Sandia National Laboratories

Administered by:
BlueCross BlueShield of New Mexico

NTESS Blue Cross Blue Shield of New Mexico Benefits Summary

(Employees, Pre-Medicare Retirees, Surviving Spouses, & Long-Term Disability Terminees)

Benefit Summary

Revised: January 1, 2024

IMPORTANT

This Benefit Summary applies to Employees and Pre-Medicare Retirees, Surviving Spouses, and Long-Term Disability Terminees effective January 1, 2024.

For more information, refer to the NTESS Health and Welfare Benefits Plan for Active Employees Summary Plan Description or the NTESS Post-Employment Health and Welfare Benefits Plan Summary Plan Description.

The Total Health PPO Plan and Health Savings Plan (HDHP for Pre-Medicare Retirees, Surviving Spouses, and LTD Terminees) are maintained at the discretion of NTESS and is not intended to create a contract of employment and does not change the at will employment relationship between you and NTESS. The NTESS Board of Managers (or designated representative) reserves the right to amend (in writing) any or all provisions of the Total Health PPO Plan and Health Savings Plan (HDHP for Pre-Medicare Retirees, Surviving Spouses, and LTD Terminees), and to terminate (in writing) the Total Health PPO Plan and Health Savings Plan (HDHP for Pre-Medicare Retirees, Surviving Spouses, and LTD Terminees) at any time without prior notice, subject to applicable collective bargaining agreements.

The Total Health PPO Plan and Health Savings Plan (HDHP for Pre-Medicare Retirees, Surviving Spouses, and LTD Terminees), terms cannot be modified by written or oral statements to you from human resources representatives or other NTESS personnel.

U.S. DEPARTMENT OF ENERGY

National Nuclear Security Administration

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1. INTRODUCTION

This summary highlights healthcare benefits of the Total Health PPO Plan and the Health Savings Plan (High Deductible Health Plan for Pre-Medicare Retirees, Surviving Spouses, and Long-Term Disability (LTD) Terminees) (collectively, the "Programs"). The Programs are components of the NTESS Health and Welfare Benefits Plan for Active Employees (the "Employee H&W Plan") (ERISA Plan 540), and the NTESS Post-Employment Health and Welfare Benefits Plan (the "Post-Employment H&W Plan") (ERISA Plan 545). This Benefit Summary is part of the Employee H&W Plan Summary Plan Description (the "Employee H&W Plan SPD") and the Post-Employment H&W Plan Summary Plan Description (the "Post-Employment H&W Plan SPD." It contains important information about Your NTESS or "Sandia" healthcare benefits. Note: The Health Savings Plan option is available to eligible Active Employees only. Although eligible Pre-Medicare Retirees, LTD Terminees, and Surviving Spouses may participate in the High Deductible Health Plan (HDHP) option, there is no health savings account ("HSA") available to Pre-Medicare Retirees, LTD Terminees and Surviving Spouses through NTESS. Pre-Medicare Retirees, LTD Terminees, and Surviving Spouses must independently establish their HSAs and make any contributions directly with an HSA provider.

Certain capitalized words in this Benefit Summary have special meaning. These words have been defined in Definitions.

When the words "we," "us," and "our" are used in this document, we are referring to the Company. When the words "You" and "Your" are used throughout this document, we are referring to people who are Covered Members as defined in Definitions.

Many sections of this Benefit Summary are related to other sections of the Benefit Summary and to information contained in the Employee H&W Plan SPD or the Post-Employment H&W Plan SPD. You will not have all of the information You need by reading only one section of one Summary.

Refer to the Employee H&W Plan SPD or the Post-Employment H&W Plan SPD for information about eligibility, enrollment, disenrollment, premiums, termination, coordination of benefits, subrogation and reimbursement rights, when coverage ends, continuation of coverage provisions, and Your rights under the Employee Retirement Income Security Act of 1974, as amended (ERISA) and the Affordable Care Act (ACA).

To receive a paper copy of this Benefit Summary, other Benefit Summary's, the Employee H&W Plan SPD, or the Post-Employment H&W Plan SPD, contact HR Solutions at 505-284-4700. These documents are also available electronically at hr.sandia.gov.

Since these documents will continue to be updated, it is recommended to check back on aregular basis for the most recent version.

2. ACCESSING CARE

This section describes how to access medical/surgical and behavioral healthcare under the Blue Preferred Plus Network, BCBS PPO Network, and out-of-network options, Prior Authorization requirements, predetermination of benefits, accessing non-Emergency or non-Urgent Care while away from home, the Employee Assistance Program, the No Surprises Act requirements, and other general information. For information regarding the prescription drug program, refer to the section for Prescription Drug Program.

2.1. Blue Preferred Plus Network, BCBS PPO Network, and Out-of-Network Options

The medical plan portion of the Programs provide You three options for accessing care: Blue Preferred Plus Network, BCBS PPO Network, and out-of-network. You receive a higher level of benefits under the Blue Preferred Plus Network option than under the BCBS PPO Network option, while You will receive the lowest level of benefits when You use out-of-network providers.

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

2.2. Blue Preferred Plus Network Option

The Blue Preferred Plus in-network option provides You access to a smaller custom network of physicians, facilities and suppliers for a better benefit and lower Out-of-Pocket expenses for You and Your Dependents. To find a listing of Blue Preferred Plus providers, go to bcbsnm.com/sandia. Optum and Lovelace, the physician groups under the Blue Preferred Plus Network, provide a dedicated hotline (Concierge Line) for NTESS: 505-262-7100 (Optum) and 505-727-2727 (Lovelace). By calling one of these numbers, as the main point of contact for Sandians, You will have direct access to representatives to help navigate You to one of the Optum or Lovelace providers and to assist You with any of their healthcare services.

The advantages of using the Blue Preferred Plus network option include:

- Lower Coinsurance
- Lower Deductible
- Lower Out-of-Pocket Limits
- No responsibility for amounts exceeding Eligible Expenses
- Certain preventive care services covered at 100%
- Generally, no claims to file
- RAPS providers' (radiology, anesthesiology, and pathology)
- Covered Health Services while You are a patient at a Lovelace or a Blue Preferred Plus contracted facility will be considered at the Blue Preferred Plus Network higher benefit level.

If Your provider participates in the Blue Preferred Plus Network, he or she will obtain Prior Authorization from BCBSNM (or from the BCBSNM Behavioral Health Unit, when applicable) on Your behalf in the following circumstances:

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

Note: You are not responsible for any penalties that apply when a provider who participates in the Blue Preferred Plus Network fails to obtain any needed Prior Authorization. You should always verify that Prior Authorization has been requested by Your Blue Preferred Plus Network provider for these services.

2.3. BCBS PPO Network Option

The BCBS PPO Network is a broader in-network option that provides You access to physicians, facilities, and suppliers who are contracted as "Preferred Providers" with BCBSNM or other BCBS Plans to provide their services at negotiated fees. No referrals are required. For the most updated in-network provider listings in Your area, contact BCBSNM Customer Service at 877-498-7652 or access the national BCBS website at provider.bcbs.com.

The advantages of using the BCBS PPO Network option include:

- Lower Coinsurance
- Lower Deductible
- Lower Out-of-Pocket Limits
- No responsibility for amounts exceeding Eligible Expenses
- Certain preventive care services covered at 100%
- Generally, no claims to file

2.4. BCBSNM Preferred Providers

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

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

Note: You are not responsible for any penalties that apply when a provider who contracts directly with BCBSNM fails to obtain any needed Prior Authorization for non-behavioral health services. However, You should verify that Your Preferred Provider contracts directly with BCBSNM and the Preferred Provider will obtain Prior Authorization.

2.5. Preferred Providers outside New Mexico

If any Preferred Provider outside New Mexico that does not contract directly with BCBSNM recommends an admission or a service that requires Prior Authorization**, the provider is not obligated to obtain the Prior Authorization for You**. In such cases, it is **Your responsibility** to ensure that Prior Authorization is obtained. If You do not, benefits may be reduced or denied, and the unpaid portion will be Your responsibility.

Note: Although Your provider may call to obtain the Prior Authorization on Your behalf, it is ultimately Your responsibility to ensure that any needed Prior Authorization is obtained.

2.6. Out-of-Network Option

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

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

Refer to No Surprises Act Requirements for detailed information regarding Surprise Billing Claims and Post-Stabilization Services.

If any provider outside New Mexico or any Non-preferred Provider recommends an admission or a service that requires Prior Authorization, **the provider is not obligated to obtain the Prior Authorization for You**. In such cases, it is **Your responsibility** to ensure that Prior Authorization is obtained. If You do not, benefits may be reduced or denied, and the unpaid portion will be Your responsibility. Although the provider may call to obtain Prior Authorization on Your behalf, it is ultimately Your responsibility to ensure that any needed Prior Authorization is obtained.

2.7. Prior Authorization Requirements for Medical Services

Certain services (listed below) require Prior Authorization. Depending on the Provider that You use, You or Your provider must notify BCBSNM and obtain Prior Authorization before You receive these services. Otherwise, you will be subjected to a $300 penalty, which will be considered an ineligible expense. BCBSNM ensures You and/or Your covered family members receive the most appropriate and most effective services available. Generally, You are responsible for obtaining Prior Authorization. However, if Your provider is a Blue Preferred Plus Network provider or a Preferred Provider who contracts directly with BCBSNM, then Your provider is responsible for obtaining Prior Authorization.

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

2.8. How Prior Authorization Works

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

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

2.9. Inpatient Admissions

You or Your provider must request Prior Authorization from BCBSNM for:

- Non-emergency admissions: at least five business days before admission
- Maternity delivery admissions: outside the 48 hours of vaginal delivery (96 hours for a C-section)
    - If home delivery/birth is planned to be at home but requires admission to the hospital, notification is required.
- Emergency admissions, non-Maternity services: within two business days following admission or as soon as reasonably possible.

If You, Your authorized representative, or Your provider fail to contact BCBSNM within the applicable time frames for inpatient services, the first $300 of Covered Charges will not be considered covered. An exception to the Prior Authorization requirement would be, if You have primary healthcare coverage for these services under Medicare or another non-Company healthcare program and that other coverage did not deny services as being ineligible for any reason.

The Prior Authorization number for inpatient care is 800-325-8334.

IMPORTANT: Providers that contract with Blue Cross Blue Shield Plans other than BCBSNM are not familiar with the Prior Authorization requirements of the Programs. You are responsible for being aware of this medical plan's requirements. Call800-325-8334 to request Prior Authorization.

2.10. Outpatient and Other Medical Services

Other non-Emergency services that require BCBSNM Prior Authorization are listed below. Your benefitsfor services listed below, will be denied if Prior Authorization is not received. If the service is determined to be covered and Medically Necessary, the penalty is your benefits may be reduced-not denial of coverage.

