining BCBSNM's fee payment to Prime. Each retail paid claim equals one weighted paid claim (including claims dispensed through the PBM's specialty pharmacy program); each extended supply or mail order (including mail service) paid claim equals three weighted paid claims. However, BCBSNM pays Prime a program management fee (PMF) on a per paid claim basis. “Funding leavers" means a mechanism though which BCBSNM funds the fees (net fee, ancillary fees and special project fees) owed to the PBM. Funding lever always include manufacturer administrative fees, mail order utilization, participating pharmacy transaction fees, and , if elected by BCBNM, may include rebates and retail spread. BCBSNM's net fee owed to Prime for core services will be offset by the funding levers. BCBSNM pays Prime the net fee for core services, ancillary fees and special project fees, offset by all applicable funding levers as agreed upon under the terms of its agreement with Prime. The net fee is calculated based on a fixed dollar amount per weighted paid claim.

The amounts received by Prime from BCBSNM, pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled and include, but are not limited to, administrative fees charges by Prime to BCBSNM, administrative fees charge by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to you as expenses, or accrue to the benefit of you, unless otherwise specially set forth in this contract. Additional information about these types of fees or the amounts of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 3% of the total sales for all rebatable products of such manufacturer dispensed during any given calendar year to members of BCBSNM and other Blue plan operating divisions.

Exceptions Process

You or your provider can ask for a drug list exception if your drug is not on the drug list (also known as a formulary). To request this exception, you or your provider can call the number on the back of our identification card to ask for a review. If you have a certain condition that may jeopardize your life, health or keep you from regaining function, or your current drug therapy uses a non-covered drug, you or your provider may be able to ask for an expedited review process. The plan will let you and your provider know the coverage decision within 24 hours after we receive your request for an expedited review. If the coverage requires is denied, the plan will let you and your provider know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination.

A determination will be made within 72 hours following receipt of the request and notice of the determination will be provided to the enrollee. If an exception request is granted. The plan will provide coverage of the non-formulary drug for the duration of the prescription including refills.

In the case of exigent circumstances, an enrollee, their designee, or their prescribing physician may request an expedited exception process. An exigent circumstances exists when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or if enrollee is undergoing a current course of treatment using non-formulary drugs. The determination must be made within 24 hours following receipt of this request and if the exception is granted, the plan will provide coverage of the non-formulary drug for the duration of the exigency.

Call the number on the back of your identification card if you have any questions.

BCBSNM's SEPARATE FINACIAL ARRANGMENTS WITH PHARMACY BENEFIT MANAGERS

BCBSNM hereby informs you that it owns a significant portion of the equity of Prime and that BCBSNM has entered into one or more agreements with Prime or other entities (collectively referred to as “Pharmacy Benefit Managers," or PBMs"), for the provision of, and payment for, prescription drug benefits to all persons entitled to

prescription drug benefits under individual certificates, group health insurance policies and contact to which BCBSNM is a party, including this contract. PBMs have agreements with pharmaceutical manufacturers to receive rebates for using their products. In addition, Prime's mail order pharmacy and other PBM services operate through the same entity, Prime Therapeutics LLC.

Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of BCBSNM, but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufacturers to cover the administrative costs of processing late payments). BCBSNM may receive such rebates from Prime. You are not entitled to receive any portion of any such rebates as they are calculated into the pricing of the product.

PREVENTIVE SERVICES

Claims filed under this provision must clearly show that the office visit and tests were for routine or preventive care.

The services listed under this provision are not limited as to the number of times you may receive the service in any given period or as to the age of the patient (except when a service is inappropriate for the patient's age group, such as providing a pediatric immunization to an adult). You and your physician are encouraged to determine how often and at what time you should receive preventive tests and examinations and you will receive coverage according to the benefits and limitations of your health care plan. Coverage for a recommended preventive service that is otherwise considered medically necessary for an individual will be provided regardless of an individual's sex assigned at birth, gender identity or gender that BCBSNM has recorded.

This Plan covers the following preventive services not subject to coinsurance, deductible, copayment, or benefit maximums when received from an in-network provider.

a. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");

b. immunizations for routine use that have in effect a recommendation by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;

c. evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents;

d. with respect to women, to the extent not described in item "a" above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.

For purposes of item "a" above, the current recommendations of the USPSTF regarding breast cancer screening mammography and prevention issued in or around November 2009 are not considered to be current.

The preventive services described in items "a" through "d" above may change as USPSTF, CDC, and HRSA guidelines are modified. For more information, you may visit the BCBSNM website at www.bcbsnm.com or contact Customer Service at the telephone number on your BCBSNM health plan identification card.

Covered preventive services **not** described in items "a" through "d" above may be subject to deductible, coinsurance, copayments, and/or dollar maximums. Allergy injections are **not** considered immunizations under the "Preventive Services" benefit. Examples of covered services include, but are not limited to:

- routine physical, breast, and pelvic examinations
- routine adult and pediatric immunizations
- an annual routine gynecological or pelvic examination and low-dose mammogram screenings
- papilloma virus screening and cytologic screening (a Pap test or liquid-based cervical cytopathology)
- human papillomavirus vaccine (HPV) for members ages 9 - 26 years old
- periodic blood hemoglobin, blood pressure and blood glucose level tests
- periodic colorectal screening tests
- periodic blood cholesterol or periodic fractionated cholesterol level including a low- density lipoprotein (LDL) and a high- density lipoprotein (HDL) level; periodic stool examination for the presence of blood

- periodic left-sided colon examination of 35 to 60 centimeters or colonoscopy
- well- child care, including well-baby and well-child screening for diagnosing the presence of autism spectrum disorder
- periodic glaucoma eye tests
- vision and hearing screenings in order to detect the need for additional vision or hearing testing for members when received as part of a routine physical examination (A screening does *not* include an eye examination, refraction or other test to determine the amount and kind of correction needed.)
- health education and counseling services if recommended by your physician, including an annual consultation to discuss lifestyle behaviors that promote health and well- being, including smoking/tobacco use cessation counseling for **Nongrandfathered** plans
- contraceptive drugs and devices

Exclusions

This Plan does **not** cover:

- employment physicals, insurance examinations, or examinations at the request of a third party (the requesting party may be responsible for payment); premarital examinations; sports or camp physicals; any other nonpreventive physical examination
- routine eye examinations; eye refractions; or any related service or supply
- routine hearing examinations; hearing aids; or any related service or supply, unless otherwise specified in this section (See "Hearing Aids/Related Services for Children Under Age 21.")

PSYCHOTHERAPY (MENTAL HEALTH AND CHEMICAL DEPENDENCY)

Note: You do not receive a separate mental health/chemical dependency ID card; use your BCBSNM ID card to receive all medical/surgical and mental health/chemical dependency services covered under this Plan.

Medical Necessity

In order to be covered, treatment must be medically necessary and not experimental, investigational, or unproven. Therapy must be:

- required for the treatment of a distinct mental disorder as defined by the latest version of the *Diagnostic and Statistical Manual* published by the American Psychiatric Association; and
- reasonably expected to result in significant and sustained improvement in your condition and daily functioning; and
- consistent with your symptoms, functional impairments and diagnoses and in keeping with generally accepted national and local standards of care; and
- provided and at the least restrictive level of care.

Covered Services/Providers

Covered services include solution- focused evaluative and therapeutic mental health services (including individual and group psychotherapy) received in a psychiatric hospital, an IOP (intensive outpatient program), or an alcoholism treatment program that complies with applicable state laws and regulations, and services rendered by psychiatrists, licensed psychologists, and other providers as defined in *Section 10: Definitions*. See your BCBSNM *Provider Directory* for a list of contracting providers or check the BCBSNM website at www.bcbsnm.com.

Residential Treatment Centers

Residential treatment centers are covered by this Plan. A residential treatment center is a facility offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, and structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, supervised living, group homes, boarding houses, or other facilities that provide primarily a supportive environment and address long-term social needs, even if

counseling is provided in such facilities. Patients in residential treatment centers are medically monitored with 24-hour medical availability and 24-hour on-site nursing service for patients with mental illness and/or chemical dependency disorders.

Preauthorization Requirements

All inpatient mental health and chemical dependency services must be preauthorized by the Behavioral Health Unit at the phone number listed on the back of your ID card. Preauthorization is also required for outpatient psychological testing, neuropsychological testing, intensive outpatient program (IOP) treatment, electroconvulsive therapy (ECT), applied behavior analysis (ABA) therapies, and repetitive transcranial magnetic stimulation for treatment of mental illness and/or chemical dependency. Preauthorization is **not** required for outpatient/office group, individual, or family therapy visits to a physician or other professional provider licensed to perform covered services under this health plan. You or your physician should call the Behavioral Health Unit **before** you schedule treatment. If you do not call before receiving nonemergency services, **benefits for covered services may be reduced or denied** as explained in the *Preauthorizations* section, earlier. In such cases, you may be responsible for all charges, so please ensure that you or your provider have received preauthorization for any services you plan to receive. The BHU Call Center is open 24/7 to assist members and providers with emergency admission inquiries and to respond to crisis calls.

Exclusions

This Plan does **not** cover:

- psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education
- services billed by a school, halfway house or group home or their staff members; foster care; or behavior modification services
- maintenance therapy or care provided after you have reached your rehabilitative potential (See the "Long-Term or Maintenance Therapy" exclusion in the *General Limitations and Exclusions* section.)
- biofeedback, hypnotherapy, or behavior modification services
- religious or pastoral counseling
- custodial care (See the "Custodial Care" exclusion in *Section 6: General Limitations and Exclusions*.)
- hospitalization or admission to a skilled nursing facility, nursing home, or other facility for the primary purpose of providing custodial care services, convalescent care, rest cures, or domiciliary care to the patient
- services or supplies received during an inpatient stay when the stay is solely related to behavior, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of mental illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions)
- any care that is patient directed and is not considered medically necessary
- care that is mandated by court order or as a legal alternative, and lacks clinical necessity as diagnosed by a licensed provider; services rendered as a condition of parole or probation
- special education, school testing and evaluations, counseling, therapy, or care for learning deficiencies or educational and developmental disorders; behavioral problems unless associated with manifest mental disorders or other disturbances
- non- national standard therapies, including those that are experimental as determined by the mental health professional practice
- the cost of any damages to a treatment facility

REHABILITATION AND OTHER THERAPY

When billed by a facility during a covered admission, therapy is covered in the same manner as the other ancillary services (see "Hospital/Other Facility Services").

Acupuncture and Spinal Manipulation

This Plan covers acupuncture and osteopathic or spinal manipulation services (application of manual pressure or force to the spine) when administered by a licensed provider acting within the scope of licensure and when necessary for the treatment of a medical condition. Benefits for acupuncture and for spinal manipulation are limited as specified in the *Summary of Benefits*. **Note:** If your provider charges for other services in addition to acupuncture or manipulation, the other services will be covered according to the type of service being claimed. For example, physical therapy services from a provider on the same day as an acupuncture or manipulation service will apply toward the "Short-Term Rehabilitation" benefit.

Cardiac and Pulmonary Rehabilitation

This Plan covers outpatient cardiac rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services.

Chemotherapy and Radiation Therapy

This Plan covers the treatment of malignant disease by standard chemotherapy and treatment of disease by radiation therapy.

Cancer Clinical Trials

If you are a participant in an approved cancer clinical trial, you may receive coverage for certain routine patient care costs incurred in the trial. The trial must be conducted as part of a scientific study of a new therapy or intervention for the prevention of reoccurrence, early detection or treatment of cancer. The persons conducting the trial must provide BCBSNM with notice of when the member enters and leaves a qualified cancer clinical trial and must accept BCBSNM's covered charges as payment in full (that includes the health care Plan's payment plus your share of the covered charge).

The routine patient care costs that are covered must be the same services or treatments that would be covered if you were receiving standard cancer treatment. Benefits shall include FDA- approved prescription drugs that are not paid for by the manufacturer, distributor, or supplier of the drug. (Member cost- sharing provisions described under "Prescription Drugs and Other Items" will apply to these benefits.)

Benefits for Routine Patient Care Costs for Participation in Certain Clinical Trials

Benefits for eligible expenses for Routine Patient Care Costs are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by:

- the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
- the National Institutes of Health;
- the United States Food and Drug Administration;
- the United States Department of Defense;
- the United States Department of Veterans Affairs; or
- an institutional review board of an institution in this state that has an agreement with the Office of Human Research Protections of the United States Department of Health and Human Services.

Benefits are not available under this section for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial.

Dialysis

This Plan covers the following services when received from a dialysis provider:

- renal dialysis (hemodialysis)
- continual ambulatory peritoneal dialysis (CAPD)

- apheresis and plasmapheresis
- the cost of equipment rentals and supplies for home dialysis

Short- Term Rehabilitation: Occupational, Physical, Speech Therapy (Inpatient and Outpatient, Including Skilled Nursing Facility)

Preauthorization Required

To be covered, all **inpatient**, short- term rehabilitation treatments, including skilled nursing facility and physical rehabilitation facility admissions, must receive **preauthorization** from BCBSNM. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Covered Services

This Plan covers the following short- term rehabilitation services when rendered for the medically necessary treatment of accidental injury or illness:

- occupational therapy performed by a licensed occupational therapist
- physical therapy performed by a physician, licensed physical therapist, or other professional provider licensed as a physical therapist (such as a doctor of oriental medicine)
- joint and spinal manipulation services when administered by a licensed provider acting within the scope of licensure and when necessary for the treatment of accidental injury or medical condition
- speech therapy, including audio diagnostic testing, performed by a properly accredited speech therapist for the treatment of communication impairment or swallowing disorders caused by disease, trauma, congenital anomaly, or a previous treatment or therapy
- inpatient physical rehabilitation and skilled nursing facility services when **preauthorized** by BCBSNM

Benefit Limits

Benefits are limited, if applicable, as specified in the *Summary of Benefits.* **Note:** Long-term therapy, maintenance therapy, and therapy for chronic conditions are **not** covered. This Plan covers short-term rehabilitation only.

Exclusions

This Plan does **not** cover:

- maintenance therapy or care provided after you have reached your rehabilitative potential (Even if you have not reached your rehabilitative potential, this Plan does not cover services that exceed maximum benefit limits, if any.)
- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay and described in this *Covered Services* section under "Autism Spectrum Disorders"
- services provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered provider
- therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights)
- speech therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic; other speech services that can be carried out by the patient, the family, or caregiver/teacher
- herbs, homeopathic preparations, or nutritional supplements
- services of a massage therapist or rolfing

SUPPLIES, EQUIPMENT AND PROSTHETICS

To be covered, items must be medically necessary and ordered by a health care provider. If you have a question about durable medical equipment, medical supplies, prosthetics or appliances not listed, please call the BCBSNM Health Services Department.

Breast Pumps

If you have a **Nongrandfathered** plan, it covers the rental (but not to exceed the total cost) or purchase of manual, electric, or hospital grade breast pumps and supplies with a written prescription from a health care provider. The rental or purchase cost of manual, electric, or hospital grade breast pumps and supplies are not subject to coinsurance, deductible, copayment, or benefit maximums when received from an in-network provider. Electric breast pumps are limited to 2 per calendar year.

Diabetic Supplies and Equipment

This Plan covers the following supplies and equipment for diabetic members and individuals with elevated glucose levels due to pregnancy (supplies are not to exceed a **30- day supply** purchased during any 30- day period):

- injection aids, including those adaptable to meet the needs of the legally blind
- insulin pumps and insulin pump supplies
- blood glucose monitors, including those for the legally blind
- medically necessary podiatric appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth- inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices, and shoe modifications

Reminder: For additional diabetic supply coverage, (e.g., insulin, needle and syringes, autolet, glucose meters, test strips for glucose monitors, glucagon emergency kits), see "Prescription Drugs and Other Items."

Durable Medical Equipment and Appliances

This Plan covers the following items**:**

- orthopedic appliances
- replacement of items only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- oxygen and oxygen equipment, wheelchairs, hospital beds, crutches, and other medically necessary durable medical equipment
- lens implants for aphakic patients (those with no lens in the eye) and soft lenses or sclera shells (white supporting tissue of eyeball)
- either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) when needed to replace lenses absent at birth or lost through cataract or other intraocular surgery or ocular injury, to treat conditions related to genetic inborn errors of metabolism, or prescribed by a physician as the only treatment available for keratoconus (Duplicate glasses/lenses are not covered. Replacement is covered only if a physician or optometrist recommends a change in prescription due to a change in your medical condition.)
- cardiac pacemakers

This Plan covers the rental (or at the option of BCBSNM, the purchase of) durable medical equipment (including repairs to or replacement of such purchased items), when prescribed by a covered health care provider and required for therapeutic use.

