CELTIC INSURANCE COMPANY

Home Office: 77 W. Wacker Drive, Suite 1200, Chicago, Illinois 60601
1-800-714-4658

Major Medical Expense Insurance Policy

In this *policy, "you"* or *"your"* will refer to the *covered person* and *"we," "our,"* or *"us"* will refer to Celtic Insurance Company.

AGREEMENT AND CONSIDERATION

We issued this *policy* in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is made a part of the *policy*. *We* will pay benefits to *you*, the *covered person*, for covered *loss* due to *illness* or bodily *injury* as outlined in this *policy*. Benefits are subject to *policy* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

You may keep this *policy* in force by timely payment of the required premiums. However, *we* may refuse renewal if: (1) *we* refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where *you* then live; or (2) there is fraud or a material misrepresentation made by or with the knowledge of a *covered person* in filing a claim for *policy* benefits.

From time to time, *we* may change the rate table used for this *policy* form. Each premium will be based on the rate table in effect on that premium's due date. The policy plan, and age of *covered persons,* type and level of benefits, and place of residence on the premium due date are some of the factors used in determining *your* premium rates. We have the right to change premiums subject to state approval.

At least 31 days notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *policy* or a change in a *covered person's* health. While this *policy* is in force, *we* will not restrict coverage already in force.

TEN DAY RIGHT TO RETURN POLICY

Please read your *policy* carefully. If you are not satisfied, return this *policy* to us or to our agent within 10 days after you receive it. All premiums paid will be refunded, less claims paid, and the *policy* will be considered null and void from the effective date.

Celtic Insurance Company

Anand Shukla
SVP, Individual Health – Celtic Insurance Company

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DEFINITIONS

In this policy, italicized words are defined. Words not italicized will be given their ordinary meaning.

Wherever used in this policy:

Acupuncture means the surgical 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 treatment of *illness, injury* or pain.

Acute rehabilitation means two or more different types of therapy provided by one or more rehabilitation medical practitioners and performed for three or more hours per day, five to seven days per week, while the covered person is confined as an inpatient in a hospital, *rehabilitation facility*, or *extended care facility*.

Adverse benefit determination means any of the following: any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time), a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payments, that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when the claimant requests health care services from a provider that does not participate in the provider network because the clinical expertise of the provider may be medically necessary for treatment of the claimant's medical condition and that expertise is not available in the provider network.

Allogeneic bone marrow transplant or ***BMT*** means a procedure in which bone marrow from a related or non-related donor is infused into the transplant recipient and includes peripheral blood stem cell transplants.

Autologous bone marrow transplant or ***ABMT*** means a procedure in which the bone marrow infused is derived from the same person who is the transplant recipient and includes peripheral blood stem cell transplants.

Bereavement counseling means counseling of members of a deceased person's *immediate family* that is designed to aid them in adjusting to the person's death.

Calendar Year is the period beginning on the initial effective date of this *policy* and ending December 31 of that year. For each following year it is the period from January 1 through December 31.

Center of Excellence means a *hospital* that:

1. Specializes in a specific type or types of *listed transplants* or other services such as cancer, bariatric or infertility; and
2. Has agreed with *us* or an entity designated by *us* to meet quality of care criteria on a cost efficient basis. The fact that a *hospital* is a *network provider* does not mean it is a *Center of Excellence.*

Chiropractic services means any service or supply administered by a chiropractor acting within the scope of his or her license and according to the standards of chiropractic medicine in New Mexico.

Coinsurance is the percentage of covered expenses that must be paid by you after the deductible.

Coinsurance percentage means the percentage of *covered expenses* that are payable by *us*.

Complaint means any expression of dissatisfaction expressed to the insurer by the claimant, or a claimant's authorized representative, about an insurer or its providers with whom the insurer has a direct or indirect contract.

Complications of pregnancy means:
1. Conditions whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy and not, from a medical viewpoint, associated with a normal pregnancy. This includes: ectopic pregnancy, spontaneous abortion, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy; and
2. An *emergency* caesarean section or a *non-elective caesarean section*.

Continuous loss means that *covered expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered expense* for the *illness* or *injury* must have been incurred before insurance of the *covered person* ceased under this *policy*. Whether or not *covered expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

Cosmetic treatment means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to the psychological consequences or socially avoidant behavior resulting from an *injury*, *illness*, or congenital anomaly.

Covered expense means an expense that is:
1. Incurred while *your* or *your dependent's* insurance is in force under this *policy*;
2. Covered by a specific benefit provision of this *policy*; and
3. Not excluded anywhere in this *policy*.

Covered person means *you*, *your* lawful *spouse* and each *eligible child*:
1. Named in the application; or
2. Whom *we* agree in writing to add as a *covered person*.

Custodial Care is treatment designed to assist a *covered person* with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from a sickness or bodily injury.

Custodial care includes but is not limited to the following:

1. Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet;
2. Preparation and administration of special diets;
3. Supervision of the administration of medication by a caregiver;
4. Supervision of self-administration of medication; or
5. Programs and therapies involving or described as, but not limited to, convalescent care, rest care, sanatoria care, educational care or recreational care.

Such treatment is custodial regardless of who orders, prescribes or provides the treatment.

Deductible amount means the amount of covered expenses that must actually be paid during any calendar year before any benefits are payable. The family deductible amount is two times the individual deductible amount. For family coverage, the family deductible amount can be met with the combination of any one or more covered persons' eligible expenses but that amount must be paid before benefits are payable for any covered person.

Dental expenses means *surgery* or services provided to diagnose, prevent, or correct any ailments or defects of the teeth and supporting tissue and any related supplies or oral appliances. Expenses for such treatment are considered *dental expenses* regardless of the reason for the services.

Dependent means *your* lawful *spouse* and/or an *eligible child*.

Durable medical equipment means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an *illness* or *injury*, can withstand repeated use, are generally not useful to a person in the absence of *illness* or *injury*, and are appropriate for use in the patient's home.

Early Intervention Services means any and all services specified in the Individual Family Service Plan that are designed to meet the developmental needs of each eligible child and the needs of the family related to enhancing the child's development.

Effective date means the applicable date a *covered person* becomes insured for *illness* or *injury*.

Eligible child means *your* or *your spouse's* child, if that child is less than 26 years of age. As used in this definition, "child" means:

1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption; or
4. A child for whom legal guardianship has been awarded to *you* or *your spouse*. It is *your* responsibility to notify *us* if *your* child ceases to be an *eligible child*. *You* must reimburse *us* for any benefits that *we* pay for a child at a time when the child did not qualify as an *eligible child*.

Eligible expense means a *covered expense* as determined below.

1. For *network providers* excluding Transplant Benefits: When a *covered expense* is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.
2. For non-*network providers*:
    a. When a *covered expense* is received from a non-*network provider* as a result of an *emergency* or as otherwise approved by *us*, the *eligible expense* is the lesser of the billed charge or a lower amount negotiated with the provider.
    b. When a *covered expense* is received from a non-*network provider* because the service or supply is not of a type provided by any *network provider*, the *eligible expense* is the lesser of the billed charge or a lower amount negotiated with the provider; and
    c. Except as provided under (1) and (2) above, when a *covered expense* excluding Transplant Benefits is received from a non-*network provider*, the *eligible expense* is determined based on the lesser of/the first of the following rules that can be applied in the order shown below:
        i. The fee that has been negotiated with the provider;
        ii. 110% of the fee Medicare allows for the same or similar services provided in the same geographical area;
        iii. The fee established by *us* by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by *us*;
        iv. The fee charged by the provider for the services; or
        v. A fee schedule that *we* develop.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain which requires immediate no later than 24 hours after onset medical or surgical care and such that an average person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the *covered person* or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Experimental *or* ***investigational treatment*** means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, *we* determine to be:

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*USFDA*) regulation, regardless of whether the trial is subject to *USFDA* oversight;
2. An *unproven service;*
3. Subject to *USFDA* approval, and:
    a. It does not have *USFDA* approval;
    b. It has *USFDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation;
    c. It has *USFDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *USFDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;

ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
iii. Not an *unproven service;* or

d. It has *USFDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *USFDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *covered person.*

4. Experimental or investigational according to the provider's research protocols.

Items (3) and (4) above do not apply to phase III or IV *USFDA* clinical trials.

Extended care facility means an institution, or a distinct part of an institution, that:

1. Is licensed as a *hospital*, *extended care facility*, or *rehabilitation facility* by the state in which it operates;
2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *physician* and the direct supervision of a registered nurse;
3. Maintains a daily record on each patient;
4. Has an effective utilization review plan;
5. Provides each patient with a planned program of observation prescribed by a *physician;* and
6. Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing standards of medical practice for that condition.

Extended care facility does not include a facility primarily for rest, the aged, treatment of *substance abuse, custodial care,* nursing care, or for care of *mental disorders* or the mentally incompetent.

Genetic Inborn Error of Metabolism means a rare, inherited disorder that:

1. is present at birth;
2. if untreated, results in mental retardation or death; and
3. causes the necessity for consumption of special medical foods.

Grievance *or* ***Administrative grievance*** means an oral or written complaint submitted by or on behalf of a covered person regarding any aspect of a health benefits plan other than a request for health care services, including but not limited to:

(1) administrative practices of the health care insurer that affects the availability, delivery, or quality of health care services;
(2) claims payment, handling or reimbursement for health care services; and
(3) terminations of coverage.

Habilitation means health care services that help keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient care setting.

Hearing Aid means durable medical equipment that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children.

Home health aide services means those services provided by a home health aide employed by a *home health care agency* and supervised by a registered nurse, which are directed toward the personal care of a *covered person.*

Home health care means care or treatment of an *illness* or *injury* at the *covered person's* home that is:
1. Provided by a *home health care agency*; and
2. Prescribed and supervised by a *physician*.

Home health care agency means a public or private agency, or one of its subdivisions, that:
1. Operates pursuant to law as a *home health care agency*;
2. Is regularly engaged in providing *home health care* under the regular supervision of a registered nurse;
3. Maintains a daily medical record on each patient; and
4. Provides each patient with a planned program of observation and treatment by a *physician,* in accordance with existing standards of medical practice for the *injury* or *illness* requiring the *home health care.*

Hospice means an institution that:
1. Provides a *hospice care program*;
2. Is separated from or operated as a separate unit of a *hospital, hospital*-related institution, *home health care agency,* mental health facility, *extended care facility,* or any other licensed health care institution;
3. Provides care for the *terminally ill;* and
4. Is licensed by the state in which it operates.

Hospice care program means a coordinated, interdisciplinary program prescribed and supervised by a *physician* to meet the special physical, psychological, and social needs of a *terminally ill covered person* and those of his or her *immediate family.*

Hospital means an institution that:
1. Operates as a *hospital* pursuant to law;
2. Operates primarily for the reception, care, and treatment of sick or injured persons as *inpatients*;
3. Provides 24-hour nursing service by registered nurses on duty or call;
4. Has staff of one or more *physicians* available at all times;
5. Provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical, or mental conditions either on its premises or in facilities available to it on a prearranged basis; and
6. Is not primarily a long-term care facility; an *extended care facility*, nursing, rest, *custodial care*, or convalescent home; a halfway house, transitional facility, or *residential treatment facility;* a place for the aged, drug addicts, alcoholics, or runaways; a facility for wilderness or outdoor programs; or a similar establishment.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility,* or *residential treatment facility,* halfway house, or transitional facility, a *covered person* will be deemed not to be confined in a *hospital* for purposes of this *policy*.

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

Human Papillomavirus Vaccine means a vaccine approved by the Federal Food and Drug Administration used for the prevention of human papillomavirus infection and cervical precancers.

Illness means a sickness, disease, or disorder of a *covered person*. *Illness* does not include learning disabilities, attitudinal disorders, or disciplinary problems. All *illnesses* that exist at the same time and that are due to the same or related causes are deemed to be one *illness*. Further, if an *illness* is due to causes that are the same as, or related to, the causes of a prior *illness*, the *illness* will be deemed a continuation or recurrence of the prior *illness* and not a separate *illness*.

Immediate family means the parents, *spouse*, children, or siblings of any *covered person*, or any person residing with a *covered person*.

Injury means accidental bodily damage sustained by a *covered person* and inflicted on the body by an external force. All *injuries* due to the same accident are deemed to be one *injury*.

Inpatient means that medical services, supplies, or treatment are received by a person who is an overnight resident patient of a *hospital* or other facility, using and being charged for room and board.

Intensive care unit means a Cardiac Care Unit, or other unit or area of a *hospital*, that meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Loss means an event for which benefits are payable under this *policy*. A *loss* must occur while the *covered person* is insured under this *policy*.

Listed transplant means one of the following procedures and no others:

1. Heart transplants;
2. Lung transplants;
3. Heart/lung transplants;
4. Kidney transplants;
5. Liver transplants;
6. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma;
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma;
    c. *BMT* for Severe Aplastic Anemia;
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia;
    e. *BMT* for Chronic Myelogenous Leukemia;
    f. *ABMT* for Testicular Cancer;
    g. *BMT* for Severe Combined Immunodeficiency;
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma;
    i. *BMT* for Myelodysplastic Syndrome;
    j. *BMT* for Wiskott-Aldrich Syndrome;
    k. *BMT* for Thalassemia Major;
    l. *BMT* or *ABMT* for Multiple Myeloma;

m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma;
n. *BMT* for Fanconi's anemia;
o. *BMT* for malignant histiocytic disorders; and
p. *BMT* for juvenile.