- Air ambulance services (non-emergent only)
- Cardiac and pulmonary rehabilitation
- Cardiac CT scans
- Clinical trials
- Congenital heart disease services
- Dental services stemming from illness or injury
- Durable Medical Equipment for items with a purchase or cumulative rental value of $1,000 or more
- Insulin pumps and continuous glucose monitoring systems, regardless of cost
- Enteral nutrition/nutritional supplements
- Gender Affirmation Surgery(for out of network services only)
- Genetic testing (including breast cancer genetic testing (BRACA))
- Hearing aids/exams and/or cochlear implants

- Home dialysis
- Home healthcare
- Hospice care
- Immunoglobulin infusion (IVIG) therapy
- Infertility treatment
- Injectable Outpatient chemotherapy
- Obesity surgery
- Orthognathic surgery
- Positron emission tomography (PET) scans
- Maternity care that exceeds the delivery time frames as described in Covered Medical Plan Services / Limitations. Note that if delivery is at home but requires admission to the hospital, notification is required
- Reconstructive procedures
- Short-term rehabilitation (Outpatient physical, occupational and speech therapy)
- Sleep disorder studies
- Transplant services, including pre-transplant evaluation
- Travel and lodging related to a service eligible for such coverage under the BlueDistinction program (explained later in this section under Provider Networks)

Prior Authorization for the above- mentioned medical care services can be requested by calling BCBSNM at 800-325-8334.

2.11. Recommended Clinical Review

It is important to note that not all services or procedures that do not require Prior Authorization are automatically covered. To determine if a service or procedure is covered, it is recommended that you obtain a Recommended Clinical Review. The Programs do not cover medical treatments that are Investigational, Experimental, or Unproven to be medically effective. It is advised to contact BCBSNM before incurring charges that may not be covered.

Certain services may only be covered under specific circumstances or may have limitations, such as temporomandibular joint (TMJ) syndrome, procedures with cosmetic effects, and unproven therapies. It is recommended to obtain a Recommended Clinical Review to determine your out-of-pocket expenses. Some services may also require Prior Authorization, so it is important to contact BCBSNM for information on benefits if you have any doubts. For assistance with obtaining a Recommended Clinical Review, you can contact BCBSNM Customer Service at 877-498-7652.

Although Prior Authorization is not required for certain procedures listed below, it is encouraged to notify BCBSNM Customer Service before receiving these services to determine if they are covered healthcare services. Failure to do so may result in these services being considered cosmetic or not medically necessary, and you may be responsible for the entire cost:

- Blepharoplasty (eyelid correction surgery)
- Vein stripping, ligation, VNUS Closure, and sclerotherapy (varicose vein treatment)
- Surgery for the diagnosis "ptosis"

- Bunionectomy
- Carpal tunnel repair
- Cholecystectomy
- Intradiscal electrothermal annuloplasty (IDET)
- Sclerotherapy
- Septoplasty
- Outpatient surgeries: diagnostic catheterization, electrophysiology implant, and sleep apnea surgeries
- Therapeutics: dialysis, intensity modulated radiation therapy, and MR-guided focused ultrasound
- Uvulopalatopharyngoplasty (UPPP)
- Outpatient hysterectomy

Please note that these services will not be covered if they are determined to be cosmetic procedures or not medically necessary, and you may be responsible for the entire cost.

2.12. Prior Authorization for Behavioral Health

Prior Authorization for behavioral health (mental health or substance use disorder) is required for the following services:

2.12.1. Inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility)

If Prior Authorization is not obtained, your benefits may be reduced if You, a family member, or Your provider does not contact the BCBSNM Behavioral Health Unit (BHU) within the applicable time frames for the Inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility You or Your provider must request Prior Authorization from BCBSNM:

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

The Blue Preferred Plus Network providers and BCBS PPO Network providers who contract directly with BCBSNM will obtain Prior Authorization. However, You should call the BCBSNM Behavioral Health Unit (BHU) at 888-898-0070 toconfirm that Prior Authorization has been obtained, even if You are using in-network services or facilities. If You are using out-of-network services or facilities, it is Your responsibility to obtain Prior Authorization.

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

2.13. Your Provider Networks

2.13.1. Blue Preferred Plus Network

The Programs provide a new higher benefit level when accessing a Blue Preferred Plus Network provider. The Blue Preferred Plus Network is an exclusive network of Preferred Providers that have contracted with BCBSNM for NTESS in the greater Albuquerque area.

In the greater Albuquerque area, the physicians, hospitals, and other healthcare providers/facilities participating in the Blue Preferred Plus Network are affiliated with the Lovelace Health System, Optum and direct agreements with various community providersincluding behavioral health, laboratories, acupuncture, chiropractors, etc.

NTESS and BCBSNM cannot guarantee quality of care. Employees always have the choice of what services they receive and who provides their healthcare regardless of what the Programs cover or pay.

2.13.2. Blue Cross Blue Shield Preferred Provider Organization (PPO) Network

The Programs provide Your benefits under agreement with an exclusive network of Preferred Providers that contract with Blue Cross Blue Shield (BCBS) Plans throughout the United States and around the world. When You need non-Emergency healthcare You must choose a provider from the national BCBS PPO Networkto receive benefits at the in-network benefit level. You may access BCBS PPO providers in most areas nationwide.

BCBSNM has established direct contracts with providers within the greater Albuquerque area and throughout New Mexico to offer in-network care. The PPO providers work with BCBSNM to organize an effective and efficient healthcare delivery system.

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

2.13.3. Network Gap Exception

The Programs have a Network Gap Exception provision for Covered Health Services. Under this provision, You will be responsible for obtaining Prior Authorization to allow the out of network services at the in-network level. BCBS will be able to verify if there is an in-network provider available for the services being required. This means the claim will be allowed in network based on an allowable amount not at billed so the member will still be responsible for the amount over the allowable.

2.13.4. Transition of Care/Special Circumstances

If You are a continuing care patient and Your healthcare provider leaves the BCBSNM provider network (for reasons other than medical competence or professional behavior) or if You are a new Member and Your provider is not in the BCBS Plans PPO network when You enroll, BCBSNM may authorize You to continue an ongoing course of treatment with the provider for a transitional period of time of not less 90 days during which that provider's covered services will be eligible for

benefits at the in-network rate. (If necessary and ordered by the treating provider, BCBSNM may also authorize transitional carefrom other non-network providers.)

The term "Continuing Care Patient" means an individual who, with respect to a provider or facility:

- is undergoing a course of treatment for a Serious and Complex Condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

The term "Serious and Complex Condition" means, with respect to a participant under the plan, one of the following:

- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- in the case of a chronic illness or condition, a condition that is—
    - is life-threatening, degenerative, potentially disabling, or congenital; and
    - requires specialized medical care over a prolonged period of time.

Note: The right to elect continued transitional care described in this section does not apply if the contract with an in-network provider or facility is terminated for failure to meet applicable quality standards or for fraud.

The period will be sufficient to permit coordinated transition planning consistent with Your condition and needs. Special provisions may apply if the required transitional period exceeds90 days. If You have entered the third trimester of pregnancy at the effective date of enrollment, the transitional period will include post-partum care directly related to the delivery. Call BCBSNM Customer Service for more details at 877-498-7652.

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

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

2.14. Finding Network Providers

Provider directories list providers, facilities, and auxiliary services that have contracted to participate in the Blue Preferred Plus Network or the BCBSNM Preferred Provider Option (PPO) network. You can select Your physician from family care physicians, internists, pediatricians, and other Specialists. Remember, by selecting a Blue Preferred Plus Networkprovider, You will have lower out of pocket expenses.

To obtain a copy BCBS PPO provider directory, for any state within theUnited States, You can contact BCBSNM Customer Service at 877-498-7652. The provider networks change often. For the most current information, it is recommended that You register on to the BCBSNM website and use the online provider search at bcbsnm.com/sandia for a Blue Preferred Plus Network and PPO provider for an up-to-date provider listing.

2.14.1. Provider Searches Online

To search for a Blue Preferred Plus Network or PPO provider online, go to bcbsnm.com/sandia. All that is needed is access to the Internet. Register at this website and create Your own username and password (have Your ID card handy). You will need Your groupand Member ID numbers to fill in the information on the Blue Access Members (BAM) registration page.

- Log on (You will need to register)
- Search for physicians and facilities by street address, ZIP Code, or provider name
- Select **Search**
- To find a hospital, select **Hospital** under the Specialty Categories
- To find health providers by specialty, make a selection from the dropdown list under the Specialty Categories

2.14.2. If You Are Outside New Mexico

The BlueCard PPO Program provides access to a nationwide network of providers when traveling in the U.S. You have access to established PPO network of doctors, hospitals and other health care providers throughout the country. No paperwork or claims to file when visiting a BlueCard PPO provider, all You need to do is show Your ID card.

Take Your BCBSNM Member ID card while You travel. Your ID card is required for providers to determine Your medical coverage. The back of Your BCBSNM Member ID card has the toll-free numbers available to You for assistance concerning Your medical coverage andPre-authorizations.

1. Always carry Your current BCBSNM Member ID card. You also have access to a digital copy of Your ID card through the mobile app.
2. In an Emergency, go directly to the nearest hospital.
3. To find doctors and hospitals nearby, call BlueCard Access® at 800-810-2583 or visitthe BlueCard Doctor and Hospital Finder at provider.bcbs.com. This website includesmaps and directions to a provider's location.
4. Call BCBSNM for Prior Authorization, if necessary. The phone number is on the backof Your Member ID card. This Prior Authorization number is different from the BlueCard Access number mentioned above.
5. When You arrive at the PPO provider's office or at the PPO hospital, show the provider Your BCBSNM Member ID card.

After You receive care from a PPO network provider, You should:

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

2.14.3. Traveling Outside the United States

1. Verify Your benefits with BCBSNM before leaving the United States.
2. Always carry Your current BCBSNM Member ID card.
3. In an Emergency, go directly to the nearest hospital.
4. Call the Blue Cross Blue Shield Global Core Service Center at 800-810-2583 or call collect: 804-673-1177. Blue Cross Blue Shield Global Core is available 24 hours a day, 7 days a week for information on doctors, hospitals, and other healthcare professionals and for medical assistance services around the world. An assistance coordinator, in conjunction with a medical professional, will help arrange a doctor's appointment or hospitalization, if necessary.
5. If You need to be hospitalized, call BCBSNM for Prior Authorization. You can find the number on the back of Your Member ID card.

Note: The number for Prior Authorization is different from the provider locator number. Pay for any inpatient, outpatient, or other professional medical care received whiletraveling outside the United States and as soon as You return home, file Your claim.

6. To submit a claim, complete an International Claim Form and send it to the address on the BCBS International Claim Form. You may find the claim form on BCBSNM's website bcbsnm.com/sandia.

2.15. Blue Distinction Center for Specialty Care Programs

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

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

- Bariatric surgery
- Cardiac care
- Complex and rare cancers
- Knee and hip replacement
- Spine surgery
- Transplant

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

IMPORTANT: Prior Authorization must be requested from BCBSNM before You travel to aBlue Distinction center for the treatment of complex conditions, including but not limited to bariatric surgery, cardiac care, complex and rare cancers, spine surgery or transplants. If authorized, a BCBSNM case manager will be assigned to You (the covered patient) and, in thecase of a transplant, You must contact the case manager with the results of the evaluation. Youmust ensure that Prior

Authorization for the actual admission is received. If Prior Authorization is not received, benefits may be denied or reduced.

For more information on the Blue Distinction program or to find a specialty care facility go to: http://www.bcbsnm.com/sandia/providers/blue_distinction.html.

