

Benefits for Healthcare Coverage



# **The New Mexico Benchmark Plan**

The New Mexico Benchmark Plan serves as a baseline for the minimum scope of benefits that most health plans sold in the individual and small group markets must cover at equal or greater value.

Since the inception of the ACA, federal guidance has allowed each state the opportunity to select their benchmark from 10 possible plans:

- The largest plan by enrollment in any of the three largest products by enrollment in the state's small group market;
- Any of the largest three state employee health benefit plan options by enrollment;
- Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment;
- The Health Maintenance Organization (HMO) plan with the largest insured commercial non-Medicaid enrollment in the state.

The largest small-group plan has served as the benchmark plan from 2014-2020.

Further, the Affordable Care Act requires non-grandfathered health plans in the individual and small group markets to cover essential health benefits (EHB), which include items and services in ten benefit categories. HHS regulations (45 CFR 156.100) define EHB based on state-specific EHB benchmark plans, which apply to individual and small group ACA compliant plants. For plan year 2020 and after, the Final 2019 HHS Notice of Benefits and Payment Parameters provides states with greater flexibility by establishing standards for States to update their EHB benchmark plans. CMS is providing States three new options for selection starting in plan year 2020, including:

- Option 1: Selecting the EHB-benchmark plan that another State used for the 2017 plan year.
- Option 2: Replacing one or more categories of EHBs under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another State used for the 2017 plan year.
- **Option 3: Otherwise selecting a set of benefits that would become the State's EHB-benchmark plan.**

The New Mexico Superintendent of Insurance (OSI) is utilizing the greater flexibility granted by CMS in **Option 3** to update their EHB benchmark plans to help address confusion in prior year plan updates for plan year 2022.

Under Option 3, the State is allowed to develop its benchmark plan by selecting a set of benefits rather than an existing plan offered in the market. Therefore, in the process of developing the 2022 EHB benchmark plan, the New Mexico OSI started with the 2017 EHB benchmark as the basis and added or clarified benefits.

As required per federal regulation, the New Mexico OSI submitted an actuarial report and certification that demonstrates the proposed 2022 EHB benchmark plan meets the following two actuarial requirements:

1. The EHB benchmark plan must be equal to, or greater than the scope of benefits provided under a typical employer plan; and
2. The EHB benchmark plan does not exceed the generosity of the most generous among the plans listed at Section 156.111(b)(2)(ii).

The first requirement states the EHB benchmark plan must be equal to or greater than the scope of benefits provided under a typical employer plan. The starting point for the proposed benchmark is the current 2017 benchmark, which is one of the most popular small group plans offered in New Mexico. Further, since it is the current 2020 benchmark plan, it already meets the criteria of being equal to or greater than a typical employer plan. OSI has elected to add or clarify benefits from the 2017 benchmark plan. Since OSI is enhancing the plans, the proposed benchmark continues to meet the criteria of the first requirement.

The second requirement states the EHB benchmark plan does not exceed the generosity of the most generous among the plans listed at Section 156.111(b)(2)(ii). To demonstrate compliance with this requirement, we performed a cost study on each of the recommendations to determine the materiality of the new benefit or criteria and the impact it would have on the overall premiums of the benchmark plan. For more information, please see the detailed actuarial report from Wakely.

At no time shall the set of benefits listed below be construed to allow an issuer to NOT cover any and all federal and state required benefits. Additionally, to the extent this EHB benchmark does not comply with current federal requirements, individual and small group market issuers in the state need to conform plan benefits to meet applicable EHB requirements when designing plans that are substantially equal to the EHB benchmark plan.

Any pediatric vision and dental services provided under EHB benchmark coverages are listed as attachments.

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# 1. At a Glance - Covered and Not Covered

Your coverage provides benefits for many services and supplies. There are also services for which this coverage does not provide benefits. The following chart is provided for your convenience as a quick reference only. This chart is not intended to be and does not constitute a complete description of all coverage details and factors that determine whether a service is covered or not.

## Set of Benefits

Category	Covered	Not Covered	Page Number and Service Note
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Abortions - Elective		<input type="checkbox"/>	p. 35
Acupuncture Treatment	<input checked="" type="checkbox"/>		p.9, 20 visits per year unless for habilitative and rehabilitative services
Allergy Testing and Treatment	<input checked="" type="checkbox"/>		p. 9
Ambulance Services	<input checked="" type="checkbox"/>		p. 9-10
Bariatric Surgery	<input checked="" type="checkbox"/>		p. 11, Bariatric surgery is Covered for patients with a Body Mass Index (BMI) of 35 kg/m2 or greater who are at high risk for increased morbidity due to specific obesity related comorbid medical conditions
Chemotherapy	<input checked="" type="checkbox"/>		p. 13
Chiropractic Care	<input checked="" type="checkbox"/>		p. 13, 20 visits per year unless for habilitative and rehabilitative services
Cosmetic Services		<input type="checkbox"/>	p. 14
Dental – Basic Care for Children	<input checked="" type="checkbox"/>		p. 15
Dental Check-Up for Children	<input checked="" type="checkbox"/>		p. 15
Dental – Major Dental Adult		<input type="checkbox"/>	p. 15-16
Dental – Major Dental Child	<input checked="" type="checkbox"/>		p. 15-16
Dental Care – Routine Adult		<input type="checkbox"/>	p. 15-16
Dental Treatment for Accidental Injury	<input checked="" type="checkbox"/>		p. 15-16
Diabetes Education	<input checked="" type="checkbox"/>		p. 16 Benefits are available when received from a practitioner/provider who is approved to provide diabetes education.
Dialysis	<input checked="" type="checkbox"/>		p. 26
Durable/Home Medical Equipment	<input checked="" type="checkbox"/>		p.19-22
Emergency Services	<input checked="" type="checkbox"/>		p. 17
Eye Glasses for Children	<input checked="" type="checkbox"/>		p. 31
Habilitative Services	<input checked="" type="checkbox"/>		p. 18
Hearing Aids	<input checked="" type="checkbox"/>		p. 19, 1 per ear every 3 years
Home Health Services	<input checked="" type="checkbox"/>		p. 19, 100 days per year
Hospice Services	<input checked="" type="checkbox"/>		p. 22

Category	Covered	Not Covered	Page Number and Service Note
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Imaging and Diagnostic (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>		p.23
Infertility Treatment	<input checked="" type="checkbox"/>		p. 23-24 Diagnosis and medically indicated treatments for physical conditions causing infertility
Infusion Therapy	<input checked="" type="checkbox"/>		p. 19
Inpatient Hospital Services (e.g. hospital stay)	<input checked="" type="checkbox"/>		p. 23
Inpatient Physician and Surgical Services	<input checked="" type="checkbox"/>		p. 23
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>		p. 23
Maternity Care – Delivery and Inpatient Services	<input checked="" type="checkbox"/>		p. 23-25
Mental Health/Behavioral Health Inpatient	<input checked="" type="checkbox"/>		p. 25-26
Mental Health/Behavioral Health Outpatient	<input checked="" type="checkbox"/>		p. 25-26
Nursing Home Care – Long Term/Custodial		<input checked="" type="checkbox"/>	p. 23
Nutritional Counseling/Support	<input checked="" type="checkbox"/>		p.26
Other Practitioner Visit (Nurse, PA)	<input checked="" type="checkbox"/>		p.27
Orthodontia - Child	<input checked="" type="checkbox"/>		p. 15
Orthodontia – Adult		<input checked="" type="checkbox"/>	p. 15
Outpatient Facility Fee (e.g. ambulatory surgical center)	<input checked="" type="checkbox"/>		p. 26-27
Outpatient Surgery (e.g. ambulatory surgical center)	<input checked="" type="checkbox"/>		p. 27
Prenatal and Postnatal Care	<input checked="" type="checkbox"/>		p. 24-25
Preventive Care/Screening/Immunization	<input checked="" type="checkbox"/>		p. 30-32
Primary Care Visits	<input checked="" type="checkbox"/>		p. 27
Private Duty Nursing		<input checked="" type="checkbox"/>	p. 19

Category	Page Number and Service Note	
	Covered	Not Covered
Prosthetic Devices	<input checked="" type="checkbox"/>	p.19-21
Radiation	<input checked="" type="checkbox"/>	p.13
Reconstructive Surgery	<input checked="" type="checkbox"/>	p.33
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	p. 28-29
Rehabilitation Services - Outpatient	<input checked="" type="checkbox"/>	p. 28-29
Routine Eye Exam for Adults	<input type="checkbox"/>	<input checked="" type="checkbox"/> p. 21
Routine Eye Exam for Children	<input checked="" type="checkbox"/>	p. 31
Routine Foot Care	<input type="checkbox"/>	<input checked="" type="checkbox"/> p. 17
Skilled Nursing Facility	<input checked="" type="checkbox"/>	p. 28, 60 days per year
Specialist Visit	<input checked="" type="checkbox"/>	p. 27
Speech Therapy	<input checked="" type="checkbox"/>	p. 28-29
Substance Use Inpatient Services	<input checked="" type="checkbox"/>	p. 25-26
Substance Use Outpatient Services	<input checked="" type="checkbox"/>	p. 25-26
Temporomandibular Joint Disorder (TMD)	<input checked="" type="checkbox"/>	p. 15
Transplants	<input checked="" type="checkbox"/>	p. 33-34
Urgent Care	<input checked="" type="checkbox"/>	p. 17
Weight loss programs	<input checked="" type="checkbox"/>	p. 35, Includes coverage for drugs and programs if medically necessary for morbid obesity and obesity.
Well-baby visits and care	<input checked="" type="checkbox"/>	p. 31-32
X-rays and diagnostic imaging	<input checked="" type="checkbox"/>	p. 23

## Prescription Drug Plan

Prescription Drug Category	Covered	Not Covered	Prescription Maximum
	Generic Prescription Drugs	<input checked="" type="checkbox"/>	
Non-preferred Brand Drugs	<input checked="" type="checkbox"/>		p. 29-30
Preferred Brand Drugs	<input checked="" type="checkbox"/>		p. 29-30
Specialty Drugs	<input checked="" type="checkbox"/>		p. 29-30
Weight Reduction Drugs	<input checked="" type="checkbox"/>		p. 35, Includes coverage for prescription drugs medically necessary for morbid obesity and obesity.

## 2. Details - Covered and Not Covered

### Set of Benefits

#### **ACUPUNCTURE TREATMENT**

**Covered:** Acupuncture is treatment by means of inserting needles into the body to reduce pain or to induce anesthesia. It may also be used for other diagnoses as determined appropriate by the practitioner/provider. It is recommended that acupuncture be part of a coordinated plan of care approved by the member's practitioner/provider. These benefits cover acupuncture and acupressure treatment.

**Limitation:** The acupuncture benefit is limited to 20 visits per plan year unless the service is prescribed by a provider for habilitative or rehabilitative purposes.