Loss of Minimum essential coverage means in the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of loss of eligibility regardless of whether the individual is eligible for or elects COBRA continuation coverage. Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status such as attaining the maximum age to be eligible as a dependent child under the plan, death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a *service area,* loss of coverage because an individual no longer resides, lives, or works in the *service area* whether or not within the choice of the individual;
3. In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a *service area*, loss of coverage because an individual no longer resides, lives, or works in the *service area* whether or not within the choice of the individual, and no other benefit package is available to the individual;
4. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals as described in § 54.9802-1(d) that includes the individual;
5. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent, and
6. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

Managed drug limitations means limits in coverage based upon time period, amount or dose of a drug, or other specified predetermined criteria.

Maximum therapeutic benefit means the point in the course of treatment where no further improvement in a *covered person's* medical condition can be expected, even though there may be fluctuations in levels of pain and function.

Medical practitioner means a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy:* , speech therapist, occupational therapist, rolfer, registered nurse, hypnotist, respiratory therapist,

X-ray technician, *emergency* medical technician, social worker, family counselor, marriage counselor, child counselor, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *covered person*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Medically necessary or ***medical necessity*** 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.

Charges incurred for treatment not *medically necessary* are not *eligible expenses*.

Medically stabilized means that the person is no longer experiencing further deterioration as a result of a prior *injury* or *illness* and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include *acute rehabilitation*.

Medicare opt-out practitioner means a *medical practitioner* who:

1. Has filed an affidavit with the Department of Health and Human Services stating that he, she, or it will not submit any claims to Medicare during a two-year period; and
2. Has been designated by the Secretary of that Department as a *Medicare opt-out practitioner*.

Medicare participating practitioner means a *medical practitioner* who is eligible to receive reimbursement from Medicare for treating Medicare-eligible individuals.

Mental disorder is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions

Necessary medical supplies means medical supplies that are:

1. Necessary to the care or treatment of an *injury* or *illness*;
2. Not reusable or *durable medical equipment*; and
3. Not able to be used by others.

Necessary medical supplies do not include first aid supplies, cotton balls, rubbing alcohol, or like items routinely found in the home.

Network means a group of *physicians* and providers who have contracts that include an agreed upon price for health care expenses.

Network eligible expense means the *eligible expense* for services or supplies that are provided by a *network provider*. For facility services, this is the *eligible expense* that is provided at and billed by a *network* facility for the services of either a *network* or non-*network provider*. *Network eligible expense* includes benefits for *emergency* health services even if provided by a non-*network provider*.

Network provider means a *physician* or provider who is identified in the most current list for the *network* shown on *your* identification card.

Non-elective caesarean section means:
1. A caesarean section where vaginal delivery is not a medically viable option; or
2. A repeat caesarean section.

Non-network provider means a *physician* or provider who is NOT identified in the most current list for the *network* shown on *your* identification card. Services received from a *non-network provider* are not covered, except as specifically stated in this policy.

Non-network eligible expense means the *eligible expense* for services or supplies that are provided and billed by a non-*network provider.*

Other plan means any plan or policy that provides insurance, reimbursement, or service benefits for *hospital*, surgical, or medical expenses. This includes payment under group or individual insurance policies, automobile no-fault or medical pay, homeowner insurance medical pay, premises medical pay, nonprofit health service plans, health maintenance organization subscriber contracts, self-insured group plans, prepayment plans, and Medicare when the *covered person* is enrolled in Medicare. *Other plan* will not include Medicaid.

Out-of-pocket expenses means those expenses that a *covered person* is required to pay that: (A) qualify as *covered expenses*; and (B) are not paid or payable if a claim were made under any *other plan*.

Outpatient surgical facility means any facility with a medical staff of *physicians* that operates pursuant to law for the purpose of performing *surgical procedures*, and that does not provide accommodations for patients to stay overnight. This does not include facilities such as: acute-care clinics, *urgent care centers*, ambulatory-care clinics, free-standing emergency facilities, and *physician* offices.

Pain management program means a program using interdisciplinary teams providing coordinated, goal-oriented services to a *covered person* who has chronic pain that significantly interferes with physical, psychosocial, and vocational functioning, for the purpose of reducing pain, improving function, and decreasing dependence on the health care system. A *pain management program* must be individualized and provide physical *rehabilitation*, education on pain, relaxation training, and medical evaluation.

Period of extended loss means a period of consecutive days:
1. Beginning with the first day on which a *covered person* is a *hospital inpatient;* and
2. Ending with the 30th consecutive day for which he or she is not a *hospital inpatient.*

Physician means a licensed medical practitioner including a practitioner of the healing arts, who is practicing within the scope of his or her licensed authority in treating a bodily injury or sickness and is required to be covered by state law. A *physician* does **NOT** include someone who is related to a *covered person* by blood, marriage or adoption or who is normally a member of the *covered person's* household.

Policy when *italicized,* means this *policy* issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

Pregnancy means the physical condition of being pregnant, but does not include *complications of pregnancy*.

Prescription drug means any medicinal substance whose label is required to bear the legend "RX only."

Prescription order means the request for each separate drug or medication by a *physician* or each authorized refill or such requests.

Proof of loss means information required by *us* to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, medical bills or records, other plan information, and *network* re-pricing information. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare.

Reconstructive surgery means *surgery* performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to improve the patient's appearance, to the extent possible.

Rehabilitation means care for restoration including by education or training of one's prior ability to function at a level of *maximum therapeutic benefit*. This type of care must be *acute rehabilitation*, *sub-acute rehabilitation*, or *intensive day rehabilitation*, and it includes *rehabilitation therapy* and *pain management programs*. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment under a *pain management program*.

Rehabilitation facility means an institution or a separate identifiable *hospital* unit, section, or ward that:

1. Is licensed by the state as a *rehabilitation facility*; and
2. Operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as *inpatients*.

Rehabilitation facility does not include a facility primarily for rest, the aged, long term care, assisted living, *custodial care,* nursing care*,* or for care of the mentally incompetent.

Rehabilitation medical practitioner means a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Rehabilitation therapy means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

Rescission of a policy means a determination by an insurer to withdraw the coverage back to the initial date of coverage. *Recession* is only allowed in cases of fraud or intentional misrepresentation of material fact.

Residence means the physical location where *you* live. If *you* live in more than one location, and *you* file a United States income tax return, the physical address, not a P.O. Box, shown on *your* United States income tax return as *your* residence will be deemed to be *your* place of residence. If *you* do not file a United States

income tax return, the *residence* where *you* spend the greatest amount of time will be deemed to be *your* place of *residence*.

Residential treatment facility means a facility that provides, with or without charge sleeping accommodations, and:

1. Is not a *hospital, extended care facility,* or *rehabilitation facility;* or
2. Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

Respite care means home health care services provided temporarily to a *covered person* in order to provide relief to the *covered person's immediate family* or other caregiver.

Service Area means a geographical area, made up of counties, where we have been authorized by the State of New Mexico to sell and market our health plans. This is where the majority of our Participating Providers are located where you will receive all of your health care services and supplies. You can receive precise *service area* boundaries from our website or our Member Services department.

Special Medical Foods means nutritional substances in any form that are:

1. formulated to be consumed or administered internally under the supervision of a *physician*;
2. specifically processed or formulated to be distinct in one or more nutrients present in natural food;
3. intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and
4. essential to optimize growth, health and metabolic homeostasis.

Spouse means *your* lawful wife or husband.

Sub-acute rehabilitation means one or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for one-half hour to two hours per day, five to seven days per week, while the *covered person* is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *extended care facility*.

Substance abuse means alcohol, drug or chemical abuse, overuse, or dependency.

Surgery or ***surgical procedure*** means:

1. An invasive diagnostic procedure; or
2. The treatment of a *covered person's illness* or *injury* by manual or instrumental operations, performed by a *physician* while the *covered person is under general or local anesthesia.*

Surveillance tests for ovarian cancer means annual screening using:

1. CA-125 serum tumor marker testing;
2. Transvaginal ultrasound; or
3. Pelvic examination.

Terminal illness counseling means counseling of the *immediate family* of a *terminally ill* person for the purpose of teaching the *immediate family* to care for and adjust to the *illness* and impending death of the *terminally ill* person.

Terminally ill means a *physician* has given a prognosis that a *covered person* has six months or less to live.

Third party means a person or other entity that is or may be obligated or liable to the *covered person* for payment of any of the *covered person's* expenses for *illness* or *injury*. The term *"third party"* includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company. However, the term *"third party"* will not include any insurance company with a policy under which the *covered person* is entitled to benefits as a named insured person or an insured *dependent* of a named insured person except in those jurisdictions where statutes or common law does not specifically prohibit *our* right to recover from these sources.

Tobacco use or ***use of tobacco*** means use of tobacco by individuals who may legally use tobacco under federal and state law on average four or more times per week and within no longer than the six months immediately preceding the date application for this *policy* was completed by the *covered person*, including all tobacco products but excluding religious and ceremonial uses of tobacco.

Unproven service(s) means services, including medications, that are determined not to be effective for treatment of the medical condition, and/or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from *well-conducted randomized controlled trials* or *well-conducted cohort studies* in the prevailing published peer-reviewed medical literature.

1. *"Well-conducted randomized controlled trials"* means that two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received; and
2. *"Well-conducted cohort studies"* means patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

DEPENDENT COVERAGE

Dependent Eligibility
Your dependents become eligible for insurance on the latter of:
1. The date *you* became insured under this *policy;* or
2. The first day of the first full calendar month after the date of becoming *your dependent*.

Adding A Newborn Child
An *eligible child* born to *you* or *your spouse* will be covered from the time of birth until the 31st day after its birth. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. The required premium will be calculated from the child's date of birth. Coverage of the child will terminate on the 31st day after its birth, unless *we* have received both: (A) written notice of the child's birth; and (B) the required premium within 60 days of the child's birth.

Adding An Adopted Child
An *eligible child* legally placed for adoption with *you* or *your spouse* will be covered from the date of *placement* until the 31st day after *placement,* unless the *placement* is disrupted prior to legal adoption and the child is removed from *your* or *your spouse's* custody.

The child will be covered for *loss* due to *injury* and *illness*, including *medically necessary* care and treatment of conditions existing prior to the date of *placement.*

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on the 31st day following *placement*, unless *we* have received both: (A) written notice of *your* or *your spouse's* intent to adopt the child; and (B) any additional premium required for the addition of the child within 60 days of the date of *placement.*

As used in this provision, *"placement"* means the earlier of:
1. The date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption; or
2. The date of entry of an order granting *you* or *your spouse* custody of the child for the purpose of adoption.

Adding Other Dependents
If *you* apply in writing for insurance on a *dependent* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent* is insured.

ONGOING ELIGIBILITY

For All Covered Persons
A *covered person's* eligibility for insurance under this *policy* will cease on the earlier of:

1. The date that a *covered person* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *policy*; or
2. The date a *covered person's* employer and a *covered person* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes.

For Dependents
A *dependent* will cease to be a *covered person* at the end of the premium period in which he or she ceases to be *your dependent* due to divorce or if a child ceases to be an *eligible child*.

We must receive notification within 90 days of the date an insured ceases to be an eligible *dependent*. If notice is received by *us* more than 90 days from this date, any unearned premium will be credited only from the first day of the calendar month in which *we* receive the notice.

A *covered person* will not cease to be a *dependent eligible child* solely because of age if the *eligible child* is:

1. Not capable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit was reached; and
2. Mainly dependent on *you* for support.

Open Enrollment
There will be an open enrollment period for coverage. The initial open enrollment period begins November 1, 2015 and extends through January 31, 2016. *Individuals* who enroll prior to December 15, 2015 will have an effective date of coverage on January 1, 2016. *Individuals* that enroll between the first and fifteenth day of any subsequent month during the initial open enrollment period, will have a coverage effective date of the first day of the following month. *Individuals* that enroll between the sixteenth and last day of the month between December 2015 and January 31, 2016March 31, 2014, will have a coverage effective date of the first day of the second following month.

For years beginning on or after January 1, 2015, the annual open enrollment period begins November 1, 2015 and extends through January 31, 2016. *Individuals* who enroll prior to December 15, 2015 will have an effective date of coverage on January 1st of the following year.

Starting in 2014, *we* will send written annual open enrollment notification to each *covered person* no earlier than September 1st, and no later than September 30th.

Special And Limited Enrollment
An *individual* has 60 days to enroll as a result of one of the following events:

1. An *individual* or *dependent loses minimum essential coverage*;
2. An *individual* gains a dependent or becomes a *dependent* through marriage, birth, adoption or placement for adoption;
3. An individual who was not previously a citizen, national, or lawfully present individual gains such status;
4. An individual's enrollment or non-enrollment in a health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an agent;

5. An *individual* or enrollee gains access to new health plans as a result of a permanent move;
6. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended; or

PREMIUMS

Premium Payment
Each premium is to be paid to *us* on or before its due date. A due date is the last day of the period for which the preceding premium was paid.

Grace Period
After the first premium is paid, a grace period of 31 days from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If payment of premium is not received within the grace period, coverage will be terminated as of the premium due date.

Misstatement Of Age
If a *covered person's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

Change Or Misstatement Of Residence
If *you* change *your residence*, *you* must notify *us* of *your* new *residence* within 60 days of the change. *Your* premium will be based on *your* new *residence* beginning on the first day of the next calendar month after the change. If *your residence* is misstated on *your* application, or *you* fail to notify *us* of a change of *residence*, *we* will apply the correct premium amount beginning on the first day of the first full calendar month *you* resided at that place of *residence*. If the change results in a lower premium, *we* will refund any excess premium. If the change results in a higher premium, *you* will owe *us* the additional premium.

Misstatement Of Tobacco Use
The answer to the tobacco question on the application is material to *our* correct underwriting. If a *covered person's use of tobacco* has been misstated on the *covered person's* application for coverage under this *policy, we* have the right to rerate the policy back to the original effective date.