Medical Supplies

This Plan covers the following medical supplies, not to exceed a **30- day supply** purchased during any 30- day period, unless otherwise indicated:

- colostomy bags, catheters

- gastrostomy tubes
- hollister supplies
- tracheostomy kits, masks
- lamb's wool or sheepskin pads
- ace bandages, elastic supports when billed by a physician or other provider during a covered office visit
- slings
- support hose prescribed by a physician for treatment of varicose veins (**six** pair per calendar year)

Orthotics and Prosthetic Devices

This Plan covers the following items when medically necessary and ordered by a provider:

- surgically implanted prosthetics or devices, including penile implants required as a result of illness or accidental injury
- externally attached prostheses to replace a limb or other body part lost after accidental injury or surgical removal; their fitting, adjustment, repairs and replacement
- replacement of prosthetics only when required because of wear and the item cannot be repaired) or because of a change in your condition
- breast prosthetics when required as the result of a mastectomy and mastectomy bras, which are limited to **four bras** per calendar year
- functional orthotics only for patients having a locomotive problem or gait difficulty resulting from mechanical problems of the foot, ankle, or leg (A functional orthotic is used to control the function of the joints and prescribed by a physician or podiatrist.)
- orthotics (e.g., collars, braces, molds) prescribed by an eligible provider to protect, restore, or improve impaired body function

When alternative prosthetic devices are available, the allowance for a prosthesis will be based upon the most cost-effective item.

Exclusions

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

- air conditioners, biofeedback equipment, humidifiers, purifiers, self- help devices, or whirlpools
- items that are primarily nonmedical in nature such as Jacuzzi units, hot tubs, exercise equipment, heating pads, hot water bottles or diapers
- nonstandard or deluxe equipment such as motor- driven wheelchairs, chairlifts or beds; external prosthetics that are suitable for heavier physical activity such as fast walking, jogging, bicycling, or skiing
- repairs to items that you do not own
- comfort items such as footboards, beds or mattresses of any kind, bathtub lifts, overbed tables, or telephone arms
- repair or rental costs that exceeds the purchase price of a new unit
- dental appliances (See "Dental- Related Services and Oral Surgery" for exceptions.)
- accommodative orthotics (deal with structural abnormalities of the foot, accommodate such abnormalities, and provide comfort, but do not alter function)
- orthopedic shoes, unless joined to braces (Diabetic members should refer to "Diabetic Supplies and Equipment" earlier in this section for information about covered podiatric equipment and orthopedic shoes.)
- equipment or supplies not ordered by a health care provider, including items used for comfort, convenience, or personal hygiene
- duplicate items; repairs to duplicate items; or the replacement of items because of loss, theft, or destruction

- stethoscopes or blood pressure monitors
- voice synthesizers or other communication devices
- eyeglasses or contact lenses or the costs related to prescribing or fitting of glasses or contact lenses, unless listed as covered; sunglasses, special tints, or other extra features for eyeglasses or contact lenses
- hearing aids or ear molds, fitting of hearing aids or ear molds, or related services or supplies for persons 21 or and older or, if under age 21, in excess of the maximum benefit described in this section (For surgically implanted devices for the profoundly hearing impaired, see "Surgery and Related Services" below.)
- syringes or needles for self- administering drugs (Coverage for insulin needles and syringes and other diabetic supplies not listed as covered in this section is described under "Prescription Drugs and Other Items.")
- items that can be purchased over- the- counter, including but not limited to dressings for wounds (i.e., bed sores) and burns, gauze, and bandages
- male contraceptive devices, including over- the- counter contraceptive products such as condoms; female contraceptive devices, including over-the-counter contraceptive products such as spermicide, when not prescribed by a health care provider. (See "Maternity/Reproductive Services and Newborn Care: Family Planning" for devices requiring a prescription.)
- items not listed as covered
- costs for items received from a nonpreferred provider

SURGERY AND RELATED SERVICES

To be covered, preauthorization from BCBSNM must be received for all inpatient surgical procedures. See "Preauthorizations" in *Section 4* for details.

Surgeon's Services

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

Cochlear Implants

This Plan covers cochlear implantation of a hearing device (such as an electromagnetic bone conductor) to facilitate communication for the profoundly hearing impaired, including training to use the device.

Mastectomy Services

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

This Plan also covers reconstructive breast surgery following a covered mastectomy. Coverage is limited to:

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

This Plan does **not** cover subsequent procedures to correct unsatisfactory cosmetic results attained during the initial breast/nipple surgery or tattooing, or breast surgery.

Reconstructive Surgery

Reconstructive surgery improves or restores bodily function to the level experienced before the event that necessitated the surgery, or in the case of a congenital defect, to a level considered normal. Such surgeries may have a coincidental cosmetic effect. This Plan covers reconstructive surgery when required to correct a **functional** disorder caused by:

- an accidental injury
- a disease process or its treatment (For breast surgery following a mastectomy, see "Mastectomy Services," above.)

- a functional congenital defect (any condition, present from birth, that is significantly different from the common form; for example, a cleft palate or certain heart defects)

Cosmetic procedures and procedures that are **not medically necessary**, including all services related to such procedures, will be **denied.**

Exclusions

This Plan does **not** cover:

- cosmetic or plastic surgery or procedures, such as breast augmentation, rhinoplasty, and surgical alteration of the eye that does not materially improve the physiological function of an organ or body part (unless covered under "Mastectomy Services")
- procedures to correct cosmetically unsatisfactory surgical results or surgically induced scars
- refractive keratoplasty, including radial keratotomy, or any procedure to correct visual refractive defect
- unless required as part of medically necessary diabetic disease management, trimming of corns, calluses, toenails, or bunions (except surgical treatment such as capsular or bone surgery)
- subsequent surgical procedures needed because you did not comply with prescribed medical treatment or because of a complication from a previous noncovered procedure (such as a noncovered organ transplant or previous cosmetic surgery)
- obesity treatment, including the surgical treatment of morbid obesity
- the insertion of artificial organs, or services related to transplants not specifically listed as covered under "Transplant Services"
- standby services unless the procedure is identified by BCBSNM as requiring the services of an assistant surgeon and the standby physician actually assists

Anesthesia Services

This Plan covers necessary anesthesia services, including acupuncture used as an anesthetic, when administered during a covered surgical procedure by a physician, certified registered nurse anesthetist (CRNA), or other practitioner licensed to provide anesthesia.

Exclusions

This Plan does **not** cover local anesthesia, except for preventive colonoscopies. (Coverage for surgical procedures includes an allowance for local anesthesia because it is considered a routine part of the surgical procedure.)

Assistant Surgeon Services

Covered services include services of a professional provider who actively assists the operating surgeon in the performance of a covered surgical procedure when the procedure requires an assistant.

Exclusions

This Plan does **not** cover:

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

TRANSPLANT SERVICES

Preauthorization, requested in writing, must be obtained from BCBSNM **before** a pretransplant evaluation is scheduled. A pretransplant evaluation is **not** covered if preauthorization is not obtained from BCBSNM. If approved, a BCBSNM case manager will be assigned to you (the transplant recipient candidate) and must later be contacted 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 also received. None of the benefits described here are available unless you have this preauthorization. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

Facility Must Be in Transplant Network

Benefits for covered services will be approved only when the transplant is performed at a facility that contracts with BCBSNM, another Blue Cross Blue Shield (BCBS) Plan or the national BCBS transplant network, for the transplant being provided. Your BCBSNM case manager will assist your provider with information on the exclusive network of contracted facilities and required approvals. Call BCBSNM Health Services for information on these BCBSNM transplant programs.

Effect of Medicare Eligibility on Coverage

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

Organ Procurement or Donor Expenses

If a transplant is covered, the surgical removal, storage, and transportation of an organ acquired from a cadaver is also covered. If there is a living donor that requires surgery to make an organ available for a covered transplant, coverage is available for expenses incurred by the donor for surgery, organ storage expenses, and inpatient follow- up care only.

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

Bone Marrow, Cornea or Kidney

This Plan covers the following transplant procedures if **preauthorization** is received from BCBSNM (See *Section 4: Preauthorizations* for more information about preauthorization requirements.):

- bone marrow transplant for a member with aplastic anemia, leukemia, severe combined immunodeficiency disease (SCID), or Wiskott- Aldrich syndrome, and other conditions determined by BCBSNM to be medically necessary and not experimental, investigational, or unproven
- cornea transplant
- kidney transplant

Cost-Sharing Provisions

Covered services related to the above transplants are subject to the usual cost- sharing features and benefit limits of this Plan (e.g., deductible, coinsurance and out- of- pocket limits; and annual home health care maximums, if applicable).

Heart, Heart- Lung, Liver, Lung, Pancreas- Kidney

This Plan covers transplant- related services for a **heart, heart- lung, liver, lung or pancreas- kidney** transplant. Services must be **preauthorized** in order to be covered. All other limitations, requirements, and exclusions of this "Transplant Services" provision apply to these transplant- related services. See *Section 4: Preauthorizations* for more information about preauthorization requirements.

In addition to the general provisions of this "Transplant Services" section, the following benefits, limitations, and exclusions apply to the above-listed transplants for **one year** following the date of the actual transplant or retransplant. After one year, usual benefits apply and the services must be covered under other provisions of the Plan in order to be considered for benefit payment.

Recipient Travel and Per Diem Expenses

If BCBSNM requires you (i.e., the transplant recipient) to temporarily relocate outside of your city of residence to receive a covered transplant, travel to the city where the transplant will be performed is covered. A standard

per diem benefit **($50)** will be allocated for lodging expenses for the recipient and one additional adult traveling with the transplant recipient. If the transplant recipient is an eligible child under the age of 18, benefits for travel and per diem expenses for **two adults** to accompany the child are available.

Travel expenses and standard per diem allowances are limited to a total combined lifetime maximum benefit of **$10,000** per transplant. Your case manager may approve travel and per diem lodging allowances based upon the total number of days of temporary relocation, up to the **$10,000** benefit maximum.

Travel expenses are **not** covered and per diem allowances are **not** paid if you *choose* to travel to receive a transplant for which travel is not considered medically necessary by the case manager or if the travel occurs **more than five days** before or **more than one year** following the transplant or retransplant date.

Transplant Exclusions

This Plan does **not** cover:

- transplant-related services for a transplant that did not receive **preauthorization** from BCBSNM (See *Section 4: Preauthorizations* for more information about preauthorization requirements.)
- any transplant or organ- combination transplant not listed as covered
- implantation of artificial organs or devices (mechanical heart, unless covered under BCBSNM medical policy)
- nonhuman organ transplants
- care for complications of noncovered transplants or follow- up care related to such transplants
- services related to a transplant performed in a facility not contracted directly or indirectly with BCBSNM to provide the required transplant (except cornea, kidney, or bone marrow)
- expenses incurred by a member of this plan for the donation of an organ to another person
- drugs that are self- administered or for use while at home (These services may be covered under "Prescription Drugs and Other Items.")
- donor expenses after the donor has been discharged from the transplant facility
- lodging expenses in excess of the per diem allowance, if available, and food, beverage, or meal expenses
- travel or per diem expenses:
  - incurred **more than five days before** or **more than one year following** the date of transplantation
  - if the recipient's case manager indicates that travel is not medically necessary
  - related to a bone marrow or kidney transplant
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; telephone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- expenses charged only because benefits are available under this provision (such as transportation received from a member of your family, or from any other person charging for transportation that does not ordinarily do so)

SECTION 6: GENERAL LIMITATIONS AND EXCLUSIONS

These general limitations and exclusions apply to **all** services listed in this benefit booklet.

This Plan does not cover any service or supply not specifically listed as a covered service in this benefit booklet. If a service is not covered, then all services performed in conjunction with it are not covered.

This Plan will not cover any of the following services, supplies, situations, or related expenses:

— Before Effective Date of Coverage

This Plan does not cover any service received, item purchased, prescription filled, or health care expense incurred before your effective date of coverage. If you are an inpatient when coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date.

— Biofeedback

This Plan does not cover services related to biofeedback.

— Blood Services

This Plan does not cover directed donor or autologous blood storage fees when the blood is used during a nonscheduled surgical procedure. **This Plan does not cover** blood replaced through donor credit.

— Complications of Noncovered Services

This Plan does not cover any services, treatments, or procedures required as the result of complications of a noncovered service, treatment, or procedure (e.g., due to a cosmetic surgery, transplant, or experimental procedure).

— Convalescent Care or Rest Cures

This Plan does not cover convalescent care or rest cures.

— Cosmetic Services

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

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

Exception: Breast/nipple surgery performed as reconstructive procedures following a covered mastectomy may be covered. However, **Preauthorization**, requested in writing, must be obtained from BCBSNM for such services. Also, reconstructive surgery, which may have a coincidental cosmetic effect, may be covered when required as the result of accidental injury, illness, or congenital defect.

— Custodial Care

This Plan does not cover Custodial Care. Custodial Care is any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care includes those services which do not require the technical

skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel assisting with routine medical needs (e.g., simple care and dressings, administration of routine medications, etc.), and/or assisting with activities of daily living (e.g., bathing, eating, dressing, etc.).

— Dental- Related Services and Oral Surgery

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see "Dental- Related Services and Oral Surgery" in *Section 5: Covered Services* for additional exclusions.

— Domiciliary Care

This Plan does not cover domiciliary care or care provided in a residential institution, treatment center, halfway house, or school because your own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

— Duplicate (Double) Coverage

This Plan does not cover amounts already paid by other valid coverage or that would have been paid by Medicare as the primary carrier if you were entitled to Medicare, had applied for Medicare, and had claimed Medicare benefits. See *Section 7: Coordination of Benefits and Reimbursement* for more information. Also, if your prior coverage has an extension of benefits provision, **this Plan will not cover** charges incurred after your effective date of coverage under this Plan that are covered under the prior plan's extension of benefits provision.

— Duplicate Testing

This Plan does not cover duplicative diagnostic testing that overlaps laboratory, pathology, or radiology tests.

— Experimental, Investigational, or Unproven Services

This Plan does not cover any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical practice* (as defined) or those considered experimental, investigational, or unproven, unless for acupuncture rendered by a licensed doctor of oriental medicine or unless specifically listed as covered under "Autism Spectrum Disorders" or under "Cancer Clinical Trials" in *Section 5: Covered Services*. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted when services were administered, the service is experimental and will not be covered. To be considered experimental, investigational or unproven, one or more of the following conditions must be met:

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

The guidelines and practices of Medicare, the FDA, or other government programs or agencies may be considered in a determination; however, approval by other bodies will neither constitute nor necessitate approval by BCBSNM.

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

The service must be medically necessary and not excluded by any other contract exclusion.

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

- have been demonstrated in standard medical textbooks published in the United States and/or peer- reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the hospital or other facility provider in which they were performed; and
- the physician or other professional provider has had the appropriate training and experience to provide the treatment or procedure.

— Food or Lodging Expenses

This Plan does not cover food or lodging expenses, except for those lodging expenses that are eligible for a per diem allowance under "Transplant Services" in *Section 5: Covered Services,* and not excluded by any other provision in this section.

— Hair Loss Treatments

This Plan does not cover wigs, artificial hairpieces, hair transplants or implants or medication used to promote hair growth or control hair loss, even if there is a medical reason for hair loss.

— Hearing Examinations, Procedures and Aids

This Plan does not cover audiometric (hearing) tests **unless** 1) required for the diagnosis and/or treatment of an accidental injury or an illness, or 2) covered as a preventive *screening* service or 3) covered as part of the hearing aid benefit for members under age 21 and described under "Hearing Aid Related Services for Children Under Age 21" in *Section 5: Covered Services.* (A screening does *not* include a hearing test to determine the amount and kind of correction needed.) **This Plan does not cover** hearing aids or ear molds, fitting of hearing aids or ear molds, or any related service or supply for **members age 21 and older.** For **members under age 21**, see "Hearing Aids/Related Services for Children Under Age 21" in *Section 5.* (For surgically implanted devices, see "Surgery and Related Services" in *Section 5: Covered Services.*)

— Home Health, Home I.V. and Hospice Services

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see "Home Health Care/Home I.V. Services" or "Hospice Care" in *Section 5: Covered Services* for additional exclusions.

— Hypnotherapy

This Plan does not cover hypnosis or services related to hypnosis, whether for medical or anesthetic purposes.