#### **ALLERGY TESTING AND TREATMENT**

**Covered:** This plan provides coverage for allergy testing and treatment.

#### **AMBULANCE SERVICES**

##### **Covered:**

**Emergency ambulance services:** Emergency ambulance services are defined as ground or air ambulance services delivered to a member who requires emergency health care services under circumstances that would lead a reasonable/prudent layperson acting in good faith to believe that transportation in any other vehicle would endanger your health. Emergency ambulance services are covered only under the following circumstances:

- o Within New Mexico, to the nearest in-network facility where emergency health care services and treatment can be rendered, or to an out-of-network facility if an in-network facility is not reasonably accessible or able to provide required care. Such services must be provided by a licensed ambulance service, in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.

- o Outside of New Mexico, to the nearest appropriate facility where emergency health care services and treatment can be rendered. Such services must be provided by a licensed ambulance service, in a vehicle that is equipped and staffed with life-sustaining equipment and personnel.

- o A plan may not pay more for air ambulance services than it would have paid for ground ambulance services over the same distance unless a member's condition renders the utilization of such ground transportation services medically inappropriate.

- o In determining whether a member acted in good faith as a reasonable/prudent layperson when obtaining emergency ambulance services, the plan will take the following factors into consideration:

- ◆ Whether the member required emergency health care services,
- ◆ The presenting symptoms
- ◆ Whether a reasonable/prudent layperson who possesses average knowledge of

health and medicine would have believed that transportation in any other vehicle would have endangered your health

- ◆ Whether the member was advised to seek an ambulance service by the member's practitioner/provider or by the plan's staff. Any such advice will result in

reimbursement for all medically necessary services rendered, unless otherwise limited or **excluded** under this plan

◆ Ground or air ambulance services to any Level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols

**High Risk Ambulance Services** are defined as ambulance services that are:

- o Non-emergency
- o Medically necessary for transporting a high-risk patient
- o Prescribed by your practitioner/provider

Coverage for High-Risk Ambulance Services is limited to:

o Air ambulance service when medically necessary. However, a plan may not pay more for air ambulance service than it would have paid for transportation over the same distance by ground ambulance services, unless your condition renders the utilization of such ground ambulance services medically inappropriate.

o Neonatal ambulance services, including ground or air ambulance service to the nearest tertiary care facility when necessary to protect the life of a newborn or mother.

o Ground or air ambulance services to any Level I or II or other appropriately designated trauma/burn center according to treatment protocols.

**Inter-facility transfer ambulance services** are defined as ground or air ambulance service between hospitals, skilled nursing facilities or diagnostic facilities. Inter-facility transfer services are covered only if they are:

- o Medically necessary
- o Prescribed by your practitioner/provider
- o Provided by a licensed ambulance service in a vehicle which is equipped and staffed with life-sustaining equipment and personnel.

**Not covered:** Ambulance service (ground or air) to the coroner's office or to a mortuary is not covered unless the ambulance has been dispatched prior to the pronouncement of death by an individual authorized under state law to make such a pronouncement.

### **ANESTHESIA**

**Covered:** These benefits include coverage for anesthesia and the administration of anesthesia. Anesthesia may include coverage of hypnotherapy. General anesthesia may be provided where local anesthesia is ineffective because of acute infection, anatomic variation or allergy.

### **AUTISM SPECTRUM DISORDER(S)**

**Covered:** The diagnosis and treatment for autism spectrum disorder(s) is covered. This coverage includes:

- Well-baby and well-child screening for diagnosis the presence of autism spectrum disorder;
- Diagnosis of autism; and
- Treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy, and applied behavioral analysis to develop, maintain, restore and maximize the functioning of the individual, which may include services that are habilitative or rehabilitative in nature.

Coverage for Autism Spectrum Disorder is limited to treatment that is prescribed by the

member's treating physician in accordance with a treatment plan. Coverage for autism spectrum disorder may be subject to other general exclusions and limitations of the insurer's plan, including coordination of benefits, participating provider requirements, restrictions on services provided by family or household members and utilization review of health care services, including the review of medical necessity, case management and other managed health care provisions.

**Limitations.** Coverage may be limited to exclude coverage for 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 three to twenty-two years of age who have autism spectrum disorder.

Any treatment plan to treat autism spectrum disorder shall include the following elements:

- (1) the diagnosis;
- (2) the proposed treatment by types;
- (3) the frequency and duration of treatment;
- (4) the anticipated outcomes stated as goals;
- (5) the frequency with which the treatment plan will be updated; and
- (6) the signature of the treating physician.

#### **AUTOPSIES**

**Not Covered:** Autopsies for deceased members are not covered.

#### **BARIATRIC SURGERY**

**Covered:** Surgical treatment of morbid obesity (bariatric surgery) is covered only if it is medically necessary as defined in this plan.

**Limitations:** Bariatric surgery is covered for patients with a Body Mass Index (BMI) of 35 kg/m<sup>2</sup> or greater who are at high risk for increased morbidity due to specific obesity related co-morbid medical conditions; and if a member meets these criteria and all other requirements of this plan.

#### **CANCER OR OTHER LIFE THREATENING MEDICAL CONDITION CLINICAL TRIALS**

**Covered:** These benefits include coverage for cancer or other life threatening medical condition clinical trials.

- Coverage for routine patient care costs means a:
  - Medical service or treatment that is a benefit under this plan that would be covered if the patient were receiving standard cancer treatment or other treatment for a life threatening medical condition, or
  - Drug provided to a patient during a clinical trial if the drug has been approved by the United States Food and Drug Administration (FDA), whether or not that organization has approved the drug for use in treating the patient's particular condition, but only to the extent that the drug is not paid for the manufacturer, distributor or provider of the drug.
- Routine patient care costs are covered for members in a clinical trial if:
  - The patient encounters other life-threatening diseases or conditions during the course of treatment;
  - The clinical trial is undertaken for the purposes of the prevention of or the prevention of reoccurrence, early detection, or treatment of cancer or other life threatening medical treatment for which no equally or more effective standard

- treatment exists;
  - The clinical trial is not designed exclusively to test toxicity or disease pathophysiology and it has a therapeutic intent;
  - The clinical trial is being provided in New Mexico as part of a scientific study of a new therapy or intervention;
  - There is no non-investigational treatment equivalent to the clinical trial;
  - There is a reasonable expectation shown in clinical or pre-clinical data that the clinical trial will be at least efficacious as any non-investigational alternative; or
  - There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial will be at least as effective as any other medical treatment.
- The clinical trial is being conducted with the approval of at least one of the following:
  - One of the federal National Institutes of Health
  - A federal National Institute of Health cooperative group or center
  - The federal Department of Defense
  - The United States Food and Drug Administration (FDA) in the form of an investigational new drug application
  - The federal Department of Veterans Affairs
  - A qualified research entity that meets the criteria established by the National Institutes of Health for grant eligibility
  - A qualified research entity that meets the criteria established by the federal National Institutes of Health for grant eligibility
  - The Agency for Health Research and Quality (AHRQ)
  - The Centers for Medicare and Medicaid Services (CMS)
  - The Department of Energy (DOE)
- The personnel providing the clinical trial or conducting the study:
  - Are providing the clinical trial or conducting the study within their scope of practice, experience and training and are capable of providing the clinical trial because of their experience, training and volume of patients treated to maintain their expertise;
  - Agree to accept reimbursement as payment in full from the health plan at the rates that are established by that plan and are not more than the level of reimbursement applicable to other similar services provided by health care providers within the plan's provider network; and
  - Agree to provide written notification to the health plan when a patient enters or leaves a clinical trial;
- There is no non-investigational treatment equivalent to the clinical trial;
- The available clinical or preclinical data provide a reasonable expectation that the clinical trial will be at least as efficacious as any non-investigational alternative;
- There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial will be at least as effective as any other medical treatment; and
- Routine patient costs outside of the state in which the individual resides.

**Limitations:** The following limitations apply.

- Pursuant to the patient informed consent document, no third party is liable for damages associated with the treatment provided during a phase of a clinical trial.

- A health plan shall not provide benefits that supplant a portion of a clinical trial that is customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources.
- In no event shall the health plan be responsible for out-of-state or out-of-network costs unless the health plan pays for standard treatment out of state or out of network. In no event shall the health plan be responsible for out-of-state costs for any trials undertaken for the purposes of the prevention of or the prevention of reoccurrence of cancer or other life threatening illness.

**Not Covered:**

- Costs of the clinical trial that are customarily paid for by the government, biochemical, pharmaceutical or medical device industry sources
- The cost of a non-FDA approved investigational drug, device, or procedure
- The cost of a non-health care service the patient is required to receive as a result of participation in the clinical trial
- Costs associated with managing the research that is associated with the clinical trial
- Costs that would not be covered if non-investigational treatments were provided
- Costs of tests that are necessary for the research of the clinical trial
- Costs paid for or not charged by the clinical trial providers

**CHEMOTHERAPY AND RADIATION THERAPY**

**Covered:** Your benefits include coverage for the use of chemical agents or radiation to treat or control a serious illness.

**CHIROPRACTIC SERVICES**

**Covered:** Chiropractic services are available for specific medical conditions and are not available for maintenance therapy such as routine adjustments. Chiropractic services are subject to the following:

- The practitioner/provider determines in advance that chiropractic treatment can be expected to result in significant improvement in the covered person's condition within a period of two months.
- Chiropractic treatment is specifically limited to treatment by means of manual manipulation, i.e. by use of hands and other methods of treatment approved by the plan, including, but not limited to, ultrasound therapy.
- Subluxation must be documented by chiropractic examination and documented in the chiropractic record. The plan may not require radiologic (X-ray) demonstration of subluxation of chiropractic treatment.
- Biofeedback is only covered for treatment of Raynaud's disease or phenomenon and urinary or fecal incontinence.

**Limitations:** Chiropractic services are limited to 20 visits per year unless medically necessary care prescribed as a component of habilitative or rehabilitative services.

**CLOTHING OR OTHER PROTECTIVE DEVICES**

**Not Covered:** Clothing or other protective devices, including prescribed photo protective clothing, windshield tinting, lighting fixtures and/or shields, and other items or devices whether by prescription or not.

**CONTRACEPTIVES**

**Covered:** Your benefits include coverage for the following conception prevention, as approved

by the U.S. Food and Drug Administration:

- Contraceptive medical devices, such as intrauterine devices and diaphragms.
- Implanted contraceptives.
- Injected contraceptives.
- Contraceptive drugs and contraceptive drug delivery devices, such as insertable rings and patches. This benefit requires coverage of a sufficient number and assortment to reflect the variety of oral contraceptives approved by the federal food and drug administration.
- Male condoms, except for prior to meeting the deductible for high-deductible individual and group health plans
- Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, ultrasounds, anesthesia, patient education, counseling, device insertion and removal, follow-up care and side-effects management.

Benefits Schedule: A plan shall provide coverage and shall reimburse a health care provider or dispensing entity on a per-unit basis for dispensing a six-month supply of contraceptives at one time; provided that the contraceptives are prescribed for self-administered.

Contraceptives may be covered under the member's prescription drug benefit.

### **COSMETIC SURGERY**

**Not Covered:** Cosmetic surgery is not covered. Examples of cosmetic surgery that are not covered include breast augmentation, dermabrasion, dermaplaning, excision of acne scarring, acne surgery (including cryotherapy), asymptomatic keloid scar revisions, microphlebectomy, sclerotherapy (except for truncal veins), and nasal rhinoplasty.