Billing/Administrative Fees
Upon prior written notice, *we* may impose an administrative fee for credit card payments. This does not obligate *us* to accept credit card payments. *We* will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

MAJOR MEDICAL EXPENSE BENEFITS

Deductible
The *deductible amount* means the amount of *covered expenses* that must be paid by all *covered Persons* before any benefits are payable.

Coinsurance Percentage
We will pay the applicable *coinsurance percentage* in excess of the applicable deductible for a service or supply that:

1. Qualifies as a *covered expense* under one or more benefit provisions; and
2. Is received while the *covered person's* insurance is in force under the *policy* if the charge for the service or supply qualifies as an *eligible expense*.

When the annual out-of-pocket maximum has been met, additional *covered expenses* will be payable at 100%.

The amount payable will be subject to:

1. Any specific benefit limits stated in the *policy*;
2. A determination of *eligible expenses*; and
3. Any reduction for expenses incurred at a *non-network provider*.

Note: The bill *you* receive for services or supplies from a *non-network provider* may be significantly higher than the *eligible expenses* for those services or supplies. In addition to the *deductible amount* and *coinsurance percentage*, *you* are responsible for the difference between the *eligible expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible expense* will not apply to *your deductible amount* or out-of-pocket maximum.

Network Availability
Your network is subject to change upon advance written notice. A *network* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium.

Coverage Under Other Policy Provisions
Charges for services and supplies that qualify as *covered expenses* under one benefit provision will not qualify as *covered expenses* under any other benefit provision of this *policy.*

Ambulance Service Benefits
Covered expenses will include ambulance services for local transportation:

1. To the nearest *hospital* that can provide services appropriate to the *covered person's illness* or *injury*; or
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.
3. Where necessary to protect the life of the infant or mother, for a medically high-risk pregnant woman with an impending delivery of a potentially viable infant to the nearest available tertiary care facility for newly-born infants.

Benefits for air ambulance services are limited to:

1. Services requested by police or medical authorities at the site of an *emergency*; or
2. Those situations in which the *covered person* is in a location that cannot be reached by ground ambulance.

Exclusions:
No benefits will be paid for:

1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law;
2. Non-*emergency* air ambulance;
3. Air ambulance:
    a. Outside of the 50 United States and the District of Columbia;
    b. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
    c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States; or
4. Ambulance services provided for a *covered person's* comfort or convenience.

Mental Health and Substance Abuse Expense Benefits
Covered expenses for mental health and substance abuse are included on a non-discriminatory basis for all *covered persons* for the diagnosis and *medically necessary* and active treatment of mental, emotional, and substance use disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. *Deductible* and treatment limits for behavioral health expense benefits will be applied in the same manner as physical health service benefits.

Covered expenses are included on a non-discriminatory basis for individuals seeking diagnosis and treatment for mental health disorders following any type of assault or violent act, including rape or an assault with intent to commit rape when the diagnosis and treatment costs exceed the maximum compensation allowed by the state.

Inpatient, intermediate and outpatient mental health and substance abuse service expenses are covered, if *medically necessary* and may be subject to prior authorization. See the Prior Authorization Section for more information regarding services that require prior authorization. Medication management visits do not require prior authorization for *network providers*.

Inpatient mental health and substance abuse *covered expenses* include the following**:** 24 hour services, delivered in a psychiatric unit of a licensed general hospital, a psychiatric hospital, or a substance abuse facility, that provide evaluation and treatment for an acute psychiatric condition or substance use diagnosis, or both.

Intermediate mental health and substance abuse *covered expenses* include the following**:** Non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the patient's needs. Intermediate care is based on *medical necessity*.

Outpatient mental health and substance abuse *covered expenses* include the following**:** Services provided in person in an ambulatory care setting. Outpatient services may be provided in a licensed *hospital*, a mental health or substance abuse clinic licensed by the appropriate state entity, a public community

mental health center, a professional office or home–based services. Such services delivered in such offices or settings are to be rendered by a licensed mental health professional, a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist acting within the scope of his/her license.

Other *covered expenses* for mental health and substance abuse include:

1. Diagnosis and treatment of the following biologically based mental disorders: Schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, eating disorders, post-traumatic stress disorder, substance abuse disorders, and autism;
2. For children and adolescents under the age of 19:
    a. Treatment of non-biologically-based mental, behavioral, or emotional disorders which substantially interfere with or limit the functioning and social interactions of a child or adolescent. Benefits may be provided if the ongoing course of treatment is completed beyond age 19; and
    b. Mandated benefits beyond age 19 may be covered even if coverage continues under other benefit contracts.
3. Adult substance abuse residential treatment;
4. Clinically managed detoxification services in a substance abuse facility;
5. Partial hospitalization;
6. Intensive Outpatient Programs (IOP); and
7. Day treatment.

Habilitation, Rehabilitation And Extended Care Facility Expense Benefits

Covered expenses include expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:

1. *Covered expenses* available to a *covered person* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision;
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay;
3. *Covered expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
    a. Daily room and board and nursing services;
    b. Diagnostic testing; and
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration;
4. *Covered expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners.*

Care ceases to be *rehabilitation* upon *our* determination of any of the following:

1. The *covered person* has reached *maximum therapeutic benefit*;
2. Further treatment cannot restore bodily function beyond the level the *covered person* already possesses;

3. There is no measurable progress toward documented goals; and
4. Care is primarily *custodial care*.

Exclusion:
No benefits will be paid under these Habilitation, Rehabilitation and Extended Care Facility Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance abuse,* excluding autism spectrum disorders.

Definition:
As used in this provision, *"provider facility"* means a *hospital, rehabilitation facility*, or *extended care facility*.

Home Health Care Expense Benefits
Covered expenses for *home health care* are limited to the following charges:
1. *Home health aide services*;
2. Services of a private duty registered nurse rendered on an outpatient basis;
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care;*
4. I.V. medication and pain medication;
5. Hemodialysis, and for the processing and administration of blood or blood components;
6. *Necessary medical supplies*; and
7. Rental of the *durable medical equipment* set forth below:
    a. I.V. stand and I.V. tubing;
    b. Infusion pump or cassette;
    c. Portable commode;
    d. Patient lift;
    e. Bili-lights; and
    f. Suction machine and suction catheters.

Charges under (4) and (7) are *covered expenses* to the extent they would have been *covered expenses* during an *inpatient hospital* stay.

At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase. If the equipment is purchased, the *covered person* must return the equipment to *us* when it is no longer in use.

An agency that is approved to provide *home health care* to those receiving Medicare benefits will be deemed to be a *home health care agency*.

Limitations:
Covered expenses for *home health aide services* will be limited to:
1. Seven visits per week; and
2. A calendar year maximum of 100 visits.

Each eight-hour period of *home health aide services* will be counted as one visit.

Covered expenses for outpatient private duty registered nurse services will be limited as follows:

1. Outpatient private duty registered nurse services will be limited to a lifetime maximum of 1,000 hours; and
2. Intermittent private duty registered nurse visits, not to exceed 4 hours each will be deemed to be 2 hours applied toward the hourly lifetime maximum above.

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care.

Hospice Care Expense Benefits
This provision only applies to a *terminally ill covered person* receiving *medically necessary* care under a *hospice care program*.

The list of *covered expenses* in the Miscellaneous Medical Expense Benefits provision is expanded to include:
1. Room and board in a *hospice* while the *covered person* is an *inpatient;*
2. Occupational therapy;
3. Speech-language therapy;
4. The rental of medical equipment while the *terminally ill covered person* is in a *hospice care program* to the extent that these items would have been covered under the *policy* if the *covered person* had been confined in a *hospital;*
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management;
6. Counseling the *covered person* regarding his or her *terminal illness;*
7. *Terminal illness counseling* of members of the *covered person's immediate family, and*
8. Up to $250 for *bereavement counseling*.

Exclusions And Limitations on Hospice Care Expense Benefits:

1. An *injury* or *illness* arising out of, or in the course of, employment for wage or profit;
2. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a *hospice care program;* or
3. Expenses for other persons, to the extent those expenses are described above, will not be applied to this provision.

Benefits for *hospice inpatient* or outpatient care are available to a *terminally ill covered person* for one continuous period up to 180 days in a *covered person's* lifetime. For each day the *covered person* is confined in a *hospice,* benefits for room and board will not exceed:
1. For a *hospice* that is associated with a *hospital* or nursing home, the most common semiprivate room rate of the *hospital* or nursing home with which the *hospice* is associated; or
2. For any other *hospice,* the lesser of the billed charge or $200 per day.

Miscellaneous Medical Expense Benefits
Medical *covered expenses* are limited to charges:
1. Made by a *hospital* for:

a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate;
b. Daily room and board and nursing services while confined in an *intensive care unit*.
c. *Inpatient* use of an operating, treatment, or recovery room;
d. Outpatient use of an operating, treatment, or recovery room for *surgery;*
e. Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatients; and*
f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required;

2. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies;
3. Made by a *physician* for professional services, including *surgery;*
4. Made by an assistant surgeon, limited to 20 percent of the *eligible expense* for the *surgical procedure;*
5. For the professional services of a *medical practitioner;*
6. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies;*
7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services. Psychometric, behavioral and educational testing are not included;
8. For chemotherapy and radiation therapy or treatment;
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components;
10. For the cost and administration of an anesthetic;
11. For oxygen and its administration;
12. For *dental expenses* when a *covered person* suffers an *injury,* after the *covered person's effective date* of coverage, that results in:
    a. Damage to his or her natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing;
13. For *surgery* to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint, excluding coverage for orthodontic appliances and treatment, crowns, bridges and dentures unless the disorder is trauma related**;**
14. For reconstructive breast surgery charges as a result of a partial or total mastectomy for breast cancer. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas;

15. For *medically necessary* services and supplies used in the treatment of diabetes*. Covered expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies, glucose strips for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication;
16. For *medically necessary chiropractic services*. *Covered expenses* are subject to all other terms and conditions of the *policy,* including deductible and *coinsurance percentage* provisions;
17. For maternity care of the primary *covered person* or *spouse*: outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology

diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other *medically necessary* reasons less any applicable *deductible*, or *coinsurance*. An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. Other maternity benefits include *complications of pregnancy,* parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests;

18. For the following types of tissue transplants:
    a. Cornea transplants;
    b. Artery or vein grafts;
    c. Heart valve grafts;
    d. Prosthetic tissue replacement, including joint replacements; and
    e. Implantable prosthetic lenses, in connection with cataracts;
19. Hearing aid coverage for children which includes a *hearing aid* and any related service for the full cost of one *hearing aid* per hearing-impaired ear up to two thousand two hundred dollars ($2,200) every thirty-six months for hearing aids for insured children under eighteen years of age or under twenty-one years of age if still attending high school. *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, licensed in New Mexico. Coverage limitations do not apply if the hearing aids are prescribed for *rehabilitation* or *habilitation* purposes;
20. Coverage for the *human papillomavirus vaccine* to females nine to fourteen years of age;
21. All FDA-approved prescription contraceptive drugs and devices. .

22. Cancer clinical trial coverage including routine patient care costs incurred as a result of the *covered person's* participation in a phase II, III or IV cancer clinical trial if:
    a. the clinical trial is undertaken for the purposes of the prevention of reoccurrence of cancer, early detection or treatment of cancer for which no equally or more effective standard cancer treatment exists;
    b. the clinical trial is not designed exclusively to test toxicity or disease pathophysiology and it has a therapeutic intent;
    c. the clinical trial is being provided in this state as part of a scientific study of a new therapy or intervention and is for the prevention of reoccurrence, early detection, treatment or palliation of cancer in humans and in which the scientific study includes all of the following:
        i. specific goals;
        ii. a rationale and background for the study;
        iii. criteria for patient selection;
        iv. specific direction for administering the therapy or intervention and for monitoring patients;
        v. a definition of quantitative measures for determining treatment response;
        vi. methods for documenting and treating adverse reactions; and
        vii. a reasonable expectation that the treatment will be at least as efficacious as standard cancer treatment;
    d. the clinical trial is being conducted with approval of at least one of the following:
        i. one of the Federal National Institutes of Health;
        ii. a Federal National Institutes of Health Cooperative Group or Center;
        iii. the Federal Department of Defense;

iv. the Federal Food and Drug Administration in the form of an investigational new drug application;
v. the Federal Department of Veterans Affairs; or
vi. a qualified research entity that meets the criteria established by the Federal National Institutes of Health for grant eligibility.

e. The clinical trial is being provided as part of a study being conducted in a phase II, phase III or phase IV cancer clinical trial;
f. the proposed clinical trial or study has been reviewed and approved by an institutional review board that has an active federal-wide assurance of protection for human subjects;
g. the personnel providing the clinical trial or conducting the study:
    i. 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;
    ii. 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
    iii. agree to provide written notification to the health plan when a patient enters or leaves a clinical trial;
h. there is no non-investigational treatment equivalent to the clinical trial; and
i. 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;

23. Circumcision coverage for newborn males;
24. Genetic inborn error of metabolism coverage for treatment of *genetic inborn errors of metabolism* that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist.
    - Coverage shall include expenses of diagnosing, monitoring and controlling disorders by nutritional and medical assessment, including clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the *genetic inborn error of metabolism*, nutritional management and *special medical foods* used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status;
25. General anesthesia and hospitalization for dental surgery coverage for hospitalization and general anesthesia provided in a *hospital* or ambulatory surgical center for dental surgery for the following:
    a. *covered person's* exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results;
    b. *covered person's* for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy;
    c. *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;
    d. *covered person's* with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; or

e. other procedures for which hospitalization or general anesthesia in a *hospital* or ambulatory surgical center is *medically necessary*;

26. Early intervention services: Coverage for *dependent* children, from birth through three years of age, for or under the family, infant, toddler program administered by the department of health, provided eligibility criteria are met, for a maximum benefit of three thousand five hundred dollars ($3,500) per *calendar year* for *medically necessary early intervention services* provided as part of an individualized family service plan and delivered by certified and licensed personnel who are working in early intervention programs approved by the Department of Health;
27. Autism spectrum disorder coverage for a covered person who is 19 years of age or younger or an eligible individual who is 22 years of age or younger and is enrolled in high school for well-baby and well-child screening for diagnosing the presence of autism spectrum disorder and treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis.
28. Smoking cessation programs, including the use of an over-the-counter (OTC) or prescription F.D.A. smoking cessation medication.
29. Infertility treatment for *medically necessary* diagnostic and exploratory procedures to determine infertility including surgical procedures to correct a medically diagnosed disease or condition of the reproductive organs. Not covered are in-vitro fertilization and costs connected with collection, preparation, storage of sperm for artificial insemination, including donor fees, and reversal of voluntary sterilization surgery.
30. Weight loss programs.
31. *Medically necessary* Bariatric surgery for the treatment of morbid obesity. Coverage is limited to one procedure per lifetime. Prior authorization is required.
32. *Acupuncture* procedures are covered on an outpatient basis only when administered by a licensed provider for the treatment of an *illness* or *injury.*
33. Abortion services, coverage is limited to services for which federal funding is allowed.