— Infertility Services/Artificial Conception

This Plan does not cover services related to, but not limited to, procedures such as: artificial conception or insemination, fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such as in- vivo or in- vitro ("test tube") fertilization, Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), embryo transfer, drugs for induced ovulation, or other artificial methods of conception. **This Plan does not cover** the cost of donor sperm, costs associated with the collection, preparation, or storage of sperm for artificial insemination, or donor fees.

This Plan does not cover infertility testing, treatments, or related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization.

This Plan does not cover reversal of a prior sterilization procedure. (Certain treatments of medical conditions that sometimes result in restored fertility may be covered; see "Maternity/Reproductive Services and Newborn Care" in *Section 5: Covered Services*.)

— Late Claim Filing

This Plan does not cover services of a nonparticipating provider if the claim for such services is received by BCBSNM **more than 12 months** after the date of service. (Preferred providers contracting directly with BCBSNM and providers that have a "participating" provider agreement with BCBSNM will file claims for you and must submit them within a specified period of time, usually 180 days.) If a claim is returned for further information, resubmit it **within 45 days. Note:** If there is a change in the Claims Administrator, the length of the timely filing period may also change. See "Filing Claims" in *Section 8: Claim Payments and Appeals* for details.

— Learning Deficiencies/Behavioral Problems

This Plan does not cover special education, counseling, therapy, diagnostic testing, treatment, or any other service for learning deficiencies or chronic behavioral problems, whether or not associated with a manifest mental disorder, retardation, or other disturbance. See "Autism Spectrum Disorders" in *Section 5: Covered Services* for details about mandated coverage for children with these diagnoses.

— Limited Services/Covered Charges

This Plan does not cover amounts in excess of covered charges or services that exceed any maximum benefit limits listed in this benefit booklet, or any amendments, riders, addenda, or endorsements.

— Local Anesthesia

This Plan does not cover local anesthesia. (Coverage for surgical, maternity, diagnostic, and other procedures includes an allowance for local anesthesia because it is considered a routine part of the procedure.)

— Long- Term and Maintenance Therapy

This Plan does not cover long- term therapy whether for physical or mental conditions, even if medically necessary and even if any applicable benefit maximum has not yet been reached, except that medication management for chronic conditions is covered. Therapies considered long- term if measurable improvement is not possible **within two months** of beginning active therapy. Long-term therapy includes treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Treatment of chronic conditions is not covered. (Chronic conditions include, but are not limited to, muscular dystrophy, Down's syndrome, and cerebral palsy.) **Note:** This exclusion does **not** apply to benefits for medication or medication management or to certain services covered for children with autism spectrum disorders.

This Plan does not cover maintenance therapy or care or any treatment that does not significantly improve your function or productivity, or care provided after you have reached your rehabilitative potential (unless therapy is covered during an approved hospice benefit period). In a dispute about whether your rehabilitative potential has been reached, you are responsible for furnishing documentation from your physician supporting his/her opinion. **Note:** Even if your rehabilitative potential has not yet been reached, **this Plan does not cover** services that exceed maximum benefit limits.

— Medical Policy Determinations

Any technologies, procedures, or services for which medical policies have been developed by BCBSNM are either limited or excluded as defined in the medical policy. (See "Medical Policy" in *Section 10: Definitions).*

— Medically Unnecessary Services

This Plan does not cover services that are not medically necessary as defined in *Section 5: Covered Services* unless such services are specifically listed as covered (e.g., see "Preventive Services" or "Autism Spectrum Disorders" in *Section 5: Covered Services*).

BCBSNM, in consultation with the provider, determines whether a service or supply is medically necessary and whether it is covered. Because a provider prescribes, orders, recommends, or approves a service or supply does *not* make it medically necessary or make it a covered service, even if it is not specifically listed as an exclusion. (BCBSNM, at its sole discretion, determines medical necessity based on the criteria given in *Section 5: Covered Services*.)

— No Legal Payment Obligation

This Plan does not cover services for which you have no legal obligation to pay or that are free, including:

- charges made only because benefits are available under this Plan
- services for which you have received a professional or courtesy discount
- volunteer services
- services provided by you for yourself or a covered family member, by a person ordinarily residing in your household, or by a family member
- physician charges exceeding the amount specified by Centers for Medicare & Medicaid Services (CMS) when primary benefits are payable under Medicare

Note: The "No Legal Payment Obligation" exclusion does not apply to services received at Department of Defense facilities or covered by Indian Health Service/Contract Health Services, and Medicaid.

— Noncovered Providers of Service

This Plan does not cover services prescribed or administered by a:

- member of your immediate family or a person normally resident in your home
- physician, other person, supplier, or facility (including staff members) that are not specifically listed as covered in this benefit booklet, such as a:
  - — health spa or health fitness center (whether or not services are provided by a licensed or registered provider)
  - — school infirmary
  - — halfway house
  - — massage therapist
  - — private sanitarium
  - — extended care facility or similar institution
  - — dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group
  - — homeopathic or naturopathic provider

— Nonemergency Services

This Plan does not cover nonemergency services outside the United States.

— Nonmedical Expenses

This Plan does not cover nonmedical expenses (even if medically recommended and regardless of therapeutic value), including costs for services or items such as, but not limited to:

- adoption or surrogate expenses
- educational programs such as behavior modification and arthritis classes (Some diabetic services and other educational programs may be covered; see "Physician Visits/Medical Care" and "Preventive Services" in *Section 5: Covered Services* for details.)
- vocational or training services and supplies
- mailing and/or shipping and handling
- missed appointments; "get- acquainted" visits without physical assessment or medical care; provision of medical information to perform admission review or other preauthorizations; filling out of claim forms; copies of medical records; interest expenses
- modifications to home, vehicle, or workplace to accommodate medical conditions; voice synthesizers; other communication devices

- membership at spas, health clubs, or other such facilities
- personal convenience items such as air conditioners, humidifiers, exercise equipment, or personal services such as haircuts, shampoos, guest meals, and television rentals, Internet services
- personal comfort services, including homemaker and housekeeping services, except in association with respite care covered during a hospice admission
- immunizations or medications required for international travel
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; phone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- physicals or screening examinations and immunizations given primarily for insurance, licensing, employment, camp, weight reduction programs, medical research programs, sports, or for any nonpreventive purpose
- hepatitis B immunizations when required due to possible exposure during the member's work
- court- or police- ordered services unless the services would otherwise be covered or services rendered as a condition of parole or probation
- the cost of any damages to a treatment facility that are caused by the member

— Nonpreferred Provider Services

This Plan does not cover transplants when received from a nonpreferred provider.

— Nonprescription Drugs

This Plan does not cover nonprescription or over- the- counter drugs, medications, ointments, or creams, including herbal or homeopathic preparations, or prescription drugs that have over- the- counter equivalents, except for those products specifically listed as covered under "Prescription Drugs and Other Items."

— Nutritional Supplements

This Plan does not cover vitamins, dietary/nutritional supplements, special foods, formulas, mother's milk, or diets, unless prescribed by a physician. Such supplements require a prescription to be covered under the "Home Health Care/Home I.V. Services" in *Section 5: Covered Services*. This Plan covers other nutritional products only under specific conditions set forth under "Prescription Drugs and Other Items."

— Obesity Surgery

This Plan does not cover any and all surgical treatments of obesity including, without limitation, gastric bypass or other type of bariatric surgery under any circumstance. This is true regardless of the presence or absence of other medical conditions that can be either directly or indirectly attributed to obesity. Obesity means any diagnosis of obesity including morbid obesity.

— Post- Termination Services

This Plan does not cover any service received or item or drug purchased after your coverage is terminated, even if: 1) preauthorization for such service, item, or drug was received from BCBSNM, or 2) the service, item, or drug was needed because of an event that occurred while you were covered. (If you are an inpatient when coverage ends, benefits for the admission will be available only for those covered services received before your termination date.)

— Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products and Special Medical Foods

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see *Section 5: Covered Services,* "Prescription Drugs and Other Items" for additional exclusions.

— Preauthorization Not Obtained When Required

This Plan does not cover certain services if you do not obtain preauthorization from BCBSNM before those services are received. See *Section 4: Preauthorizations.*

— Private Duty Nursing Services

This Plan does not cover private duty nursing services.

— Psychotherapy (Mental Health and Chemical Dependency)

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see "Psychotherapy (Mental Health and Chemical Dependency)" in *Section 5: Covered Services* for additional exclusions.

— Sexual Dysfunction Treatment

This Plan does not cover services related to the treatment of sexual dysfunction.

— Supplies, Equipment and Prosthetics

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see "Supplies, Equipment and Prosthetics" in *Section 5: Covered Services* for additional exclusions.

— Surgery and Related Services

In addition to services excluded by the other general limitations and exclusions listed throughout this section, see "Surgery and Related Services" in *Section 5: Covered Services* for additional exclusions.

— Therapy and Counseling Services

This Plan does not cover therapies and counseling programs other than the therapies listed as covered in this benefit booklet. In addition to treatments excluded by the other general limitations and exclusions listed throughout this section, (see "Rehabilitation and Other Therapy" in *Section 5: Covered Services* for additional exclusions) **this Plan does not cover** services such as, but not limited to:

- recreational, sleep, crystal, primal scream, sensory and Z therapies
- self- help, stress management, weight-loss and chemical dependency programs
- Smoking/tobacco use cessation counseling program that does not meet the standards described under "Cessation Counseling" in *Section 10: Definitions*.
- services of a massage therapist or rolfing
- transactional analysis, encounter groups, and transcendental meditation (TM); moxibustion; sensitivity or assertiveness training
- vision therapy; orthoptics
- pastoral, spiritual, or religious counseling
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this plan
- therapy for chronic conditions such as, but not limited to, cerebral palsy or developmental delay and described in *Section 5* under "Autism Spectrum Disorders"
- any therapeutic exercise equipment for home use (e.g., treadmill, weights)
- speech therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic, other speech services that can be carried out by the patient, the family, or caregiver/teacher

— Thermography

This Plan does not cover thermography (a technique that photographically represents the surface temperatures of the body).

— Transplant Services

Please see "Transplant Services" in *Section 5: Covered Services* for specific transplant services that are covered and related limitations and exclusions. In addition to services excluded by the other general limitations and exclusions listed throughout this section, **this Plan does not cover** any other transplants (or organ- combination transplants) or services related to any other transplants.

— Travel or Transportation

This Plan does not cover travel expenses, even if travel is necessary to receive covered services unless such services are eligible for coverage under "Transplant Services" or "Ambulance Services" in *Section 5: Covered Services*.

— Veteran's Administration Facility

This Plan does not cover services or supplies furnished by a Veterans Administration facility for a service- connected disability or while a member is in active military service.

— Vision Services

This Plan does not cover any services related to refractive keratoplasty (surgery to correct nearsightedness) or any complication related to keratoplasty, including radial keratotomy or any procedure designed to correct visual refractive defect (e.g., farsightedness or astigmatism). **This Plan does not cover** eyeglasses, contact lenses, prescriptions associated with such procedures, and costs related to the prescribing or fitting of glasses or lenses, unless listed as covered under "Supplies, Equipment and Prosthetics" in *Section 5: Covered Services.* **This Plan does not cover** sunglasses, special tints, or other extra features for eyeglasses or contact lenses.

— War- Related Conditions

This Plan does not cover any service required as the result of any act of war or related to an illness or accidental injury sustained during combat or active military service.

— Weight Management

This Plan does not cover weight-loss or other weight-management programs, dietary control, or medical obesity treatment, other than counseling programs as required under federal law for **Nongrandfathered** plans unless dietary advice and exercise are provided by a physician, nutritionist, or dietitian licensed by the appropriate agency. Call a Customer Service Advocate for assistance.

— Work- Related Conditions

This Plan does not cover services resulting from work- related illness or injury, or charges resulting from occupational accidents or sickness covered under:

- occupational disease law
- employer's liability
- municipal, state or federal law (except Medicaid)
- Workers' Compensation Act

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

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

- You fail to file a claim within the filing period allowed by the applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations.
- You obtain care not authorized by Workers' Compensation insurance.
- Your employer fails to carry the required Workers' Compensation insurance. (The employer may be liable for an employee's work- related illness or injury expenses.)
- You fail to comply with any other provisions of the law.

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

SECTION 7: COORDINATION OF BENEFITS (COB) AND REIMBURSEMENT

For a work- related injury or condition, see the "Work- Related Conditions" exclusion in Section 6: General Limitations and Exclusions.

This Plan contains a coordination of benefits (COB) provision that prevents duplication of payments. When you are enrolled in any other valid coverage, the combined benefit payments from all coverages cannot exceed 100 percent of BCBSNM's covered charges. (Other valid coverage is defined as all other group and individual (or direct-pay) insurance policies or health care plans including Medicare, but excluding Indian Health Service and Medicaid coverages, that provide payments for medical services and are considered other valid coverage for purposes of coordinating benefits under this Plan.)

If you are also covered by Medicare, special COB rules may apply. Contact a Customer Service Advocate for more information. If you are enrolled in federal continuation coverage, coverage ends at the beginning of the month when you become entitled to Medicare or when you become insured under any other valid coverage.

When this Plan is secondary, all provisions (such as obtaining preauthorization) must be followed or benefits may be denied.

The following rules determine which coverage pays first:

No COB Provision — If the other valid coverage does not include a COB provision, that coverage pays first.

Medicare — If the other valid coverage is Medicare and Medicare is not secondary according to federal law, Medicare pays first.

Child/Spouse — If a covered child under this health plan is also covered as a spouse under another health plan, the covered child's spouse's health plan is primary over this health plan.

Subscriber/Family Member — If the member who receives care is covered as an employee, retiree, or other policy holder (i.e., as the subscriber) under one health plan and as a spouse, child, or other family member under another, the health plan that designates the member as the employee, retiree, or other policy holder (i.e., as the subscriber) pays first.

If you have other valid coverage *and* Medicare, contact the other carrier's customer service department to find out if the other coverage is primary to Medicare. There are many federal regulations regarding Medicare Secondary Payer provisions, and other coverage may not be subject to those provisions.

Child — For a child whose parents are not separated or divorced, the coverage of the parent whose birthday falls earlier in the calendar year pays first. If the other valid coverage does not follow this rule, the father's coverage pays first.

Child, Parents Separated or Divorced — For a child of divorced or separated parents, benefits are coordinated in the following order:

— *Court- Decreed Obligations.* Regardless of which parent has custody, if a court decree specifies which parent is financially responsible for the child's health care expenses, the coverage of that parent pays first.

— *Custodial/Noncustodial.* The plan of the custodial parent pays first. The plan of the spouse of the custodial parent pays second. The plan of the noncustodial parent pays last.

— *Joint Custody.* If the parents share joint custody, and the court decree does not state which parent is responsible for the health care expenses of the child, the plans follow the rules that apply to children whose parents are not separated or divorced.

Active/Inactive Employee — If a member is covered as an active employee under one coverage and as an inactive employee under another, the coverage through active employment pays first. (Even if a member is covered as a family member under both coverages, the coverage through active employment pays first.) If the other plan does not have this rule and the plans do not agree on the order of benefits, the next rule applies.

Longer/Shorter Length of Coverage — When none of the above applies, the plan in effect for the longest continuous period of time pays first. (The start of a new plan does not include a change in the amount or scope of benefits, a change in the entity that pays, provides, or administers the benefits, or a change from one type of plan to another.)

Responsibility For Timely Notice

BCBSNM is not responsible for coordination of benefits if timely information is not provided.

Facility of Payment

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

Overpayments - Right of Recovery

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

REIMBURSEMENT

If you or one of your covered family members incur expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for covered services described in this benefit booklet, you agree:

- **County of Los Alamos** has the right to reimbursement for all benefits provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of that sickness or injury, in the amount of the total covered charges for covered services for which **County of Los Alamos** has provided benefits to you or your covered family members.
- **County of Los Alamos** is subrogated the right to recover from the third party, or his or her insurer, to the extent of the benefits **County of Los Alamos** provided for that sickness or injury.

County of Los Alamos shall have the right to full reimbursement out of all funds you, your covered family members, or your legal representative, collect or were able to obtain for the same expenses for which **County of Los Alamos** has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that BCBSNM and/or **County of Los Alamos** may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

SECTION 8: CLAIMS PAYMENTS AND APPEALS

FILING CLAIMS

You must submit claims **within 12 months** after the date services or supplies were received. If a claim is returned for further information, resubmit it **within 45 days. Note:** If there is a change in the Claims Administrator, the length of the timely filing period may also change.