Circumcisions, performed other than during the newborn's initial hospital stay, are not covered unless medically necessary.

Reconstructive surgery following a mastectomy is not considered cosmetic surgery and will be covered.

Medically necessary surgery performed to confirm a covered person's gender is not considered cosmetic surgery and will be covered.

Cosmetic treatment, devices, orthotics and prescription drugs/medications are not covered.

### **COUNSELING AND EDUCATION SERVICES**

**Not Covered:** Your benefits do not include:

- Coverage for bereavement, pastoral/spiritual and sexual counseling;
- Psychological testing when not medically necessary;
- Special education, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary or behavioral problems;
- Court ordered evaluation or treatment, treatment that is a condition of parole or probation or in lieu of sentencing, such as psychiatric evaluation or therapy; and
- Codependency treatment.

## **DENTAL SERVICES**

**Covered:** Dental benefits shall be provided with the following conditions when deemed medically necessary except in an emergency care situation as described in the section on Accidental Injury/Urgent Care/Emergency Health Care Services and Observational Services Section.

- Accidental injury to sound natural teeth, jawbones or surrounding tissue. Dental injury caused by chewing, biting, or malocclusion is not considered an accidental injury and will not be covered.
- The correction of non-dental physiological conditions such as, but not limited to, cleft palate repair that has resulted in a severe functional impairment.
- The treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Hospitalization, day surgery, outpatient and/or anesthesia for non-covered dental services, are covered, if provided in a hospital or ambulatory surgical center for dental surgery.
  - For members who exhibit physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results.
  - For members for whom local anesthesia is ineffective of acute infection, anatomic variation or allergy.
  - For covered dependent children or adolescents who are extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity.
  - For members with extensive oral-facial or dental trauma for which treatment under local anesthesia would be inefficient or compromised.
  - For other procedures for which hospitalization or general anesthesia in a hospital or ambulatory surgical center is medically necessary.
- Oral surgery that is medically necessary to treat infections or abscess of the teeth that involved the fascia or have spread beyond the dental space.
- Pediatric dental services, including routine check-ups, major dental care, and orthodontia. See attached documents.
- Removal of infected teeth in preparation for an organ transplant, joint replacement surgery or radiation therapy of the head and neck.
- **Temporo/Craniomandibular Joint Disorders (TMJ/CMJ):** The surgical and non-surgical treatment of Temporo/Craniomandibular Joint disorders (TMJ/CMJ) such as arthroscopy, physical therapy, or the use of orthotic devices (TMJ splints) are subject to the same conditions and limitations as they apply to treatment of any other joint in the body.

**Not Covered:** The following services are not covered:

- Routine, preventive, and major adult dental care.
- Dental care and dental X-rays are not covered, excepted as specifically provided above.

- Dental implants.
- Malocclusion treatment, if part of routine dental care and orthodontics.
- Orthodontic appliances and orthodontic treatment (braces), crowns, bridges and dentures used for the treatment of Temporo/Craniomandibular Joint disorders are not covered unless the disorder is trauma related.

### **DIABETES SERVICES**

**Covered:** Covered benefits are provided if the member has insulin dependent (Type I) diabetes, non-insulin dependent (Type 2) diabetes, and elevated blood glucose levels induced by pregnancy (gestational diabetes). Coverage includes equipment, appliances, prescription drug medications, insulin or supplies that meet the United States Food and Drug (FDA) approval, and are the generally medically accepted standards for diabetes treatment, supplies and education.

- Diabetes Education (Limited). The following benefits are available when received from a practitioner/provider who is approved to provide diabetes education.
  - Medically necessary visits upon the diagnosis of diabetes.
  - Visits following practitioner/provider diagnosis that represents a significant change in condition or symptoms requiring changes in the patient's self-management.
  - Visits when re-education or refresher training is prescribed by a health care practitioner/provider with prescribing authority.
  - Telephonic visits with a certified diabetes education (CDE)
  - Medical nutrition therapy related to diabetes management
  - **Limitations:** Approved diabetes educators may be required to be practitioners/providers who are registered, certified or licensed health care professional with recent education in diabetes management.
- Diabetes supplies and services. The following equipment, supplies, appliances, and services are covered when prescribed by your practitioner/provider. These items require the use of approved brands and may be required to be purchased at in-network pharmacy, preferred vendor or preferred durable medical equipment supplier.
  - Insulin pumps when medically necessary, prescribed by a provider
  - Specialized monitors/meters for the legally blind
  - Medically necessary covered podiatric appliances for the prevention of feet complications associated with diabetes.
  - Preferred prescriptive diabetic oral agents for controlling blood sugar levels
  - Glucagon emergency kits
  - Preferred insulin
  - Syringes
  - Injection aids, including those adaptable to meet the needs of the legally blind
  - Preferred blood glucose monitors/meters
  - Preferred test strips for blood glucose monitors
  - Lancets and lancet devices
  - Visual reading urine and ketone strips

**Cost-Sharing Limitation:** Cost-sharing for preferred formulary prescription insulin drugs or a medically necessary alternative is limited to an amount not to exceed a total of \$25 per thirty- 16 day supply.

**Limitation:** Routine foot care, such as treatment of flat feet or other structural misalignments of the feet, removal of corns, and calluses, is not covered, unless medically necessary due to diabetes or other significant peripheral neuropathies.

**Not Covered:** Routine food care, such as treatment of flat feet or other structural misalignments of the feet, removal of corns, and calluses, is not covered unless medically necessary due to diabetes or other significant peripheral neuropathies.

**EMERGENCY, URGENT CARE, ACCIDENTAL INJURY (TRAUMA),  
OBSERVATIONAL SERVICES**

**Emergency Care Covered:** Emergency care is covered:

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

**Emergency Care Not Covered:** Use of an emergency facility for non-emergent services is not covered.

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

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

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

When a hospital places a patient under outpatient observation, it is based upon the practitioner's/provider's written order. To transition from observation to inpatient admission, level of care criteria may need to be met. The length of time spent in the hospital is not the sole factor an insurer may use to determine an observation versus inpatient stay. Insurers may also consider medical criteria.

### **FERTILITY SERVICES**

**Covered:** Male vasectomies are covered except for under high-deductible individual or group health plans until an insured's deductible has been met. Tubal ligation/sterilization is also a covered benefit.

### **GENETIC INBORN ERROR OF METABOLISM**

**Covered:** This health plan covers:

- Coverage is provided for diagnosing, monitoring, and controlling disorders of genetic inborn errors of metabolism. Medical services provided by licensed health care professionals, including practitioners/providers, dieticians and nutritionists with specific training in managing members diagnosed with IEM are covered. These services include:
  - Nutritional and medical assessment
  - Clinical services
  - Biochemical analysis
  - Medical supplies
  - Prescription drugs/medications
  - Corrective lenses for conditions related to IEM
  - Nutritional management
  - Special Medical Foods are dietary items that are specially processed and prepared to use in the treatment of IEM to compensate for the metabolic abnormality and to maintain adequate nutritional status. Special medical foods may be prescribed for other medically necessary conditions.
- One pair of standard (non-tinted) eyeglasses (or contact lenses if medically necessary) within 12 months after cataract surgery or when related to genetic inborn error of metabolism. This includes the eye refraction examination, lenses and standard frames.

**Not Covered:** This plan does not cover:

- Food substitutes for lactose intolerance or other carbohydrate intolerances, including soy foods or elemental formulas or other over-the-counter (OTC) digestive aids are not covered, unless listed as a covered over-the-counter (OTC) medication on an insurer's drug formulary.
- Ordinary foodstuffs that might be part of an exclusionary diet.
- Food substitutes that do not qualify as special medical foods for the treatment of IEM.
- Special medical foods that are not medically necessary
- Dietary supplements and items for conditions including, but not limited to, diabetes mellitus, hypertension, hyperlipidemia, obesity, autism spectrum disorder, celiac disease and allergies to food products.

### **HABILITATIVE SERVICES**

**Covered:** This plan covers services that help a person learn, keep, or improve skills and functional abilities that they may not be developing normally. Habilitative services include physical, occupational and speech therapy and autism spectrum disorder diagnosis and treatment.

### **HAIR LOSS (or baldness)**

**Not Covered:** Hair-loss or baldness treatments, medications, supplies and devices, including wigs, and special brushes are not covered regardless of the medical cause of the hair-loss or baldness.

## **HEARING SERVICES**

**Covered:** This plan covers one hearing aid per ear every three years as a covered benefit. Hearing aid coverage shall include fitting and dispensing services, including providing ear molds as necessary to maintain optimal fit, provided by an audiologist, a hearing aid dispenser or a physician.

## **HOME HEALTH SERVICES**

**Covered:** Covered services are provided when a member is confined to the home due to physical illness. These services include medically necessary skilled intermittent health care services provided by a registered nurse or a licensed practical nurse; physical occupational, and/or respiratory therapist and/or speech pathologist. Intermittent Home Health aide services are only covered when part of an approved plan of care which includes skilled services. These services may include

- Collection of specimens to be submitted to an approved laboratory facility for analysis.
- Medical equipment, prescription drugs and medications, laboratory services and supplies deemed medically necessary by a practitioner/provider for the provision of health services in the home, except durable medical equipment, will be covered.
- Home health care or home intravenous services as an alternative to hospitalization, as determined by the practitioner/provider.
- Total parenteral and enteral nutrition as the sole source of nutrition.
- Medical drugs (obtained through the medical benefit): Medical drugs are defined as medications administered in the office, infusion suite, or facility (including home health care) that require a health care professional to administer. These medications include, but are not limited to, injectable, infused, oral or inhaled drugs. They may involve unique distribution and may be required to be obtained from the carrier's vendor. Infusion therapy is a benefit covered under this section.

**Limitations:** The plan may limit this benefit to 100 days per year.

**Not Covered:** The following services are not covered:

- Private duty nursing.
- Custodial care needs that can be performed by non-licensed medical personnel to meet the normal activities of daily living do not qualify for home health care services. Examples of custodial care that are not covered include, but are not limited to, bathing, feeding, preparing meals, or performing housekeeping tasks.

## **HOME/DURABLE MEDICAL EQUIPMENT**

**Covered generally:** This plan covers equipment that meets the following standards:

- Equipment that is medically necessary for the treatment of an illness or accidental injury or to prevent further deterioration.
- Equipment that is designed for repeated use, including oxygen equipment, functional wheelchairs, and crutches.
- Equipment that is considered standard and/or basic for the treatment of an illness or accidental injury as defined by nationally recognized guidelines.
- **Covered orthotic appliances** including:
  - Podiatric appliances for prevention of feet complications associated with diabetes.
  - Braces and other external devices used to correct a body function including clubfoot deformity.

**Limitations on orthotic appliances:** Foot orthotics or shoe appliances are not covered, except for our members with diabetic neuropathy or other significant neuropathy. Custom fabricated knee-ankle foot orthoses (KAFO) and ankle-foot orthoses (AFO) are Covered for members in accordance with nationally recognized guidelines. Orthotic appliances may be limited to a calendar year maximum.