Miscellaneous Outpatient Medical Services and Supplies Expense Benefits

Covered expenses for miscellaneous outpatient medical services and supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs but not the replacement thereof, unless required by a physical change in the *covered person* and the item cannot be modified. If more than one prosthetic device can meet a *covered person's* functional needs, only the charge for the most cost effective prosthetic device will be considered a *covered expense*;
2. For one pair of foot orthotics per *covered person*;
3. For *medically necessary* genetic blood tests;
4. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV);
5. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy;
6. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator;
7. For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery;
8. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns;

9. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery;

10. For a renewal of prescription eye drops when:
    (1) the renewal is requested by the *covered person* at least twenty-three days for a thirty-day supply of eye drops, forty-five days for a sixty-day supply of eye drops or sixty-eight days for a ninety-day supply of eye drops from the later of the date that the original prescription was dispensed to the *covered person* or the date that the last renewal of the prescription was dispensed to the *covered person*; and
    (2) the prescriber indicates on the original prescription that additional quantities are needed and that the renewal requested by the *covered person* does not exceed the number of additional quantities needed.

Outpatient Prescription Drug Expense Benefits
Covered expenses in this benefit subsection are limited to charges from a licensed *pharmacy* for:
1. A *prescription drug;* and
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician.*

The appropriate drug choice for a *covered person* is a determination that is best made by the *covered person* and his or her *physician.*

Notice And Proof Of Loss:
In order to obtain payment for *covered expenses* incurred at a *pharmacy* for *prescription orders,* a notice of claim and *proof of loss* must be submitted directly to *us.*

Exclusions And Limitations:
No benefits will be paid under this benefit subsection for expenses incurred:
1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance;
2. For medication that is to be taken by the *covered person,* in whole or in part, at the place where it is dispensed;
3. For medication received while the *covered person* is a patient at an institution that has a facility for dispensing pharmaceuticals;
4. For a refill dispensed more than 12 months from the date of a *physician's* order;
5. Due to a *covered person's* addiction to, or dependency on foods;
6. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs;
7. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary;
8. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs;
9. For a *prescription drug* that contains an active ingredient(s) that is/are:
    a. Available in and *therapeutically equivalent* to another covered *prescription drug;* or
    b. A modified version of and *therapeutically equivalent* to another covered *prescription drug.* Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph;

10. For more than a 34-day supply when dispensed in any one prescription or refill, a 90-day supply when dispensed by mail order;
11. In excess of the cost of the generic equivalent, if any, regardless of whether the *physician* specifies name brand on the written prescription; and
12. For *prescription drugs* for any *covered person* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.

Preventive Care Expense Benefits

Covered service expenses are expanded to include the charges incurred by a *member* for the following preventive health services if appropriate for that *member* in accordance with the following recommendations and guidelines:

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF). Examples of these services are screenings for breast cancer, cervical cancer colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, prostate specific antigen testing and screenings for child and adult obesity;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual;
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration;
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.
5. Anesthesia for covered preventive colonoscopy services.
6. Covers without cost sharing:
    a. Screening for *tobacco use*; and
    b. For those who *use tobacco* products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
        i. Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
        ii. All Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

You can access the USPSTF ratings at: http://www.uspreventiveservicestaskforce.org/

Benefits for preventive health services listed in this provision , except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any *deductibles, cost sharing percentage* provisions, and *copayment amounts* under the *contract* when the services are provided by a *network provider.*

Benefits for *covered expenses* for preventive care expense and chronic disease management benefits may include the use of reasonable medical management techniques authorized by federal law to promote the

use of high value preventive services from *network providers*. Reasonable medical management techniques may result in the application of deductibles, coinsurance provisions, or *copayment amounts* to services when a *covered person* chooses not to use a high value service that is otherwise exempt from deductibles, coinsurance provisions, and *copayment amounts*, when received from a *network provider*.

As new recommendations and guidelines are issued, those services will be considered *covered service expenses* when required by the United States Secretary of Health and Human Services, but not earlier than one year after the recommendation or guideline is issued.

Newborns' And Mothers' Health Protection Act Statement Of Rights
If expenses for *hospital* confinement in connection with childbirth are otherwise included as *covered expenses*, *we* will not limit the number of days for these expenses to less than that stated in this provision.

Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, *we* may provide benefits for *covered expenses* incurred for a shorter stay if the attending provider (e.g., *your physician*, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

The level of benefits and out-of-pocket costs for any later part of the 48-hour or 96-hour stay will not be less favorable to the mother or newborn than any earlier part of the stay. *We* do not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours.

Note: This provision does not amend the *policy* to restrict any terms, limits, or conditions that may otherwise apply to *covered expenses* for childbirth.

Transplant Service Expense Benefits
Covered expenses for transplant expenses:
If it is determined that a *covered person* is an appropriate candidate for a *listed transplant,* Medical Benefits and *covered expenses* will be provided for:

1. Pre-transplant evaluation;
2. Pre-transplant harvesting;
3. Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize a *covered person* to prepare for a later transplant, whether or not the transplant occurs;
4. High dose chemotherapy;
5. Peripheral stem cell collection;
6. The transplant itself, not including the acquisition cost for the organ or bone marrow except at a *Center of Excellence;* and
7. Post transplant follow-up.

Transplant Donor Expenses:
We will cover the medical expenses incurred by a live donor as if they were medical expenses of the *covered person* if:

1. They would otherwise be considered *covered expenses* under the *policy;*

2. The *covered person* received an organ or bone marrow of the live donor; and
3. The transplant was a *listed transplant.*

Ancillary "Center Of Excellence" Benefits:
A *covered person* may obtain services in connection with a *listed transplant* from any *physician*. However, if a *listed transplant* is performed in a *Center of Excellence:*

1. *Covered expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow; and
2. *We* will pay a maximum of $10,000 per lifetime for the following services:
    a. Transportation for the *covered person,* any live donor, and the *immediate family* to accompany the *covered person* to and from the *Center of Excellence.*
    b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *covered person* while the *covered person* is confined in the *Center of Excellence. We* will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Exclusions:
No benefits will be paid under these Transplant Expense Benefits for charges:

1. For search and testing in order to locate a suitable donor;
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs;
3. For animal to human transplants;
4. For artificial or mechanical devices designed to replace a human organ temporarily or permanently;
5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision;
6. To keep a donor alive for the transplant operation;
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ;
8. Related to transplants not included under this provision as a *listed transplant;* and
9. For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*USFDA*) regulation, regardless of whether the trial is subject to *USFDA* oversight.

Limitations on Transplant Expenses Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. *Covered expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *covered person*, unless additional transplants are found to be *medically necessary*;
2. If a designated *Center of Excellence* is not used, *covered expenses* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant; and
3. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

PRIOR AUTHORIZATION

Prior Authorization Required
Some *covered expenses* require prior authorization. In general, *network providers* must obtain authorization from *us* prior to providing a service or supply to a *covered person.* However, there are some *network eligible expenses* for which *you* must obtain the prior authorization.

For services or supplies that require prior authorization, *you* must obtain authorization from *us* before the *covered person:*

1. Receives a service or supply from a *non-network provider;*
2. Is admitted into a *network* facility by a *non-network provider;* or
3. Receives a service or supply from a *network provider* to which the *covered person* was referred by a *non-network provider.*

The following services or supplies require prior authorization:

1. *Hospital confinement*s;
2. *Hospital confinement* as the result of a *medical emergency;*
3. *Hospital confinement* for *psychiatric care;*
4. *Outpatient surgeries* and *major diagnostic tests*;
5. *All inpatient services;*
6. *Extended care facility* confinements;
7. *Rehabilitation facility* confinements;
8. *Skilled nursing facility* confinements;
9. *Transplants;* and
10. Chemotherapy, *specialty drugs* and biotech medications.

Except for *medical emergencies*, prior authorization must be obtained before services are rendered or expenses are *incurred*

How To Obtain Prior Authorization
To obtain prior authorization or to confirm that a *network provider* has obtained prior authorization, contact *us* by telephone at the telephone number listed on *your* health insurance identification card before the service or supply is provided to the *covered person.*

Failure To Obtain Prior Authorization
Failure to comply with the prior authorization requirements may result in benefits being reduced. Please see the *policy* for specific details.

There is a benefit reduction if treatment is not authorized prior to service. The reduction is 20% of the eligible expenses for all charges related to the treatment. The benefit reduction applies to all otherwise eligible expenses that are:

- Incurred for treatment without prior authorization;
- Incurred during additional *hospital* days without prior authorization; or
- Determined to be inappropriately authorized following a retrospective review, or inappropriately authorized due to misrepresentation of facts or false statements.

Network providers cannot bill *you* for services for which they fail to obtain prior authorization as required.

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

Prior Authorization Does Not Guarantee Benefits
Our authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *policy.*

Requests For Predeterminations
You may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

1. The predetermination was based on incomplete or inaccurate information initially received by *us;*
2. The medical expense has already been paid by someone else; and
3. Another party is responsible for payment of the medical expense.

We will make all benefit determinations after a *loss* in good faith. All benefit determinations are subject to *our* receipt of proper *proof of loss.*

GENERAL LIMITATIONS AND EXCLUSIONS

No benefits will be paid for:

1. Any service or supply that would be provided without cost to *you* or *your* covered *dependent* in the absence of insurance covering the charge;
2. Expenses/surcharges imposed on *you* or *your* covered *dependent* by a provider, including a *hospital*, but that are actually the responsibility of the provider to pay;
3. Any services performed by a member of a *covered person's immediate family;* and
4. Any services not identified and included as *covered expenses* under the *policy*. *You* will be fully responsible for payment for any services that are not *covered expenses.*

Even if not specifically excluded by this *policy,* no benefit will be paid for a service or supply unless it is:

1. Administered or ordered by a *physician;* and
2. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness,* or covered under the Preventive Care Expense Benefits provision.

Covered expenses will not include, and no benefits will be paid for any charges that are incurred:

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*, except as expressly provided for under the Benefits After Coverage Terminates clause in this *policy's* Termination section;
2. For any portion of the charges that are in excess of the *eligible expense;*
   ;
3. For cosmetic breast reduction or augmentation;
4. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *covered person,* such as sex-change *surgery*;
5. For vasectomies, and reversal of sterilization and vasectomies;
6. For abortion unless the life of the mother would be endangered if the fetus were carried to term.
7. For expenses for television, telephone, or expenses for other persons;
8. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions;
9. For telephone consultations or for failure to keep a scheduled appointment;
10. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission;
11. For stand-by availability of a *medical practitioner* when no treatment is rendered;
12. For *dental expenses,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Major Medical Expense Benefits;
13. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect in a child who has been a *covered person* from its birth until the date *surgery* is performed;
14. For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.
15. For diagnosis or treatment of nicotine addiction, except as otherwise covered under the Preventive Care Expense Benefits provision of this *policy*;
16. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Expense Benefits;
17. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Expense Benefits;

18. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism;
19. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services unless expressly provided for by the *policy*;
20. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*;
21. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs;
22. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under the *policy*;
23. For maternity expenses due to *pregnancy* of an *eligible child* except for *complications of pregnancy*;
24. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition;

25. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *covered person* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *covered person's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *covered person's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency;
26. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Major Medical Expense Benefits;
27. For or related to surrogate parenting;
28. For or related to treatment of hyperhidrosis (excessive sweating);
29. For fetal reduction surgery;
30. Except as specifically identified as a *covered expense* under the *policy*, expenses for alternative treatments, including acupressure, , aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health;
31. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *covered person* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft;
32. As a result of any *injury* sustained while at a *residential treatment facility;*
33. For prescription drugs for any *covered person* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription drug coverage may not be reinstated at a later date;
34. For the following miscellaneous items: artificial Insemination except where required by federal or state law; biofeedback; care or complications resulting from non-*covered expenses*; chelating agents; domiciliary care; food and food supplements; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services

provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; private duty nursing; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the *service area*; sclerotherapy for varicose veins; treatment of spider veins; transportation expenses, unless specifically described in this *policy*; and

35. Services or supplies eligible for payment under either federal or state programs (except Medicaid). This exclusion applies whether or not *you* assert *your* rights to obtain this coverage or payment of these services.

Limitation On Benefits For Services Provided By Medicare Opt-Out Practitioners

Benefits for *covered expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare participating practitioner*. Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare participating practitioner*.