IMPORTANT NOTE ABOUT FILING CLAIMS

This section addresses the procedures for filing claims and appeals. The instructions in no way imply that filing a claim or an appeal will result in benefit payment and do not exempt you from adhering to all of the provisions described in this benefit booklet. All claims submitted will be processed by BCBSNM according to the patient's eligibility and benefits in effect at the time services are received. Whether inside or outside New Mexico and/or the United States, you must meet all preauthorization requirements or benefits may be reduced or denied as explained in *Section 4: Preauthorizations.* Covered services are the same services listed as covered in *Section 5: Covered Services* and all services are subject to the limitations and exclusions listed throughout this booklet.

IF YOU HAVE OTHER VALID COVERAGE

When you have other valid coverage that is "primary" over this Plan, you must file your claim with the other coverage first. (See *Section 7: Coordination of Benefits (COB) and Reimbursement.*) After your other coverage (including health care insurance, dental or vision plan, Medicare, automobile, or other liability insurance, Workers' Compensation, etc.) pays its benefits, a copy of their payment explanation form must be attached to the claim sent to BCBSNM or to the local BCBS Plan, as instructed under "Where to Send Claim Forms" later in this section.

If the other valid coverage pays benefits to you (or your family member) directly, give your provider a copy of the payment explanation so that he/she can include it with the claim sent to BCBSNM or to the local BCBS Plan. (If a nonparticipating provider does not file claims for you, attach a copy of the payment explanation to the claim that you send to BCBSNM or to the local BCBS Plan, as applicable.)

PARTICIPATING AND PREFERRED PROVIDERS

Your "preferred" provider may have two agreements with the local BCBS Plan — a preferred provider contract and another participating provider contract. Some providers have **only** the participating provider contract and are **not** considered preferred providers and their services are **not** covered except during an emergency or unless listed as an "exception" in *Section 3: How Your Plan Works.* However, all participating and preferred providers file claims with their local BCBS Plan and payment is made directly to them. Be sure that these providers know you have health care coverage administered by BCBSNM. Do **not** file claims for these services yourself.

Preferred providers (and participating providers contracting directly with BCBSNM) also have specific timely filing limits in their contracts with BCBSNM (usually 180 days). The providers' contract language lets them know that they may not bill the employer, any member for a service if the provider does not meet the filing limit for that service and the claim for that service is denied due to timely filing limitations.

NONPARTICIPATING PROVIDERS

A nonparticipating provider is one that has neither a preferred or a participating provider agreement. If your nonparticipating provider does not file a claim for you, submit a separate claim form for each family member as the services are received. Attach itemized bills and, if applicable, your other valid coverage's payment explanation, to a *Member Claim Form.* (Forms can be printed from the BCBSNM website at www.bcbsnm.com or requested from a Customer Service Advocate.) Complete the claim form using the instructions on the form. (See special claim filing instructions for out- of- country claims under "Where to Send Claim Forms" later in this section.)

Payment normally is made to the provider. However, if you have already paid the provider for the services being claimed, your claim must include evidence that the charges were paid in full. Upon approval of the claim, BCBSNM will reimburse you for covered services, based on covered charges, less any required member copayment. You will be responsible for charges not covered by the Plan.

ITEMIZED BILLS

Claims for covered service must be itemized on the provider's billing forms or letterhead stationery and must show:

- member's identification number
- member's and subscriber's name and address
- member's date of birth and relationship to the subscriber
- name, address, National Provider Identification number (NPI), and tax ID or social security number of the provider
- date of service or purchase, diagnosis, type of service or treatment, procedure, and amount charged for each service (each service must be listed separately)
- accident or surgery date (when applicable)
- amount paid by you (if any) along with a receipt, cancelled check, or other proof of payment

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

Do not file for the same service twice unless asked to do so by a Customer Service Advocate. If your itemized bills include services previously filed, identify clearly the new charges that you are submitting. (See "Where to Send Claim Forms" below, for special instructions regarding out- of- country claims.)

WHERE TO SEND CLAIM FORMS

If your nonparticipating provider does not file a claim for you, you (not the provider) are responsible for filing the claim. **Remember:** Participating and preferred providers will file claims for you; these procedures are used only when you must file your own claim.

Services in United States, Canada, Jamaica, U.S. Virgin Islands, and Puerto Rico

If a nonparticipating provider will not file a claim for you, ask for an itemized bill and complete a claim form the same way that you would for services received from any other nonparticipating provider. Mail the claim forms and itemized bills to BCBSNM at the address below (or, if you prefer, you may send to the local Blue Cross Blue Shield Plan in the state where the services were received):

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

Mental Health/Chemical Dependency Claims

Claims for covered mental health and chemical dependency services received in New Mexico should be submitted to:

BCBSNM, BH Unit
P.O. Box 27630
Albuquerque, New Mexico 87125- 7630

Drug Plan Claims

If you purchase a prescription drug or other item covered under the drug plan from a nonparticipating pharmacy or other provider in an emergency, or if you do not have your ID card with you when purchasing a prescription or other covered item, you must pay for the prescription in full and then submit a claim to BCBSNM's pharmacy benefit manager. **Do not send these claims to BCBSNM.** The bills or receipts must be issued by the pharmacy and must include the pharmacy name and address, drug name, prescription number, and amount charged. If not included in

your enrollment materials, you can obtain the name and address of the pharmacy benefit manager and the necessary claim forms from a Customer Service Advocate or on the BCBSNM website at www.bcbsnm.com.

Services Outside the United States, U.S. Virgin Islands, Jamaica, Puerto Rico, or Canada

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

You will need to pay up front for care received from a **doctor,** a **participating outpatient hospital,** and/or a **nonparticipating hospital.** Then, complete an *International Claim Form* and send it with the bill(s) to the BlueCard Worldwide Service Center (the address is on the form). The *International Claim Form* is available from BCBSNM, the BlueCard Worldwide Service Center, or on-line at:

www.bcbs/com/already-a-member/coverage-home-and away.html

The BlueCard Worldwide *International Claim Form* is to be used to submit institutional and professional claims for benefits for covered emergency services received outside the United States, Puerto Rico, Jamaica and the U.S. Virgin Islands. For filing instructions for other claim types (e.g., dental, prescription drugs, etc.) contact your Blue Cross and Blue Shield Plan. 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* (available at www.bcbs.com), 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, the *Explanation of Benefits* will be mailed to the subscriber 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

CLAIMS PAYMENT PROVISIONS

Most claims will be evaluated and you and/or the provider notified of the BCBSNM benefit decision within 30 days of receiving the claim. If all information needed to process the claim has been submitted, but BCBSNM cannot make a determination within 30 days, you will be notified (before the expiration of the 30- day period) that an additional 15 days is needed for claim determination.

After a claim has been processed, the subscriber will receive an *Explanation of Benefits* (EOB). The EOB indicates what charges were covered and what charges, if any, were not. **Note:** If a Qualified Child Medical Support Order (QCMSO) is in effect, the QCMSO provisions will be followed. For example, when the member is an eligible child of divorced parents, and the subscriber under this Plan is the noncustodial parent, the custodial parent may receive the payment and the EOB.

If A Claim or Preauthorization Is Denied

If benefits are denied or only partially paid, BCBSNM will notify you of the determination. The notice to you will include: 1) the reasons for denial; 2) a reference to the health care plan provisions on which the denial is based; and 3) an explanation of how you may appeal the decision if you do not agree with the denial. (See "Complaints/Appeals Summary," later in this section.) **You also have 180 days in which to appeal a decision.**

Covered Charge

Provider payments are based upon preferred provider and participating provider agreements and covered charges as determined by BCBSNM. For services received outside of New Mexico, covered charges may be based on the local Plan practice (e.g., for out- of- state providers that contract with their local Blue Cross and Blue Shield Plan, the covered charge may be based upon the amount negotiated by the other Plan with its own contracted providers). You are responsible for paying copayments, deductibles, coinsurance, any penalty amounts, and noncovered expenses. For covered services received in foreign countries, BCBSNM will use the exchange rate in effect on the date of service in order to determine billed charges.

Participating and Preferred Providers

Payments for covered services usually are sent directly to network (preferred or participating) providers. The EOB you receive explains the payment.

Nonparticipating Providers

If covered services are received from a nonparticipating provider, payments are usually made to the subscriber (or to the applicable alternate payee when a QCMSO is in effect). The check will be attached to an EOB that explains BCBSNM's payment. In these cases, you are responsible for arranging payment to the provider and for paying any amounts greater than covered charges plus copayments, deductibles, coinsurance, any penalty amounts, and noncovered expenses.

Accident- Related Hospital Services

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

Assignment of Benefits

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

Emergency Service Pricing

Notwithstanding anything in this booklet to the contrary, for out-of-network emergency care services, the covered charge shall be equal to at least the greatest of the following three amounts - not to exceed billed charges:

- the median amount negotiated with in-network providers for emergency care services furnished;
- the amount for the emergency care service calculated using the same method the Plan generally uses to determine payments for nonparticipating provider services but substituting the in-network provider cost-sharing provisions for the out-of-network cost-sharing provisions; or
- the amount that would be paid under Medicare for the emergency care service.

Each of these three amounts is calculated excluding any in-network copayment or coinsurance imposed with respect to the member.

Medicaid

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

Medicare

If you are 65 years of age or older, BCBSNM will suspend your claims until it receives (a) an *Explanation of Medicare Benefits (EOMB)* for each claim (if you are entitled to Medicare), or (b) Social Security Administration documentation showing that you are not entitled to Medicare.

Overpayments

If BCBSNM makes an erroneous benefit payment to the subscriber or member for any reason (e.g., provider billing error, claims processing error), BCBSNM may recover overpayments from you. If you do not refund the overpayment, BCBSNM reserves the right to withhold future benefit payments to apply to the amount that you owe the Plan, and to take legal action to correct payments made in error.

BLUECARD® PROGRAM

Blue Cross and Blue Shield of New Mexico (BCBSNM) has relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Program Arrangements." Whenever you obtain healthcare services outside of the BCBSNM service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard program.

Typically, when accessing care outside of the BCBSNM service area, you will obtain care from healthcare providers that have a contractual agreement (i.e. are "contracted providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from noncontracted providers. BCBSNM payment practices in both instances are described below.

Inter-Plan Program Arrangements link the BCBSNM provider network with other individual Blue Cross Blue Shield networks across the country to provide you broad access to contracted providers. Contracted providers may be contracted with either BCBSNM or the Host Blue. Noncontracted providers are not contracted with either BCBSNM or the Host Blue.

You always have the choice to receive services from contracted or noncontracted providers in New Mexico or outside New Mexico, but the difference in the amount you pay may be substantial. When services are received by you outside of New Mexico from either contracted or noncontracted providers, the Host Blue will provide BCBSNM with a covered charge based on what it uses for its own local members for services received from either contracted or noncontracted providers in the state where the Host Blue is located.

For purposes of the Inter-Plan Arrangements described in this section, "covered charge" means the amount that BCBSNM determines is fair and reasonable for a particular covered and medically necessary service, as provided to BCBSNM by a Host Blue. After the member's share of the covered charge is calculated, BCBSNM will pay the remaining amount of the covered charge up to the maximum benefit limitation, if any. For services received in foreign countries, BCBSNM will use the exchange rate in effect on the date of service in order to determine the covered charge.

Services Received from Contracted Providers Outside New Mexico

Under the BlueCard Program, when you access covered services within the geographic area served by a Host Blue, BCBSNM will remain responsible for fulfilling BCBSNM contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its contracted providers.

Whenever you access covered services outside of the BCBSNM service area and the claim is processed through the BlueCard Program, the amount you pay for covered services is calculated based on the lower of:

- the billed charges for your covered services; or
- the negotiated price or "allowable amount" that the Host Blue makes available to BCBSNM.

If the services are provided by a contracted provider of the Host Blue, the provider will submit your claims directly to the Host Blue to determine the allowable amount. BCBSNM will use the allowable amount to determine the covered charge so that your claim can be processed timely. The covered charge will be an amount up to, but not in excess of, the allowable amount the Host Blue has passed on to BCBSNM. Because the services were provided by a contracted provider, you will receive the benefit of the payment/rate negotiated by the Host Blue with the provider. As always, you will be responsible for any applicable deductible, copay and/or coinsurance amounts ("member share"). The amount that BCBSNM pays together with your member share is the total amount the contracted provider has contractually agreed to accept as payment in full for the services you have received.

Often, this "allowable amount" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price BCBSNM uses for your claim because they will not be applied retroactively to claims already paid.

In some cases, BCBSNM may, but is not required to, in its sole and discretion, negotiate a payment with a non-contracting health care provider on an exception basis.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your liability calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, BCBSNM would then calculate your liability for any covered services according to applicable law.

Services Received from a Noncontracted Provider Outside of New Mexico

If services are provided by a noncontracted provider, the provider may, but is not required to, submit claims on your behalf. A noncontracted provider has not negotiated his/her payment/rates with either the Host Blue or BCBSNM. If the noncontracted provider does not submit claims on your behalf, you will be required to submit the claims directly to the Host Blue. You will be subject to balance billing when you receive services from a noncontracted provider. This amount may be significant. "Balance billing" means that the noncontracted provider may require you to pay any amount that the provider bills that exceeds the sum of what BCBSNM pays toward a covered charge and your member share of the covered charge.

Member Liability Calculation

1. In General

Under Inter-Plan Program Arrangements, when services are received outside the state of New Mexico from a noncontracted provider, the covered charge will be determined by the Host Blue servicing area or by applicable laws and rules, including but not limited to statutes, ordinances, judicial decisions and regulations, and will be passed on to BCBSNM. BCBSNM will use the Host Blue's covered charge as its covered charge so that your claim can be processed timely. BCBSNM's covered charge will be an amount up to but not in excess of the covered charge the Host Blue has passed on to BCBSNM. In addition to being responsible to pay your member share, you may be subject to balance billing by the noncontracted provider who provided services to you. Before you receive services from a noncontracted provider, you should ask for a written breakdown of all amounts that you will have to pay, including member share and balance billing amounts for the services you will receive.

2. Exceptions

In certain situations, BCBSNM may use other payment bases, such as billed charges for covered services, as the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Program Arrangements policies, to determine the amount BCBSNM will pay for services rendered by noncontracted providers. In these situations, you may be liable for the difference between the amount that the noncontracted provider bills and the payment BCBSNM will make for the covered services as set forth in this paragraph.

MEMBER DATA SHARE

You may, under certain circumstances as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by BCBSNM, a division of

Health Care Service Corporation, or, if you do not reside in the BCBSNM service area, by the Host Blue whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise in various ways, such as from involuntary termination of your health coverage sponsored by the subscriber. As part of the overall plan of benefits that BCBSNM offers to you if you do not reside in the BCBSNM service area, BCBSNM may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which you reside. To do this, BCBSNM may (1) communicate directly with you and/or (2) provide the Host Blues whose service area covers the geographic area in which you reside with your personal information and may also provide other general information relating to your coverage under the Plan the subscriber has with BCBSNM to the extent reasonably necessary to enable the relevant Host Blues to offer you coverage continuity through replacement coverage.

COMPLAINTS (GRIEVANCES) AND APPEALS: SUMMARY OF PROCEDURES

If you want to make an oral complaint or file a written appeal about a claims payment or denial, a preauthorization denial, the termination of your coverage (other than due to nonpayment of premium), or any other issue, a BCBSNM Customer Service Advocate is available to assist you. You will not be subject to retaliatory action by BCBSNM for making a complaint, filing an appeal, or requesting a reconsideration.

IMPORTANT: Within 180 days after you receive notice of a BCBSNM decision on, for example, a claim, a preauthorization request, the quality of care you receive, or the termination of your coverage, call or write BCBSNM Customer Service and explain your reasons for disagreeing with the decision. If you do not submit the request for internal review within the 180-day period, you waive your right to internal review as described in this section, unless you can satisfy BCBSNM that matters beyond your control prevented you from timely filing the request.

Many complaints or problems can be handled informally by calling, writing or e-mailing BCBSNM Customer Service. If you are not satisfied with the initial response, you can request internal review as described in the detailed *Inquiries/Complaints and Internal/External Appeals* notice applicable to your health plan you should have received in your enrollment packet (or included in the back of your book

BCBSNM Contacts for Appeals

An appeal is an oral or written request for review of an "adverse benefit determination" or an adverse action by BCBSNM, its employees, or a participating provider. To file an appeal or for more information about appeals, contact:

BCBSNM Appeals Unit
P.O. Box 27630
Albuquerque, NM 87125-9815

Telephone (toll-free): (800) 205-9926
Email: See Website at www.bcbsnm.com
Fax: (505) 816-3837

External Actions

If you are still not satisfied after having completed the BCBSNM complaint, appeal, grievance, or reconsideration procedure, you may have the option of taking other steps, as outlined in the *Inquiries/Complaints and Internal/External Appeals* notice applicable to your health plan. No legal action may be taken or arbitration demand made 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.