**Covered prosthetic devices.** Prosthetic devices are artificial devices that replace or augment a missing or impaired part of the body. The purchase, fitting, and necessary adjustments of prosthetic devices and supplies that replace all or part of the function of a permanently inoperative or malfunctioning body part are covered when they replace a limb or other part of the body, after accidental or surgical removal and/or when the body's growth necessitates replacement.

Examples of prosthetic devices include, but are not limited to:

- breast prostheses when required because of mastectomy and prophylactic mastectomy
- artificial limbs
- prosthetic eye
- prosthodontic appliances
- penile prosthesis
- joint replacements
- heart pacemakers
- tracheostomy tubes and cochlear implants

#### **Repair and replacement of durable medical equipment, prosthetics and orthotic devices**

- Repair and replacement of durable medical equipment, prosthetics and orthotic devices must comport with state law. Please see the Diabetes Section.
- Repair and replacement is covered when medically necessary due to chance in the member's condition, wear or after the product's normal life expectancy has been reached.
- One-month rental of a wheelchair is covered if the member owned the wheelchair that is being repaired.

**Surgical Dressing.** Surgical dressings that require a practitioner's/provider's prescription, and cannot be purchased over the counter are covered when medically necessary for the treatment of a wound caused by, or treated by, a surgical procedure.

**Gradient compression stockings** are covered for:

- Severe and persistent swollen and painful varicosities, or lymphedema/edema or venous insufficiency not responsive to simple elevation
- Venous stasis ulcers that have been treated by a practitioner/provider or other health care professional requiring medically necessary debridement (wound cleaning).

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

**Eyeglasses and contact lenses (Limited)** will only be covered under the following circumstances: 20

- Contact lenses are covered for the correction of aphakia (those with no lens in the eye) or

keratoconus. This includes the eye refraction examination.

- One pair of standard (non-tinted) eyeglasses (or contact lenses if medically necessary) is covered within 12 months after cataract surgery or when related to genetic inborn error of metabolism. This includes eye refraction examination, lenses and standard frames.

**Hearing Aids:** See coverage outlined under **Hearing Services**.

**Not covered:** The following services are not covered:

- Upgraded or deluxe durable medical equipment
- Convenience items including, but not limited to, an appliance device, object or service that is for comfort and ease and is not primarily medical in nature, such as, shower or tub stools/chairs, seats, bath grab bars, shower heads, hot tubs/Jacuzzis, vaporizers, accessories such as baskets, trays, seat or shades for wheelchairs, walkers and strollers, clothing, pillows, fans, humidifiers, and special beds and chairs (excluding those covered under the durable medical equipment benefit).
- Duplicate durable medical equipment items (i.e. for home and office)
- Repair and replacement including:
  - Repair or replacement of durable medical equipment, orthotic appliances and prosthetic devices due to loss, neglect, misuse, abuse, or improve appearance or convenience
  - Repair and replacement of items under the manufacturer or supplier's warranty
  - Additional wheelchairs are not covered if the member has a functional wheelchair, regardless of the original purchaser of the wheelchair
- Orthotic appliances
  - Functional foot orthotics including those for plantar fasciitis, pes planus (flat feet), heel spurs and other conditions as the plan determines, orthopedic or corrective shoes, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints are not covered, except for patients with diabetes or other significant peripheral neuropathies.
  - Custom-fitted orthotics/orthosis are not covered except for ankle-foot (KAFO) orthosis and/or ankle-foot orthosis (AFO) except for members who meet national recognized guidelines.
- Prosthetic devices
  - Artificial aids including speech synthesis devices, except items as covered benefits in this section
- Surgical dressing
  - Common disposable medical supplies that can be purchased over the counter such as, but not limited to, bandages, adhesive bandages, gauze (such as 4 by 4's), elastic wrap bandages are not covered, except when provided in a hospital or practitioner's/providers office or by a home health professional.
  - Gloves are not covered, unless part of a wound treatment kit
  - Elastic support hose
- Eyeglasses and contact lenses (nonpediatric):
  - Routine vision care and eye refractions for determining prescriptions for corrective lenses are not covered
  - Eye refractive procedures including radial keratotomy, laser procedures, and other techniques

- Visual training
- Eye movement therapy

## **HOSPICE SERVICES**

**Covered:** Benefits for inpatient and in-home hospice care services are covered if you are terminally ill. Services must be provided by an approved hospice program during a hospice benefit period and will not be covered to the extent that they duplicate other covered services available to you. Benefits that are approved by a hospice provider or other facility require approval by your practitioner/provider.

**Limitations:** The hospice benefit period is defined as follows:

- Beginning on the date your practitioner/provider certifies that you are terminally ill with a life expectancy of six months or less.
- Ending six months after it began, unless you require an extension of the hospice benefit period below, or upon your death.
- If a member requires an extension of the hospice benefit period, the hospice must provide a new treatment plan and the practitioner/provider must **re-authorize** the member's medical condition to the plan. The plan may not authorize more than one additional hospice benefit period.
- The individual seeking hospice care must be a covered member throughout his or her hospice benefit period.

**Services:** The following services are covered:

- Inpatient hospice care
- Practitioner/provider visits by certified hospice practitioner/providers
- Home health care services by approved home health care personnel
- Physical therapy
- Medical supplies
- Prescription drugs and medication for the pain and discomfort specifically related to the terminal illness
- Medical transportation
- Respite care (care that provides a relief for the care-giver) for a period not to exceed five continuous days for every 60 days of hospice care. No more than two respite care stays will be available during a hospice benefit period.

Where there is not a certified hospice program available, regular home health care services benefits will apply.

**Not Covered:** The following benefits are not covered:

- Food, housing, and delivered meals
- Volunteer services
- Personal or comfort items such as, but not limited to aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those covered under the durable medical equipment benefit)
- Homemaker and housekeeping services
- Private duty nursing

- Pastoral and spiritual counseling
- Bereavement counseling
- Long-term, custodial nursing home care for non-terminal conditions

**Not Covered** under this benefit, but may be **Covered Benefits** elsewhere in the plan:

- Acute inpatient hospital care for curative services
- Durable medical equipment
- Practitioner/provider visits by other than a certified hospice practitioner/provider
- Ambulance services

### **HOSPITAL SERVICES - INPATIENT**

**Covered:** Inpatient means the member has been admitted by a health care practitioner/provider to a hospital for the purposes of receiving hospital services. Eligible inpatient hospital services are acute care services provided when the member is a registered bed patient and there is a room and board charge. Admissions are considered inpatient based on medical necessity, regardless of the length of time spent in the hospital. Inpatient hospital benefits include acute medical detoxification. Covered services include medical and surgical care provided by physicians and other practitioners as well as facility fees.

**Not Covered:** Acute medical detoxification in a residential treatment center is not covered. Rehabilitation is not covered as a part of acute medical detoxification.

### **HYPERBARIC OXYGEN THERAPY**

**Covered:** Hyperbaric oxygen therapy is a covered benefit only if the therapy is proposed for a condition recognized as one of the accepted indications as defined by the Hyperbaric Oxygen Therapy Committee of the Undersea and Hyperbaric Medical Society (UHMS) or as medically necessary.

### **IMAGING, LABORATORY AND DIAGNOSTIC SERVICES**

**Covered:** Diagnostic services are tests performed to determine if a member has a medical problem or to determine the status of any existing medical conditions. The following benefits are examples of covered procedures to include, but are not limited to, the following:

- Artery calcification testing (plan year 2022 and after)
- Computerized Axial Tomography (CAT) scans
- Magnetic Resonance Angiogram(MRA) tests, Magnetic Resonance Imaging (MRI) tests
- Sleep disorder studies in home or facility
- Bone density studies
- Clinical laboratory tests and related professional services
- Gastrointestinal lab procedures
- Pulmonary function tests
- Radiology/X-ray services

### **INFERTILITY TREATMENT**

**Covered:** Diagnosis and medically necessary treatments for physical conditions causing infertility are covered.

**Not Covered:** The following services are not covered:

- Prescription drugs/medications used for the treatment of infertility.

- Prescription drugs/medications used for the treatment of sexual dysfunction.
- Reversal of voluntary sterilization
- In-vitro, Gamete Intra Fallopian Transfer (GIFT) and zygote intrafallopian transfer (ZIFT) fertilization
- Storage or banking of sperm, ova (human eggs), embryos, zygotes or other human tissue

### **MATERNITY SERVICES**

**Covered:** The following services are covered:

- **Prenatal maternity** care services:
  - Prenatal care
  - Pregnancy related diagnostic tests, (including an alpha-fetoprotein IV screening test, generally between sixteen and twenty weeks of pregnancy, to screen for certain abnormalities in the fetus)
  - Visits to an obstetrician
  - Certified nurse-midwife
  - Midwife
  - Nutritional supplements as determined and prescribed by the attending practitioner/provider.
  - Childbirth in a hospital or licensing birthing center.
- **Maternity care** services:
  - Maternity coverage is available to a mother and the mother's newborn (if a member) for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following a cesarean section.
  - Maternity inpatient care in excess of 48 hours following a vaginal delivery and 96 hours following a cesarean section will be covered if determined to be medically necessary by the mother's attending practitioner/provider.
  - High-risk ambulance services are covered in accordance with the ambulance service benefit.
- **Services of a Midwife or Certified Nurse Midwife** are covered, for the following:
  - The midwife's services must be provided strictly according to their legal scope of practice and in accordance with all applicable state licensing regulations which may include a supervisory component.
  - The services must be provided in preparation for or in connection with the delivery of a newborn.
  - For purpose of coverage under this agreement, the only allowable sites of delivery are a hospital or a licensed birthing center. Elective home births and any prenatal or postpartum services connected with elective home births are not covered. Elective home birth means a birth that was planned or intended by the member or practitioner/provider to occur in the home.
- **Newborn Care** will be covered from the moment of birth when enrolled as follows:
  - The member's newborn or the newborn of a member's spouse will be covered from the moment of birth if the carrier receives notice that the member has elected coverage for the newborn within specified timeframes in state and federal law.
  - Neonatal care is available for the newborn of a member for at least 48 hours of

inpatient care following vaginal delivery and at least 96 hours of inpatient care following a Caesarean section. A plan may cover newborn care after the mother is discharged from the hospital, but this care may be considered a separate hospital stay.

- Benefits for a newborn who is a member shall include coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Where necessary to protect the life of the infant coverage includes transportation, including air ambulance services to the nearest tertiary facility. Newborn member benefits also include coverage for newborn visits to the hospital by the baby's practitioner/provider, circumcisions, incubator, and routine hospital nursery charges.

**Not Covered:** The following maternity care services are not covered:

- Use of an emergency facility for non-emergent services.
- Elective home birth and any prenatal or postpartum services connected with an elective home birth are not covered. Allowable sites for a delivery of a child are hospitals and licensed birthing centers. Elective home birth means a birth that was planned or intended by the member or practitioner/provider to occur in the home.

## **MENTAL HEALTH, BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES**

*Benefits will be provided for treatment of mental and behavioral health conditions and chemical dependency.*

**Covered:** The following services are covered under this plan's mental health, behavioral health and substance use services benefit:

- Inpatient and outpatient services
- Partial hospitalization can be substituted for inpatient services upon request. Partial hospitalization is a non-residential, hospital-based program that includes various daily and weekly therapies.
- Detail on the medical detoxification benefit are covered under the inpatient and outpatient medical services section.