TERMINATION

Termination of Policy
All insurance will cease on termination of this *policy.* This *policy* will terminate on the earliest of:

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *policy*;
2. The date *we* receive a request from *you* to terminate this *policy,* or any later date stated in *your* request;
3. The date *we* decline to renew this *policy,* as stated in the Discontinuance provision;
4. The date of *your* death, if this *policy* is an Individual Plan;
5. The date that a *covered person* accepts any direct or indirect contribution or reimbursement through wage adjustment or otherwise, by or on behalf of an employer for any portion of the premium for coverage under this *policy,* or the date a *covered person's* employer and a *covered person* treat this *policy* as part of an employer-provided health plan for any purpose, including tax purposes;
6. The date a *covered person's* eligibility for insurance under this *policy* ceases due to losing network access as the result of a permanent move; or
7. The date a *covered person's* eligibility for insurance under this *policy* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *policy*.

We will refund any premium paid and not earned due to *policy* termination.

If this *policy* is other than an Individual Plan, it may be continued after *your* death:

1. By *your spouse*, if a *covered person;* otherwise,
2. By the youngest child who is a *covered person.*

This *policy* will be changed to a plan appropriate, as determined by *us,* to the *covered person(s)* that continue to be covered under it. *Your spouse* or youngest child will replace *you* as the primary covered person. A proper adjustment will be made in the premium required for this *policy* to be continued. *We* will also refund any premium paid and not earned due to *your* death. The refund will be based on the number of full months that remain to the next premium due date.

Discontinuance
90-Day Notice:
If *we* discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where *you* reside, *we* will provide a written notice to *you* at least 90 days prior to the date that *we* discontinue coverage. *You* will be offered an option to purchase any other coverage in the individual market *we* offer in *your* state at the time of discontinuance of this *policy*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

180-Day Notice:
If *we* discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where *you* reside, *we* will provide a written notice to *you* and the Commissioner of Insurance at least 180 days prior to the date that *we* stop offering and terminate all existing individual policies in the individual market in the state where *you* reside.

Portability Of Coverage
If a person ceases to be a *covered person* due to the fact that the person no longer meets the definition of *dependent* under the *policy*, the person will be eligible for continuation of coverage. If elected, *we* will continue the person's coverage under the *policy* by issuing an individual policy. The premium rate applicable to the new policy will be determined based on the residence of the person continuing coverage.

All other terms and conditions of the new policy, as applicable to that person, will be the same as this *policy*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new policy to the extent satisfied under this *policy* at the time that the continuation of coverage is issued. If the original coverage contains a family deductible which must be met by all *covered persons* combined, only those expenses incurred by the *covered person* continuing coverage under the new policy will be applied toward the satisfaction of the *deductible amount* under the new policy.

Notification Requirements
It is the responsibility of *you* or *your* former *dependent* to notify *us* within 31 days of *your* legal divorce or *your dependent's* marriage. *You* must notify *us* of the address at which their continuation of coverage should be issued.

Continuation of Coverage
We will issue the continuation of coverage:
1. No less than 30 days prior to a *covered person's* 26th birthday; or
2. Within 30 days after the date *we* receive timely notice of *your* legal divorce. *Your* former *dependent* must pay the required premium within 31 days following notice from *us* or the new *policy* will be void from its beginning.

Benefits After Coverage Terminates
Benefits for *covered expenses* incurred after a *covered person* ceases to be insured are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *policy* is terminated because of:
1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss,* as defined below. The *period of extended loss* must begin before insurance of the *covered person* ceases under this *policy*. No benefits are provided for *covered expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *policy* is terminated because *we* refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where *you* live, termination of this *policy* will not prejudice a claim for a *continuous loss* that begins before insurance of the *covered person* ceases under this *policy.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:
1. The date the *continuous loss* ends; or
2. 12 months after the date renewal is declined.

During coverage for a *period of extended loss* or a *continuous loss,* as described above, the terms and conditions of this *policy,* including those stated in the Premiums section of this *policy,* will apply as though insurance had remained in force for that *illness* or *injury*.

Reinstatement
If any premium is not paid by the end of the grace period *your* coverage will terminate. Later acceptance of premium by *us*, within four calendar days of the end of the grace period, will reinstate *your policy* with no break in *your* coverage. *We* will refund any premium that *we* receive after this three-day period. However, subsequent acceptance of premium by Celtic or by any agent duly authorized to accept such premium, without requiring therewith an application for reinstatement, shall reinstate the *policy*; provided, however, that if Celtic or such agent requires an application for reinstatement and issues a conditional receipt of the premium tendered, the certificate will be reinstated upon approval of such application by Celtic or, lacking such approval, upon the thirtieth day following the date of such conditional receipt unless Celtic has previously notified *you* in writing of *our* disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such *sickness* as may begin more than ten days after such date. In all other respects *you* and Celtic shall have the same rights thereunder as held under the certificate immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

Reinstatement shall not change any provisions of the *policy*.

REIMBURSEMENT

If a *covered person's illness* or *injury* is caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*.

However, if payment by or for the *third party* has not been made by the time *we* receive acceptable *proof of loss, we* will pay regular *policy* benefits for the *covered person's loss*. *We* will have the right to be reimbursed to the extent of benefits *we* paid for the *illness* or *injury* if the *covered person* subsequently receives any payment from any *third party*. The *covered person* or the guardian, legal representatives, estate, or heirs of the *covered person* shall promptly reimburse *us* from the settlement, judgment, or any payment received from any *third party*.

As a condition for *our* payment, the *covered person* or anyone acting on his or her behalf including, but not limited to, the guardian, legal representatives, estate, or heirs agrees:

1. To fully cooperate with *us* in order to obtain information about the *loss* and its cause;
2. To immediately inform *us* in writing of any claim made or lawsuit filed on behalf of a *covered person* in connection with the *loss*;
3. To include the amount of benefits paid by *us* on behalf of a *covered person* in any claim made against any *third party*;
4. That *we*:
    a. Will have a lien on all money received by a *covered person* in connection with the *loss* equal to the amount *we* have paid;
    b. May give notice of that lien to any *third party* or *third party's* agent or representative;
    c. Will have the right to intervene in any suit or legal action to protect *our* rights;
    d. Are subrogated to all of the rights of the *covered person* against any *third party* to the extent of the benefits paid on the *covered person's* behalf; and
    e. May assert that subrogation right independently of the *covered person*;
5. To take no action that prejudices *our* reimbursement and subrogation rights;
6. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights;
7. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so;
8. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses; and
9. That *we* may reduce other benefits under the *policy* by the amounts a *covered person* has agreed to reimburse *us*.

Furthermore, as a condition of *our* payment, *we* may require the *covered person* or the *covered person's* guardian, if the *covered person* is a minor or legally incompetent, to execute a written reimbursement agreement. However, the terms of this provision remain in effect regardless of whether or not an agreement is actually signed.

We have a right to be reimbursed in full regardless of whether or not the *covered person* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

We will not pay attorney fees or costs associated with the *covered person's* claim or lawsuit unless *we* previously agreed in writing to do so.

If a dispute arises as to the amount a *covered person* must reimburse *us*, the *covered person* or the guardian, legal representatives, estate, or heirs of the *covered person* agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by *us* until the dispute is resolved.

CLAIMS

Notice Of Claim
We must receive notice of claim within 30 days of the date the *loss* began or as soon as reasonably possible.

Proof Of Loss
You or *your* covered *dependent* must give *us* written *proof of loss* within 90 days of the *loss* or as soon as is reasonably possible. *Proof of loss* furnished more than one year late will not be accepted, unless *you* or *your* covered *dependent had no legal capacity in that year.*

Cooperation Provision
Each *covered person*, or other person acting on his or her behalf, must cooperate fully with *us* to assist *us* in determining *our* rights and obligations under the *policy* and, as often as may be reasonably necessary:

1. Sign, date and deliver to *us* authorizations to obtain any medical or other information, records or documents *we* deem relevant from any person or entity;
2. Obtain and furnish to *us*, or *our* representatives, any medical or other information, records or documents *we* deem relevant;
3. Answer, under oath or otherwise, any questions *we* deem relevant, which *we* or *our* representatives may ask; and
4. Furnish any other information, aid or assistance that *we* may require, including without limitation, assistance in communicating with any person or entity including requesting any person or entity to promptly provide to *us*, or *our* representative, any information, records or documents requested by *us*.

If any *covered person*, or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by *us* unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the *policy*.

In addition, failure on the part of any *covered person*, or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of claims of all *covered persons*.

Time For Payment Of Claims
Benefits will be paid as soon as *we* receive proper *proof of loss*.

Payment Of Claims
Except as set forth in this provision, all benefits are payable to *you.* Any accrued benefits unpaid at *your* death, or *your dependent's* death may, at *our* option, be paid either to the beneficiary or to the estate. If any benefit is payable to *your* or *your dependent's* estate, or to a beneficiary who is a minor or is otherwise not competent to give valid release, *we* may pay up to $1,000 to any relative who, in *our* opinion, is entitled to it.

We may pay all or any part of the benefits provided by this *policy* for *hospital,* surgical, nursing, or medical services, directly to the *hospital* or other person rendering such services.

Any payment made by *us* in good faith under this provision shall fully discharge *our* obligation to the extent of the payment. *We* reserve the right to deduct any overpayment made under this *policy* from any future benefits under this *policy*.

Foreign Claims Incurred For Emergency Care
Claims incurred outside of the United States for *emergency* care and treatment of a *covered person* must be submitted in English or with an English translation. Foreign claims must include the applicable medical records in English to show proper *proof of loss*.

Assignment
We will reimburse a *hospital* or health care provider if:
1. *Your* health insurance benefits are assigned by *you* in writing; and
2. *We* approve the assignment.

Any assignment to a *hospital* or person providing the treatment, whether with or without *our* approval, shall not confer upon such *hospital* or person, any right or privilege granted to *you* under the *policy* except for the right to receive benefits, if any, that *we* have determined to be due and payable.

Medicaid Reimbursement
The amount payable under this *policy* will not be changed or limited for reason of a *covered person* being eligible for coverage under the Medicaid program of the state in which he or she lives.

We will pay the benefits of this *policy* to the state if:
1. A *covered person* is eligible for coverage under his or her state's Medicaid program; and
2. *We* receive proper *proof of loss* and notice that payment has been made for *covered expenses* under that program.

Our payment to the state will be limited to the amount payable under this *policy* for the *covered expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

Insurance With Other Insurers
If *you* are eligible to receive *benefits* under this policy and any basic hospital, medical-surgical, major medical plan, long term care policy or Medicare supplement plan, then the policy with the earliest effective date is the primary policy of coverage and the other policy is the secondary policy. *You* must obtain *benefits* from *your* primary policy before *you* can obtain *benefits* from the secondary policy. This policy does not pay *benefits* for any *benefits you* receive under any primary policy.

Insurance With Medicare
If a person is also a Medicare beneficiary, Medicare is always the primary plan. This means that benefits paid for *eligible expenses* by *your* plan will be reduced by the amount that Medicare pays.

Custodial Parent
This provision applies if the parents of a covered *eligible child* are divorced or legally separated and both the custodial parent and the non-custodial parent are subject to the same court or administrative order establishing custody. The custodial parent, who is not a *covered person*, will have the rights stated below if *we* receive a copy of the order establishing custody.

Upon request by the custodial parent, *we* will:

1. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the *policy*;
2. Accept claim forms and requests for claim payment from the custodial parent; and
3. Make claim payments directly to the custodial parent for claims submitted by the custodial parent. Payment of claims to the custodial parent, which are made under this provision, will fully discharge *our* obligations.

A custodial parent may, with *our* approval, assign claim payments to the *hospital* or *medical practitioner* providing treatment to an *eligible child*.

Physical Examination and Autopsy

We shall have the right and opportunity to examine a *covered person* while a claim is pending or while a dispute over the claim is pending. These examinations are made at *our* expense and as often as *we* may reasonably require and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions

No suit may be brought by *you* on a claim sooner than 60 days after the required *proof of loss* is given. No suit may be brought more than three years after the date *proof of loss* is required.

No action at law or in equity may be brought against *us* under the *policy* for any reason unless the *covered person* first completes all the steps in the complaint/grievance procedures made available to resolve disputes in *your* state under the *policy*. After completing that complaint/grievance procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date *we* notified *you* of the final decision on *your* complaint/grievance.

GRIEVANCE AND COMPLAINT PROCEDURES

The following provisions outline Celtic Insurance Company's procedures for the presentation, review and resolution of:

1 adverse determination grievances; and
2 administrative grievances.

If a grievance contains clearly divisible administrative and adverse decision issues, then Celtic will initiate separate complaints for each issue; with an explanation of our actions contained in one acknowledgement letter.

Assistance to grievants. In those instances where a grievant makes an oral grievance or request for internal review to Celtic, or expresses interest in pursuing a written grievance, Celtic will assist grievant to complete all the forms required to pursue internal review and shall advise grievant that the managed health care bureau of the insurance division is available for assistance.

Retaliatory action prohibited. No person shall be subject to retaliatory action by Celtic for any reason related to a grievance.

Computation of Time: Whenever these rules require that an action be taken within a certain period of time from receipt of a request or document, the request or document shall be deemed to have been received within three (3) working days of the date it was mailed.