SECTION 9: GENERAL PROVISIONS

AVAILABILITY OF PROVIDER SERVICES

BCBSNM does not guarantee that a certain type of room or service will be available at any hospital or other facility within the BCBSNM network, nor that the services of a particular hospital, physician, or other provider will be available.

CATASTROPHIC EVENTS

In case of fire, flood, war, civil disturbance, court order, strike, or other cause beyond BCBSNM's control, BCBSNM may be unable to process claims or provide preauthorization for services on a timely basis. If due to circumstances not within the control of BCBSNM or a network provider (such as partial or complete destruction of facilities, war, riot, disability of a network provider, or similar case), BCBSNM and the provider will have no liability or obligation if medical services are delayed or not provided. BCBSNM and its network providers will, however, make a good- faith effort to provide services.

CHANGES TO THE BENEFIT BOOKLET

No employee of BCBSNM may change this benefit booklet by giving incomplete or incorrect information, or by contradicting the terms of this benefit booklet. Any such situation will not prevent BCBSNM from administering this benefit booklet in strict accordance with its terms. See the inside back cover for further information.

DISCLAIMER OF LIABILITY

BCBSNM has no control over any diagnosis, treatment, care or other service provided to you by any facility or professional provider, whether preferred or not. BCBSNM is not liable for any loss or injury caused by any health care provider by reason of negligence or otherwise.

Nothing in this benefit booklet is intended to limit, restrict, or waive any member rights under the law and all such rights are reserved to the individual.

DISCLOSURE AND RELEASE OF INFORMATION

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

EXECUTION OF PAPERS

On behalf of yourself and your eligible family members you must, upon request, execute and deliver to BCBSNM any documents and papers necessary to carry out the provisions of this Plan.

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 the group 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 the group.

MEMBER RIGHTS

All members have these rights:

- The right to available and accessible services, when medically necessary, as determined by your primary care or treating physician in consultation with BCBSNM, 24 hours per day, 7 days a week, or urgent or emergency care services, and for other health services as defined by your benefit booklet.
- The right to be treated with courtesy and consideration, and with respect for your dignity and your need for privacy.

- The right to have their privacy respected, including the privacy of medical and financial records maintained by BCBSNM and its health care providers as required by law.
- The right to be provided with information concerning BCBSNM's policies and procedures regarding products, services, providers, and appeals procedures and other information about the company and the benefits provided.
- The right to choose a PPP within the limits of the covered benefits and plan network, including the right to refuse care of specific practitioners.
- The right to receive from your physician(s) or provider, in terms that you understand, an explanation of your complete medical condition, recommended treatment, risk(s) of treatment, expected results and reasonable medical alternatives, irrespective of BCBSNM's position on treatment options. If you are not capable of understanding the information, the explanation shall be provided to your next of kin, guardian, agent or surrogate, if able, and documented in your medical record.
- The right to file a complaint or appeal with BCBSNM and to receive an answer to those complaints within a reasonable time.
- The right to detailed information about coverage, maximum benefits, and exclusions of specific conditions, ailments or disorders, including restricted prescription benefits, and all requirements that you must follow for preauthorization and utilization review.
- The right to make recommendations regarding BCBSNM's member rights and responsibilities policies.
- The right to a complete explanation of why care is denied, an opportunity to appeal the decision to BCBSNM's internal review and the right to a secondary appeal.

MEMBER RESPONSIBILITIES

As a member enrolled in a managed health care plan administered by BCBSNM, you have these responsibilities:

- The responsibility to supply information (to the extent possible) that BCBSNM and its preferred practitioners and providers need in order to provide care.
- The responsibility to follow plans and instructions for care that you have agreed on with your treating provider or practitioners.
- The responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals with your treating provider or practitioner to the degree possible.

MEMBERSHIP RECORDS

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

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.

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 subscriber at the latest address on BCBSNM membership records or to the employer.

TRANSFER OF BENEFITS

All documents described in this booklet are personal to the member. Neither these benefits nor health care plan payments may be transferred or given to any person, corporation, or entity. Any attempted transfer will be void. Use of benefits by anyone other than a member will be considered fraud or material misrepresentation in the use of services or facilities, which may result in cancellation of coverage for the member and appropriate legal action by BCBSNM and/or **County of Los Alamos**.

SECTION 10: DEFINITIONS

It is important for you to understand the meaning of the following terms. The definition of many terms determines your benefit eligibility.

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

Acupuncture — The use of needles inserted into the human body for the prevention, cure, or correction of any disease, illness, injury, pain, or other condition.

Adjustment factor — The percentage by which the Medicare Allowable amount is multiplied in order to arrive at the "noncontracting allowable amount." (See definition of "Covered charge.") Adjustment factors will be evaluated and updated no less than every two years.

Admission — The period of time between the dates when a patient enters a facility as an inpatient and is discharged as an inpatient. (If you are an inpatient at the time your coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date.)

Administrative Services Agreement — A contract for health care services which by its terms limits eligibility to members of a specified group. The Administrative Services Agreement includes the Group Master Application and may include coverage for family members.

Adverse determination — A decision made either pre-service or post-service by BCBSNM that a health care service requested by a provider or member has been reviewed and based upon the information available does not meet the requirements for coverage or medical necessity and the requested health care service is either denied, reduced, or terminated.

Alcohol abuse — Conditions defined by patterns of use that continue despite occupational, social, marital, or physical problems related to compulsive use of alcohol. Alcohol abuse may also be defined by significant risk of severe withdrawal symptoms if the use of alcohol is discontinued.

Alcohol abuse treatment facility or alcohol abuse treatment program — An appropriately licensed provider of medical detoxification and rehabilitative treatment for alcohol abuse.

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

Ambulatory surgical facility — An appropriately licensed provider, with an organized staff of physicians, that meets all of the following criteria:

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis; *and*
- provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility; *and*
- does not provide inpatient accommodations; *and*
- is not a facility used primarily as an office or clinic for the private practice of a physician or other provider.

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

Applied behavioral analysis (ABA) — Services that include behavior modification training programs that are based on the theory that behavior is learned through interaction between an individual and the environment. The goal

of behavior management is to reinforce and increase desirable, functional behaviors while reducing undesirable, "maladaptive" behaviors.

Autism spectrum disorder — A condition that meets the diagnostic criteria for the pervasive developmental disorders published in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision, also known as *DSM-IV-TR*, published by the American Psychiatric Association, including autistic disorder; Asperger's disorder; pervasive development disorder not otherwise specified; Rhett's disorder; and childhood integrative disorder.

Benefit booklet — This document or evidence of coverage issued to you along with your separately issued *Summary of Benefits*, explains the benefits, limitations, exclusions, terms, and conditions of your health coverage.

Blue Access for Members (BAM) — On-line programs and tools that BCBSNM offers its members to help track claims payments, make health care choices, and reduce health care costs. For details, see *Section 1: How To Use This Benefit Booklet.*

BlueCard — BlueCard is a national program that enables members of one Blue company to obtain healthcare services while traveling or living in another Blue company's service area. The program links participating healthcare providers with the independent Blue companies across the country and in more than 200 countries and territories worldwide., through a single electronic network for claims processing and reimbursement.

BlueCard Access — The term used by Blue Cross and Blue Shield companies for national doctor and hospital finder resources available through the Blue Cross and Blue Shield Association. These provider location tools are useful when you need covered health care outside New Mexico. Call BlueCard Access at 1 (800) 810-BLUE (2583) or visit the BlueCard Doctor and Hospital Finder at bcbsnm.com

Blue Cross and Blue Shield of New Mexico — A Division of Health Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association; also referred to as BCBSNM.

Calendar year — A calendar year (also known as a benefit period) is a period of one year that begins on January 1 and ends on December 31 of the same year (also referred to as calendar year). The initial calendar year benefit period is from a member's effective date of coverage and ends on December 31, which may be less than 12 months.

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

Cardiac rehabilitation — An individualized, supervised physical reconditioning exercise session lasting 4- 12 weeks. Also includes education on nutrition and heart disease.

Certified nurse- midwife — A person who is licensed by the Board of Nursing as a registered nurse and who is licensed by the New Mexico Department of Health (or appropriate state regulatory body) as a certified nurse- midwife.

Certified nurse practitioner — A registered nurse whose qualifications are endorsed by the Board of Nursing for expanded practice as a certified nurse practitioner and whose name and pertinent information is entered on the list of certified nurse practitioners maintained by the Board of Nursing.

Cessation counseling — As applied to the "smoking/tobacco use cessation" benefit described in *Section 5: Covered Services*, under "Preventive Services," cessation counseling means a program, including individual, group, or proactive telephone quit line, that:

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

Chemical dependency — Conditions defined by patterns of usage that continue despite occupational, marital, or physical problems that are related to compulsive use of alcohol, drugs or other substance. Chemical dependency (also referred to as "substance abuse," which includes alcohol or drug abuse) may also be defined by significant risk of severe withdrawal symptoms if the use of alcohol, drugs, or other substance is discontinued.

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

Child — See definition of "Eligible Family Member" in *Section 2: Enrollment and Termination Information.*

Chiropractor services— Any service or supply administered by a chiropractor acting within the scope of his/her licensure and according to the standards of chiropractic medicine in New Mexico or the state in which services are rendered.

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

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

Claim — The term "claim," as used in this document, refers only to post-service bills for services already received and sent to BCBSNM (or its designee) for benefit determination.

Claims Administrator — Blue Cross and Blue Shield of New Mexico (BCBSNM), which is the entity providing consulting services connected with the operation of this benefit plan, including the processing and payment of claims and other such functions as agreed to from time to time by **County of Los Alamos** and BCBSNM.

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

Coinsurance — A percentage of covered charges that you are required to pay for a covered service. For covered services that are subject to coinsurance, you pay the percentage (indicated on the *Summary of Benefits*) of BCBSNM's covered charge after the deductible (if any) has been met.

Contracted provider — A provider that has a contract with BCBSNM or another BCBS Plan to bill BCBSNM (or other BCBS Plan) directly and to accept this health plan's payment (provided in accordance with the provisions of the contract) plus the member's share (coinsurance, deductibles, copayments, etc.) as payment in full for covered services. Also see "Network provider (in-network provider)," in this section.

Copayment — The fixed- dollar amount (or, in some cases, a percentage) that you must pay to a health care provider upfront in order to receive a specific service or benefit covered under this Plan. Copayments are listed on the *Summary of Benefits.*

Cosmetic — See the "Cosmetic Services" exclusion in *Section 6: General Limitations and Exclusions.*

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

Covered charge — The amount that BCBSNM determines is a fair and reasonable allowance for a particular covered service. After your chare of a covered charge (e.g., deductible, copayment, coinsurance, and/or penalty amount) has been calculated, BCBSNM pays the remaining amount of the covered charge, up to maximum benefit limits, if any. **The covered charge may be less than the billed charge.** Also see "Claims Payment Provision" in *Section 8: Claim Payments and Appeals*.

Covered services — Those services and other items for which benefits are available under the terms of the benefit plan of an eligible plan member.

Creditable coverage — Health care coverage through an employment- based group health care plan; health insurance coverage; Part A or B of Title 18 of the Social Security Act (Medicare); Title 19 of the Social Security Act (Medicaid) except coverage consisting solely of benefits pursuant to section 19[illegible] of that title; 10 USCA Chapter 55 (military benefits); a medical care program of the Indian Health Service or of a[illegible]ndian n[illegible]on, tribe, or pueblo; the NM Medical Insurance Pool (NMMIP) Act, or similar state sponsored health insura[illegible] po[illegible] a health plan offered pursuant to 5 USCA Chapter 89; a public health plan as defined in federal regulations, whether fo[illegible]gn or domestic; any coverage provided by a governmental entity, whether or not insured, a State Children's Health Insurance Program; or a health benefit plan offered pursuant to section 5(e) of the federal Peace Corps Act.

Custodial care services — Any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial care services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g., simple care and dressings, administration of routine medications, etc.), and are to assist with activities of daily living (e.g., bathing, eating, dressing, etc.).

Deductible — The amount of covered charges that you must pay in a calendar year before this Plan begins to pay its share of covered charges you incur during the same benefit period. If the deductible amount remains the same during the calendar year, you pay it only once each calendar year and it applies to all covered services you receive during that calendar year.

Dental- related services — Services performed for treatment or conditions related to the teeth or structures supporting the teeth.

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

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

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

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

Drug abuse — A condition defined by patterns of usage that continue despite occupational, marital, or physical problems related to compulsive use of drugs or other non- alcoholic substance. There may also be significant risk of

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

Drug abuse treatment facility— An appropriately licensed provider primarily engaged in detoxification and rehabilitation treatment for chemical dependency.

Durable medical equipment — Any equipment that can withstand repeated use, is made to serve a medical purpose, and is generally considered useless to a person who is not ill or injured.

Effective date of coverage — 12:01 a.m. of the date on which a member's coverage under this plan begins.

Eligible family members — See "Eligible Family Members" in *Section 2: Enrollment and Termination Information* for more information about eligible family members.

Emergency, emergency care — Medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to his/her health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part, or disfigurement. In addition, services must be received in an emergency room, trauma center or ambulance to qualify as an emergency. Examples of emergency conditions include, but are not limited to, heart attack or suspected heart attack, coma, loss of respiration, stroke, acute appendicitis, severe allergic reaction, or poisoning.

Employee probationary period — The number of months or days of continuous employment beginning with the employee's most recent date of hire and ending on the date the employee first becomes eligible for coverage under the employer's group. Your employer determines the length of the probationary period.

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

Experimental, investigational or unproven — See the "Experimental, Investigational or Unproven Services" exclusion in *Section 6: General Limitations and Exclusions*.

Facility — A hospital (see "Hospital" later in this section) or other institution (also, see "Provider" later in this section).

Genetic inborn error of metabolism — A rare inherited disorder that is present at birth; if untreated, results in mental retardation or death, and requires the affected person consume special medical foods.

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

Group — A bonafide employer covering employees of such employer for the benefit of persons other than the employer; or an association including a labor union, that has a constitution and bylaws and is organized and maintained in good faith for purposes other than that of obtaining insurance.

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

Group Master Application — The application for coverage completed by the employer (or association representative).

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

Home health care agency — An appropriately licensed provider that both:

- brings skilled nursing care and other services on an intermittent, visiting basis into your home in accordance with the licensing regulations for home health care agencies in New Mexico or in the state where the services are provided; *and*
- is responsible for supervising the delivery of these services under a plan prescribed and approved in writing by the attending physician.

Home health care services — Covered services, as listed under "Home Health Care/Home I.V. Services" in *Section 5: Covered Services,* that are provided in the home according to a treatment plan by a certified home health care agency under active physician and nursing management. Registered nurses must coordinate the services on behalf of the home health care agency and the patient's physician.

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

Hospice benefit period — The period of time during which hospice benefits are available. It begins on the date the attending physician certifies that the member is terminally ill and ends **six months** after the period began (or upon the member's death, if sooner). The hospice benefit period must begin while the member is covered for these benefits, and coverage must be maintained throughout the hospice benefit period.

Hospice care — An alternative way of caring for terminally ill patients in the home or institutional setting, which stresses controlling pain and relieving symptoms but does not cure. Supportive services are offered to the family before the death of the patient.

Hospital — A health institution offering facilities, beds and continuous services 24 hours a day, 7 days a week. The hospital must meet all licensing and certification requirements of local and state regulatory agencies. Services provided include:

- diagnosis and treatment of illness, injury, deformity, abnormality or pregnancy
- clinical laboratory, diagnostic x- ray and definitive medical treatment provided by an organized medical staff within the institution
- treatment facilities for emergency care and surgical services either within the institution or through a contractual arrangement with another licensed hospital (These contracted services must be documented by a well- defined plan and related to community needs.)

Host Blue — When you are outside New Mexico and receive covered services, the provider will submit claims to the Blue Cross Blue Shield (BCBS) Plan in that state. That BCBS Plan (the "Host Blue" Plan) will then price the claim according to local practice and contracts, if applicable, and then forward the claim electronically to BCBSNM - your "Home" Plan - for completion of processing (e.g., benefits and eligibility determination). For details, see "BlueCard" in *Section 8: Claims Payments and Appeals.*

Identification card (ID card) — The card BCBSNM issues to the subscriber that identifies the cardholder as a Plan member.