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

IMPORTANT: For travel and lodging services to be covered, the patient must be receiving treatment of complex conditions, including but not limited to bariatric surgery, cardiac care,

complex and rare cancers, spine surgery or transplants services at a designated facility througha Blue Distinction Center for Specialty Care Program.

The Programs cover expenses with Prior Authorization approval for traveland lodging related to a covered complex condition, including but not limited to bariatric surgery, cardiac care, complex and rare cancers, spine surgery or transplants treatment as follows:

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

Travel and lodging expenses are only available if the covered patient lives more than 50 milesfrom the designated Blue Distinction Centers for Specialty Care facility that is being accessedfor covered services through the Blue Distinction program. BCBSNM must receive valid receipts for such charges before You will be reimbursed. Examples of travel expenses may include:

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

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

2.16. Virtual Visits (MD Live)

Covered Services provided via consultation with a Virtual Visit Provider through interactive video via online portal or mobile application. Virtual Visits provide access to Providers who can provide diagnosis and treatment of non-Emergency medical conditions Mental Disorder and Chemical Dependency conditions in situations that may be handled without a traditional office visit, Urgent Care visit or Emergency Care visit. Network Benefits are available only when services are delivered

through the MD Live portal at mdlive.com/bcbsnm You will needYour Member ID number located on Your BCBSNM insurance card to register Your account. For members of the Total Health PPO Plan, coverage is a flat copay amount without having to meet the annual deductible. For members of the Health Savings Plan (HDHP for Pre-Medicare Retirees, Surviving Spouses, and LTD Terminees), the annual deductible must be met before the copay is applicable. There is a $10 copay for virtual visit services.

Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Benefits under this section do not include email, or fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (CMS defined originatingfacilities).

2.16.1. Telemedicine Medical Services

Covered Services provided via consultation with a contracted Provider through information and telecommunication technology. Telemedicine provides access to Providers who can provide diagnosis and treatment of non-Emergency medical conditions, Mental Disorders andChemical Dependency in situations that may be handled without a traditional office visit, Urgent Care visit or Emergency Care visit. All non-preventive telemedicine services are subject to plan deductibles and coinsurance.

2.17. 24/7 Nurseline

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

BCBSNM's 24/7 Nurseline provides You with a toll-free telephone service that puts You in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days aweek, for routine or urgent health concerns.

Call 800-973-6329 to learn more about:

- A recent diagnosis
- Mental Health and Substance Use Disorder resources
- A minor Illness or Injury
- Men's, women's, and children's wellness
- How to take prescription drugs safely
- What questions to ask Your doctor before a visit
- For help understanding Your test results
- Information that can help You decide when the Emergency room, Urgent Care, a doctor visit, or self-care is appropriate
- Self-care tips and treatment options
- Healthy living habits
- Any other health related topic

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

2.18. Nurseline Audio Health Library

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

2.19. Women's and Family Health

BCBSNM provides comprehensive support for fertility, pregnancy and parenting. Visit https://www.bcbsnm.com/sandia/health-and-wellness/women-s-and-family-health or call 1-888-421-7781 (Monday through Friday, 8:00 a.m. to 6:30 p.m. CT) to learn more about:

- App-based coaching delivered by Ovia Health addressing pre-pregnancy, pregnancy and post-pregnancy wellness.
- Personal phone support and education from a BCBSNM maternity specialist for high-risk cases.
- Digital self-management programs through Well on Target to help You plan for a healthy pregnancy and baby.

2.20. Case Management Program

When BCBSNM helps You, Your doctor, and other providers for major services, it is called "case management." When You have a need for many long-term services or services for more than one condition, BCBSNM case management for medical healthcare uses a team of medicalsocial workers and nurses (case managers) to help You make sure You are getting the help You need.

Case managers are there to help if You:

- Have special healthcare needs
- Need help with a lot of different appointments or getting community services notcovered by this program
- Are going to have a transplant or another serious operation
- Have a high-risk pregnancy or having problems with Your pregnancy

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

2.20.1. Care Coordination for Special Healthcare Needs

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

If You believe You or Your covered family member has special healthcare needs, please call a BCBSNM case manager, who can provide You a list of resources to help You with special needs. BCBSNM also provides education for Members with special healthcare needs and theircare givers.

Programs include dealing with stress and information help both You and Your family cope with a chronic illness.

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

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

You may call BCBSNM case management at 800-325-8334.

2.21. Disease Management Program

The disease management program's goal is to assist Members with chronic health conditionsby providing resources and education designed to improve health status and quality of life.

Blue Care Advisors (credentialed nurses) are able to customize the intervention based on each Member's unique needs. Interventions include written education, automated telephone messages, web-based support, tools for self-management, monitoring tools and, when appropriate, one-on-one telephonic coaching and education.

This disease management program is a voluntary program that helps You manage chronicconditions such as:

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

2.22. Additional Health Support and Management Programs

BCBSNM also provides the following health support and management programs as part of plan benefits:

- **Health Advisor.** Health Advisor provides You with access to a care team, led by a health advisor, to help You address the mental, physical, and emotional aspects of health issues. You can reach a health advisor through email, secure messaging, or by scheduling a call back.
- **Behavioral Health Programs.** BCBSNM provides comprehensive behavioral health support, including:
    - Cognitive behavioral therapy-based programs delivered by Digital Mental Health through Learn to Live.
    - Specialty team treatment and care for opioid and substance use, Autism Spectrum Disorder (ASD), and eating disorders.
    - Personal support to help You adjust to new life events or when You need intensive behavioral health services.
- **Well onTarget Member Wellness Portal.** Well onTarget helps jumpstart and support Your journey toward overall wellbeing through personalized action plans, fitness and nutrition device integration, and convenient digital self-management programs focused on a variety of wellness and lifestyle topics, including:
    - Stress
    - Weight loss
    - Tobacco cessation
    - Asthma, diabetes and other chronic conditions
    - Sleep health
    - Financial wellbeing
- **Fitness Program.** BCBSNM provides flexible fitness program plan options to best fit Your family's budget and preferences. Fitness program benefits include:
    - Access to a studio class network
    - Family friendly perks
    - Digital fitness access
    - Mobile app with real time data
- **Telehealth Powered by MDLIVE.** Telehealth provides access to board-certified MDLIVE doctors who are available 24 hours a day/seven days a week. You can speak to a doctor immediately or schedule an appointment based on Your availability.
- **Blue365.** Blue365 helps You save money on health and wellness products and services from top retailers that may not be covered by the Programs, without requiring You to file a claim, or obtain a referral or preauthorization. Once You sign up for Blue365 at blue365deals.com/bcbsnm, You are emailed weekly "Featured Deals" that offer special savings for a specified period. See Blue365 for more information.

2.23. Healthcare Fraud Information

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

- Being wary of offers to waive copays, Coinsurance, and Deductibles. These costs arepassed on to You eventually.
- Being wary of mobile health testing labs. Ask what Your healthcare insurance will becharged for the tests.
- Reviewing the bills from Your providers and the Explanation of Benefits (EOB) form You receive from BCBSNM. Verify that services for all charges were received. If thereare any discrepancies, call BCBSNM Customer Service.

Be very cautious about giving information about Your healthcare insurance over the phone. If You suspect fraud, contact the BCBSNM Fraud Hotline at 888-841-7998.

2.24. Employee Assistance Program

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

2.24.1. EAP Services

Contact Magellan Health Services at 800-424-0320 to receive EAP services. Your EAP benefit allows up to eight visits per calendar year (California Members areeligible for up to three EAP visits every six months) to an offsite, in-network EAP provider at no cost to You.

Note: Retirees, Surviving Spouses, and LTD Terminees and their covered Dependents are not eligible for EAP benefits.

2.24.2. *Accessing EAP Services*

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

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

2.24.3. Confidentiality

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

3. NO SURPRISES ACT REQUIREMENTS

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes certain requirements relating to surprise billing claims under the No Surprises Act (NSA). This section explains the requirements and Your rights under the NSA.

Surprise Billing Claims

Surprise Billing Claims are claims that are subject to the NSA requirements (as applicable to each type of claim listed below):

- Emergency Services provided by out-of-network providers;
- Covered services provided by an out-of-network provider at an in-network Health Care Facility; and
- Out-of-network air ambulance services.

3.1. Emergency Services

Emergency Services (i.e., services relating to an emergency medical condition in an emergency department of a hospital or in an Independent Freestanding Emergency Department) are covered without the need for prior authorization and regardless of whether the services are received from an in-network provider or an out-of-network provider. If Emergency Services are received from an out-of-network provider, the following NSA protections will also apply:

- Any applicable administrative requirements or coverage limitations will not be more restrictive than the requirements or limitations that apply to Emergency Services received from in-network providers and in-network emergency facilities.
- Your cost-sharing payments will count toward any in-network deductible or Out-of-Pocket Limits under Your medical plan, and the in-network deductible or Out-of-Pocket Limits will be applied in the same manner as if Your cost-sharing payments were made for services by an in-network provider or facility.
- Your cost-sharing will be no more than the cost-sharing that would apply if the services were provided by an in-network provider or in-network emergency facility.

Additionally, Your out-of-network provider may not balance bill You for Emergency Services, meaning the out-of-network provider may not charge You for any difference between the maximum allowable amount payable under Your medical plan and the out-of-network provider's billed charges.

Refer to Covered Medical Plan Services / Limitations for information regarding Emergency Services.

3.2. Post-Stabilization Services

Post-Stabilization Services are additional Covered Health Services that are provided by an out-of-network provider or out-of-network emergency facility after You have received Emergency Services and are stabilized, and as part of outpatient observation or an inpatient or outpatient stay for such services. Post-Stabilization Services are subject to the same NSA protections as Emergency Services unless excepted under the Notice and Consent Exception (see "Notice and Consent Exception for Certain Services" section below for specific requirements). The Notice and Consent Exception requires that the out-network provider supply You with proper notice of the Post-Stabilization

Services and that You provide informed consent to receive such services. The out-of-network provider must also determine that You are:

- stable;
- able to travel to an in-network facility within a reasonable travel distance by non-medical or non-emergency transport, taking into account Your medical condition; and
- in a condition to receive the information and provide informed consent.

If the out-of-network provider meets the Notice and Consent Exception requirements and You continue to receive services from the out-of-network provider after You are stabilized, You will be responsible for the out-of-network provider cost-shares, and the out-of-network provider will also be able to balance bill You (i.e., charge You any difference between the maximum allowable amount payable under Your medical plan and the out-of-network provider's billed charges). However, there are certain services that cannot be excepted under the notice and consent exception even if the out-of-network provider meets all the requirements (refer to Ancillary Services in the "Notice and Consent Exception for Certain Services" section below).

3.3. Non-Emergency Services from an Out-of-Network Provider at an In-Network Health Care Facility

If You receive non-Emergency Services covered under the Plan from an out-of-network provider at an in-network Health Care Facility, the following NSA protections will apply:

- Any applicable administrative requirements or coverage limitations will not be more restrictive than the requirements or limitations that would apply if the services were received from an in-network provider.
- Your cost-sharing payments will count toward any in-network deductible or Out-of-Pocket Limits under the Plan, and the in-network deductible or Out-of-Pocket Limits will be applied in the same manner as if Your cost-sharing payments were made for services by an in-network provider.
- Your cost-sharing will be no more than the cost-sharing that would apply if the services were provided by an in-network provider.