Information about grievance procedures

A. For **grievants.** Celtic will:

(1) include a clear and concise description of all grievance procedures, both internal and external, in boldface type in the enrollment materials, including in member handbooks or evidences of coverage, issued to grievants;
(2) for a person who has been denied coverage, provide him or her with a copy of the grievance procedures;
(3) notify grievants that a Celtic representative and the managed health care bureau of the insurance division are available upon request to assist grievants with grievance procedures by including such information, and a toll-free telephone number for obtaining such assistance, in the enrollment materials and summary of benefits issued to grievants;
(4) provide a copy of *our* grievance procedures and all necessary grievance forms at each decision point in the grievance process and immediately upon request, at any time, to a grievant, provider or other interested person;
(5) provide a detailed written explanation of the appropriate grievance procedure and a copy of the grievance form to a grievant or provider when *we* make either an adverse determination or adverse administrative decision; the written explanation shall describe how *we* review and resolve grievances and provide a toll-free telephone number, facsimile number, e-mail address, and mailing address of *our* consumer assistance office; and
(6) provide consumer education brochures and materials developed and approved by the superintendent, annually or as directed by the superintendent in consultation with Celtic for distribution;

(7) provide notice to enrollees in a culturally and linguistically appropriate manner as defined in Subsection E of 13.10.17.7 NMAC;
(8) provide continued coverage for an ongoing course of treatment pending the outcome of an internal appeal;
(9) not reduce or terminate an ongoing course of treatment without first notifying the grievant sufficiently in advance of the reduction or termination to allow the grievant to appeal and obtain a determination on review of the proposed reduction or termination; and
(10) allow individuals in urgent care situations and receiving an ongoing course of treatment to proceed with an expedited external review at the same time as the internal review process.

B. For **providers**. Celtic will inform all providers of the grievance procedures available to grievants and providers acting on behalf of grievants, and shall make all necessary forms available to providers, including consumer education brochures and materials developed and approved by the superintendent, annually or as directed by the superintendent in consultation with Celtic for distribution.

C. **Special needs**. Information about grievance procedures must be provided in accordance with the Americans with Disabilities Act, 42 U.S.C. Sections 12101 et seq., and 13.10.13 NMAC, Managed Health Care, particularly 13.10.13.29 NMAC, Cultural and Linguistic Diversity.

Confidentiality of a grievant's records and medical information

A. Confidentiality. Health care insurers, the superintendent, independent co-hearing officers, and all others who acquire access to identifiable medical records and information of grievants when reviewing grievances shall treat and maintain such records and information as confidential except as otherwise provided by federal and New Mexico law.

B. Procedures required. The superintendent and health care insurers shall establish procedures to ensure the confidential treatment and maintenance of identifiable medical records and information of grievants submitted as part of any grievance.

Record of grievances

A. **Record required**. Celtic will maintain a grievance register to record all grievances received and handled during the calendar year. The register shall be maintained in a manner that is reasonably clear and accessible to the superintendent.

B. **Contents.** For each grievance received, the grievance register shall:
(1) assign a grievance number;
(2) indicate whether the grievance is an adverse determination or administrative grievance, or a combination of both;
(3) state the date, and for an expedited review the time, the grievance was received;
(4) state the name and address of the grievant, if different from the grievant;
(5) identify by name and member number the grievant making the grievance or for whom the grievance was made;
(6) indicate whether the grievant's coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act, the medicaid program, or a commercial health care insurer;

(7) identify the health insurance policy number and the group if the policy is a group policy;
(8) identify the individual employee of Celtic to whom the grievance was made;
(9) describe the grievance;
(10) for adverse determination grievances, indicate whether the grievance received expedited or standard review;
(11) indicate at what level the grievance was resolved and what the actual outcome was; and
(12) state the date the grievance was resolved and the date the grievant was notified of the outcome.

C. **Annual report.** Each year, the superintendent shall issue a data call for information based on the grievances received and handled by a health care insurer during the prior calendar year. The data call will be based on the information contained in the grievance register.

D. **Retention.** Celtic will maintain such records for at least six (6) years.
E. Submittal. Celtic will submit information regarding all grievances involving quality of care issues to the health care insurer's continuous quality improvement committee and to the superintendent and shall document the qualifications and background of the continuous quality improvement committee members.

F. Examination. Celtic will make such record available for examination upon request and provide such documents free of charge to a grievant, or state or federal agency officials, subject to any applicable federal or state law regarding disclosure of personally identifiable health information.

Preliminary determination

Upon receipt of a grievance, Celtic will first determine the type of grievance at hand.

A. If the grievance seeks review of an adverse determination of a pre- or post- health care service, it is an adverse determination grievance and Celtic will review the grievance in accordance with its procedures for adverse determination grievances and the requirements of 13.10.17.17 NMAC through 13.10.17.22 NMAC.

B. If the grievance is not based on an adverse determination of a pre- or post- health care service, it is an administrative grievance and Celtic will review the grievance in accordance with its procedures for administrative grievances and the requirements of 13.10.17.33 NMAC through 13.10.17.36 NMAC.

Timeframes for initial determinations

A. Expedited decision. Celtic will make its initial certification or adverse determination decision in accordance with the medical exigencies of the case. *We* will make decisions within twenty-four (24) hours of the written or verbal receipt of the request for an expedited decision whenever:
(1) the life or health of a grievant would be jeopardized;
(2) the grievant's ability to regain maximum function would be jeopardized;
(3) the provider reasonably requests an expedited decision;
(4) in the opinion of the physician with knowledge of the grievant's medical condition, would subject the grievant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim;
(5) the medical exigencies of the case require an expedited decision; or
(6) the grievant's claim involves urgent care.

B. Standard decision. Celtic will make all other initial utilization management decisions within five (5) working days. *We* may extend the review period for a maximum of ten (10) working days if *we*:
(1) can demonstrate reasonable cause beyond *our* control for the delay;
(2) can demonstrate that the delay will not result in increased medical risk to the grievant; and
(3) provide a written progress report and explanation for the delay to the grievant and provider within the original five (5) working day review period.

Initial determination

A. Coverage. When considering whether to certify a health care service requested by a provider or grievant, Celtic will determine whether the requested health care service is covered by the health benefits plan. Before denying a health care service requested by a provider or grievant on grounds of a lack of coverage, *we* will determine that there is no provision of the health benefits plan under which the requested health care service could be covered. If *we* find that the requested health care service is not covered by the health benefits plan, *we* will not address the issue of medical necessity.

B. Medical necessity.
(1) If *we* find that the requested health care service is covered by the health benefits plan, then when considering whether to certify a health care service requested by a provider or grievant, a physician, registered nurse, or other health care professional shall, within the timeframe required by the medical exigencies of the case, determine whether the requested health care service is medically necessary.
(2) Before Celtic denies a health care service requested by a provider or grievant on grounds of a lack of medical necessity, a physician shall render an opinion as to medical necessity, either after consultation with specialists who are experts in the area that is the subject of review, or after application of uniform standards used by Celtic. The physician shall be under the clinical authority of the medical director responsible for health care services provided to grievants.

Notice of initial determination

A. Certification. Celtic will notify the grievant and provider of the certification by written or electronic communication within two (2) working days of the date the health care service was certified, unless earlier notice is required by the medical exigencies of the case.

B. 24-hour notice of adverse determination; explanatory contents. Celtic will notify a grievant and provider of an adverse determination by telephone or as required by the medical exigencies of the case, but in no case later than twenty-four (24) hours after making the adverse determination, unless the grievant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or have insurance coverage. If the grievant fails to provide such information, he or she must be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. Additionally, *we* will notify the covered person and provider of the adverse determination by written or electronic communication sent within one (1) working day of the telephone notice.

C. Contents of notice of adverse determination.

(1) if the adverse determination is based on a lack of medical necessity, *we* will clearly and completely explain why the requested health care service is not medically necessary; a statement that the health care service is not medically necessary will not be sufficient;
(2) if the adverse determination is based on a lack of coverage, *we* wil identify all health benefits plan provisions relied on in making the adverse determination, and clearly and completely explain why the requested health care service is not covered by any provision of the health benefits plan; a statement that the requested health care service is not covered by the health benefits plan will not be sufficient;
(3) the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
(4) include a description of the health care insurer standard that was used in denying the claim;
(5) provide a summary of the discussion which triggered the final determination;
(6) advise the grievant that he or she may request internal or external review of *our* adverse determination; and
(7) describe the procedures and provide all necessary forms to the grievant for requesting internal appeals and external reviews.

Rights regarding internal review of adverse determinations

A. Right to internal review. Every grievant who is dissatisfied with an adverse determination shall have the right to request internal review of the adverse determination by the health care insurer.

B. Acknowledgement of request. Upon receipt of a request for internal review of an adverse determination, the health care insurer shall date and time stamp the request and, within one (1) working day from receipt, send the grievant an acknowledgment that the request has been received. The acknowledgment shall contain the name, address, and direct telephone number of an individual representative of the health care insurer who may be contacted regarding the grievance.

C. Full and fair hearing. To ensure that a grievant receives a full and fair internal review, the healthcare insurer must, in addition to allowing the grievant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process, provide the grievant, free of charge, with any new or additional evidence, and new or additional rationale, considered, relied upon, or generated by the health care insurer, as soon as possible and sufficiently in advance of the date of the notice of final internal adverse benefit determination to allow the grievant a reasonable opportunity to respond before the final internal adverse benefit determination is made.

D. Conflict of interest. The health care insurer must ensure that all internal claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions in such a way that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

Timeframes for internal review of adverse determinations

Upon receipt of a request for internal review of an adverse determination, the health care insurer shall conduct either a standard or expedited review, as appropriate.

A. Expedited review. A health care insurer shall complete its internal review as required by the medical exigencies of the case but in no case later than seventy-two (72) hours from the time the internal review request was received whenever:
(1) the life or health of a grievant would be jeopardized;
(2) the grievant's ability to regain maximum function would be jeopardized;
(3) the provider reasonably requests an expedited decision;
(4) in the opinion of the physician with knowledge of the grievant's medical condition, would subject the grievant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim; or
(5) the medical exigencies of the case require an expedited decision.

B. Standard review. A health care insurer shall complete a standard review of both internal reviews as described in 13.10.17.19 NMAC and 13.10.17.20 NMAC within twenty (20) working days of receipt of the request for internal review in all cases in which the request for review is made prior to the service requested, and does not require expedited review, and within forty (40) working days of receipt of the request in all post-service requests for internal review. The health care insurer may extend the review period for a maximum of ten (10) working days in pre-service cases, and twenty (20) working days for post-service cases if it:
(1) can demonstrate reasonable cause beyond its control for the delay;
(2) can demonstrate that the delay will not result in increased medical risk to the grievant; and
(3) provides a written progress report and explanation for the delay to the grievant and provider within the original thirty (30) day for pre-service or sixty (60) day for post-service review period;
(4) if the grievance contains clearly divisible administrative and adverse decision issues, then the health care insurer shall initiate separate complaints for each decision.

C. Failure to comply with deadline. If the health care insurer fails to comply with the deadline for completion of an internal review, the requested health care service shall be deemed approved unless the grievant, after being fully informed of his or her rights, has agreed in writing to extend the deadline.

Internal panel review of adverse determinations

A. Selection of an internal review panel. In cases of appeal from an adverse determination or from a third party administrator's decision to uphold an adverse determination, the issuer shall select an internal review panel to review the adverse determination or the decision to uphold the adverse determination.

B. Notice of review. Unless the grievant chooses not to pursue the grievance, the health care insurer shall notify the grievant of the date, time, and place of the internal panel review. The notice shall advise the grievant of the rights specified in Subsection G of this section. If the health care insurer indicates that it will have an attorney represent its interests, the notice shall advise the grievant that an attorney will represent the health care insurer and that the grievant may wish to obtain legal representation of their own.

C. Panel membership. The health care insurer shall select one or more representatives of the health care insurer and one or more health care or other professionals who have not been previously involved in the adverse determination being reviewed to serve on the internal review panel. At least one of the health care professionals selected shall practice in a specialty that would typically manage the case that is the subject of the grievance or be mutually agreed upon by the grievant and the health care insurer.

D. Scope of review.
(1) Coverage. The internal review panel shall review the health benefits plan and determine whether there is any provision in the plan under which the requested health care service could be certified.
(2) Medical necessity. The internal review panel shall render an opinion as to medical necessity, either after consultation with specialists who are experts in the area that is the subject of review, or after application of uniform standards used by the health care insurer.

E. Information to grievant. No fewer than three (3) working days prior to the internal panel review, the health care insurer shall provide to the grievant copies of:
(1) the grievant's pertinent medical records;
(2) the treating provider's recommendation;
(3) the grievant's health benefits plan;
(4) the health care insurer's notice of adverse determination;
(5) uniform standards relevant to the grievant's medical condition that is used by the internal panel in reviewing the adverse determination;
(6) questions sent to or reports received from any medical consultants retained by the health care insurer; and
(7) all other evidence or documentation relevant to reviewing the adverse determination.

F. Request for postponement. The health care insurer shall not unreasonably deny a request for postponement of the internal panel review made by the grievant. The timeframes for internal panel review shall be extended during the period of any postponement.

G. Rights of grievant. A grievant has the right to:
(1) attend and participate in the internal panel review;
(2) present his or her case to the internal panel;
(3) submit supporting material both before and at the internal panel review;
(4) ask questions of any representative of the health care insurer;
(5) ask questions of any health care professionals on the internal panel;
(6) be assisted or represented by a person of her choice, including legal representation; and
(7) hire a specialist to participate in the internal panel review at his or her own expense, but such specialist may not participate in making the decision.

H. Timeframe for review; attendance. The internal review panel will complete its review of the adverse determination as required by the medical exigencies of the case and within the timeframes set forth in 13.10.17.18 NMAC. Internal review panel members must be present physically or by video or telephone conferencing to hear the grievance. An internal review panel member who is not present to hear the grievance either physically or by video or telephone conferencing shall not participate in the decision.

Additional requirements for expedited internal review of adverse determinations

A. In an expedited review, all information required by Subsection D of 13.10.17.20 NMAC shall be transmitted between the health care insurer and the grievant by the most expeditious method available.

B. If an expedited review is conducted during a patient's hospital stay or course of treatment, health care services shall be continued without cost (except for applicable co-payments and deductibles) to the grievant until the health care insurer makes a final decision and notifies the grievant.

C. A health care insurer shall not conduct an expedited review of an adverse determination made after health care services have been provided to a grievant.