Initial enrollment eligibility date — A member's effective date of coverage or the first day of any employee probationary period imposed on the member by the employer, whichever is earlier. For a late applicant or for a person applying under a special enrollment provision, the initial enrollment eligibility date is his/her effective date of coverage.

Inpatient services — Care provided while you are confined as an inpatient in a hospital or treatment center for at least 24 hours. Inpatient care includes partial hospitalization (a nonresidential program that includes from 5- 12 hours of continuous mental health or chemical dependency care during any 24-hour period in a treatment facility).

Intensive outpatient program (IOP) — Distinct levels or phases of treatment that are provided by a certified/licensed chemical dependency or mental health program. IOPs provide a combination of individual, family, and/or group therapy in a day, totaling nine or more hours in a week.

Investigational drug or device — For purposes of the "Cancer Clinical Trial" benefit described in *Section 5: Covered Services* under "Rehabilitation and Other Therapy," an "investigational drug or device" means a drug or device that has not been approved by the federal Food and Drug Administration.

Involuntary loss of coverage — As applied to special enrollment provisions, loss of other coverage due to legal separation, divorce, death, moving out of an HMO service area, termination of employment, reduction in hours or termination of employer contributions (even if the affected member continues such coverage by paying the amount previously paid by the employer). A loss of coverage may also occur if your employer ceased offering coverage to the particular class of workers or similarly situated individuals to which you belonged or terminated your benefit package option and no substitute Plan was offered. If the member is covered under a state or federal continuation policy due to prior employment, involuntary loss of coverage includes exhaustion of the maximum continuation time period. Involuntary loss of coverage does not include a loss of coverage due to the failure of the individual or member to pay premiums on a timely basis or termination of coverage for good cause.

Late applicant — Unless eligible for a special enrollment, applications from the following enrollees will be considered late:

- anyone not enrolled **within 31 days** of becoming eligible for coverage under this health care plan (e.g., a child added **more than 31 days** after legal adoption, a new spouse or stepchild added more than 31 days after marriage)
- anyone enrolling on the group's initial BCBSNM enrollment date who was not covered under the group's prior plan (but who was eligible for such coverage)
- anyone eligible but not enrolled during the group's initial enrollment
- anyone who voluntarily terminates his/her coverage and applies for reinstatement of such coverage at a later date (except as provided under the USERRA of 1994)

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

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

Managed health care plans — A "managed health care plan" is a health plan that requires a member to use, or encourages a member to use, a "network" provider (your provider network is determined by the type of health plan you have). Your health plan may require you to use network providers in order to receive benefits. Therefore, your choice of provider under a managed health care plan determines the amount and kind of **benefits** you receive under your health care plan. **Your BCBSNM health plan does not prevent you from choosing to receive services from a provider outside the network.** The choice of provider is still up to you - but the health plan is not obligated to provide benefits for every service you seek to receive. You receive no benefits for nonemergency services received outside the network.

Maternity — Any condition that is related to pregnancy. Maternity care includes prenatal and postnatal care and care for the complications of pregnancy, such as ectopic pregnancy, spontaneous abortion (miscarriage), elective abortion or C- section. See "Maternity/Reproductive Services and Newborn Care" in *Section 5: Covered Services* for more information.

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

Medical detoxification — Treatment in an acute care facility for withdrawal from the physiological effects of alcohol or drug abuse. (Detoxification usually takes about three days in an acute care facility.)

Medical policy — A coverage position developed by BCBSNM that summarizes the scientific knowledge currently available concerning new or existing technology, products, devices, procedures, treatment, services, supplies, or drugs and used by BCBSNM to adjudicate claims and provide benefits for covered Services. Medical policies are posted on

the BCBSNM website for review or copies of specific medical policies may be requested in writing from a Customer Service Advocate.

Medical supplies — Expendable items (except prescription drugs) ordered by a physician or other professional provider, that are required for the treatment of an illness or accidental injury.

Medically necessary, medical necessity — See "Medically Necessary Services" in *Section 5: Covered Services.*

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

Member — An enrollee (the subscriber or any eligible family member) who is enrolled for coverage and entitled to receive benefits under this Plan in accordance with the terms of the Administrative Services Agreement. Throughout this benefit booklet, the terms "you" and "your" refer to each member.

Mental disorder — A clinically significant behavioral or psychological syndrome or condition that causes distress and disability and for which improvement can be expected with relatively short- term treatment. Mental disorder does not include developmental disabilities, autism or autism spectrum disorders, drug or alcohol abuse, or learning disabilities.

Network provider (in-network provider) — A contracted provider that has agreed to provide services to members in your *specific* type of health plan (e.g., EPO, PPO, etc.).

Noncontracted provider — A provider that does not have any contract with BCBSNM, either directly or indirectly (for example, through another BCBS Plan), to accept the covered charge as payment in full under your health plan.

Nonpreferred provider — Providers that have not contracted with BCBSNM, either directly or indirectly (for example, through another BCBS Plan). These providers may have "participating-only" or "HMO" provider agreements, but are **not** considered "preferred" providers and are **not** eligible for Preferred Provider coverage under your health plan -unless listed as an exception under "Exceptions for Nonpreferred Providers" earlier in the booklet.

Occupational therapist — A person registered to practice occupational therapy. An occupational therapist treats neuromuscular and psychological dysfunction caused by disease, trauma, congenital anomaly or prior therapeutic process through the use of specific task- oriented goal- directed activities designed to improve functional performance of the patient.

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

Optometrist — A doctor of optometry (O.D.) licensed to examine and test eyes and treat visual defects by prescribing and adapting corrective lenses and other optical aids.

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

Other valid coverage — All other group and individual (or direct- pay) insurance policies or health care benefit plans (including Medicare, but excluding Indian Health Service and Medicaid coverages), that provide payments for medical services will be considered other valid coverage for purposes of coordinating benefits under this Plan.

Other providers — Clinical psychologists and the following masters- degreed psychotherapists (an independently licensed professional provider with either an M.A. or M.S. degree in psychology or counseling): licensed independent social workers (L.I.S.W.); licensed professional clinical mental health counselors (L.P.C.C.); masters- level registered nurse certified in psychiatric counseling (R.N.C.S.); licensed marriage and family therapist (L.M.F.T.). For chemical dependency services, a provider also includes a licensed alcohol and drug abuse counselor (L.A.D.A.C.).

Out- of- pocket limit — The maximum amount of deductible, coinsurance, and/or copayments that you pay for most covered services in a calendar year. After an out- of- pocket limit is reached, this Plan pays **100 percent** of most of your covered charges for the rest of that calendar year, not to exceed any benefit limits.

Outpatient services — Medical/surgical services received in the outpatient department of a hospital, observation room, emergency room, ambulatory surgical facility, freestanding dialysis facility, or other covered outpatient treatment facility.

Outpatient surgery — Any surgical services that is performed in an ambulatory surgical facility or the outpatient department of a hospital, but **not** including a procedure performed in an office or clinic. Outpatient surgery includes any procedure that requires the use of an ambulatory surgical facility or an outpatient hospital operating or recovery room.

Participating pharmacy — See the definition of "Provider."

Participating provider — Any provider that, for the service being provided, contracts with BCBSNM, a BCBSNM contractor or subcontractor, another Blue Cross and Blue Shield (BCBS) Plan, or the national BCBS transplant network. Your "preferred" provider may have two agreements with the local BCBS Plan — a preferred provider contract and another "participating" provider contract. Providers that have only the participating provider contract are **not** considered preferred providers. See definition of "Provider."

Pharmacy-related definitions — The definitions below are specifically related to pharmacy services.

Brand- name drug — A drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license known as a co-licensed product, which would also be considered as a brand-name drug. There may also be situations where a drug's classification changes from generic to preferred or nonpreferred brand-name due to a change in the market resulting in the generic drug being a single source, or the drug product database information changing, which would also result in a corresponding change to your payment obligations from generic to preferred or nonpreferred brand-name.

Coinsurance — A **percentage** amount paid by you for each covered specialty pharmacy prescription order filled through a designated specialty pharmacy provider.

Copayment (or "Copay") — The maximum fixed-dollar amount you pay for each covered prescription order filled or refilled or a covered supply purchased through a retail pharmacy or designated mail-order service vendor under this plan.

Deductible - The annual deductible described in your benefit booklet for the medical portion of your health benefits plan that also applies to the drug portion of the health benefits plan described. This deductible is the maximum amount of covered charges you must pay in a calendar year under your health benefits plan, including covered pharmacy prescription charges for order filled or refilled, or for covered supplies purchases through a retail pharmacy, specialty pharmacy provider or designated mail-order service vendor, before your health benefits plan begins to pay its hare of covered charges, including the covered pharmacy prescription charges you incur during the same calendar year under this plan. If the deductible amount remains the same during the calendar year you pay it only once each calendar year, and its applied to all covered charges that are subject to hits deductible and to Coinsurance that you receive during that calendar year including all covered pharmacy prescription charges under this plan.

Drug List — A list of non-specialty prescription drugs and specialty drugs preferred for use by BCBSNM for pharmacy benefits under BCBSNM health plans. (Specialty drugs are also listed on the separate specialty drug list). The drugs on the drug list have been selected to provide coverage for a broad range of diseases. Each drug listed shows to which tiered category it belongs under your 3-tier drug plan: tier 1 for generic drugs; tier 2 for preferred brand-name drugs; and tier 3 for nonpreferred brand-name drugs. How your cost for a covered prescription drug is determined, in accordance with the applicable tier to which it belongs, is described in the "Member Copayment and Coinsurance" section of this rider. Brand-Name Drugs may be included on the drug list when a generic drug is not available to treat a specific medial condition or the brand-name drug offers a significant advantage over available generic drugs as determined by BCBSNM. The drug list is developed using information from the American Medical Association, Academy of Managed Care Pharmacies, and other pharmacy- and medical-related organizations. The drug list is subject to periodic review and change by

BCBSNM; a copy of it is available on the BCBSNM web site at www.bcbsnm.com. You may also contact a customer service advocate, and BCBSNM-contracted providers may contract their network representative, for a copy.

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

Generic drug — A drug that has the same active ingredient as a brand-name drug and is allowed to be produced after the brand-name drug's patent has expired. In determining the brand or generic classification for covered drugs, BCBSNM uses the generic/brand status assigned by a nationally recognized provider of drug product database information. A list of preferred generic drugs is available on the BCBSNM web site at www.bcbsnm.com. You may also contact a customer service advocate for more information.

Genetic inborn errors of metabolism — A rare, inherited disorder that is present at birth; if untreated, results in mental retardation or death, and required that the affected person consume special medical foods.

Nonpreferred brand-name drug — A covered non-specialty brand-name prescription drug product or other item that is not identified on the *Preferred Drug List.* See "Specialty drugs," below if the drug is listed on the *Specialty Drug List*.

Pharmacy — A state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any provider's office, and where drugs and devices are dispensed under prescription orders to the general public by a pharmacist licensed to dispense such drugs and devices under the law of the state in which he/she practices.

Pharmacy benefit manager — An entity with which BCBSNM has entered into one or more agreements for the provision of, and payment for prescription drug benefits to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which BCBSNM is a party, including the benefits plan to which the drug plan. (For more information, see section entitled BCBSNM's Separate Financial Arrangements with Pharmacy Benefits Managers.")

Preferred brand-name drug — A covered non-specialty brand-name prescription drug product or other item that is identified on the *Preferred Drug List*.

Prescription drugs, medicines and devices — Those that are taken at the direction and under the supervision of a provider, that require a prescription before being dispensed, and are labeled as such on their packages. All prescription drugs, medicines and devices must be approved by the FDA, and must not be experimental, investigational, or unproven. (See "Experimental, Investigational, or Unproven Service" in *Section 6: General Limitations and Exclusions*.)

Special medical foods — Nutritional substances in any form that are consumed or administered internally under the supervision of a physician, specially processed or formulated to be distinct in one or more nutrients present in natural foods; intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and essential to optimize growth, health, and metabolic homeostasis. Special medical foods are covered only when prescribed by a physician for treatment of genetic errors of metabolism, and the member is under the physician's ongoing care.

Specialty drugs — Prescription drugs that: a) are high cost, b) are used in limited patient populations or indications, c) are typically self-injected, d) have limited availability, require special dispensing or delivery, and/or patient support is required and, therefore, are difficult to obtain via traditional pharmacy channels, and/or e) require complex reimbursement procedures. These drugs must be purchased through the designated BCBSNM specialty pharmacy provider in order to be covered. Specialty drugs are subject to the Tier 3 copayment level; see "Member Copayments and Coinsurance":

Specialty Drug List — A list of the names of specialty drugs indicating for each whether it is considered "preferred" or "nonpreferred," and which must be purchased through BCBSNM's specialty pharmacy provider. Preferred specialty drugs are considered the drug of choice and you will pay the Tier 3 copayment for them. You will pay a Tier 4 copayment for covered nonpreferred specialty drugs. The *Specialty Drug List* is subject to periodic review and change by BCBSNM. If you need a list of specialty drugs, request it from a Customer Service Advocate or visit the BCBSNM website at www.bcbsnm.com.

Physical therapist — A licensed physical therapist. Where there is no licensure law, the physical therapist must be certified by the appropriate professional body. A physical therapist treats disease or accidental injury by physical and mechanical means (regulated exercise, water, light, or heat).

Physical therapy — The use of physical agents to treat disability resulting from disease or injury. Physical agents include heat, cold, electrical currents, ultrasound, ultraviolet radiation, and therapeutic exercise.

Physician — See definition of "Provider," below.

Physician assistant — A graduate of a physician assistant or surgeon assistant program approved by a nationally recognized accreditation body or a skilled person who is currently certified by the National Commission on Certification of Physician Assistants, who is licensed in the state of New Mexico (or by the appropriate state regulatory body) to practice medicine under the supervision of a licensed physician.

Podiatrist — A licensed doctor of podiatric medicine (D.P.M.). A podiatrist treats conditions of the feet.

Preauthorization — An advance confirmation to determine medical necessity, as may be required where permitted by law, for certain services to be eligible for benefits.

Predetermination — An advance confirmation, or "predetermination," of benefits for a requested covered service. Predetermination does not guarantee benefits if the actual circumstances of the case differ from those originally described.

Preferred provider or preferred specialist — See definition of "Provider," below.

Pregnancy- related services — See definition of "Maternity," earlier in this section.

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

Primary Preferred Provider (PPP) — See definition of "Provider."

Probationary period — The amount of time an employee must work before becoming eligible for any health care coverage offered by the employer sponsoring this plan. Your employer determines the length of the probationary period.

Prosthetics or prosthetic device — An externally attached or surgically implanted artificial substitute for an absent body part; for example, an artificial eye or limb.

Provider — A duly licensed hospital, physician, or other practitioner of the healing arts authorized to furnish health care services within the scope of his license.

> **Health care facility:** An institution providing health care services, including a hospital or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing facility, a residential treatment center, a home health care agency, a diagnostic laboratory or imaging center, and a rehabilitation or other therapeutic health setting.
>
> **Physician:** A practitioner of the healing arts who is also a doctor of medicine (M.D.) or osteopathy (D.O.) and who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.
>
> **Professional provider:** A physician or health care practitioner, including a pharmacist, who is licensed, certified, or otherwise authorized by the state to provide health care services consistent with state law.

A provider may belong to one or more networks, but if you want to visit a network provider, you must choose the provider from the *appropriate* network:

> **PPP (Primary Preferred Provider):** A preferred provider in one of the following medical specialties **only:** Family Practice; General Practice; Internal Medicine; Obstetrics/Gynecology; Gynecology; or Pediatrics. PPPs do **not** include Physicians specializing in any other fields such as Obstetrics only, Geriatrics, Pediatric Surgery or Pediatric Allergy.

PPO Specialist: A practitioner of the healing arts who is in the Preferred Provider Network - but does not belong to one of the specialties defined above as being for a "Primary Preferred Provider" (or "PPP"). A specialist does not include hospitals or other treatment facilities, urgent care facilities, pharmacies, equipment suppliers, ambulance companies, or similar ancillary health care providers.

Participating pharmacy: A retail supplier that has contracted with BCBSNM or its authorized representatives to dispense prescription drugs and medicines, insulin, diabetic supplies, and nutritional products to members covered under the drug plan portion of this Plan and that has contractually accepted the terms and conditions as set forth by BCBSNM and/or its authorized representatives. Some participating pharmacies are contracted with BCBSNM to provide specialty drugs to members; these pharmacies are called "Specialty Pharmacy Providers" and some drugs must be dispensed by these specially contracted pharmacy providers in order to be covered.