**Not Covered:** Member benefits do not include coverage for the following:

- For **Mental/Behavioral Health Services:**
  - Codependency treatment
  - Bereavement, pastoral/spiritual and sexual counseling
  - Psychological testing when not medically necessary special education, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary or behavioral problems.
  - Court ordered evaluation or treatment, or treatment that is a condition of parole or probation or in lieu of sentencing, such as psychiatric evaluation or therapy.
- For **Alcoholism and Substance Abuse Services:**
  - Treatment in a halfway house.
  - Residential treatment centers unless for the treatment of alcoholism and/or substance abuse.
  - Codependency treatment
  - Bereavement, pastoral/spiritual and sexual counseling

- Court ordered evaluation or treatment, or treatment that is a condition of parole or probation or in lieu of sentencing, such as psychiatric evaluation or therapy.

### **NUTRITIONAL SUPPORTS, COUNSELING AND SUPPLEMENTS**

**Covered:** The following are covered benefits:

- Nutritional supplements for prenatal care when prescribed by a practitioner/provider are covered for pregnant women.
- Nutritional counseling as medically necessary
- Nutritional supplements that require a prescription to be dispensed are covered when prescribed by a practitioner/provider and when medically necessary to replace a specific documented deficiency.
- Nutritional supplements administered by injection at the practitioner's/provider's office are covered when medically necessary.
- Enteral formulas or products, as nutritional support, are covered only when prescribed by a practitioner/provider and administered by enteral tube feedings.
- Total Parenteral Nutrition (TPN) is the administration of nutrients through intravenous catheters via central or peripheral veins and is covered when ordered by a practitioner/provider.
- Special medical foods as listed as covered benefits in the Genetic Inborn Errors of Metabolism(IEM) benefit or as medically necessary.

**Not Covered:** The following are not covered:

- Baby food (including baby formula or breast milk) or other regular grocery products that can be blenderized and used with the enteral system for oral or tube feedings.
- Nutritional supplements prescribed by an attending practitioner/provider not due to a deficiency or as the sole source of nutrition.

### **OUTPATIENT MEDICAL SERVICES**

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

These covered services include, but are not limited to, the following services:

- Chemotherapy and radiation therapy treatment or control of disease.
- Hypnotherapy (Limited) – Hypnotherapy is only covered when performed by an anesthesiologist or psychiatrics, trained in the use of hypnosis when medically necessary or when:
  - Used within two weeks prior to surgery for chronic pain management and
  - For chronic pain management when part of a coordinated treatment plan
- Dialysis
- Diagnostic Services – refer to the diagnostic services section
- Acute Medical Detoxification – medically necessary services for substance use detoxification
- Medical drugs (medications obtained through the medical benefit). Medical drugs are defined as medications administered in the office of facility that require a health care professional to administer. These medications include, but are not limited to oral,

injectable, infused, or inhaled drugs. Office administered applies to all outpatient settings including, but not limited to, physician's offices, emergency rooms, urgent care center, and outpatient surgery facilities

- Observation following outpatient services
- Sleep disorder studies, in home or outpatient facility
- Surgery
- Therapeutic and support care services, supplies, appliances, and therapies
- Wound care
- Facilities fees

**Not Covered:** These benefits do not include coverage for the following:

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

### **PRACTITIONER/PROVIDER SERVICES**

**Covered:** Practitioner/provider services are those services that are reasonably required to maintain good health, including primary care services. Practitioner/provider services include, but are not limited to, periodic examinations and office visits by:

- A licensed practitioner/provider, including nurses and physician assistants
- Specialist services provided by other health care professionals who are licensed to practice, are certified, and practicing as authorized by applicable law or authority
- A medical group
- An independent practice association
- Other authority authorized by applicable state law

This benefit includes, but is not limited to, health care services and supplies provided by your practitioner/provider as described below:

- Office visits provided by a qualified practitioner/provider, including primary care providers.
- Outpatient surgery and inpatient surgery including necessary anesthesia services. Anesthesia may include hypnotherapy.
- Hospital and skilled nursing facility visits as part of continued supervision of covered care. Skilled nursing facility stays are limited to 60 days per year.
- Allergy services, including testing and serology
- FDA approved contraceptive devices and prescription drugs as described on the drug formulary
- Sterilization procedures
- Student health centers: Dependent Students attending school either in New Mexico or outside New Mexico may receive care through their primary care physician or at the student health center. Services provided outside of the student health center are limited to important medically necessary covered services for the initial care or treatment of an emergency health care service or urgent care situation.
- Second medical opinions.

**Not Covered:** This plan does not cover:

- Services provided by an excluded provider. Excluded provider is defined and maintained by the following regulatory agencies: Department of Health and Human Services; Office of the Inspector General (OIG); U.S. Department of Health; the General Services Administration; and the Office of Personnel Management, Office of Inspector General, which includes, but is not limited to, the:
  - Excluded Parties Lists System (EPLS),
  - List of Excluded Individuals/Entities (LEIE),
  - Office of Personnel Management (OPM).

## **PHYSICAL AND REHABILITATION THERAPY**

**Covered.** The following benefits are covered:

- Cardiac rehabilitation services for continuous electrocardiogram (ECG) monitoring, progressive exercises and intermittent ECG monitoring.
- Pulmonary rehabilitation services for progressive exercises and monitoring of pulmonary functions.
- Short-term rehabilitation service for physical therapy and occupational therapy, provided in a rehabilitation facility, skilled nursing facility, home health agency, or outpatient setting. Short-term rehabilitation is designed to assist you in restoring functions that were lost or diminished due to a specific episode of illness or injury (for example stroke, motor vehicle accident, or heart attack). Coverage is subject to the following requirements and **limitations**:
  - Outpatient physical and occupational therapy require that a member's primary care practitioner or other appropriate treating practitioner/provider must determine in advance that your physical therapy or rehabilitation services can be expected to result in significant improvement in the member's condition.
  - The treatment plans that defined expected significant improvement must be established at the initial visit.
  - Treatments by a physical or occupational therapy technician must be performed under the direct supervision and in the presence of a licensed physical or occupational therapist.
  - Massage therapy is only covered when provided by a licensed physical therapist and as part of prescribed short-term rehabilitation physical therapy program.
  - Outpatient speech therapy means language, dysphagia (difficulty swallowing) and hearing therapy. Speech therapy is covered when provided by a licensed or certified speech therapist.

**Limitations:** The following limitations may apply:

- A primary care physician or other physician or practitioner must determine that speech therapy will result in significant improvement in the covered person's condition.
- If short-term rehabilitation therapy is provided in an inpatient setting (such as, but not limited to, rehabilitation facilities, skilled nursing facilities, intensive day-hospital programs that are delivered by a rehabilitation facility) or through home health the therapy may not be subject to the time limitation requirements of outpatient therapies. Inpatient and home health therapies may not be included with outpatient services when calculating the accumulated benefit usage.
- Skilled nursing facility stays are limited to 60 days per plan year.

**Not Covered:** These benefits do not include:

- Short or Long-term Rehabilitation services including:
  - Athletic trainers or treatments delivered by athletic trainers
  - Vocational rehabilitation services
  - Long-term therapy or rehabilitation services. These therapies include treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Therapies are considered long-term rehabilitation when:
    - The member has reached maximum rehabilitation potential
    - The member has reached a point where significant improvement is unlikely to occur
    - You have had therapy for four consecutive months
  - 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, but are not limited to Muscular Dystrophy, Down Syndrome, and Cerebral Palsy not associated with a defined event of illness or injury.
- Speech Therapy services including:
  - Therapy for stuttering
  - Additional benefits described in the speech therapy benefit

### **PRESCRIPTION DRUGS**

**Covered:** The following drugs are covered when prescribed by a practitioner/provider. Refer to the plan's drug formulary for further information.

- Medically necessary prescription nutritional supplements for prenatal care
- Preferred insulin and diabetic oral agents for controlling blood sugar levels
- Immunosuppressant drugs
- Special medical foods used to compensate and maintain adequate nutritional status for genetic inborn errors of metabolism (IEM) or as medically necessary
- Smoking Cessation Pharmacotherapy
- FDA approved contraceptive prescription drugs/medications and devices
- Generic drugs
- Preferred brand drugs
- Non-preferred brand drugs
- Specialty drugs
- 90-day supply of mail order medications, as appropriate, from retail or mail order pharmacies

**Limitation:** Continuation of therapy using any drug is dependent upon its demonstrable efficacy.

**Not Covered:** This plan does not cover:

- Drugs used for cosmetic purposes
- Convenience packaging unless convenience packaging is medically necessary for drug adherence due to a disability
- Prescription drugs purchased outside of the United States
- Replacement prescription drugs/medications resulting from loss, theft, or destruction

- Compounded prescription drugs/medications
- New medications for which the determination of criteria for coverage has not yet been established by the plan's Pharmacy and Therapeutics Committee
- Over-the-counter (OTC) medications and drugs with the exception of medications and devices as determined by the plan's Pharmacy and Therapeutics Committee and described in the plan's formulary. Addition, plans shall cover condoms purchased over the counter. A plan shall have a system by which a covered person can request reimbursement for these products.
- Prescription drugs/medications, medicines, treatments, procedures or devices that the plan determines are experimental or investigational.
- Disposable medical supplies, except when provided in a hospital or practitioner/provider's office or by a home health professional

### **PREVENTIVE CARE**

**Covered:** This plan covers the following preventive care services under five broad categories:

- Screening and counseling services
- Routine immunizations
- Adult preventive services
- Childhood preventive services
- Preventive services for women
- Other services

For a complete list of covered services, please see the U.S. Preventive Services Task Force list of A or B rated preventive care services.

Screening and counseling services. This benefit includes coverage for evidence-based services that have a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force for individuals in certain age groups or based on risk factors. Key screenings include:

- Preventive Physical Examinations
- Health appraisal exams, laboratory and radiological tests, and early detection procedures for the purpose of a routine physical exam
- Periodic tests to determine metabolic, blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level, or alternatively, a fractionated cholesterol level including a Low-Density Lipoprotein (LDL) level and a High-Density Lipoprotein (HDL) level
- Periodic stool examination for the presence of blood
- Colorectal cancer screening in accordance with the evidence-based recommendations established by the United States Preventive Services Task Force for determining the presence of pre-cancerous or cancerous conditions and other health problems including:
  - Fecal occult blood testing (FOBT)
  - Flexible Sigmoidoscopy
  - Colonoscopy
  - Virtual colonoscopy
  - Double contrast barium enema
- Smoking Cessation Program
- Artery calcification screening

- Screening to determine the need for vision and hearing correction
- Periodic glaucoma eye test
- Preventive screening services including screening for depression, diabetes, cholesterol, obesity, various cancers, HIV and sexually transmitted infections, as well as counseling for drug and tobacco use, healthy eating and other common health concerns.
- Health education and consultation from practitioners/providers to discuss lifestyle behaviors that promote health and well-being including, but not limited to, the consequences of tobacco use, and/or smoking control, nutrition and diet recommendations, and exercise plans. Health education also includes information related to lower back protection, immunization practices, breast self-examination, testicular self-examination, use of seat belts in motor vehicles and other preventive health care practices.