Notice of internal panel decision

A. Notice required. Within the time period allotted for completion of its internal review, the health care insurer shall notify the grievant and provider of the internal review panel's decision by telephone within twenty-four (24) hours of the panel's decision and in writing or by electronic means within one (1) working day of the telephone notice.

B. Contents of notice. The written notice shall contain:
(1) the names, titles, and qualifying credentials of the persons on the internal review panel;
(2) a statement of the internal panel's understanding of the nature of the grievance and all pertinent facts;
(3) a description of the evidence relied on by the internal review panel in reaching its decision;
(4) a clear and complete explanation of the rationale for the internal review panel's decision;
(a) the notice shall identify every provision of the grievant's health benefits plan relevant to the issue of coverage in the case under review, and explain why each provision did or did not support the panel's decision regarding coverage of the requested health care service;
(b) the notice shall cite the uniform standards relevant to the grievant's medical condition and explain whether each supported or did not support the panel's decision regarding the medical necessity of the requested health care service;
(5) notice of the grievant's right to request external review by the superintendent, including the address and telephone number of the managed health care bureau of the insurance division, a description of all procedures and time deadlines necessary to pursue external review, and copies of any forms required to initiate external review; this notice of the grievant's right to request external review is in addition to the same notice provided the grievant in the summary of benefits and health benefits plan.

External review of adverse determinations

A. Right to external review. Every grievant who is dissatisfied with the results of a medical panel review of an adverse determination by a health care insurer and where applicable, with the results of a grievance review by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act, may request external review by the superintendent at no cost to the grievant. There shall be no minimum dollar amount of a claim before a grievant may exercise this right to external review.

B. Exhaustion of internal appeals process. The superintendent may require the grievant to exhaust any grievance procedures adopted by the health care insurer or the entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act, as appropriate, before accepting a grievance for external review.

C. Deemed exhaustion. If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary and the internal appeals process will be deemed exhausted if:
(1) the health care insurer waives the exhaustion requirement;
(2) the health care insurer is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process; or
(3) the grievant simultaneously requests an expedited internal appeal and an expedited external review.

D. Exception to exhaustion requirement.
(1) Notwithstanding Subsection B of this section, the internal claims and appeals process will not be deemed exhausted based on violations by the health care insurer that are *de minimus* and do not cause, and are not likely to cause, prejudice or harm to the grievant, so long as the health care insurer demonstrates that the violation was for good cause or due to matters beyond the control of the health care insurer, and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the grievant. This exception is not available if the violation is part of a pattern or practice of violations by the health care insurer.
(2) The grievant may request a written explanation of the violation from the health care insurer, and the health care insurer must provide such explanation within ten (10) days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects the grievant's request for immediate review under Subsection B of this section on the basis that the health care insurer met the standards for the exception under Paragraph (1) of Subsection D of this section, the grievant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the health care insurer shall provide the grievant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon grievant's receipt of such notice.

Filing requirements for external review of adverse determinations

A. Deadline for filing request.
(1) When required by the medical exigencies of the case. If required by the medical exigencies of the case, a grievant or provider may telephonically request an expedited review by calling the managed health care bureau at (505) 827-3928 or 1-877-673-1732.
(2) In all other cases. To initiate an external review, a grievant must file a written request for external review with the superintendent within one hundred twenty (120) calendar days from receipt of the written notice of internal review decision unless extended by the superintendent for good cause shown. The cost of the external review will be borne by the health care insurer or health care plan. The request shall be:
(a) mailed to the Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, New Mexico Office of Superintendent of Insurance, Post Office Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269; or
(b) e-mailed to *mhcb.grievance@state.nm.us*, subject External Review Request;
(c) faxed to the Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, at (505) 827-4734; or
(d) completed on-line with an Office of Superintendent of Insurance Complaint Form available at *http://www.osi.state.nm.us*.

B. Documents required to be filed by the grievant. The grievant shall file the request for external review on the forms provided to the grievant by the health care insurer or entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act pursuant to Paragraph (5) of Subsection B of 13.10.17.22 NMAC, and shall also file:
(1) a copy of the notice of internal review decision;
(2) a fully executed release form authorizing the superintendent to obtain any necessary medical records from the health care insurer or any other relevant provider; and

(3) if the grievance involves an experimental or investigational treatment adverse determination, the provider's certification and recommendation as described in Subsection B of 13.10.17.28 NMAC.

C. Other filings. The grievant may also file any other supporting documents or information the grievant wishes to submit to the superintendent for review.

D. Extending timeframes for external review. If a grievant wishes to supply supporting documents or information subsequent to the filing of the request for external review, the timeframes for external review shall be extended up to 90 days from the receipt of the complaint form, or until the grievant submits all supporting documents, whichever occurs first.

Acknowledgement of request for external review of adverse determination and copy to health care insurer

A. Upon receipt of a request for external review, the superintendent shall immediately send:
(1) the grievant an acknowledgment that the request has been received;
(2) the health care insurer a copy of the request for external review.

B. Upon receipt of the copy of the request for external review, the health care insurer shall, within five (5) working days for standard review or the time limit set by the superintendent for expedited review, provide to the superintendent and the grievant by any available expeditious method:
(1) the summary of benefits;
(2) the complete health benefits plan, which may be in the form of a member handbook/evidence of coverage;
(3) all pertinent medical records, internal review decisions and rationales, consulting physician reports, and documents and information submitted by the grievant and health care insurer;
(4) uniform standards relevant to the grievant's medical condition that were used by the internal panel in reviewing the adverse determination; and
(5) any other documents, records, and information relevant to the adverse determination and the internal review decision or intended to be relied on at the external review hearing.

C. If the health care insurer fails to comply with the requirements of Subsection B of this section, the superintendent may reverse the adverse determination.

D. The superintendent may waive the requirements of this section if necessitated by the medical exigencies of the case.

Timeframes for external review of adverse determinations

The superintendent shall conduct either a standard or expedited external review of the adverse determination, as required by the medical exigencies of the case.
A. Expedited review.
(1) The superintendent shall complete an external review as required by the medical exigencies of the case but in no case later than seventy-two (72) hours of receipt of the external review request whenever:
(a) the life or health of a grievant would be jeopardized; or
(b) the grievant's ability to regain maximum function would be jeopardized.

(2) If the superintendent's initial decision is made orally, written notice of the decision must be provided within forty-eight (48) hours of the oral notification.

B. Standard review. The superintendent shall conduct a standard review in all cases not requiring expedited review. Insurance division staff shall complete the initial review within ten (10) working days from receipt of the request for external review and the information required of the grievant and health care insurer in Subsection B of 13.10.17.24 and Subsection B of 13.10.17.25 NMAC respectively. If a hearing is held in accordance with 13.10.17.30 NMAC, the superintendent shall complete the external review within forty-five (45) working days from receipt of the complete request for external review in compliance with 13.10.17.24 NMAC. The superintendent may extend the external review period for up to an additional ten (10) working days when the superintendent has been unable to schedule the hearing within the required timeframe and the delay will not result in increased medical risk to the grievant.

Criteria for initial external review of adverse determination by insurance division staff

Upon receipt of the request for external review, insurance division staff shall review the request to determine whether:
A. the grievant has provided the documents required by Subsection B of 13.10.17.24 NMAC;

B. the individual is or was a grievant of the health care insurer at the time the health care service was requested or provided;

C. the grievant has exhausted the health care insurer's internal review procedure and any applicable grievance review procedure of an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act; and

D. the health care service that is the subject of the grievance reasonably appears to be a covered benefit under the health benefits plan.

Additional criteria for initial external review of experimental or investigational treatment adverse determinations by insurance division staff

If the request is for external review of an experimental or investigational treatment adverse determination, insurance division staff shall also consider whether:
A. coverage; the recommended or requested health care service:
(1) reasonably appears to be a covered benefit under the grievant's health benefit plan except for the health care insurer's determination that the health care service is experimental or investigational for a particular medical condition; and
(2) is not explicitly listed as an excluded benefit under the grievant's health benefit plan; and

B. medical necessity; the grievant's treating provider has certified that:
(1) standard health care services have not been effective in improving the grievant's condition; or
(2) standard health care services are not medically appropriate for the grievant; or
(3) there is no standard health care service covered by the health care insurer that is as beneficial or more beneficial than the health care service:

(a) recommended by the grievant's treating provider that the treating provider certifies in writing is likely to be more beneficial to the grievant, in the treating provider's opinion, than standard health care services; or
(b) requested by the grievant regarding which the grievant's treating provider, who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the grievant's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service requested by the grievant is likely to be more beneficial to the grievant than available standard health care services.

Initial external review of adverse determination by insurance division staff

A. Request incomplete. If the request for external review is incomplete, insurance division staff shall immediately notify the grievant and require the grievant to submit the information required by Subsection B of 13.10.17.25 NMAC within a specified period of time.

B. Request does not meet criteria. If the request for external review does not meet the criteria prescribed by 13.10.17.27 and, if applicable, 13.10.17.28 NMAC, insurance division staff shall so inform the superintendent. The superintendent shall notify the grievant and the health care insurer that the request does not meet the criteria for external review and is thereby denied, and that the grievant has the right to request a hearing in the manner provided by NMSA 1978 Sections 59A-4-15 and 59A-4-18 within thirty-three (33) days from the date the notice was mailed.

C. Request meets criteria. If the request for external review is complete and meets the criteria prescribed by 13.10.17.27 and, if applicable, 13.10.17.28 NMAC, insurance division staff shall so inform the superintendent. The superintendent shall notify the grievant and the health care insurer that the request meets the criteria for external review and that an informal hearing pursuant to NMSA 1978 Section 59A-4-18 and 13.10.17.30 NMAC has been set to determine whether, as a result of the health care insurer's adverse determination, the grievant was deprived of medically necessary covered services. Prior to the hearing, insurance division staff shall attempt to informally resolve the grievance in accordance with NMSA 1978 Section 12-8-10.

D. Notice of hearing. The notice of hearing shall be mailed no later than eight (8) working days prior to the hearing date. The notice shall state the date, time, and place of the hearing and the matters to be considered and shall advise the grievant and the health care insurer of the rights specified in Subsection G of 13.10.17.30 NMAC. The superintendent shall not unreasonably deny a request for postponement of the hearing made by the grievant or the health care insurer.

Hearing procedures for external review of adverse determinations

A. Conduct of hearing. The superintendent may designate a hearing officer who shall be an attorney licensed to practice in New Mexico. The hearing may be conducted by telephone conference call, video conferencing, or other appropriate technology at the insurance division's expense.

B. Co-hearing officers. The superintendent may designate two (2) independent co-hearing officers who shall be licensed health care professionals and who shall maintain independence and impartiality in the process. If the superintendent designates two (2) independent co-hearing officers, at least one of them shall practice in a specialty that would typically manage the case that is the subject of the grievance.

C. Powers. The superintendent or attorney hearing officer shall regulate the proceedings and perform all acts and take all measures necessary or proper for the efficient conduct of the hearing. The superintendent or attorney hearing officer may:
(1) require the production of additional records, documents, and writings relevant to the subject of the grievance;
(2) exclude any irrelevant, immaterial, or unduly repetitious evidence; and
(3) if the grievant or health care insurer fails to appear, proceed with the hearing or adjourn the proceedings to a future date, giving notice of the adjournment to the absent party.

D. Staff participation. Staff may attend the hearing, ask questions, and otherwise solicit evidence from the parties, but shall not be present during deliberations among the superintendent or his designated hearing officer and any independent co-hearing officers.

E. Testimony. Testimony at the hearing shall be taken under oath. The superintendent or hearing officers may call and examine the grievant, the health care insurer, and other witnesses.

F. Hearing recorded. The hearing shall be stenographically recorded at the insurance division's expense.

G. Rights of parties. Both the grievant and the health care insurer have the right to:
(1) attend the hearing; the health care insurer shall designate a person to attend on its behalf and the grievant may designate a person to attend on grievant's behalf if the grievant chooses not to attend personally;
(2) be assisted or represented by an attorney or other person;
(3) call, examine and cross-examine witnesses; and
(4) submit to the ICO, prior to the scheduled hearing, in writing, additional information that the ICO must consider when conducting the internal review hearing and require that the information be submitted to the health care insurer and the MHCB staff.

H. Stipulation. The grievant and the health care insurer shall each stipulate on the record that the hearing officers shall be released from civil liability for all communications, findings, opinions, and conclusions made in the course and scope of the external review.

Independent co-hearing officers (ICOs)

A. Identification of ICOs. The superintendent shall provide for maintenance of a list of licensed professionals qualified to serve as independent co-hearing officers. The superintendent shall select appropriate professional societies, organizations, or associations to identify licensed health care and other professionals who are willing to serve as independent co-hearing officers in external reviews who maintain independence and impartiality of the process.

B. Disclosure of interests. Prior to accepting designation as an ICO, each potential ICO shall provide to the superintendent a list identifying all health care insurers and providers with whom the potential ICO maintains any health care related or other professional business arrangements and briefly describe the nature of each arrangement. Each potential ICO shall disclose to the superintendent any other potential conflict of interest that may arise in hearing a particular case, including any personal or professional relationship to the grievant or to the health care insurer or providers involved in a particular external review.

C. Compensation of hearing officers and ICOs.
(1) Compensation schedule. The superintendent shall consult with appropriate professional societies, organizations, or associations in New Mexico to determine reasonable compensation for health care and other professionals who are appointed as ICOs for external grievance reviews and shall annually publish a schedule of ICO compensation in a bulletin.
(2) Statement of ICO compensation. Upon completion of an external review, the attorney and co-hearing officers shall each complete a statement of ICO compensation form prescribed by the superintendent detailing the amount of time spent participating in the external review and submit it to the superintendent for approval. The superintendent shall send the approved statement of ICO compensation to the grievant's health care insurer.
(3) Direct payment to ICOs. Within thirty (30) days of receipt of the statement of ICO compensation, the grievant's health care insurer shall remit the approved compensation directly to the ICO.
(4) No compensation with early settlement. If the parties provide written notice of a settlement up to three (3) working days prior to the date set for external review hearing, compensation will be unavailable to the hearing officers or ICOs.