Additionally, Your out-of-network provider may not balance bill You for the non-Emergency Services (i.e., charge You any difference between the maximum allowable amount payable under the Plan and the out-of-network provider's billed charges).

However, the NSA protections will not apply if the Notice and Consent Exception applies (see "Notice and Consent Exception for Certain Services" section below for specific requirements). Under the Notice and Consent Exception, the out-of-network provider must provide You with proper notice of the non-Emergency Services and You must provide informed consent to receive such services. However, there are certain services that cannot be excepted under the notice and consent exception even if the out-of-network provider meets all the requirements (refer to Ancillary Services in the "Notice and Consent Exception for Certain Services" section below).

3.4. Notice and Consent Exception for Certain Services

For certain Post-Stabilization Services and certain non-Emergency Services, applicable NSA protections will not apply if the out-of-network provider provides You with proper notice and You provide written informed consent to such services that meet the requirements discussed below. The provider's notice is required to inform You about Your NSA protections from unexpected medical

charges, give You the option to give up those protections and potentially pay more for out-of-network care, and provide an estimate of what Your out-of-network care might cost.

"Proper notice" from a provider requires that at least 72 hours before the day of the appointment, or three (3) hours in advance of services rendered in the case of a same-day appointment, the provider supplies You with a written notice disclosing:

- the provider is an out-of-network provider with respect to Your medical plan;
- the good faith estimated charges for Your covered services;
- any advance limitations that Your medical plan may put on Your treatment (e.g., any prior authorization requirements, etc.); and
- You may elect to seek care from an available in-network provider instead.

Note: If the notice relates to Post-Stabilization Services (see "Post-Stabilization Services" section above), the notice must also include a list of the names of any in-network providers at the facility who are able to treat You and a statement that You may elect to be referred to one of the in-network providers.

"Informed consent" requires that You give the provider written consent to any charges disclosed in the provider's notice, acknowledging that You understand that continued treatment by the out-of-network provider may result in greater cost to You. This means You will be responsible for out-of-network provider cost-shares for those services and the out-of-network provider can also balance bill You for such services (i.e., charge You any difference between the maximum allowable amount under Your medical plan and the out-of-network provider's billed charges).

The notice and consent exception does not apply to the following services, which are always covered by the NSA protections:

- Ancillary Services, which means:
    - Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
    - Items and services provided by assistant surgeons, hospitalists, and intensivists;
    - Diagnostic services, including radiology and laboratory services; and
    - Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.
- Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.

3.5. Current Provider Directory

BCBSNM updates the list of in-network providers in its provider directory every 90 days. You may request information from BCBSNM regarding whether a provider or facility is in the Program network or otherwise has a contractual relationship with the Program. If You request such information through a telephone call, email or other electronic web-based or Internet-based means, BCBSNM will respond to You no later than one business day after Your request is received, through a written electronic communication or, if requested, paper communication. The Program is required to retain this communication in Your file for at least two years afterwards.

If You can show that You received inaccurate information from the Program that a provider was an in-network provider on a particular claim, then You will only be liable for in-network cost-shares applicable to in-network providers (i.e., copayments, deductibles, and/or coinsurance) for that claim. Your cost-sharing payments will be counted toward any in-network deductible or Out-of-Pocket Limits under the Program, and the in-network deductible or Out-of-Pocket Limits will be applied in the same manner as if Your cost-sharing payments were made for services by an in-network provider or facility.

Refer to Accessing Care for information regarding how You can access in-network provider information.

3.6. How Cost-Shares Are Calculated

Your cost-shares for NSA-protected Emergency Services or covered non-Emergency Services received by an out-of-network provider at an in-network facility are calculated using the median in-network contract rate that the medical plan applies to in-network providers for the geographic area where the covered service is provided. Any out-of-pocket cost-shares You pay to an out-of-network provider for either Emergency Services or covered non-Emergency Services provided by the out-of-network provider at an in-network facility will be applied to Your in-network out-of-pocket limit and Your in-network deductible in the same manner as if such cost-sharing payment was made with respect to items and services furnished by an in-network provider or facility.

3.7. Coverage of Air Ambulance Services

If You receive Air Ambulance Services (i.e., medical transport by helicopter or airplane for patients) from an out-of-network provider, and such services would have been covered under the Plan if provided by an in-network provider, then the Plan will cover the services as follows:

- Your cost-sharing payments will be counted toward any in-network deductible or Out-of-Pocket Limits under the medical plan, and the in-network deductible or Out-of-Pocket Limits will be applied in the same manner as if Your cost-sharing payments were made for services by an in-network provider.
- Your cost-sharing will be no more than the cost-sharing that would apply if the services were provided by an in-network provider.
- Cost-sharing will be calculated based on the lesser of the qualifying payment amount (i.e., the median in-network contract rates the medical plan applies to in-network providers for the geographic area where the covered service is provided) or the out-of-network provider's billed amount.
- Not later than 30 calendar days after all information necessary to decide Your claim for the services has been received, BCBSNM will send the provider an initial payment or a notice of denial of payment.

Refer to Covered Medical Plan Services / Limitations for information regarding Air Ambulance services.

3.8. Appeals and External Reviews

If You have a claim that is denied and You believe the claim is protected by the surprise billing and cost-sharing protections under the NSA, You have the right to appeal Your claim under the Program's internal claims and appeals process.

If You have exhausted, or are deemed to have exhausted, the Program's internal claims and appeals process or You have requested an expedited external review, You may request external review for any adverse determination involving consideration of whether the Program is complying with the surprise billing and cost-sharing protections under the NSA.

Examples of NSA Adverse Benefit Determinations Eligible for External Review

- Patient cost-sharing and surprise billing for emergency services;
- Patient cost-sharing and surprise billing protections related to care provided by nonparticipating providers at participating facilities;
- Whether patients are in a condition to receive notice and provide informed consent to waive NSA protections; and
- Whether a claim for care received is coded correctly and accurately reflects the treatments received, and the associated NSA protections related to patient cost-sharing and surprise billing.

Refer to How to File a Claim and How to File an Appeal of this Benefit Summary for information regarding the Program's claims and appeals process and external review procedures.

3.9. Continuity of Care

If You are a continuing care patient, and the contract with Your in-network provider or facility terminates:

- You will be notified in a timely manner of the contract termination and of Your right to elect continued transitional care from the provider or facility; and
- You will be allowed up to 90 days of continued coverage at in-network cost-sharing to allow for a transition of care to an in-network provider.

The term "Continuing Care Patient" means an individual who, with respect to a provider or facility:

- is undergoing a course of treatment for a Serious and Complex Condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

The term "Serious and Complex Condition" means, with respect to a participant under the plan, one of the following:

- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- in the case of a chronic illness or condition, a condition that is—
    - is life-threatening, degenerative, potentially disabling, or congenital; and
    - requires specialized medical care over a prolonged period of time.

Note: the right to elect continued transitional care described in this section does not apply if the contract with an in-network provider or facility is terminated for failure to meet applicable quality standards or for fraud.

Refer to Transition of Care/Special Circumstances of this Benefit Summary for additional information regarding continuity of care.

3.10. Transparency

The following information is publicly available at hr.sandia.gov (search "Plan Documents"). The following information is also provided on each explanation of benefits for any item or service You receive that is covered by the NSA:

- Protections with respect to Surprise Billing Claims by providers;
- Estimates on what out-of-network providers may charge for a particular service;
- Information on contacting state and federal agencies in case You believe a provider has violated the No Surprises Act's requirements.

You may obtain the following information through hr.sandia.gov (under "Publicly Available Files"):

- Cost sharing information that You would be responsible for, for a service from a specific in-network provider;
- Cost sharing information on an out-of-network provider's services based on the medical plan's reasonable estimate based on what the medical plan would pay an out-of-network provider for the service;
- A list of all in-network providers (refer to "Finding Network Providers" above for additional information).

In addition, You may access the following information online at hr.sandia.gov (under "Publicly Available Files"):

- In-network negotiated rates;
- Historical out-of-network rates; and
- Drug pricing information.

4. DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET LIMITS AND LIFETIME LIMITS

This section summarizes the annual Deductibles and Out-of-Pocket Limits, as well as any Coinsurance that applies to the Blue Preferred Plus Network, in-network option and the out-of-network option. In addition, this section describes any lifetime limits under the Programs.

4.1. Deductibles

This section describes Your Deductibles. You must first pay the annual Deductible before the Program begins to pay for Covered Health Services. Your annual deductible begins on January 1. When You meet the full Deductible amount, the Program begins to pay for Covered Charges at the applicable Coinsurance amount. Deductibles are not prorated for mid-year enrollments and reset every January.

If You retire mid-year and qualify for NTESS's Post Employment Health and Welfare Benefit Plan and are Pre-Medicare, any amounts applied towards Your Deductibles under Your active employee coverage will transfer to Your NTESS retiree coverage provided You keep the same coverage into retirement.

If You change medical plans mid-year (e.g., You move from the Kaiser Permanente Program to either of these Programs), any amounts applied towards Your Deductible under your current NTESS plan will be applied to the applicable new NTESS program; however, You must coordinate the transfer of your deductible through HR Solutions at the time of enrollment.

The following charges do not apply to the annual Deductible amounts above the Medicare-Approved Amount, charges not covered by the Programs, virtual visit copay (only on the Total Health PPO plan), and penalties incurred because of failure to obtain required Prior Authorization. If You are enrolled in the Total Health PPO Plan, there is no deductible for prescription drugs and prescription drug Coinsurance amounts do not apply to the annual Deductible described in the Summary Benefits and Coverage (SBCs). However, the Health Savings Plan Deductibles described in the Summary of Benefits and Coverage (SBCs) accumulate with covered medical and prescription drug costs.

For the Total Health PPO: This Program has an embedded Deductible, which means:

- If You are the only person covered by this Plan, only the Primary Covered Member Only (also referred to as individual) Deductible applies to You.
- If You are enrolled in Primary + Spouse/Child or Primary + Spouse + Child(ren) coverage, both the individual and the Family amounts apply. The family Deductible amounts can be satisfied by any combination of family members, but You could satisfy Your own individual Deductible amount before the family amount is met. You will never have to satisfy more than Your own individual Deductible amount. If You meet Your individual Deductible amount, Your other family member's claims will still accumulate towards their own individual Deductible as well as the overall family amounts. This continues until Your other family members meet their own individual Deductible or the entire family Deductible is met.

For the Health Savings Plan: If You are enrolled in either Primary Covered Member plus either Spouse or Child(ren), or Primary Covered Member plus Spouse + Child(ren) coverage, then the family Deductible must be satisfied before the Program will begin to pay for Covered Health Services. The family Deductible amounts can be satisfied by a single Member or any combination of family members.

4.1.1. Deductibles for Admissions Spanning Two Calendar Years

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

4.2. Coinsurance

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

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

IMPORTANT: You are responsible for any amount above the Medicare-Approved Amount ifYou receive services out-of-network. Some services require Prior Authorization, otherwise You will receive reduced benefits or, in certain cases where billed charges are not covered by Medicare, no benefits.

4.3. Out-of-Pocket Limit

This section describes Your Out-of-Pocket Limits.

Note that Out-of-Pocket Limits are not pro-rated for mid-year enrollments.