Routine Immunizations. This benefit includes coverage for adult and child immunizations (shots or vaccines), in accordance with the recommendations of:

- The American Academy of Pediatrics
- The Advisory Committee on Immunization Practices
- The U.S. Preventive Services Task Force
  - Immunizations for routine use in children, adolescents, and adults that have, in effect, a recommendation from the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved.
  - HPV Vaccine coverage for the Human Papillomavirus as approved by the United States Food and Drug Administration (FDA) and in accordance with all applicable federal and state requirements and the guidelines established by the Advisory Committee on Immunization Practices (ACIP).

Childhood Preventive Services: Childhood Preventive Health Services includes coverages for well-child care in accordance with the recommendations of the American Academy of Pediatrics.

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). Key preventive care includes:
  - Health appraisal exams, laboratory and radiological tests, and early detection procedures for the purpose of a routine physical exam or as required for participation in sports, school, or camp activities.
  - Hearing and vision screening for correction. This does not include routine eye exams or eye vision and hearing screening to determine refractions performed by eye care specialists. One eye refraction per calendar year is covered for children under age six when medically necessary to aid in the diagnosis of certain eye diseases.
  - Pediatric Vision, including routine eye care and glasses. Please see attached documents.
  - Behavioral assessments
  - Screening for alcohol use, drug use, anemia, blood pressure, congenital hypothyroidism, depression, developmental development and surveillance dyslipidemia, hematocrit/hemoglobin or sickle cell, lead, obesity, oral health, sexually transmitted diseases, Phenylketonuria (PKU) and Tuberculin.
  - Counseling from Practitioners/Providers to discuss lifestyle behaviors that

promote health and well-being including, but not limited to, the consequences of tobacco use, and/or smoking control, nutrition and diet recommendations, and exercise plans. As deemed appropriate by the member's practitioner/provider or as requested by the parents or legal guardian, education information on alcohol and substance abuse, sexually transmitted diseases, and contraception.

Preventive Health Services for Women: Preventive services for women include all clinical preventive health services discussed in this section and those specific to women.

- Well-woman visits to include adult and female-specific screenings and preventive benefits
  - Breastfeeding comprehensive support, supplies and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women are covered for one year after delivery
  - Contraception: Food and Drug Administration-approved contraceptive methods sterilization procedures, and patient education and counseling, not including abortifacient drugs
    - Includes methods of preferred generic oral contraceptives, injectable contraceptives or contraceptive devices.
  - Counseling for HIV, sexually transmitted diseases and domestic violence abuse
  - Domestic and interpersonal violence screening and counseling for all women
  - Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
  - Human Immunodeficiency Virus (HIV) screening for counseling for sexually active women
  - Human Papillomavirus (HPV) DNA test: High risk HPV DNA testing every three years for women with normal cytology results
  - HPV Vaccine coverage for the Human Papillomavirus as approved by the United States Food and Drug Administration (FDA) and in accordance with all applicable federal and state requirements and the guidelines established by the Advisory Committee on Immunization Practices (ACIP)
  - Screenings and counseling for pregnant women including screenings for anemia, bacteriuria, Hepatitis B, and Rh incompatibility and breast feeding counseling
  - Sexually Transmitted Infections (STI) counseling for sexually active women
  - Sterilization services for women.
  - Well-woman visits to obtain recommended preventive services for women

Other services: The following additional services are covered:

- Vasectomy, excluding pre-deductible coverage for HSA-eligible high deductible plans
- Preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.

**Not Covered:** Preventive care benefits do not include:

- Physical examinations, vaccinations, drugs and immunizations for the primary intent of medical research or non-medically necessary purpose(s) such as, but not limited to, licensing certification, employment, insurance, flight, foreign travel, passports or functional capacity examinations related to employment
- Immunizations for the purpose of foreign travel

### **RECONSTRUCTIVE SURGERY**

**Covered:** Reconstructive surgery is surgery from which an improvement in physiological function can reasonably be expected. This surgery is covered if performed as medically necessary. The following reconstructive surgery benefits are covered:

- Surgery and follow-up treatment to correct a physical functional disorder resulting from a disease or congenital anomaly
- Surgery and follow-up treatment to correct a physical functional disorder following an injury or incidental to any surgery
- Reconstructive surgery and associated procedures following a mastectomy that resulted from disease, illness, or injury, and internal breast prosthesis incidental to the surgery

**Not Covered:** Cosmetic services as outlined in the cosmetic services section.

### **SEXUAL DYSFUNCTION TREATMENT**

**Not Covered:** This plan does not cover treatment for sexual dysfunction, including medication, counseling, and clinics are not covered except for penile prosthesis as described in this plan.

### **SKILLED NURSING FACILITY CARE**

**Covered:** This benefit covers room and board and other necessary services furnished by a skilled nursing facility.

**Not Covered:** This plan does not cover custodial or domiciliary care.

### **SMOKING CESSATION COUNSELING/PROGRAM**

**Covered:** Coverage is provided for diagnostic services, smoking cessation counseling and pharmacotherapy. Medical services are provided by licensed health care professionals with specific training in managing a smoking cessation program. The program shall include:

- Individual counseling under the medical benefit.
- Group counseling, including classes or a telephone quit line.

**Limitations:** Pharmacotherapy benefit limitations are limited to two 90-day courses of treatment per calendar year.

**Not Covered:** This plan does not cover:

- Hypnotherapy for smoking cessation counseling
- Over-the-counter (OTC) drugs
- Acupuncture for smoking cessation

### **SURGERY**

**Covered.** Your benefits provide coverage for the following:

- Major endoscopic procedures.
- Operative and cutting procedures.
- Preoperative and postoperative care.

### **TRANSPLANTS**

**Covered:** The following benefits are covered:

- Human Solid Organ transplants for:
  - Kidney
  - Liver

- Pancreas
- Intestine
- Heart
- Lung
- Multi-visceral (3 or more abdominal organs)
- Simultaneous multi-organ transplants – unless investigational
- Pancreas islet cell infusion
- Meniscal Allograft
- Autologous Chondrocyte Implantation – knee only
- Bone marrow transplant including peripheral blood bone marrow stem cell harvesting and transplantation (stem cell transplant) following high dose chemotherapy. Bone marrow transplants are covered for the following indications
  - Multiple myeloma
  - Leukemia
  - Aplastic anemia
  - Lymphoma
  - Severe combined immunodeficiency disease (SCID)
  - Wiskott Aldrich syndrome
  - Ewing's Sarcoma
  - Germ cell tumor
  - Neuroblastoma
  - Wilm's Tumor
  - Myelodysplastic syndrome
  - Myelofibrosis
  - Sickle cell disease
  - Thalassemia major
- 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 living donor for surgery, laboratory and X-ray services, organ storage expenses, and inpatient follow-up care only.

**Limitations:** Travel benefits are available for the transplant recipient, live donor and one other person. Transportation costs will be covered if out-of-state travel is required. Reasonable expenses for lodging and meals will be covered for both out-of-state and in-state, up to a maximum of \$150 per day for the transplant recipient, live donor and one other person combined.

**Not Covered:** The following services are not covered:

- Non-human organ transplants, except for porcine (pig) heart valve
- Transportation costs for deceased members
- The medical and hospital services of an organ transplant donor when the receipt of an organ transplant is not a member or when the transplant procedure is not a covered benefit
- Travel and lodging expenses except as noted above.

## **TREATMENT WHILE INCARCERATED**

**Not Covered:** Services or supplies a member receives while in the custody of any state or federal law enforcement authorities or while in jail or in prison are not covered.

## **WEIGHT LOSS PROGRAMS**

**Covered:** Dietary evaluations and counseling for the medical management of morbid obesity and obesity. Prescription drugs medically necessary for the treatment of obesity and morbid obesity are also covered. See also, benefits described under Bariatric Surgery.

**Not Covered:** The following are not covered:

- Treatments and medications for the purpose of weight reduction or control, except for medically necessary treatment of morbid obesity and obesity.
- Exercise equipment, videos, personal trainers, club members and weight reduction programs.

## **WOMEN'S HEALTH CARE**

**Covered:** The following women's health care services are covered in addition to the services listed in the preventive care and other sections of this plan.

- Gynecological care includes:
  - Annual exams
  - Care related to pregnancy
  - Miscarriage
  - Therapeutic abortions
  - Other gynecological services
- Mammography
- Mastectomy, prophylactic mastectomy, prosthetic devices and reconstructive surgery.
  - Coverage for medically necessary surgical removal of the breast (mastectomy) is for not less than 48 hours of inpatient care following a mastectomy and not less than 24 hours of inpatient care following a lymph node dissection for the treatment of breast cancer, unless the member and the attending practitioner/provider determine that a shorter period of hospital stay is appropriate.
  - Coverage is provided for external breast prostheses following medically necessary surgical removal of the breast (mastectomy). Two bras per year are covered for members with external breast prosthesis.
  - As an alternative, post mastectomy reconstructive breast surgery is provided, including nipple reconstruction and/or tattooing, tram flap (or breast implant if necessary), and reconstruction of the opposite breast if necessary to produce symmetrical appearance.
  - Prostheses and treatment for physical complications of mastectomy, including lymphedema are Covered at all stages of mastectomy
- Osteoporosis coverage for services related to the treatment and appropriate management of osteoporosis when such services are determined to be medically necessary
- Alpha-fetoprotein IV screening test for pregnant women, generally between sixteen and twenty weeks for pregnancy, to screen for certain genetic abnormalities in the fetus.

**Not covered:** The following benefits are not covered:

- Elective abortions

- Maternity and newborn care, as follows, are not covered
  - Use of an emergency facility for non-emergent services
  - Elective Home Birth and any prenatal or postpartum services connected to an elective home birth. Elective home birth means a birth that was planned or intended by the member or practitioner/provider to occur in the home.

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## 3. General Conditions of Coverage, Exclusions, and Limitations

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The provisions in this section describe general conditions of coverage and important exclusions and limitations that apply generally to all types of services or supplies.

### **CONDITIONS OF COVERAGE**

**Medically Necessary:** This health benefit plan helps pay for health care expenses that are medically necessary and specifically covered by this plan. Medically necessary means health care services determined by a practitioner/provider in consultation the health plan, 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, for the diagnosis or direct care and treatment of physical, behavioral or mental health condition, illness, injury, or disease.

### **GENERAL EXCLUSIONS**

Even if a service, supply, device, or drug is listed as otherwise covered in Details – Covered and Not Covered, it is not eligible for benefits if any of the following general exclusions apply.

#### **Experimental or Investigational Drugs, Medicines, Treatments, Procedures or Devices**

Not Covered: As used in this plan, “experimental” or “investigational” as related to drugs, devices, medical treatments or procedures means:

- The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given at the time the drug or device is furnished; or
- Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Reliable evidence shows that the consensus of opinion among experts regarding the drug, medicine, and/or device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Except as required by state law, the drug or device is used for a purpose that is not approved by the FDA; or
- For the purposes of this section, “reliable evidence” shall mean only published reports and articles in the authoritative medical and scientific literature listed in state law; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure; however
- As used in this section, “experimental” or “investigational” does not mean cancer chemotherapy or other types of therapy that are the subjects of on-going phase IV clinical trials.