A network provider agrees to provide health care services to members with an expectation of receiving payment (other than copayments, coinsurance or deductibles) directly or indirectly from BCBSNM (or other entity with whom the provider has contracted). A network provider agrees to bill BCBSNM (or other contracting entity) directly and to accept this Plan's payment (provided in accordance with the provisions of the contract) plus the member's share (coinsurance, deductibles, copayments, etc.) as payment in full for covered services. BCBSNM (or other contracting entity) will pay the network provider directly. BCBSNM (or other contracting entity) may add, change, or terminate specific network providers at its discretion or recommend a specific provider for specialized care as medical necessity warrants.

Psychiatric hospital — A psychiatric facility licensed as an acute care facility or a psychiatric unit in a medical facility that is licensed as an acute care facility. Services are provided by or under the supervision of an organized staff of physicians. Continuous 24- hour nursing services are provided under the supervision of a registered nurse.

Pulmonary rehabilitation — An individualized, supervised physical conditioning program. Occupational therapists teach you how to pace yourself, conserve energy, and simplify tasks. Respiratory therapists train you in bronchial hygiene, proper use of inhalers, and proper breathing.

Radiation therapy — X- ray, radon, cobalt, betatron, teletherapy and radioactive isotope treatment for malignant diseases and other medical conditions.

Reconstructive surgery — Reconstructive surgery improves or restores bodily function to the level experienced before the event that necessitated the surgery, or in the case of a congenital defect, to a level considered normal. Such surgeries may have a coincidental cosmetic effect.

Registered lay midwife — Any person who practices lay midwifery and is registered as a lay midwife by the New Mexico Department of Health.

Registered nurse (R.N.) — A nurse who has graduated from a formal program of nursing education (diploma school, associate degree, baccalaureate program) and is licensed by appropriate state authority.

Rehabilitation hospital — An appropriately licensed facility that provides rehabilitation care services on an inpatient basis. Rehabilitation care services consist of the combined use of a multidisciplinary team of physical, occupational, speech, and respiratory therapists, medical social workers, and rehabilitation nurses to enable patients disabled by illness or accidental injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

Rehabilitative service — Including, but not limited to speech therapy, physical therapy and occupational therapy. Treatment, as determined by your physician that must be limited to therapy which is expected to result in significant improvement in the conditions for which it is rendered, "rehabilitative services" must expected to help a person regain, maintain or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, inquiry or disabling condition.

Residential Treatment Center — A facility offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, and structure and is

licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, supervised living, group homes, boarding houses, or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients in residential treatment centers are medically monitored with 24-hour medical availability and 24-hour on-site nursing service for patients with mental illness and/or chemical dependency disorders.

Respiratory therapist — A person qualified for employment in the field of respiratory therapy. A respiratory therapist assists patients with breathing problems.

Routine newborn care — Care of a child immediately following his/her birth that includes:

- routine hospital nursery services, including alpha- fetoprotein IV screening
- routine medical care in the hospital after delivery
- pediatrician
- services related to circumcision of a male newborn
- standby care at a C- section procedure

Routine patient care cost — For purposes of the cancer clinical trial benefit described under "Rehabilitation and Other Therapy" in *Section 5: Covered Services*, a "routine patient care cost" means a medical service or treatment that is covered under a health plan that would be covered if you were receiving standard cancer treatment, or an FDA- approved drug provided to you during a cancer clinical trial, but only to the extent that the drug is not paid for by the manufacturer, distributor, or supplier of the drug. **Note:** For a covered cancer clinical trial, it is not necessary for the FDA to approve the drug for use in treating your particular condition. A routine patient care cost does **not** include the cost of any investigational drug, device or procedure, the cost of a non- health care service that you must receive as a result of your participation in the cancer clinical trial, costs for managing the research, costs that would not be covered or that would not be rendered if non- investigational treatments were provided, or costs paid or not charged for by the trial providers.

Routine screening colonoscopy/mammography — Tests to screen for occult colorectal and/or breast cancer in persons who, at the time of testing, are not known to have active cancer of the colon or breast, respectively. (If there is a history of colon or breast cancer, for the purposes of the "Preventive Services" benefit, a cancer is no longer active if there has been no treatment for it and no evidence of recurrence for the previous three years.) Routine screening tests are performed at defined intervals based on recommendations of national organizations as summarized in the BCBSNM Preventive Care Guidelines. Routine screening tests do not include tests (sometimes called "surveillance testing") intended to monitor the current status or progression of a cancer that is already diagnosed.

Routine screening mammography does **not** include "diagnostic mammography" which is a mammogram done after an abnormal finding has first been detected, or screening the opposite breast when the other breast has cancer. Routine colonoscopy does **not** include colonoscopy done for follow-up of colon cancer. A colonoscopy is still considered screening if, during the colonoscopy, **previously unknown** polyps were removed. Colonoscopies performed to remove **known** polyps are not routine screening colonoscopies. Routine screening colonoscopy does not include upper endoscopy (esophagogastroduodenal endoscopy), sigmoidoscopy, or computerized tomographic colonography (sometimes referred to as "virtual colonoscopy").

Note: BCBSNM Preventive Care Guidelines may be found at the BCBSNM website:

www.bcbsnm.com/health/know_your_numbers

Short- term rehabilitation — Inpatient, outpatient, office- and home-based occupational, physical, and speech therapy techniques that are medically necessary to restore and improve lost bodily functions following illness or accidental injury. (This does not include services provided as part of an approved home health or hospice admission, which are subject to separate benefit limitations and exclusions, and does not include alcohol or drug abuse rehabilitation.)

Skilled nursing care — Care that can be provided only by someone with at least the qualifications of a licensed practical nurse (L.P.N.) or registered nurse (R.N.).

Skilled nursing facility — A facility or part of a facility that:

- is licensed in accordance with state or local law; *and*
- is a Medicare- participating facility; *and*
- is primarily engaged in providing skilled nursing care to inpatients under the supervision of a duly licensed physician; *and*
- provides continuous 24- hour nursing service by or under the supervision of a registered nurse; *and*
- does **not** include any facility that is primarily a rest home, a facility for the care of the aged, or for treatment of tuberculosis, or for intermediate, custodial care or educational care.

Sound natural teeth — Teeth that are whole, without impairment, without periodontal or other conditions and not in need of treatment for any reason other than accidental injury. Teeth with crowns or restorations (even if required due to a previous injury) are **not** sound natural teeth. Therefore, injury to a restored tooth will not be covered as an accident- related expense. (Your provider must submit x- rays taken *before* the dental or surgical procedure in order for BCBSNM to determine whether the tooth was "sound.")

Special care unit — A designated unit that has concentrated facilities, equipment and supportive services to provide an intensive level of care for critically ill patients. Examples of special care units are intensive care unit (ICU), cardiac care unit (CCU), subintensive care unit, and isolation room.

Special enrollment — When an otherwise eligible employee or eligible family member did not enroll in the Plan when initially eligible, there are certain instances (or "qualifying events") during which the employee and his/her eligible family members, if any, may enroll in the Plan at a later date - no more than 31 days after becoming eligible - and not considered late applicants. The "special enrollment" period is the period of time during which an otherwise late applicant may apply for coverage outside the annual open enrollment period.

Special medical foods — Nutritional substances in any form that are consumed or administered internally under the supervision of a physician, specifically processed or formulated to be distinct in one or more nutrients present in natural food; intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs, or certain nutrients contained in ordinary foodstuffs, or who have other specific nutrient requirements as established by medical evaluation; and essential to optimize growth, health, and metabolic homeostasis. Special medical foods are covered only when prescribed by a physician for treatment of genetic orders of metabolism, and the member is under the physician's ongoing care. Special medical foods are not for use by the general public and may not be available in stores or supermarkets. Special medical foods are not those foods included in a health diet intended to decrease the risk of disease, such as reduced-fat foods, low sodium foods, or weight loss products.

Specialty pharmacy provider — See definition of "Participating Pharmacy."

Speech therapist — A speech pathologist certified by the American Speech and Hearing Association. A speech therapist assists patients in overcoming speech disorders.

Speech therapy — Services used for the diagnosis and treatment of speech and language disorders.

Subscriber — The individual whose employment or other status, except for family dependency, is the basis for enrollment eligibility, or in the case of an individual contract, the person in whose name the contract is issued.

Summary of Benefits and Coverage (SBC) — The separately issued schedule that defines your copayment and/or coinsurance requirements, deductible, out-of-pocket limit, and annual or lifetime benefits, and provides an overview of covered services. It is referred to as the *Summary of Benefits* throughout this benefit booklet.

Surgical services — Any of a variety of technical procedures for treatment or diagnosis of anatomical disease or accidental injury including, but not limited to: cutting; microsurgery (use of scopes); laser procedures; grafting, suturing, castings; treatment of fractures and dislocations; electrical, chemical, or medical destruction of tissue; endoscopic examinations; anesthetic epidural procedures; other invasive procedures. Benefits for surgical services also

include usual and related local anesthesia, necessary assistant surgeon expenses, and pre- and post- operative care, including recasting.

Temporomandibular joint (TMJ) syndrome — A condition that may include painful temporomandibular joints, tenderness in the muscles that move the jaw, clicking of joints, and limitation of jaw movement.

Terminally ill patient — A patient with a life expectancy of **six months or less**, as certified in writing by the attending physician.

Tertiary care facility — A hospital unit that provides complete perinatal care (occurring in the period shortly before and after birth) and intensive care of intrapartum (occurring during childbirth or delivery) and perinatal high- risk patients. This hospital unit also has responsibilities for coordination of transport, communication and data analysis systems for the geographic area served.

Transplant — A surgical process that involves the removal of an organ from one person and placement of the organ into another. Transplant can also mean removal of organs or tissue from a person for the purpose of treatment and re- implanting the removed organ or tissue into the same person.

Transplant- related services — Any hospitalizations and medical or surgical services related to a covered transplant or retransplant and any subsequent hospitalizations and medical or surgical services related to a covered transplant or retransplant, and received within one year of the transplant or retransplant.

Urgent care — Medically necessary health care services received for an unforeseen condition that is not life- threatening. This condition does, however, require prompt medical attention to prevent a serious deterioration in your health (e.g., high fever, cuts requiring stitches).

APPENDIX A: CONTINUATION COVERAGE RIGHTS UNDER COBRA

This notice contains important information about your possible right to COBRA continuation coverage, which is a temporary extension of coverage under this group health care plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), for certain larger group employers. COBRA continuation coverage may be available to you and to other members of your family who are covered under the health care plan when you would otherwise lose your group health coverage. Contact your employer to determine if you or your group are eligible for COBRA continuation coverage.

This notice generally explains:

- COBRA continuation coverage;
- when it may become available to you and your family if your group is subject to the provisions of COBRA; and
- what you need to do to protect your right to receive it.

This notice gives only a summary of COBRA continuation coverage rights. For more information about the rights and obligations under the Plan and under federal law, contact the Plan administrator or see *Section 2: Enrollment and Termination Information* of this benefit booklet.

The Plan administrator of the Plan is named by the employer or by the group health plan. Either the Plan administrator or a third party named by the Plan administrator is responsible for administering COBRA continuation coverage. Contact your Plan administrator for the name, address, and telephone number of the party responsible for administering your COBRA continuation coverage.

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of health care plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the health care plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and eligible children of employees may be qualified beneficiaries. Under the Plan, generally most qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Contact the employer and/or COBRA administrator for specific information for your Plan.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- your hours of employment are reduced; or
- your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- your spouse dies;
- your spouse's hours of employment are reduced;
- your spouse's employment ends for any reason other than his or her gross misconduct;
- your spouse becomes enrolled in Medicare (Part A, Part B or both); or
- you become divorced or legally separated from your spouse.

Your eligible children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens and if your group is subject to the provisions of COBRA:

- the parent- employee dies;
- the parent- employee's hours of employment are reduced;
- the parent- employee's employment ends for any reason other than his or her gross misconduct;
- the parent- employee becomes enrolled in Medicare (Part A, Part B or both);

- the parents become divorced or legally separated; or
- the child stops being eligible for coverage under the Plan as an "eligible child".

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer, and that bankruptcy results in the loss of coverage of any retiree covered under the Plan, the retiree is a qualified beneficiary with respect to the bankruptcy. The retiree's spouse, surviving spouse and eligible children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan administrator has been notified that a qualifying event has occurred.

The employer must notify the Plan administrator **within 30 days** when the qualifying event is:

- the end of employment;
- the reduction of hours of employment;
- the death of the employee;
- with respect to a retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
- the enrollment of the employee in Medicare (Part A, Part B or both).

For the other qualifying events (divorce or legal separation of the employee and spouse or an eligible child losing eligibility for coverage as an eligible child), you must notify the Plan administrator. The Plan requires you to notify the Plan administrator **within 60 days** after the qualifying event occurs. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

Once the Plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage may last for up to 36 months when the qualifying event is:

- the death of the employee;
- the enrollment of the employee in Medicare (Part A, Part B or both);
- your divorce or legal separation;
- an eligible child losing eligibility as an eligible child.

When the qualifying event is the end of employment or reduction in hours of employment, COBRA continuation coverage lasts for **up to 18 months**. There are two ways in which this 18- month period of COBRA continuation can be extended:

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during **the first 60 days** of COBRA continuation coverage and you notify the Plan administrator in a timely fashion, you and your entire family can receive **up to an additional 11 months** of COBRA continuation coverage, **for a total maximum of 29 months**. You must make sure that your Plan administrator is notified of the Social Security Administration's determination **within 60 days** of the date of the determination and before the end of the 18- month period of COBRA continuation coverage. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension of 18- Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and eligible children in your family can get additional months of COBRA continuation coverage, **up to a maximum of 36 months**. This extension is available to the spouse and eligible children if the former employee dies, enrolls in

Medicare (Part A, Part B or both), or gets divorced or legally separated. The extension is also available to an eligible child when that child stops being eligible under the Plan as an eligible child.

In all of these cases, you must make sure that the Plan administrator is notified of the second qualifying event **within 60 days** of the second qualifying event. Contact your employer and/or the COBRA administrator for procedures for this notice, including a description of any required information or documentation.

IF YOU HAVE QUESTIONS

If you have questions about COBRA continuation coverage, contact the Plan administrator or the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

In order to protect your family's rights, you should keep the Plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Plan administrator.

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

Appendix: Notice - Inquiries/Complaints and Internal/External Appeals for Self-Funded Plans

This notice is made a part of your employer's self-funded health care plan benefit booklet, administered by Blue Cross and Blue Shield of New Mexico (BCBSNM). If you have a question about these procedures, please call a Customer Service Advocate at the phone number printed on the back of your identification card. NOTE: Whenever these procedures require that an action be taken by any party, including BCBSNM, within a certain period of time from receipt of a request or document, the request or document will be deemed to have been received within three working days of the date it was mailed.

Change in state or federal law or regulations, or interpretations thereof, may change the terms and conditions of coverage.

GENERAL INQUIRIES AND COMPLAINTS

Inquiry - A general request for information regarding claims, benefits, or membership.

Complaint - An expression of dissatisfaction by you, either orally or in writing. Issues may include, but are not limited to, claims payments or denials, quality of care, and locating a network provider.

The Claims Administrator, BCBSNM, has a team available to assist you with inquiries and complaints. To make an inquiry or complaint, contact a Customer Service Advocate at the phone number on the back of your ID card or by mail at the address on the inside front cover of your benefit booklet (inquiries about behavioral health services are directed to the Behavioral Health Unit; appeals are directed to the general BCBSNM Appeals Unit as indicated later in this appendix notice).

INITIAL INTERNAL REVIEW OF CLAIMS/PREAUTHORIZATION REQUESTS

When you or your treating health care professional requests a preauthorization or files a claim for a health care service, BCBSNM first determines whether the requested service is covered under your Plan. If the requested service is not covered, BCBSNM will not review for medical necessity, but will send you notice that there is no coverage for the requested service.

Only if the requested service is possibly covered will BCBSNM review for medical necessity. If the requested service is approved as medically necessary, you will receive notice of that determination. An approval does not ensure that the service will be covered. For example, if you are not eligible for coverage at the time services are received, if the service you receive is different from the service authorized, or if your benefit plan changes or terminates before you receive the service in question, the service may still be denied.

Preauthorization - A decision by BCBSNM that a health care service has been reviewed and, based upon the information available, meets BCBSNM's requirements for coverage and medical necessity.

TIMING OF REQUIRED NOTICES AND EXTENSIONS

Separate schedules apply to the timing of required notices and extensions, depending on the type of claim. There are three types of claims as defined below.