If You retire mid-year and are Pre-Medicare, any amounts applied towards Your Out-of-Pocket Limits under Your employee coverage will transfer to Your retiree coverage, provided You keep the same coverage into retirement.

If You change your medical carrier mid-year (e.g. You move from the Kaiser STH Program to either of these Programs), any amounts applied toward Your Out-of-Pocket Limits under your current NTESS plan will not be transferred to the new carrier and you limits start over. If you change plans within the same carrier (e.g. you move from the Health Savings Plan to the Total Health PPO plan within UHC, then the out-of-pocket limit will be applied to the applicable new medical Plan.

For details regarding annual Out of Pocket Limits, please refer to the Summary of Benefits and Coverage (SBCs).

Table 1. The following table identifies what does and does not apply toward in-network and Out-of-Network Out-of-Pocket Limits:

Features	Applies to the Blue Preferred Plus Network/ BCBS PPO Network (In-Network) Out-of-Pocket Limit?	Applies to the Out-of-Network Out-of-Pocket Limit?
Payments toward the annual Deductible	Yes	Yes

Member Coinsurance payments	Yes	Yes
Charges for non-covered Healthcareservices	No	No
Amounts of any reductions in benefits You incur by not following Prior Authorization or Precertification requirements	No	No
Amounts You pay toward behavioral health services	Yes	Yes
Charges that exceed Covered Expenses	Not applicable	No
Prescription drugs and other items obtained through Express Scripts	No for Total Health PPO Plan / Yes for Health Savings Plan	No

4.4. Prescription Drug Expenses Incurred Through Express Scripts

Your medical and prescription drug costs combine and accumulate toward a single Out-of-Pocket Limit for the Health Savings Plan (HDHP for Pre-Medicare Retirees, Surviving Spouses, and LTD Terminees) (described in Out-of-Pocket Limit Section above).

For the Total Health PPO Plan, the prescription drug program has a separate Out-of-Pocket Limit, which is as follows:

TOTAL HEALTH PPO PLAN	In-Network Option	Out-of-Network Option
Annual Out-of-Pocket Limit	$1,500 per person	None

Once a Covered Member has met his/her $1,500 Prescription Drug Out-of-Pocket Limit (or

$5,950 per family) for the year, no additional co-insurance will be required for covered in-network prescription drugs for the remainder of the calendar year.

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

4.5. Lifetime Maximums

The Programs do not have any lifetime maximums, with the exception ofthe infertility benefit and travel and lodging and Bone Marrow and Stem Cell Donor search.

1. **Infertility benefit**: when You reach the $30,000 lifetime maximum benefit, no additional reimbursement for any procedures incurred to treat infertility are payable. Other covered procedures related to family planning or reproduction (excluding infertility) may be payable.Refer to Covered Medical Plan Services / Limitations.
2. **Travel and lodgin**g: a combined overall maximum benefit of $10,000 per covered recipient applies for all travel and lodging expenses reimbursed. This applies to all treatments during theentire period that the recipient is covered under this medical plan.
3. **Bone Marrow and Stem Cell Donor Search**: An overall maximum benefit of $25,000 percovered recipient in-network or out-of-network combined.

5. HEALTH REIMBURSEMENT ACCOUNT AND HEALTH SAVINGS ACCOUNT

Total Health PPO Plan is paired with a health reimbursement account (HRA) and the Health Savings Plan is paired with a health savings account (HSA). Although the HRA and HSA are similar because they are both accounts that reimburse certain health care expenses, there are important differences between the HRA and HSA. The HRA and HSA are described below.

Note: Pre-Medicare Retirees, Surviving Spouses, and LTD Terminees enrolled in the HDHP, if they are eligible to contribute to an HSA, they must establish and contribute to an HSA directly with an HSA provider (i.e., the HDHP for Pre-Medicare Retirees, Surviving Spouses, and LTD Terminees does not include HSA contributions through the Company).

5.1. Health Reimbursement Account (HRA)

5.1.1. Health Reimbursement Account Administrator

To be eligible for HRA funding, You must be enrolled in the Total Health PPO MedicalPlan. Inspira Financial will administer the HRA. You can log onto their website to view all Your HRA information and submit claims https://inspirafinancial.com/. Inspira Financial customer service can be reached at 833-419-0287.

5.1.2. Health Reimbursement Account Amounts

The Health Reimbursement Account is an arrangement that will allow You to determine how some of Your healthcare dollars are spent. NTESS will allocate an amount to theaccount that is based on:

- Your coverage and enrollment status (active, Pre-Medicare/single, family, etc.),
- Whether or not You and Your covered Spouse have completed a Health Assessment, through the Virgin Pulse Program website, and
- Whether or not You and Your covered Spouse have participated in the Virgin Pulse Incentive Program.
- Whether or not You and Your covered Spouse have participated in a Health Action Plan.

5.1.3. Annual Allocation of HRA Contributions

The HRA is entirely funded by NTESS and not taxable to You. You are not permitted to make any contribution to Your HRA, whether on a pre-tax or after-tax basis. Your HRA is an "unfunded" account, and benefit dollars are payable solely from NTESS's general assets.

Both the primary covered member and covered Spouse are responsible for completing the health assessment to receive the HRA contributions associated with that activity. Other covered Dependents are not required to complete a health assessment.

Note: To receive HRA funding for the following calendar year, **Employees and their Spouses must** complete their Health Assessments by **December 1** of the current year and remain covered on the Total Health PPO Plan as of January 1 of the next year. Employees who switch from the Total Health PPO plan to the Health Savings Plan as part of the annual open enrollment will have all earned Virgin Pulse incentives deposited into their HSA for the following year provided their HSA is active as of the date of transfer.

Coverage Category/ Tier	Virgin Pulse Activity Completion	Health Action Plan Completion	Health Assessment isTaken	Health Assessment is NOT Taken	Total Possible HRA allocation[1]
Employee only	Maximum $300	$100	$100	$0	$500
Employee + Spouse	Maximum $600 ($300 max each Employee and Spouse)	Maximum $200 ($100 each Employee and Spouse)	Maximum $200 ($100 each Employee and Spouse)	$0	$1,000
Employee + Child(ren)	Maximum $300	$100	$100(Employee completes)	$250	$750
Employee + Spouse + Child(ren)	Maximum $600 ($300 max each employee and Spouse)	Maximum $200 ($100 each employee and Spouse)	Maximum $200 ($100 each Employee and Spouse)	$250	$1,250

[1] This is the maximum amount that may be placed in Your HRA in January of the following calendar year and may be used for allqualified 213(d) expenses, which include eligible medical, dental, vision, and prescription expenses.

If You don't spend all Your HRA dollars in a calendar year, and You remain enrolled in the Total Health PPO Plan for the following year, any remaining HRA balance remains inthe HRA for the next calendar year. The maximum balance in an HRA is capped at:

- $1,500 for Primary Covered Member only coverage
- $3,000 for Primary Covered Member plus Spouse or plus child(ren)
- $4,500 for family coverage

5.1.4. *Events Resulting in Loss of HRA Funds*

The maximum balance in an HRA at the beginning of any new year is capped at the amounts shown above. If You have an event that forces You to change coverage, Your HRA balance will be adjusted accordingly at the beginning of the next calendar year. Example: You are enrolled as Primary Covered Member and Spouse and get divorced. At the time of the divorce You have $2,500 in Your HRA. You may keep the HRA funds through the end of the calendar year, however the HRA balance will be reduced to $1,500 after the rollover period of the following calendar year, as that is the maximum balance for Primary Covered Member Only coverage.

Note: Expenses incurred in the previous plan year cannot be paid with HRA funds that were earned for the current plan year.

If You terminate employment or lose coverage, You have 90 days to file claims for expenses incurred while You were covered under Total Health PPO Plan. If You do not use Your HRAfunds and do not elect COBRA coverage, You forfeit any remaining HRA funds. Refer to Employee H&W Plan SPD for information on continuing coverage under COBRA.

If You are a Pre-Medicare Retiree, and You become Medicare- eligible, You have 90 days from date of Medicare eligibility to file claims from the date that the claims were incurred when You were enrolled in the Total Health PPO Plan. Any HRA funds remaining after 90 days will be forfeited.

Note: If You are new to this plan at the start of the plan year and were previously enrolled in a different medical carrier, any HRA funds will not rollover until 90 days after the end of the previous calendar year. This ensures that Your current carrier has access to Your prior year HRA funds to pay for claims for medical services received in the previous year but processed during this 90-day window.

5.1.5. *New Hires*

NTESS will automatically make the full applicable Health Assessment portion of the HRA contribution (see Annual Allocation of HRA Contributions) for the calendar year in which You hire. To receive the Health Assessment portion of the HRA contribution for the next calendar year, You and Your covered Spouse must complete the Health Assessment by **December 1** to receive funds in January of the new calendar year.

5.1.6. *Eligible Mid-Year Election Change Events*

NTESS will automatically make the applicable HRA contribution for any Employees and/or their Dependents that enroll in the Total Health PPO Plan during thecalendar year as a result of an eligible mid-year election change event. Examples include:

- If You have waived coverage because You have coverage elsewhere, and You lose that coverage and enroll in the Total Health PPO Plan within 31 calendar days of the loss of coverage, NTESS will contribute the applicable HRA contribution.
- If You get married mid-year, NTESS will contribute the applicable additional HRA contribution ($100 to include Spouse coverage or $250 for children) if You enroll Your new eligible family members within 31 calendar days of marriage.

5.1.7. *Open Enrollment Changes for Dual Sandians*

If You change Primary Covered Members during Open Enrollment, the total HRAwill be assigned to the new Primary Covered Member up to the allowed maximum.

If You have Primary Covered Member + Spouse or Primary Covered Member + Family coverage and change to Primary Covered Member only coverage, the HRA funds will remainwith the original Primary Covered Member. Dual Sandians who split coverage (are enrolled in their own coverage) will result in the HRA funds remaining with the original Primary Covered Member.

5.2. What Healthcare Expenses are Eligible for HRA Reimbursement

Your Health Reimbursement Account may only be used for all qualified 213(d) expenses, which include eligible medical, dental, vision, and prescription expenses. For example, if Youreceive elective cosmetic surgery that is not eligible under Total Health PPO Plan, these claims are not eligible for payment by the HRA.

Note: Expenses incurred in the previous plan year cannot be paid with HRA funds that wereearned for the current plan year.

5.3. How the HRA Works

Your HRA dollars are used to pay for qualified 213(d) expenses up to the amount allocated to Your HRA. The complete HRA funds are available for use by any of Your covered family members and are not apportioned on a per person basis.

The plan year begins on January 1 of each year and ends December 31.

1. Usually, in January newly earned funds are deposited into the HRA. For example, incentives earned in 2024 will be deposited in January 2025.
2. You can start using these funds once they have been deposited for current year claims.
3. Unused HRA funds from the previous can be rolled over up, to the maximum allowed, into the next year.
4. At the beginning of each new plan year, you have a 90-day runout period to submit claims incurred in the previous year, for reimbursement..
5. The debit card issued by the carrier for HRA expenses can only be used for current year expenses. All claims submitted during the runout period for previous years services, must be filed manually online directly with the carrier.
6. Once the previous year's funds have rolled over to the new plan year, after the 90-day runout period is over, you can no longer submit claims for the previous year.