D. The hearing officer and ICOs must maintain written records for a period of three (3) years and make them available upon request to the state.

Superintendent's decision on external review of adverse determination

A. Deliberation. At the close of the hearing, the hearing officers shall review and consider the entire record and prepare findings of fact, conclusions of law, and a recommended decision. Any hearing officer may submit a supplementary or dissenting opinion to the recommended decision.

B. Order. Within the time period allotted for external review, the superintendent shall issue an appropriate order. If the order requires action on the part of the health care insurer, the order shall specify the timeframe for compliance.
(1) The order shall be binding on the grievant and the health care insurer and shall state that the grievant and the health care insurer have the right to judicial review pursuant to NMSA 1978 Section 59A-4-20 and that state and federal law may provide other remedies.
(2) Neither the grievant nor the health care insurer may file a subsequent request for external review of the same adverse determination that was the subject of the superintendent's order.

Internal review of administrative grievances

A. Request for internal review of grievance. Any person dissatisfied with a decision, action or inaction of a health care insurer, including termination of coverage, has the right to request internal review of an administrative grievance orally or in writing.

B. Acknowledgement of grievance. Within three (3) working days after receipt of an administrative grievance, the health care insurer shall send the grievant a written acknowledgment that it has received the administrative grievance. The acknowledgment shall contain the name, address, and direct telephone number of an individual representative of the health care insurer who may be contacted regarding the administrative grievance.

C. Initial review. The health care insurer shall promptly review the administrative grievance. The initial review shall:
(1) be conducted by a health care insurer representative authorized to take corrective action on the administrative grievance; and
(2) allow the grievant to present any information pertinent to the administrative grievance.

Initial internal review decision on administrative grievance

The health care insurer shall mail a written decision to the grievant within fifteen (15) working days of receipt of the administrative grievance. The fifteen (15) working day period may be extended when there is a delay in obtaining documents or records necessary for the review of the administrative grievance, provided that the health care insurer notifies the grievant in writing of the need and reasons for the extension and the expected date of resolution, or by mutual written agreement of the health care insurer and the grievant. The written decision shall contain:
A. the name, title, and qualifications of the person conducting the initial review;

B. a statement of the reviewer's understanding of the nature of the administrative grievance and all pertinent facts;

C. a clear and complete explanation of the rationale for the reviewer's decision;

D. identification of the health benefits plan provisions relied upon in reaching the decision;

E. reference to evidence or documentation considered by the reviewer in making the decision;

F. a statement that the initial decision will be binding unless the grievant submits a request for reconsideration within twenty (20) working days of receipt of the initial decision; and

G. a description of the procedures and deadlines for requesting reconsideration of the initial decision, including any necessary forms.

Reconsideration of internal review of administrative grievance

A. Committee. Upon receipt of a request for reconsideration, the health care insurer shall appoint a reconsideration committee consisting of one or more employees of the health care insurer who have not participated in the initial decision. The health care insurer may include one or more employees other than the grievant to participate on the reconsideration committee.

B. Hearing. The reconsideration committee shall schedule and hold a hearing within fifteen (15) working days after receipt of a request for reconsideration. The hearing shall be held during regular business hours at a location reasonably accessible to the grievant, and the health care insurer shall offer the grievant the opportunity to communicate with the committee, at the health care insurer's expense, by conference call, video conferencing, or other appropriate technology. The health care insurer shall not unreasonably deny a request for postponement of the hearing made by a grievant.

C. Notice. The health care insurer shall notify the grievant in writing of the hearing date, time and place at least ten (10) working days in advance. The notice shall advise the grievant of the rights specified in

Subsection E of this section. If the health care insurer will have an attorney represent its interests, the notice shall advise the grievant that the health care insurer will be represented by an attorney and that the grievant may wish to obtain legal representation of her own.

D. Information to grievant. No fewer than three (3) working days prior to the hearing, the health care insurer shall provide to the grievant all documents and information that the committee will rely on in reviewing the case.

E. Rights of grievant. A grievant has the right to:
(1) attend the reconsideration committee hearing;
(2) present their case to the reconsideration committee;
(3) submit supporting material both before and at the reconsideration committee hearing;
(4) ask questions of any representative of the health care insurer; and
(5) be assisted or represented by a person of their choice.

Decision of reconsideration committee

The health care insurer shall mail a written decision to the grievant within seven (7) working days after the reconsideration committee hearing. The written decision shall include:
A. the names, titles, and qualifications of the persons on the reconsideration committee;

B. the reconsideration committee's statement of the issues involved in the administrative grievance;

C. a clear and complete explanation of the rationale for the reconsideration committee's decision;

D. the health benefits plan provision relied on in reaching the decision;

E. references to the evidence or documentation relied on in reaching the decision;

F. a statement that the initial decision will be binding unless the grievant submits a request for external review by the superintendent within twenty (20) working days of receipt of the reconsideration decision; and

G. a description of the procedures and deadlines for requesting external review by the superintendent, including any necessary forms. The notice shall contain the toll-free telephone number and address of the superintendent's office.

External review of administrative grievances

A. Right to external review. Every grievant who is dissatisfied with the results of the internal review of an administrative decision shall have the right to request external review by the superintendent.

B. Exhaustion of remedies. The superintendent may require the grievant to exhaust any grievance procedures adopted by the health care insurer or the entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act, as appropriate, before accepting a grievance for external review.

C. Deemed exhaustion. If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary and the internal appeals process will be deemed exhausted if:
(1) the health care insurer waives the exhaustion requirement;
(2) the health care insurer is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process; or
(3) the grievant simultaneously requests an expedited internal appeal and an expedited internal appeal and an expedited external review.

D. Exception to exhaustion requirement.
(1) Notwithstanding Subsection B of this section, the internal claims and appeals process will not be deemed exhausted based on violations by the health care insurer that are *de minimus* and do not cause, and are not likely to cause, prejudice or harm to the grievant, so long as the health care insurer demonstrates that the violation was for good cause or due to matters beyond the control of the health care insurer, and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the grievant. This exception is not available if the violation is part of a pattern or practice of violations by the health care insurer.
(2) The grievant may request a written explanation of the violation from the health care insurer, and the health care insurer must provide such explanation within ten (10) days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects the grievant's request for immediate review under Subsection B of this section on the basis that the health care insurer met the standards for the exception under Paragraph (1) of Subsection D of this section, the grievant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed ten (10) days), the health care insurer shall provide the grievant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon grievant receipt of such notice.

Filing requirements for external review of administrative grievance

A. Deadline for filing request. To initiate an external review, a grievant must file a written request for external review with the superintendent within twenty (20) working days from receipt of the written notice of reconsideration decision. The request shall either be:
(1) mailed to the Superintendent of Insurance, Attn: Managed Health Care Bureau – External Review Request, Office of Superintendent of Insurance, Post Office Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269;
(2) e-mailed to *mhcb.grievance@state.nm.us*, subject External Review Request;
(3) faxed to the Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, (505) 827-4734; or
(4) completed on-line using an Office of Superintendent of Insurance Complaint Form available at *http://www.osi.state.nm.us*.

B. Documents required to be filed by the grievant. The grievant shall file the request for external review on the forms provided to the grievant by the health care insurer pursuant to Subsection G of 13.10.17.36 NMAC.

C. Other filings. The grievant may also file any other supporting documents or information the grievant wishes to submit to the superintendent for review.

D. Extending timeframes for external review. If a grievant wishes to supply supporting documents or information subsequent to the filing of the request for external review, the timeframes for external review shall be extended up to 90 days from the receipt of the complaint form, or until the grievant submits all supporting documents, whichever occurs first.

Acknowledgement of request for external review of administrative grievance and copy to health care insurer

A. Upon receipt of a request for external review, the superintendent shall immediately send the:
(1) grievant an acknowledgment that the request has been received;
(2) health care insurer a copy of the request for external review.

B. Upon receipt of the copy of the request for external review, the health care insurer shall provide to the superintendent and the grievant by any available expeditious method within five (5) working days all necessary documents and information considered in arriving at the administrative grievance decision.

Review of administrative grievance by superintendent

The superintendent shall review the documents submitted by the health care insurer and the grievant, and may conduct an investigation or inquiry or consult with the grievant, as appropriate. The superintendent shall issue a written decision on the administrative grievance within twenty (20) working days of receipt of the complete request for external review in compliance with 13.10.17.38 NMAC.

Definitions

A. *administrative grievance* means an oral or written complaint submitted by or on behalf of a grievant regarding any aspect of a health benefits plan other than a request for health care services, including but not limited to: (1) administrative practices of the health care insurer that affects the availability, delivery, or quality of health care services; (2) claims payment, handling or reimbursement for health care services; and (3) terminations of coverage;

B. *adverse determination* means any of the following: any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time), a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payments, that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate;

C. *adverse determination grievance* means an oral or written complaint submitted by or on behalf of a

grievant regarding an adverse determination;

D. *certification* means a decision by a health care insurer that a health care service requested by a provider or grievant has been reviewed and, based upon the information available, meets the health care insurer's requirements for coverage and medical necessity, and the requested health care service is therefore approved; E. culturally and linguistically appropriate manner of notice means: (1) notice that meets the following requirements: (a) the health care insurer must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language; (b) the health care insurer must provide, upon request, a notice in any applicable non-English language; (c) the health care insurer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the health care insurer; and (2) for purposes of this definition, with respect to an address in any New Mexico county to which a notice is sent, a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county is literate only in the same non-English language, as determined by the department of health and human services (HHS); the counties that meet this ten percent (10%) standard, as determined by HHS, are found at http://cciio.cms.gov/resources/factsheets/clas-data.html and any necessary changes to this list are posted by HHS annually;

E. *culturally and linguistically appropriate manner of notice* means a notice that meets the following requirements: (1) the health care insurer must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language; (2) the health care insurer must provide, upon request, a notice in any applicable non-English language; (3) the health care insurer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the health care insurer. For purposes of this definition, with respect to an address in any New Mexico county to which a notice is sent, a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county is literate only in the same non-English language, as determined by the department of health and human services (HHS); the counties that meet this ten percent (10%) standard, as determined by HHS, are found at http://cciio.cms.gov/resources/factsheets/clas-data.html and any necessary changes to this list are posted by HHS annually;

F. *grievant* means any of the following: (1) a policyholder, subscriber, enrollee, or other individual , or that person's authorized representative or provider, acting on behalf of that person with that person's consent, entitled to receive health care benefits provided by the health care plan; (2) an individual, or that person's authorized representative, who may be entitled to receive health care benefits provided by the health care plan; (3) Medicaid recipients enrolled in a health care insurer's Medicaid plan; or (4) individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act;

G. *health benefits plan* means a health plan or a policy, contract, certificate or agreement offered or issued by a health care insurer or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of health care services; this includes a traditional fee-for-service health benefits plan ;

H. *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;

I. *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;

J. *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;

K. *hearing officer, independent co-hearing officer or ICO* means a health care or other professional licensed to practice medicine or another profession who is willing to assist the superintendent as a hearing officer in understanding and analyzing medical necessity and coverage issues that arise in external review hearings;

L. *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;

M. *provider* means a 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;

N. *rescission of coverage* means a cancellation or discontinuance of coverage that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if: (1) the cancellation or discontinuance of coverage has only a prospective effect; or (2) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage;

O. *summary of benefits* means the written materials required by NMSA 1978 Section 59A-57-4 to be given to the grievant by the health care insurer or group contract holder;

P. *termination of coverage* means the cancellation or non-renewal of coverage provided by a health care

insurer to a grievant but does not include a voluntary termination by a grievant or termination of a health benefits plan that does not contain a renewal provision;

Q. *traditional fee-for-service indemnity benefit* means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage grievants to utilize preferred providers, to follow pre-authorization rules, to utilize prescription drug formularies or other cost-saving procedures to obtain prescription drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services;

R. *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 the 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 or deny a requested health care service.

GENERAL PROVISIONS

Entire Contract
This *policy,* with the application and any rider-amendments is the entire contract between *you* and *us.* No change in this *policy* will be valid unless it is approved by one of *our* officers and noted on or attached to this *policy.* No agent may:

1. Change this *policy*;
2. Waive any of the provisions of this *policy*;
3. Extend the time for payment of premiums; or
4. Waive any of *our* rights or requirements.

Non-Waiver
If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *policy*, that will not be considered a waiver of any rights under the *policy*. A past failure to strictly enforce the *policy* will not be a waiver of any rights in the future, even in the same situation or set of facts.

Rescissions
No misrepresentation of fact made regarding a *covered person* during the application process that relates to insurability will be used to void/rescind the insurance coverage or deny a claim unless:

1. The misrepresented fact is contained in a written application, including amendments, signed by a *covered person;*
2. A copy of the application, and any amendments, has been furnished to the *covered person(s),* or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *covered person.* A *covered person's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. “Rescind” has a retroactive effect and means the coverage was never in effect.

Repayment For Fraud, Misrepresentation Or False Information
During the first two years a *covered person* is insured under the *policy*, if a *covered person* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *covered person* under this *policy* or in filing a claim for *policy* benefits, *we* have the right to demand that *covered person* pay back to *us* all benefits that *we* paid during the time the *covered person* was insured under the *policy*.

Conformity With State Laws
Any part of this *policy* in conflict with the laws of the state in which your policy was issued on this *policy's effective date* or on any premium due date is changed to conform to the minimum requirements of that state's laws.