- ***Urgent care clinical claim*** - Any pre-service claim that requires preauthorization, as described in the benefit booklet, for a benefit determination for medical care or treatment for which the application of regular notification time periods could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of the physician with knowledge of your medical condition, would subject you to severe pain that cannot adequately be managed without the care or treatment
- ***Post-service claim*** - A notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

— ***Pre-service claim*** - A request for preauthorization, which is any non-urgent request for a benefit or for a benefit determination for which the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. A voluntary request for advance determination of benefits is not a pre-service request for purposes of this provision.

URGENT CARE CLINICAL CLAIMS	
Type of Notice or Extension	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	**24 hours**
If you are notified that your claim is incomplete, you must then provide completed claim information to the Claims Administrator within:	**48 hours** after receiving notice
The Claims Administrator must notify you of the claim determination (whether adverse or not):	
if the claim is complete, as soon as possible (taking into account medical exigencies), but no later than:	**72 hours**
after receiving the completed claim (if the initial claim is incomplete), within:	**48 hours**

*You do not need to submit appeals of Urgent Care Clinical Claims in writing. You should call the Claims Administrator at the toll-free number listed on the back of your Identification Card as soon as possible to appeal an Urgent Care Clinical Claim.

PRE-SERVICE CLAIMS	
Type of Notice or Extension	**Timing**
If your claim is filed improperly, the Claims Administrator must notify you within:	**5 days**
If your claim is incomplete, the Claims Administrator must notify you within:	**15 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to the Claims Administrator within:	**45 days** after receiving notice
The Claims Administrator must notify you of the claim determination (whether adverse or not):	
if the claim is complete, within:	**15 days**
after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
If you require post-stabilization care after an emergency, within:	**the time appropriate to the circumstance not to exceed one hour after the time of request**

*This period may be extended one time by the Claims Administrator for up to 15 days, provided that the Claims Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

POST-SERVICE CLAIMS	
Type of Notice or Extension	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	**30 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to the Claims Administrator within:	**45 days** after receiving notice
The Claims Administrator must notify you of the claim determination (whether adverse or not):	
if the claim is complete, as soon as possible (taking into account medical exigencies), but no later than:	**30 days**
after receiving the completed claim (if the initial claim is incomplete), within:	**45 days**

*This period may be extended one time by the Claims Administrator for up to 15 days, provided that the Claims Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

Concurrent Care

For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your claim for benefits.

MANNER AND CONTENT OF CLAIM/PREAUTHORIZATION DENIAL NOTICES

On occasion, the Claim Administrator may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the *Explanation of Benefits* summary prepared by the Claim Administrator; then review the benefit booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to the Claims Administrator and request a review of the decision as described in Internal Appeal Procedures below.

If your preauthorization request or claim is denied in whole or in part, you will be notified in writing or by electronic means, within the time frames stated above, of the following:

- subject to privacy laws and other restrictions, if any, the identification of the claim, the date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- the specific reason(s) for determination;
- a reference to the specific health plan provision(s) on which the denial is based, or the contractual, administrative or protocol for the determination;
- the specific internal rule, guideline, protocol, or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request;
- an explanation of the scientific or clinical judgment relied on in the determination, if the denial was based on medical necessity, experimental treatment, or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- a description of additional information that may be needed to perfect the request or claim and an explanation of why such material is needed;
- a description of BCBSNM's internal review/appeals and external review procedures and time limits (and how to initiate a review/appeal or external review) including a statement of your right, if any, to pursue any state and, if applicable, federal legal remedies, including bringing a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;

- in certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- in certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
- the right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;
- in the case of a denial of an urgent care clinical claim, a description of the expedited internal review procedure applicable to such claims (an urgent care claim decision may be provided orally, so long as written notice is furnished to you within three days of oral notification);
- contact information for applicable office of health insurance consumer assistance or ombudsman.

IMPORTANT: For *Adverse Benefit Determinations* that are related to any claim or preauthorization denial, reduction, termination, or failure to provide or make payment that is based on a **determination of eligibility** to participate in the Plan, including contributions for coverage, you must contact your **Employee Benefits Department**.

INTERNAL APPEAL PROCEDURES

The following definitions apply to the Claims Administrator's internal appeal procedures (i.e., for issues not related to eligibility determinations):

Adverse Benefit Determination - A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment for a benefit resulting from the application of utilization review, as well as failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claims Administrator or your employer and the Claims Administrator or your employer reduces or terminates such treatment (other than by amendment or termination of the employer's benefit plan) before the end of the approved treatment period; that is also an *Adverse Benefit Determination*. A rescission of coverage is also an *Adverse Benefit Determination*. A rescission of coverage does not include a termination of coverage for reasons related to nonpayment of premium.) In addition, an *Adverse Benefit Determination* also includes an Adverse Determination. For purposes of this Plan, BCBSNM will refer to both an "Adverse Determination" and an "Adverse Benefit Determination" as an "Adverse Benefit Determination," unless indicated otherwise.

Appeal - An oral or written request for review of an *Adverse Benefit Determination* or an adverse action by the Claims Administrator ("BCBSNM"), its employees or a participating provider.

Final Internal Adverse Benefit Determination - An *Adverse Benefit Determination* that has been upheld by BCBSNM, at the completion of its internal appeal process or with respect to which the internal appeals process has been deemed exhausted.

Expedited Clinical Appeal

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An expedited clinical appeal is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, as well as continued hospitalization. Before authorization of benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, the Claims Administrator will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, the Claims Administrator will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Claims Administrator shall render a determination on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by the Claims Administrator.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for preauthorization, or any other determination made by the Claim Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

An appeal of an *Adverse Benefit Determination* may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your ID card.

If you believe the Claim Administrator incorrectly denied all or part of your benefits, you may have your claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of an *Adverse Benefit Determination*, you may call or write to the Claim Administrator to request a claim review. The Claim Administrator will need to know the reasons why you do not agree with the *Adverse Benefit Determination*. You may contact the Claim Administrator at:

BCBSNM Appeals Unit
P.O. Box 27630
Albuquerque, NM 87125-9815
Telephone (toll-free): (800) 205-9926

- In support of your Claim review, you have the option of presenting evidence and testimony to the Claim Administrator. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an *Adverse Benefit Determination* or at any time during the Claim review process.

The Claim Administrator will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of your Claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial *Adverse Benefit Determination*. Such new or additional evidence, rationale and information will be provided to you or your authorized representative sufficiently in advance of the date the final decision on appeal is made in order to give you a chance to respond. The appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors, but who were not involved in making the initial denial of your claim. If the initial benefit determination regarding the claim is based in whole or in part on a medical judgement, the appeal determination will be made by a Physician associate contracted with us and/or by external advisors, but who were not involved in making the initial denial of your claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator or your employer.

For non-eligibility issues, you or your authorized representative may request an appeal of a claims or preauthorization decision orally or in writing, by contacting:

BCBSNM Appeals Unit
P.O. Box 27630
Albuquerque, NM 87125-9815
Telephone (toll-free): (800) 205-9926
FAX: (505) 816-3837

Timeframe for Completion of Internal Appeal

Upon receipt of a non-urgent pre-service appeal, the Claim Administrator shall render a determination of the appeal as soon as practical, but in no event more than 30 days after the appeal has been received by the Claim Administrator.

Upon receipt of a post-service appeal, the Claim Administrator shall render a determination of the appeal as soon as practical, but in no event more than 60 days after the appeal has been received by the Claim Administrator.

You have the right to request a postponement of the appeal review process by submitting your request in writing.

Manner and Content of Notification of Internal Appeal Decision

BCBSNM will provide you with written or electronic notice of the Internal Appeal Decision within the timeframes described above. You have the right to request, free of charge, reasonable access to and copies of all documents, records, and other information related to your appeal. If your appeal is denied in whole or in part, you will be notified in writing of the following:

- subject to privacy laws and other restrictions, if any, the identification of the claim, the date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- the specific reason(s) for the determination;
- the right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- an explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
- a description of the standard that was used in denying the Claim and a discussion of the decision;
- a description of BCBSNM's external review procedures and time limits including your right to pursue, if applicable, federal legal remedies including bringing a civil action under §502(a) of ERISA following a final adverse determination on external appeal;
- in certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- in certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
- contact information for applicable office of health insurance consumer assistance or ombudsman.

If the Claims Administrator's or your employer's decision is to continue to deny or partially deny your claim or preauthorization request or you do not receive a timely decision, you may be able to request an external review of your claim or preauthorization request by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the next section.

INDEPENDENT EXTERNAL REVIEW

For non-eligibility issues, you or your authorized representative may make a request for a standard external review or expedited external review of an *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* by an independent review organization (IRO). External review is available for an *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* that involves medical judgment (including, but not limited to, those based on requirements, for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational), as determined by the external reviewer. Rescissions are also eligible for external review.

1.**Request for external review.** Within four months after the date of receipt of a notice of an *Adverse Benefit Determination* or *Final Internal Adverse Benefit Determination* from BCBSNM, you or your authorized representative must file your request for standard external review.

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 *Final Internal 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 about the exhaustion of the internal appeal process; and
- You or your authorized representative has 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 (toll-free number 866-444-EBSA (3272).

3.**Referral to Independent Review Organization**. When an eligible request for external review is completed within the time period allowed, BCBSNM or your employer 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;
  - 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 upon 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, BCBSNM 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 *Adverse Benefit Determination* involves a medical condition of the claimant for which 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 claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the *Final Internal Adverse Benefit Determination* concerns an

admission, availability 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 "Standard External Review" section above. BCBSNM must immediately send you a notice of its eligibility determination that meets the requirements set forth in the "Standard External Review" section above.

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

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

4.**Notice of final external review decision**. BCBSNM's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the "Standard External Review" section above, 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 have exhausted the internal review process due to BCBSNM's failure to comply with the internal claims and appeals process, you may 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 ACTION

If you are still not satisfied after having completed BCBSNM's or, for eligibility and employee contribution issues, your employer's complaint, appeal, grievance, or reconsideration procedure, you may have the option of taking one of the following steps. No legal action at law or in equity may be taken or arbitration demand made earlier than 60 days after the Claims Administrator 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 the Claims Administrator.

Arbitration for Non-ERISA Plans — The "Arbitration for Non-ERISA Plans" provision applies to all governmental plans, church plans, and plans maintained outside the United States primarily for the benefit of persons substantially all of whom are non-resident aliens. If a dispute about coverage, benefits, or handling of claims or appeals continues after you have followed and **exhausted** the appeals and grievance process set forth above, including having completed the external review process, the issue or claim may be submitted to arbitration. The rules for arbitration shall be the "Commercial Arbitration Rules" developed by the American Arbitration Association. You may obtain a copy of these rules from a Customer Service Advocate. The rules are also available from the American Arbitration Association's Web site (www.adr.org).

Additional Resources — If you need additional assistance, you may call the U.S. Department of Labor's Employee Benefits Security Administration (EBSA):

Call toll-free at (866) 444-EBSA (3272) or visit the EBSA Web site at www.askebsa.dol.gov

The Managed Health Care Bureau of the New Mexico Office of Superintendent of Insurance is also available to assist you with questions or complaints about the Claims Administrator's appeal process:

Office of Superintendent of Insurance
1120 Paseo de Peralta
Room 428
Santa Fe, NM 87501
(855) 427-5674 (1-855-4 ASK OSI)
http://www.OSI.state/nm.us

RETALIATORY ACTION

BCBSNM and your employer shall not take any retaliatory action against you for making a complaint, filing an appeal, or requesting external review under this health plan.

NOTE: BCBSNM provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims, except as may be specified in the Administrative Services Agreement.

Acceptance of coverage under this benefit booklet constitutes acceptance of its terms, conditions, limitations, and exclusions. Members are bound by all of the terms of this benefit booklet.

The legal agreement between **County of Los Alamos** and Blue Cross and Blue Shield of New Mexico (BCBSNM) includes the following documents:

- this benefit booklet and any amendments, riders, or endorsements;
- the enrollment/change form(s) for the subscriber and his/her dependents;
- the members' identification cards; and
- the *Summary of Benefits*

In addition, **County of Los Alamos** has important documents that are part of the legal agreement:

- the Benefit Program Application from the employer; and
- the Administrative Services Agreement between BCBSNM and **County of Los Alamos**

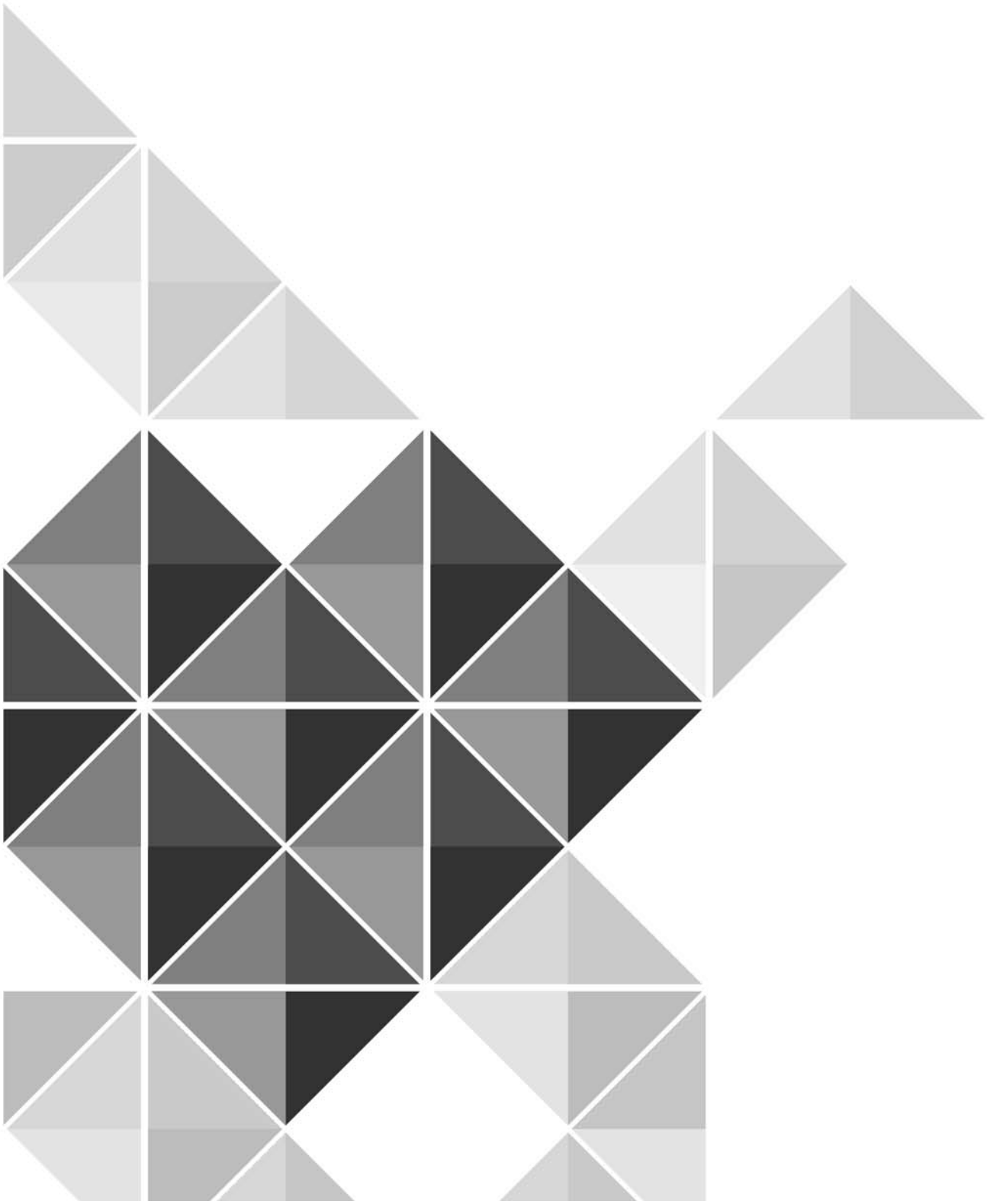
The above documents constitute the entire legal agreement between BCBSNM and **County of Los Alamos**. No agent or employee of BCBSNM has authority to change this benefit booklet or waive any of its provisions. You will be notified of any changes to this benefit booklet at least 30 days before the changes become effective.

County of Los Alamos reserves the right to amend, modify, or discontinue coverage provided for employees and their dependents. This benefit booklet is not an implied contract and does not guarantee benefits or employment.

BCBSNM provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims, except as may be specified in the Administrative Services Agreement.

Exhibit B

BlueCross BlueShield of New Mexico



Attachment A