NOTE: If you change carriers' mid-year or at Open Enrollment, you may have the opportunity to transfer your unused HRA funds to the new carrier. Please contact HR Solutions at 505-284-4700 for more information on how this may apply to you.

IMPORTANT: When using a debit card to pay for HCFSA/HRA claims, there are certain claims which are not automatically substantiated and require additional documentation (receipts that indicate the date of service, the vendor, the nature of the service and cost). For unsubstantiated claims identified by the HRA administrator, You will receive three (3) notifications requesting additional documentation. Following the second notice, debit cards will be inactivated until claim receipt documentation is received. For any unsubstantiated FSA or HRA claim expenses not validated by the established deadline, the full amount of the unsubstantiated claim will be garnished from Your paycheck. Please remember to save all HCFSA and HRA claim receipts.

5.3.1. *Medical Plan Expenses*

When You or Your covered family member seeks Covered Health Services under the medicalplan, You must present Your BCBSNM identification card.

If You have HCFSA or HRA funds available, You can pay the patient portion of Your 213(d) medical expenses using Your debit card (if applicable) or by filing a manual claim for reimbursement. You are responsible for filing the claim with Inspira Financial for processing. Eligible 213(d) expenses will be paid first from Your HCFSA (if elected) until depleted and then the HRA will pay.

Note: You can keep track of the dollars in Your HCFSA and HRA by going online to https://inspirafinancial.com/ or by calling Customer Service toll-free at 833-419-0287.

5.3.2. *Prescription Drugs and Other Items Covered Under the Drug Plan*

When You or Your covered family member needs to purchase a prescription or other item covered through the prescription drug program, You must first present Your Express Scripts identification

card. Then, if You have an HCFSA or HRA funds available, You can pay the patient portion of pharmacy benefits by using Your debit card or by filing a manual claim. You are responsible for filing the claim with ExpressScripts and Inspira Financial for processing. Eligible 213(d) expenses will be paid first from Your HCFSA (if elected) until depleted and then the HRA will pay.

5.4. Health Savings Account (HSA)

5.4.1. HSA for Health Savings Plan Participants

When You elect coverage under the Health Savings Plan, You can set aside money (up to the IRS-established limits) through payroll deductions on a pretax basis to help cover qualified out-of-pocket health expenses through an HSA. Unlike the HRA, the HSA also has investment features similar to a retirement account because HSA amounts grow tax-free. (some states may tax HSA earnings). Additionally, an HSA is a portable individual account meaning that if You do not forfeit the HSA amounts if You terminate participation or employment. Accordingly, HSA funds can be used now or in the future to offset health expenses during retirement. NTESS also provides a contribution towards Your HSA based on when You enroll in the Health Savings Plan. The Company contribution is based on Your effective date of coverage. You must timely establish an account with the HSA provider (Optum Bank) before the HSA contributions can be posted. Note: Although the HSA is available to Health Savings Plan participants, the HSA is not sponsored by NTESS and is not an ERISA benefit provided under the Plan. The information in this section is provided only as an overview of the HSA benefit and should not be taken as tax advice.

Note: Pre-Medicare Retirees, Surviving Spouses, and LTD Terminees who are enrolled in the High Deductible Health Plan will not have an HSA administered by Optum Bank and cannot make HSA contributions through NTESS. Pre-Medicare Retirees, Surviving Spouses, and LTD Terminees who meet the IRS rules regarding eligibility to make and receive HSA contributions can independently establish and contribute to an HSA, but it is Your responsibility to do so directly with an HSA provider of Your choice. Retirees, Surviving Spouses, and LTD Terminees moving from the Total Health PPO Plan to the High Deductible Health Plan will need to exhaust all of their HRA funds prior to moving to the High Deductible Health Plan in order to comply with IRS rules or forfeit the balance.

5.4.2. How the HSA Works

An HSA works in conjunction with a "high deductible health plan" (HDHP) as defined by the IRS, that covers eligible health care expenses. NTESS may contribute an annual amount, if any (as shown in Your enrollment materials) to Your HSA. The HSA contribution amounts are not taxable for Federal tax purposes; however, it may be taxable for state purposes, depending on Your state of residence.

Funds must be deposited into Your HSA before eligible expenses can be reimbursed. You can use funds in Your account to pay for current and future qualified health care expenses. These include medical and prescription drug expenses, as well as deductible and coinsurance amounts, for Yourself and Your eligible Dependents.

In addition, You can use these funds for other qualified expenses, such as dental, vision, and alternative medicine expenses, and for certain non-health care expenses. However, if You use the money in Your account for non-health care expenses, the amount is subject to ordinary income tax, plus a tax penalty if You are under age 65. The tax penalty generally does not apply if the

distribution occurs after You reach age 65, become disabled, or die; however, ordinary income tax may still apply.

5.4.3. HSA Contribution Limits

The annual maximum HSA contribution amount (a combination of NTESS contributions and Your contributions) is set each year by the IRS. You may wish to discuss Your individual tax situation with Your tax advisor or obtain IRS Publication 969 - Health Savings Accounts and Other Tax-Favored Health Plans.

The annual HSA contribution limits can change each year. Published amounts can be found in the annual open enrollment materials at hr.sandia.gov.

5.4.4. Catch-Up Contributions

If You are age 55 or older, You are also permitted to make a 'catch-up' contribution to Your HSA. The amount You are eligible to contribute is determined annually by the IRS. This amount can also be found in the annual open enrollment materials on hr.sandia.gov.

5.4.5. Annual Allocation of HSA Contributions

Coverage Category/ Tier	Virgin Pulse Activity Completion	Health Action Plan Completion	Health Assessment is Taken	Health Assessment is NOT Taken	Matching Contribution[1]
Employee only	Maximum $300	$100	$100	$0	Maximum $600
Employee + Spouse	Maximum $600 ($300 max each Employee and Spouse)	Maximum $200 ($100 each Employee and Spouse)	Maximum $200 ($100 each Employee and Spouse)	$0	Maximum $1000
Employee + Child(ren)	Maximum $300	$100	$100 (Employee completes)	$250	Maximum $1000
Employee + Spouse + Child(ren)	Maximum $600 ($300 max each employee and Spouse)	Maximum $200 ($100 each Employee and Spouse)	Maximum $200 ($100 each Employee and Spouse)	$250	Maximum $1000

[1] The Employee can contribute up to the applicable federal maximum limit. NTESS matches 66 2/3% of employee's contribution. The limit for 2024 is $4,150 (Employee only) and $8,300 (Employee + family). The maximum includes both NTESS contributions and employee contributions.

The HSA may be funded by NTESS and Your employee contributions, which are not taxable to You.

Both the primary covered member and covered Spouse are responsible for completing the health assessment to receive the full HSA contribution. Other covered Dependents are notrequired to complete a health assessment.

Note: In order to receive HSA funding for each calendar year, **Active Employees and their Spouses** must complete their Health Assessments by **December 1**. Health Assessments completed in the current year prior to the deadline will earn incentives for the following year.

If You don't spend all Your HSA dollars in a calendar year, any unused balance rolls over from year to year, and earns interest. Your HSA balance is available to You indefinitely, even if You change plans, changes jobs, leave NTESS, or retire.

5.4.6. *New Hires*

NTESS will automatically make the full applicable Health Assessment portion of the HSA contribution (see Annual Allocation of HSA Contributions table) for the calendar year in which You are hired. To receive the Health Assessment portion of the HSA contribution for thenext calendar year, You and Your covered Spouse must complete the Health Assessment by December 1 to receive funds within the new calendar year.

5.4.7. *Eligible Mid-Year Election Change Events*

NTESS will automatically make the applicable HSA contribution for any Employees, and/or their Dependents who enroll in the Health Savings Plan during thecalendar year as a result of an eligible mid-year election change event. Examples include:

- If You have waived coverage because You have coverage elsewhere, and You lose that coverage and enroll in the Health Savings Plan within 31 calendar days of the loss of coverage, NTESS will contribute the applicable Virgin Pulse Incentives based on who you cover on your medical plan.
- If You get married mid-year, NTESS will contribute the applicable additional HSA contribution ($100 to include Spouse coverage or $250 for children) if You enroll Your new eligible family members within 31 calendar days of marriage.

5.5. IRS HSA Eligibility Requirements

The IRS sets the requirements for whether an individual is eligible to make and receive HSA contributions. Although You can continue to use amounts already contributed to Your HSA even if You are not HSA eligible, You cannot continue to make/receive HSA contributions to Your account.

Below is a summary of the HSA eligibility requirements:

- You must be enrolled in HDHP coverage (such as the Health Savings Plan) on the first day of the month for which You make/receive HSA contributions.
- You cannot be enrolled in other medical coverage (including a plan through Your Spouse's employer) that is not considered a 'high-deductible health plan,' (as defined by the IRS) even as a Dependent.
- You cannot be enrolled in Medicare coverage (such as Medicare Part A). Beginning with the first month You are enrolled in Medicare, You cease to be eligible to make/receive HSA contributions. Note: the interactions between Medicare and HSA eligibility are complicated, particularly because Medicare coverage is sometimes retroactive. We recommend consulting with Your tax advisor if You are or will soon be eligible for Medicare coverage.

5.6. How to File an HSA Claim to Reimburse Qualifying Health Expenses

You will receive information about how to file a claim for reimbursement when You open Your account. Optum Bank will send You a debit card to pay for eligible expenses. It is important for You to keep receipts in order to document expenses for any tax year that may come under review.

5.7. When Participation Ends - Health Savings Account

If Your Health Savings Plan coverage terminates, the funds in Your HSA are Yours. Your HSA is portable which means You can continue to use the funds You have accumulated. You can also make tax-free contributions to Your HSA (directly to the HSA administrator, not through payroll deductions) if You participate in another high-deductible health plan. You may continue to use Your HSA to pay for eligible medical, prescription drug, dental, and/or vision expenses, or You may elect to leave the money in Your account to grow on a tax-free basis to use for future health care expenses. However, once You enroll in Medicare or otherwise cease to be HSA eligible, You are not permitted to make contributions to Your HSA.

5.8. Virgin Pulse Incentive Management Program

With Virgin Pulse, employees and their covered Spouses may participate in healthy activities and get rewarded - with better health and with points. Participants simply track their activities with tracking devices and apps of Your choice listed withinthe Virgin Pulse Program. Visit join.virginpulse.com/Sandia for more details.

5.8.1. *Health Action Plan*

Active Employees and their covered Spouses are responsible for enrolling into a health action plan by September 30 of the current year to each receive $100 HRA or HSA contribution in the following year. Health action plans are available only for active employees through Employee Health Services by visiting healthactionplan.sandia.gov until September 30. Child Dependents are not required to complete a health action plan.

For spouses who need to complete the Health Action Plan, then they need to complete that with Virgin Pulse.

Retirees, Surviving Spouses, and Long-Term Disability Terminees, and their Dependents, are not eligible for the Virgin Pulse Program. If You participated in the Virgin Pulse Program, as an Employee, and retired at the beginning of a calendar year, You will **not** receive any HRA funds in the subsequent calendar year. However, if You participated as an Employee and retireon or after February 1 of the subsequent calendar year, any Virgin Pulse that You earned in the previous year will be transferred if there is an applicable balance to Your Employee account (so long as You have no break in coverage) and You will be eligible to keep those funds or the funds will be rolled over to the Retiree PreMedciare HRA.