#### **Personal Convenience Items**

This plan does not include personal convenience items, including, but not limited to, an appliance device, object or service that is for comfort and ease and is not primarily medical in nature, such as, shower or tub stools/chairs, seats, bath grab bars, shower heads, hot tubs/Jacuzzis, vaporizers, accessories such as

baskets, trays, seat or shades for wheelchairs, walkers and strollers, clothing, pillows, fans, humidifiers, and special beds and chairs (excluding those covered under the durable medical equipment benefit).

### **Provider Is Family Member**

This plan does not cover a service or supply received from a provider who is in your immediate family (which includes yourself, parent, child, or spouse or domestic partner) unless the provider is the only provider within a reasonable geographic distance and the provider is acting within the scope of his or her practice.

### **Covered by Other Programs or Laws**

This plan does not cover a service, supply, device, or drug if:

- You are entitled to claim benefits from a governmental program (other than Medicaid).
- Someone else has the legal obligation to pay for services and without this group health set of benefits, you would not be charged.
- Your benefits do not include care for military service connected disabilities to which you are legally entitled and for which facilities are reasonably available to the member.

### **Workers' Compensation**

This plan does not cover services or supplies that are compensated under workers' compensation laws, including services or supplies applied toward satisfaction of any deductible under your employer's workers' compensation coverage. This plan does not cover any services or supplies that could have been compensated under workers' compensation laws if you had complied with the legal requirements relating to notice of injury, timely filing of claims, and medical treatment authorization.

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## 4. Glossary

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The definitions in this section are terms that are used in various sections of this plan manual. A term that appears in only one section is defined in that section.

### GLOSSARY OF TERMS

**This Section defines some of the important terms used in this plan.**

**Accidental Injury** means 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** means the use of needles inserted into and removed from the body and the use of other devices, modalities and procedures at specific locations on the body for the prevention, cure or correction of any disease, illness, injury, pain or other condition by controlling and regulating the flow and balance of energy and functioning of the person to restore and maintain health.

**Alcoholism** means alcohol dependence or alcohol abuse meeting the criteria as stated in the Diagnostic and Statistical Manual IV for these disorders.

**Ambulance Service** means a duly licensed transportation service capable of providing Medically Necessary life support care in the event of a life-threatening emergency situation.

**Autism Spectrum Disorder** means a condition that meets the diagnostic criteria for the pervasive development disorders published in the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association, including Autistic Disorder; Asperger's Disorder; Pervasive Development Disorder not otherwise specified; Rett's Disorder; and Childhood Disintegrative Disorder.

**Bariatric Surgery** means surgery that modifies the gastrointestinal tract with the purpose of decreasing calorie consumption and therefore decreasing weight.

**Biofeedback** means therapy that provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition.

**Calendar Year** means the period beginning January 1 and ending December 31 of the same year.

**Cancer Clinical Trial** means a course of treatment provided to a Member for the purpose of prevention or reoccurrence, early detection or treatment of cancer that is being provided in New Mexico.

**Cardiac Rehabilitation** means a program of therapy designed to improve the function of the heart.

**Certified Nurse Midwife** means any Person who is licensed by the board of nursing as a registered nurse and who is licensed by the New Mexico Department of Health as a Certified Nurse-Midwife.

**Certified Nurse Practitioner** means 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.

**Codependency** means a popular term referring to all the effects that people who are dependent on alcohol or other substances have on those around them, including the attempts of those people to affect the dependent Person (DSM V- The Diagnostic & Statistical Manual of Mental Disorders Fifth Edition Copyright 2013).

**Complications of Pregnancy** means conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section are not Complications of Pregnancy.

**Cosmetic Surgery** means surgery that is performed primarily to improve appearance and self-esteem, which may include reshaping normal structures of the body.

**Coverage/Covered** means benefits extended under this Plan, subject to the terms, conditions, **limitations**, and **exclusions** of this Plan.

**Covered Benefits** means benefits payable extended under this Plan for Covered Health Services provided by Health Care Professionals subject to the terms, conditions, **limitations** and **exclusions** of this Contract.

**Craniomandibular** means the joint where the jaw attaches to the skull. Also refer to Temporomandibular Joint (TMJ).

**Custodial or Domiciliary Care** means care provided primarily for maintenance of the patient and designed essentially to assist in meeting the patient's normal daily activities. It is not provided for its therapeutic value in the treatment of an illness, disease, Accidental Injury, or condition. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring the constant attention of trained medical personnel.

**Custom-fitted Orthosis** means an Orthosis which is individually made for a specific patient starting with the basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, bars, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending, or making other modifications to a substantially prefabricated item.

**Cytologic Screening (PAP Smear)** means a Papanicolaou test or liquid based cervical cytopathology, a Human Papillomavirus Screening test and a pelvic exam for symptomatic as well as asymptomatic female patients.

**Dependent** means any Member of a Subscriber's family who meets the requirements of the **Eligibility, Enrollment and Effective Dates Section** of this Plan, who is enrolled as our Member, and for whom we have actually received an Application and the payment.

**Diagnostic Service** means procedures ordered by a Practitioner/Provider to determine a definite condition or disease or review the medical status of an existing condition or disease.

**Durable Medical Equipment** means equipment or supplies prescribed by a Practitioner/Provider that is Medically Necessary for the treatment of an illness or Accidental Injury, or to prevent the Member's further deterioration. This equipment is designed for repeated use, generally is not useful in the absence of illness or Accidental Injury, and includes items such as oxygen equipment, wheelchairs, Hospital beds, crutches, and other medical equipment.

**Elective Home Birth** means a birth that was planned or intended by the Member or Practitioner/Provider to occur in the home.

**Emergency Health Care Services** means health care evaluations, procedures, treatments, or services delivered to a Member after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a Reasonable/Prudent Layperson, to result in:

- Jeopardy to the person's health
- Serious impairment of bodily functions
- Serious dysfunction of any bodily Organ or part
- Disfigurement to the person

**Emergency Medical Condition** means an illness, injury, symptom or condition that is so serious that a Reasonable/Prudent Layperson, who is without medical training and who uses his or her experience and knowledge when deciding whether or not to seek Emergency Health Care Services would seek care right away to avoid severe harm. Refer to

**Reasonable/Prudent Layperson** definition in this Glossary.

**Evidence-based Medical Literature** means only published reports and articles in authoritative, peer-reviewed medical and scientific literature.

**Excluded Services** means Health Care Services that are not Covered Services and that we will not pay for.

**Experimental or Investigational** medical, surgical, other health care procedures or treatments, including drugs. As used in this Plan, "Experimental" or "Investigational" as related to drugs, devices, medical treatments or procedures means:

- The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given at the time the drug or device is furnished; or

- Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Reliable evidence shows that the consensus of opinion among experts regarding the drug, medicine, and/or device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis; or
- Except as required by State law, the drug or device is used for a purpose that is not approved by the FDA; or
- For the purposes of this section, “reliable evidence” shall mean only published reports and articles in the authoritative medical and scientific literature listed in State law; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure; or
- As used in this section, “Experimental” or “Investigational” does not mean cancer chemotherapy or other types of therapy that are the subjects of on-going phase IV clinical trials.

**Eye Refraction** means the measurement of the degree of refractive error of the eye by an eye care specialist for the determination of a prescription for eyeglasses or contact lenses.

**FDA** means the United States Food and Drug Administration.

**Formulary** means a list of drugs approved for Coverage and the tier level at which each is Covered under this Plan. The plan’s Pharmacy and Therapeutics Committee continually updates this listing.

**Genetic Inborn Errors of Metabolism (IEM)** means a rare, inherited disorder that is present at birth and results in death or developmental disabilities if untreated and requires consumption of Special Medical Foods. Categories of IEMs are as follows:

- Disorders of protein metabolism (i.e. amino acidopathies such as PKU, organic acidopathies, and urea cycle defects)
- Disorders of carbohydrate metabolism (i.e. carbohydrate intolerance disorders, glycogen storage disorders, disorders of gluconeogenesis and glycogenolysis)
- Disorders of fat metabolism

**Habilitative Services** means services that help a person learn, keep, or improve skills and functional abilities that they may not be developing normally.

**Health Care Facility** means 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 Agency; a diagnostic laboratory or imaging center; and a Rehabilitation Facility or other therapeutic health setting.

**Health Care Insurer** means a person that has a valid certificate of authority in good standing issued pursuant to the Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan, fraternal benefit society, vision plan, or pre-paid dental plan.

**Health Care Professional** means a physician or other 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. See **Practitioner**.

**Health Care Services** means services, supplies and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the Health Benefits Plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay.

**Hearing Aid** means Durable Medical Equipment that is of a design and circuitry to optimize audibility and listening.

**Home Health Agency** means a facility or program, which is licensed, certified or otherwise authorized pursuant to state laws as a Home Health Agency.

**Home Health Care Services** means Health Care Services provided to a Member confined to the home due to physical illness. Home Health Care Services and home intravenous services and supplies will be provided by a Home Health Agency at a Member's home when prescribed by the Member's Practitioner/Provider.

**Hospice** means a duly licensed facility or program, which has entered into an agreement with us to provide Health Care Services to Members who are diagnosed as terminally ill.

**Hospital** means an acute care general Hospital, which:

- Has entered into an agreement with us to provide Covered Hospital services to our Members.
- Provides Inpatient diagnostic and therapeutic facilities for surgical or medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of duly licensed Practitioners/Providers.
- Is not, other than incidentally, a place for rest, a place for the aged, or a nursing home.
- Is duly licensed to operate as an acute care general Hospital under applicable state or local law.

**Human Papillomavirus Screening** means a test approved by the Federal Food and Drug Administration for detection of the Human Papillomavirus.

**Immunosuppressive Drugs** means Prescription Drugs/Medications used to inhibit the human immune system. Some of the reasons for using Immunosuppressive Drugs include, but are not limited to:

- Preventing transplant rejection
- Supplementing chemotherapy
- Treating certain diseases of the immune system (i.e. "autoimmune" diseases)
- Reducing inflammation
- Relieving certain symptoms
- Other times when it may be helpful to suppress the human immune response

**Inpatient** means a Member who has been admitted by a health care Practitioner/Provider to a Hospital for the purposes of receiving Hospital services. Eligible Inpatient Hospital services shall be those acute care services rendered to Members who are registered bed patients, for which there is a room and board charge. Admissions are considered Inpatient based on Medical Necessity, regardless of the length of time spent in the Hospital. This may also be known as Hospitalization.

**Long-term Therapy or Rehabilitation Services** means therapies that the Member's Practitioner/Provider, in consultation with us, does not believe will likely result in Significant Improvement within a reasonable number of visits. Long-term Therapy includes, but is not limited to, treatment of chronic or incurable conditions for which Rehabilitation Services produce minimal or temporary change or relief. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down Syndrome and Cerebral Palsy.