5.9. Health Assessment and Biometric Screenings

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

When completing a Health Assessment, You will be asked to enter Your cholesterol, glucose, height, weight, waist measurement, and blood pressure. Although this information is not required to submit the Health Assessment, You are strongly encouraged to obtaina biometric screening to input into the Health Assessment so that You have an accurate pictureof Your health risks.

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

5.9.1. *Health Assessment Process*

Active Employees and their Spouses enrolled in NTESS medical plans must complete a Health Assessment by logging into their Virgin Pulse account to receive HRA/HSA incentives. Health Assessments must be completed by **December 1** of the current year to receive funding for January of the following year.

If an employee retires on or after February 1st, retiree will receive their previous years Virgin Pulse earnings.

5.10. Biometric Screenings Process

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

To obtain the biometric screenings through the Sandia Onsite Clinic, You may schedule an appointment by calling HR Solutions at 505-284-4700.

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

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

5.11. Tools and Resources to Become a More Informed Consumer

In addition to the many resources listed in this Benefit Summary (such as the 24/7 Nurseline, MD Live Virtual Visits, and the Ovia Health Program), You can also access important tools and resources from BCBSNM, Inspira Financial, and Express Scripts throughtheir websites.

5.11.1. *Blue Access for Members*

Blue Access for Members (BAM), the Member portal, offers You information on Your health and health plan in one convenient location. To register for BAM, go to bcbsnm.com/sandia and select Register Now in the BAM log-in box; with Your BCBSNM ID card handy, follow the on-screen registration instructions. Create a username and password for instant and secureaccess to Your personal information. After logging in, from Your personal home page You can:

- Check Your claims, including payment status and amounts, and sort/print claim information
- Confirm who is covered under Your plan
- Download and print various forms

- Locate a doctor or hospital in Your plans' network using Integrated Provider Finder
- Research and estimate costs for common healthcare services with the Member Liability Estimator tool
- Request a new or replacement ID

5.11.2. *Express Scripts Website*

The Express Scripts Member website, www.express-scripts.com, provides information at Your fingertips anywhere and anytime You have access to the Internet. Express-Scripts.com offers practical and personalized tools and information so You can get the most out of Your benefits. Log on to:

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

You can also access the above information on the Express Scripts phone app from any smartphone. Simply enter Express-scripts.com into Your smartphone browser or download theapp by going to the Apple App Store, Google Play, Android Market or Blackberry World.

6. COVERED MEDICAL PLAN SERVICES / LIMITATIONS

The Programs provide coverage for a wide range of healthcare servicesfor You and any covered family members. This section outlines the medical plan benefits available under the Programs. For information on Your prescription drugbenefits administered by Express Scripts, refer to Prescription Drug Program.

6.1. Program Highlights

The Programs do not have any pre-existing condition limitations. This means, for example, that if You have a condition such as pregnancy or cancer before You begincoverage, You are not required to wait a specific amount of time before You are eligible for medical plan benefit coverage. If a health service is not listed in this section as a Covered Health Service or listed What's Not Covered – Exclusions as a specific exclusion, it may or may not be a Covered Health Service. Members and Dependents may contact the NTESS BCBSNM Dedicated Advocate. Information can be found on hr.sandia.gov by searching for "Get to Know Your Providers." Members may also reach out to BCBSNM Customer Service at 877-498-7652 for information.

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

- Provided for the purpose of preventing, diagnosing, or treating Illness, Injury, mentalillness, Chemical Dependency, or their symptoms
- Medically Necessary
- Included in this section (subject to limitations and conditions and exclusions as stated inthis Benefit Summary)
- Provided to You and Your covered family members, if the eligibility requirements are metas described in the Employee H&W Plan Summary Plan Description or the Post-Employment H&W Plan SPD

6.2. Coverage Details

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

Refer to Accessing Care.

6.2.1. Acupuncture Services

Acupuncture services are covered as follows:

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

6.2.2. Allergy Services

Services related to allergies are covered as follows:

- Office visits

- Allergy testing
- Allergy serum
- Allergy shots

6.2.3. Ambulance Services

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

6.2.3.1. Ground Ambulance Services

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

6.2.3.2. Air Ambulance Services

IMPORTANT: Prior Authorization is required before receiving services. Refer to the Prior Authorization Requirements for Medical Services section for more information. If Prior Authorization is not received, benefits may be denied or reduced.

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

Refer to No Surprises Act Requirements for information regarding Surprise Billing Claims relating to Air Ambulance Services.

6.2.4. Auditory Integration Training

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

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

6.2.5. Autism Spectrum Disorders

This Plan covers the Habilitative treatment and rehabilitative treatment of Autism Spectrum Disorder through Speech Therapy, Occupational Therapy, Physical Therapy, and Applied Behavioral Analysis (ABA) therapies with no age restrictions or age limits for the Member. Providers must be credentialed to provide such therapy.

6.2.6. Behavioral Health Services

Behavioral health services are subject to reimbursement with demonstrated improvement as determined by BCBSNM.

IMPORTANT: Prior Authorization is required before receiving inpatient, Partial Hospitalization, Residential Treatment Center, Intensive Outpatient Programs, or psychological testing services. Refer to the Prior Authorization for Behavioral Health for more information. If Prior Authorization is not received, benefits may bedenied or reduced.

The Programs cover Outpatient mental health and Chemical Dependencyservices as follows:

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

The Programs cover inpatient, Partial Hospitalization, and Residential Treatment Facilities for mental health and Chemical Dependency services as follows:

- Services received on an inpatient or Partial Hospitalization basis in a hospital or analternate facility that is licensed to provide mental health or Chemical Dependencytreatment
- Room and board in a semi-private room (a room with two or more beds)
- Two Partial Hospitalization days are counted as one 24-hour hospitalization day
- Services received in a Residential Treatment Facility as long as there are at least sixhours of therapy provided every calendar day

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

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

If there are multiple diagnoses, the Programs will only pay for treatment ofthe diagnoses that are identified in the current edition of the Diagnostic and Statistical Manualof the American Psychiatric Association.

The Programs cover intensive behavioral therapies such as ABA for Autism Spectrum Disorders (ASD).

6.2.7. *Cancer Services*

Oncology services are covered as follows:

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

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

Cancer clinical trials and related treatment and services may be eligible for coverage. IMPORTANT: Prior authorization is required for injectable outpatient chemotherapy and clinical trials. While You are not required to receive treatment at a Blue Distinction Center, if You do select such a facility and it is more than 50 miles from Your home, You may be eligible for the travel and lodging benefit described in Accessing Care. Facilities selected as Blue DistinctionCenters feature:

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

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

6.2.8. *Cardiac Care and Pulmonary Rehabilitation*

The Programs cover Outpatient cardiac rehabilitation programs initiatedwithin six months of a cardiac incident and Outpatient pulmonary rehabilitation services.

6.2.9. *Chiropractic Services*

Chiropractic services are covered as follows:

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

6.2.10. Congenital Heart Disease

Congenital heart disease services that are covered include:

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

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

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

6.2.11. *Dental Services*

IMPORTANT: Prior Authorization is required before receiving dental services. Refer to the Prior Authorization Requirements for Medical Services for more information. If PriorAuthorization is not received, benefits may be denied or reduced.

The Programs cover dental services due to Illness or Injury to sound, natural teeth, or Injury to the jaw as follows:

- As a result of tooth or bone loss, due to a medical condition (e.g., osteoporosis,radiation to the mouth, etc.)
- Oral surgery, if performed in a hospital because of a complicating medical conditionthat has been documented by the attending physician

- Anesthesia, hospital and/or ambulatory surgical center expenses for dental procedures when services must be provided in that setting due to disability or for Young children as determined by the attending physician
- Dental implants, implant-related surgery, and associated crowns or prosthetics arecovered in situations where:
    - Permanent teeth are congenitally missing (anodontia), the result of anodontia is impaired function (e.g., chewing/eating), and the implants are not done solely for cosmetic reasons
- Orthognathic surgery limited to documented skeletal Class II and Class III conditionsas determined by cephalometric diagnosis, provided the condition is:
    - Both functional and aesthetic, and
    - Not adequately treatable by conventional orthodontic therapy
- Dental services related to medical transplant procedures
- Initiation of immunosuppressive therapy
- Direct treatment of cancer
- Direct treatment of cleft palate
    - Orthodontic appliances and treatment based on medical necessity, and
    - Children under 19 years of age with congenital anomaly
- As a result of accidental Injury to sound, natural teeth and jaw
- Tooth loss occurs as a result of accidental Injury to a sound, natural tooth

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

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

6.2.12. *Diabetes Services/Device/Supplies*

The Programs cover diabetes services as follows:

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

The Programs cover diabetes devices and supplies as follows:

- External Insulin pump that delivers insulin by continuous subcutaneous infusion fortreating patients with diabetes. Disposal external insulin pumps are considered equivalent to standard insulin pumps. Insulin pump criteria:
    1. Type 1 diabetes or Type 2 diabetes requiring basal and bolus insulin AND

2. Inability to achieve adequate glycemic control with intensive insulin therapyusing multiple daily injections (MDI) as evidenced by:
    a. A1c>7% and/or
    b. Frequent hypoglycemia and/or
    c. Marked dawn phenomenon and/or
    d. Marked glycemic variability (this may be related to lifestyle issues suchas participation in athletics or frequent travel AND
3. Demonstrated ability and motivation to monitor glucose frequently (at least four times daily), count carbohydrates, and adjust the insulin regime as neededto achieve glycemic control.

- Supplies for external insulin pump and continuous glucose monitoring system
- Blood glucose meters, if You are diagnosed with diabetes Type I or Type II
- Long-term continuous glucose monitoring system (greater than 72 hours) criteria:
    1. Type 1 diabetes or Type 2 diabetes requiring basal and bolus insulin AND
    2. Willingness to wear the rt-CGM device at least 60% of the time AND
    3. Have demonstrated the ability to perform self-monitoring blood glucose frequently and to adjust the diabetes regimen based on the data obtained withmonitoring.

IMPORTANT: Prior Authorization is required (with the exception of blood glucose meters) before receiving. Refer to Prior Authorization Requirements for Medical Services for more information. If Prior Authorization is not received, benefits may be denied. For itemswith a purchase or cumulative rental value of $1,000 or more, BCBSNM will decide if the equipment should be purchased or rented, and You must purchase or rent the device from the vendor BCBSNM identifies for in-network benefit level.

6.2.13. *Dialysis*

The Programs cover the following services when received from adialysis provider or when Prior Authorization has been approved by BCBSNM, when received inYour home:

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

6.2.14. Diagnostic Tests

Diagnostic tests are covered as follows:

- Laboratory and pathology tests
- X-ray and radiology services, ultrasound and imaging studies
- Computerized Tomography (CT) scans (Prior Authorization Required for cardiac CTscans)
- EKG, EEG, and other electronic diagnostic medical procedures
- Genetic testing (Prior Authorization Required)
- Echocardiograms
- Electroencephalograms

- Magnetic Resonance Imaging (MRI)
- Nuclear medicine
- Psychological testing (Prior Authorization Required)
- Position Emission Tomography (PET) scans (Prior Authorization Required)
- Sleep disorder studies performed in a facility (Prior Authorization Required)
- Other diagnostic tests

6.2.15. Durable Medical Equipment (DME)

IMPORTANT: Prior Authorization is required before receiving services with a purchase or cumulative rental value of $1,000 or more. Refer to Prior Authorization Requirements for Medical Services for more information. If Prior Authorization is not received, benefitsmay be denied.