**Malocclusion** means abnormal growth of the teeth causing improper and imperfect matching.

**Maternity** means Coverage for prenatal, intrapartum, perinatal or postpartum care.

**Medicaid** means Title XIX and/or Title XXI of the Social Security Act and all amendments thereto.

**Medical Drugs** (Medications obtained through the medical benefit). Medical drugs are defined as medications administered in the office or facility that require a Health Care Professional to administer. They may involve unique distribution and may be required to be obtained from our specialty pharmacy vendor. Office administered applies to all outpatient settings including, but not limited to, physician's offices, infusions suites, emergency rooms, Urgent Care facilities and outpatient surgery facilities.

**Medical Necessity or Medically Necessary** means Health Care Services determined by a Provider, in consultation with the Health Care Insurer, to be appropriate or

necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by the Health Care Insurer consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease.

**Medicare** means Title XVIII of the Social Security Act and all amendments thereto.

**Medicare Eligible** means people age 65 and older, people under age 65 with certain illnesses or disability and people of any age with kidney disease that require kidney dialysis or kidney transplant.

**Member** means the Subscriber or Dependent eligible to receive Covered Benefits for Health Care Services under this Agreement. Also known as an **Enrollee**.

**Nurse Practitioner** means any person licensed by the board of nursing as a registered nurse approved for expanded practice as a **Certified Nurse Practitioner** pursuant to the Nursing Practice Act.

**Nutritional Support** means the administration of solid, powder or liquid preparations provided either orally or by enteral tube feedings. It is Covered only when enteral tube feedings are required or when medically necessary.

**Observation Services** means outpatient services furnished by a Hospital and Practitioner/Provider on the Hospital's premises. These services may include the use of a bed and periodic monitoring by a Hospital's nursing staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the Hospital, or where rapid improvement of the patient's condition is anticipated or occurs. When a Hospital places a patient under outpatient observation stay, it is on the Practitioner/Providers written order. Our level of care criteria must be met in order to transition from Observation Services to an Inpatient admission. The length of time spent in the Hospital is not the sole factor determining Observation versus Inpatient status. Medical criteria will also be considered.

**Obstetrician/Gynecologist** means a Practitioner/Provider who is board eligible or board certified by the American Board of Obstetricians and Gynecologists or by the American College of Osteopathic Obstetricians and Gynecologists.

**Organ** means an independent body structure that performs a specific function.

**Orthopedic Appliances /Orthotic Device /Orthosis** means an individualized rigid or semi- rigid supportive device constructed and fitted by a licensed orthopedic technician which supports or eliminates motion of a weak or diseased body part. Examples of Orthopedic Appliances are functional hand or leg brace, Milwaukee Brace, or fracture brace.

**Orthotic Appliance** means an external device intended to correct any defect of form or function of the human body.

**Over-the-counter (OTC)** means a drug for which a prescription is not normally needed.

**Physician** means any duly licensed Practitioner of the healing arts acting within the scope of his/her license.

**Practitioner/Provider** means any duly licensed Practitioner of the healing arts acting within the scope of his/her license.

**Practitioner/Provider Assistant** means a skilled person who is a graduate of a Practitioner/Provider Assistant or surgeon assistant program approved by a nationally recognized accreditation body or who is currently certified by the national commission on certification of Practitioner/Provider Assistants, and who is licensed in the state of New Mexico to practice medicine under the supervision of a licensed Practitioner/Provider.

**Preferred (as it refers to medication and diabetic supplies)** means medication that is selected for inclusion on Preferred tiers of the *Formulary* based on clinical efficacy, safety, and financial value.

**Prescription Drugs/Medications** means those drugs that, by federal law, require a Practitioner's/Provider's prescription for purchase (the original packaging of which, under the federal Food, Drug and Cosmetic Act, is required to bear the legend, Caution: Federal law prohibits dispensing without a prescription or is so designated by the New Mexico State Board of Pharmacy as one which may only be dispensed pursuant to a prescription).

**Primary Care Physician or Practitioner (PCP)** means a Health Care Professional who, within the scope of his or her license, supervises, coordinates, and provides initial and basic care to Members, who may initiate their referral for specialist care, and who maintains continuity of patient care. We designate Practitioners/Providers to be Primary Care Physicians, provided they:

- Provide care within their scope of practice as defined under the relevant state licensing law
- Meet the plan's eligibility criteria for health care Providers/Practitioners who provide primary care
- Agree to participate and to comply with a plan's care coordination and referral policies

Primary Care Physicians include, but are not limited to, General Practitioners, Family Practice Physicians, Internists, Pediatricians, and Obstetricians / Gynecologists (if applicable), Practitioner/Provider Assistants and Nurse Practitioners. Other Health Care Professionals may also provide primary care as necessitated by a Member's health care needs.

**Prosthetic Device** means an artificial device to replace a missing part of the body.

**Provider** means any duly licensed Hospital or other licensed facility, physician, or other Health Care Professional authorized to furnish Health Care Services within the scope of their

license.

**Pulmonary Rehabilitation** means a program of therapy designed to improve lung functions.

**Reasonable/Prudent Layperson** means a person who is without medical training and who uses his or her experience and knowledge when deciding whether or not to seek Emergency Health Care Services. A Reasonable/Prudent Layperson is considered to have acted “reasonably” if someone else in their same situation would also have believed that emergency care was necessary. Acting “reasonably” could include deciding that severe pain and other symptoms require emergency health care. In determining whether the Member acted as a Reasonable/Prudent Layperson we will consider the following factors:

- A reasonable person’s belief that the circumstances required immediate medical care that could not wait until the next working day or the next available appointment
- The presenting symptoms
- Any circumstance that prevented the Member from using nonemergent care

**Reconstructive Surgery** means the following:

- Surgery and follow-up treatment to correct a physical functional disorder resulting from a disease or congenital anomaly.
- Surgery and follow-up treatment to correct a physical functional disorder following an injury or incidental to any surgery.
- Reconstructive Surgery and associated procedures following a mastectomy that resulted from disease, illness, or injury, and internal breast prosthesis incidental to the surgery.

**Rehabilitation Facility** means a Hospital or other freestanding facility licensed to perform Rehabilitation Services.

**Rehabilitation Services** means Health Care Services that help a Member keep, get back or improve skills and functioning for daily living that have been lost or impaired because a Member was sick, injured or disabled. These services may include physical and occupational therapy, and speech-language pathology in a variety of Inpatient and/or Outpatient settings.

**Residential Treatment Center** means a non-acute level facility that is credentialed and provides overnight lodging that is monitored by medical personnel, has a structured treatment program, and has staff available twenty-four hours a day.

**Screening Mammography** means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic Members and includes the X-ray examination of the breast using equipment that is specifically for mammography, including the X-ray tube, filter, compression device, screens, film, and cassettes, and that has a radiation exposure delivery of less than one rad mid-breast. Screening Mammography includes two views for each breast. Screening Mammography includes the professional interpretation of the film, but does not include diagnostic mammography.

**Service Area** means the geographic area in which we are authorized to provide services as a Health Maintenance Organization and includes the entire state of New Mexico.

**Short-term Rehabilitation** means Rehabilitation Services and therapy, including physical, occupational, speech and hearing therapies from which Significant Improvement of the physical condition may be expected. See *Summary of Benefits and Coverage* for the number of visits.

**Significant Improvement** means that:

- The patient is likely to meet all therapy goals for a reasonable number of visits of therapy or
- The patient has met all therapy goals in the preceding visits of therapy, as specifically documented in the therapy record.

**Skilled Nursing Facility** means an institution that is licensed under state law to provide skilled care nursing care services and has entered into an agreement with the plan to provide Covered Services to Members.

**Smoking Cessation Counseling/Program** means a program, including individual, group, or proactive telephone quit line, that:

- Is designed to build positive behavior change practices and provides for quitting Tobacco use, understanding nicotine addiction, various techniques for quitting Tobacco use and remaining Tobacco free, 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 at a minimum includes an overview of service, service objectives and key topics covered, general teaching/learning strategies, clearly stated methods of assessing participant success, description of audio or visual materials that will be used, distribution plan for patient education material and method for verifying a Member's attendance.
- Employs counselors who have formal training and experience in Tobacco cessation programming and are active in relevant continuing education activities.
- Uses a formal evaluation process, including mechanisms for data collection and measuring participant rate and impact of the program.

**Special Medical Foods** means nutritional substances in any form that are used in treatment to compensate and maintain adequate nutritional status for genetic Inborn Errors of Metabolism (IEM) or other medically necessary conditions.

**Specialty Pharmaceuticals** Medications obtained through the Prescription

Drug/Medication pharmacy benefit are defined as any drug defined as high cost medications. These drugs are self-administered meaning they are administered by the patient or to the patient by a family Member or care-giver.

**Spouse** - Legally married husband or wife.

**Subluxation (Chiropractic)** means misalignment, demonstrable by x-ray or Chiropractic examination, which produces pain and is correctable by manual manipulation.

**Substance Abuse** means dependence on or abuse of substances meeting the criteria as stated in the Diagnostic and Statistical Manual V for these disorders.

**Summary of Benefits and Coverage** means the written materials required by state or federal law to be given to the Covered Person/Grievant by the Health Care Insurer or Contract holder.

**Superintendent** means The Superintendent of Insurance.

**Temporomandibular Joint (TMJ)** is the joint that hinges the lower jaw (mandible) to the temporal bone of the skull.

**Tertiary Care Facility** means a Hospital unit which provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education and data analysis systems for the geographic area served.

**Tobacco** means cigarettes (including roll-your own or handmade cigarettes), bidis, kreteks, cigars (including little cigars, cigarillos, regular cigars, premium cigars, cheroots, chuttas, and dhumti), pipe, smokeless Tobacco (including snuff, chewing Tobacco and beetle nut), and novel Tobacco products, such as *eclipse*, *accord* or other low-smoke cigarettes.

**Uniform Standards** means all generally accepted practice guidelines, evidence-based practice guidelines or practice guidelines developed by the federal government or national and professional medical societies, boards and associations, and any applicable clinical review criteria, policies, practice guidelines, or protocols developed by a Health Care Insurer consistent with the federal, national, and professional practice guidelines that are used by a Health Care Insurer in determining whether to certify (authorize) or deny a requested Health Care Service.

**Urgent Care** means Medically Necessary Health Care Services provided in urgent situations for unforeseen conditions due to illness or injury that are not life threatening but require prompt medical attention.

**Urgent Care Center** means a facility operated to provide Health Care Services in emergencies or after hours, or for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention.

**Utilization Review** means a system for reviewing the appropriate and efficient allocation of medical services and Hospital resources given or proposed to be given to a patient or group of patients.

**Vocational Rehabilitation** means services which are required in order for the individual to prepare for, enter, engage in, retain or regain employment.

**Well-child Care** means routine pediatric care and includes a history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests in accordance with prevailing medical standards as published by the American Academy of Pediatrics.

**Women's Health Care Practitioner/Provider** means any Practitioner/Provider who specializes in Women's Health Care and who the plan recognizes as a Women's Health Care Practitioner/Provider.