Durable medical equipment is covered as follows:

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

The Women's Preventive Services Initiative recommends comprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and the postpartum period to ensure the successful initiation and maintenance of breastfeeding. Personal double electric breast pumps/supplies at no cost share from a network doctor or an approved DME provider. Hospital grade breast pumps/supplies (rental only) covered at deductible/coinsurance. **IMPORTANT:** For items with a purchase or cumulative rental value of $1,000 or more, BCBSNM will decide if the equipment should be purchased or rented, and You must purchaseor rent the DME from the vendor BCBSNM identifies to receive in-network benefit level.

Examples of DME include, but are not limited to:

- Wheelchairs
- Hospital beds
- Equipment for the treatment of chronic or acute respiratory failure or conditions
- Equipment to administer oxygen
- Orthotic appliances when custom manufactured or custom fitted to You
- Oxygen
- Orthopedic shoes:
- Up to two pairs of custom-made orthopedic shoes per year when necessary dueto illness such as diabetes, post-polio, or other such conditions
- Post-mastectomy bras
- C-PAP machine

- Bilirubin lights
- Braces that stabilize an injured body part and braces to treat curvature of the spine
- Delivery pumps for tube feedings, including tubing and connectors
- Lenses for aphakic patients (those with no lens in the eye) and soft lenses or sclerashells (white supporting tissue of eyeball)

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

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

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

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

6.3. Emergency Care

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

Medical Emergency care worldwide is covered as follows:

- Emergency services obtained from a Blue Preferred Plus Network provider will be considered at the Blue Preferred Plus Network level of benefits.
- Emergency services obtained from a BCBS PPO Network provider will be considered at the BCBS PPO Network level of benefits.
- Emergency services obtained from an out-of-network provider (including those outsidethe United States) will be considered at the BCBS PPO Network level of benefits.
- If You are hospitalized in an out-of-network hospital, You will be transferred to a Blue Preferred Plus Network or BCBS PPO Network hospital when medically feasible, with any ground ambulance charges reimbursed at the BCBS PPO Network level of benefits. If You decline to be transferred, coverage will be provided under the out-of-network benefit level.

Follow-up care worldwide is covered as follows:

- Follow-up care that results from a Medical Emergency while on travel outside the United States will be covered at the out-of-network level of benefit for services from anout-of-network provider and at the BCBS PPO Network level of benefit for services from an in-network provider.

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

Note: If You are on NTESS-authorized business travel, You may be eligible to have follow-upcare covered at the BCBS PPO Network level of benefits. Contact BCBSNM dedicated advocate for details.

6.4. What is Not an Emergency

The Emergency room should never be used because it seems easier for You or Your family. You may have to wait to be seen for a very long time and the charges for Emergency room services are very expensive – even if You have only a small problem. Members who use an Emergency room when it is not necessary will be responsible for paying all Emergency room charges. If You disagree with the Claim Administrator's determination in processing Your benefits as non-Emergency Care instead of Emergency Care, You may call the Claim Administrator at the number on the back of Your Identification Card. Please review How to File an Appeal of this Policy for specific information on Your right to seek and obtain a full and fair review of Your Claim.

You should not go to the Emergency room for conditions such as (but not limited to) sore throat, earache, runny nose or cold, rash, and stomachache. If You have one of these problemsor any other condition that is not an emergency, call Your doctor first. If You can't reach Your doctor or the doctor's office is closed, call the BCBSNM 24/7 Nurseline at 800-973-6329, 24hours a day/7 day a week. A nurse will help You decide what to do to get better on Your ownor where You should go to get the kind of care that You need. The nurse may tell You to go to Your doctor or an Urgent Care Center. You can now visit a PRESNow 24/7 urgent and emergency care center for these types of services. Visit https://www.presnow247.org for more information.

6.4.1. *Employee Assistance Program (EAP)*

The Employee Assistance Program is administered by Magellan Health Services. To access EAP services, You must contact Magellan by calling 800-424-0320.The Programs cover up to eight visits per calendar year, or for CaliforniaEmployees, up to three visits every six months, at no cost to the Employee for assessment, referral, and follow-up counseling for Employees and their covered family members experiencing some impairment from personal concerns that adversely affects their day-to-dayactivities.

Note: Retirees, Surviving Spouses, and LTD Terminees and their covered Dependents are not eligible for Employee Assistance benefits.

6.4.2. *Eye/Vision Services*

6.4.2.1. Eye Exam/Eyeglasses/Contact Lenses

The Programs cover eye exams for non-refractive care due to Illness orInjury of the eye such as conjunctivitis, diabetic retinopathy, glaucoma, and cataracts. An initial pair of contact lenses or glasses when required due to the loss of a natural lens or cataract surgery is allowed based on medical necessity.

6.4.2.2. Vision Therapy

The Programs cover eye exercise therapy, optometric visual (or vision) therapy, vision training, orthoptic training and preoptic training when:

The services are performed by a Physician or a licensed therapy provider

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

6.4.3. *Family Planning*

Family planning services are covered as follows:

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

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

6.4.4. Gender Affirmation

Treatment for Gender Affirmation services must be deemed medically necessary in order to be covered. Refer to Covered Medical Plan Services / Limitations for information on what is excluded under Gender Affirmation services.

The Programs cover the treatment of Gender Affirmation services as follows:

- Gender Affirmation Surgery:
    - Below waist surgery
        - Intersex surgery (male to female), clitoroplasty, labiaplasty, penile skin inversion, vaginaconstruction, bilateral orchiectomy, penile amputation, urethromeatoplasy, plastic repair of intoitus, vaginoplasty, hair removal for required for reconstructive surgery, removal of penis, removal of testicles
        - Intersex surgery (female to male), hysterectomy, salpingo oopherectomy, colpectomy,vaginectomy, vaginoplasty, vulvectomy, vulvoplasty, phalloplasty, urethroplasty and extension, scrotoplasty,plastic glans formation, insertion of penile and testicular prosthesis, metoidioplasty
    - Above waist surgery
        - Tracheal shave and facial hair removal, medically necessary breast augmentation if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment is not sufficient for comfort in the social role

        - Bilateral mastectomy with chest reconstruction andnipple/areolar reconstruction, bilateral breast reduction
        - Breast augmentation, breast enlargement, breast augmentation mammoplasty, breast augmentation with implant or without implant and with immediate or delayed insertion of prosthesis, Breast implants, Mastopexy, breast lift (*only if part of original augmentation), Nipple/areola reconstruction (includes excised skin), Revision of a reconstructed breast without medical complications, Tissue expander placements
- Facial surgical procedures
    - Blepharoplasty, brow (reduction, augmentation, lift), Cheek (implant, lipofilling), Chin reshaping (osteoplastic or alloplastic), Face/forehead lift following alteration of underlying skeletal structures, Facial bone reduction, Hair line advancement and/or transplantation, Jaw reconstruction (reduction of mandibular angle or augmentation), Lip augmentation or upper lip shortening, Neck tightening following alteration of underlying skeletal structures, Rhinoplasty, Subcutaneous injection of filler
- Other Procedures:
    - Abdominoplasty, Lipofilling, Liposuction, Excision of excessive skin and subcutaneous tissue, Monsplasty or Mons reduction, Fertility preservation, Hair removal other than with genital reconstruction such as face, arms, etc., Reversal procedures, Tracheal shave, Voice modification surgery (chondrolaryngoplasty), Voice/speech therapy/training, Skin resurfacing (dermabrasion, chemical peel), Revisions to prior gender affirmation procedures without medical complications
- Hormone therapy including continuous hormone replacement therapy
- Physician office visits
- Laboratory testing
- Psychotherapy/behavioral health services/mental health services
- Pharmaceutical coverage
- Puberty suppression
- Voice/speech therapy/training

The Covered Person must provide documentation of the following for Gender Affirmation Surgery:

- A written psychological assessment from at least one qualified behavioral healthproviders experienced in treating Gender Affirmation care, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
- Persistent, well-documented Gender Dysphoria.
- Capacity to make a fully informed decision and to consent to treatment.
- If significant medical or behavioral health concerns are present, they mustbe reasonably well controlled.
- Complete at least 6 months of successful continuous full-time real-lifeexperience in the desired gender.
- Complete 6 months of continuous cross-sex hormone therapy appropriatefor the desired gender (unless medically contraindicated).

- Prior Authorization is required for Out-of-Network services.

6.4.5. Genetic Testing

Note: Prior Authorization is required before receiving genetic testing services. Refer to Prior Authorization Requirements for Medical Services for more information. If PriorAuthorization is not received, benefits may be denied.

The Programs cover Medically Necessary genetic testing. Examples of covered genetic tests include testing related to breast and ovarian cancer. Genetic testing forbreast cancer is covered under Preventive Care. Refer to What's Not Covered – Exclusions for information on what is excluded under genetic testing/counseling.

6.4.6. Hearing Aids/Exam

Note: Prior Authorization is required before receiving hearing aid and hearing exam services.Refer to Prior Authorization Requirements for Medical Services for more information. If Prior Authorization is not received, benefits may be denied.

The Programs cover the initial hearing exam and purchase of hearing aid(s) if the hearing loss resulted from an Injury or an Illness. Refer to the Preventive Care for information on hearing screenings.

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

6.4.7. Home Healthcare Services

Note: Prior Authorization is required before receiving services. Refer to Prior Authorization Requirements for Medical Services for more information. If Prior Authorization is notreceived, benefits may be denied.

Covered Health Services are services that a home health agency provides if You arehomebound due to the nature of Your condition. Services must be:

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

6.4.8. Hospice Services

Note: Prior Authorization is required before receiving services. Refer to Prior Authorization Requirements for Medical Services for more information. If Prior Authorization is notreceived, benefits may be denied.

Hospice care is covered as follows:

- Provided on an inpatient basis
- Provided in Your home

- Physical, psychological, social, and spiritual care for the terminally ill person
- Short-term grief counseling for immediate family members

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

6.4.9. Infertility Services

In general, the Programs pay benefits for infertility services and associated expenses for the diagnosis and treatment of an underlying medical condition thatcauses infertility, when under the direction of a physician.

Note: Pre-Medicare Retirees are not eligible for Infertility Services. A Prior Authorization is required before receiving services. Refer to Prior Authorization Requirements for Medical Services for more information. If Prior Authorization is notreceived, benefits may be denied.

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

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

- Medically Necessary laparoscopies and ultrasounds
- Artificial insemination
- In Vitro Fertilization (IVF)
- Gamete intrafallopian transfers (GIFT)
- Zygote intrafallopian transfer (ZIFT)
- Embryo transplantation
- Laparoscopies for egg retrieval
- Iatrogenic fertility preservation purchase of eggs and sperm See the in-network andout-of-network options section for cost sharing information.
- Purchase of sperm, if billed separately
- Limited donor expenses for egg donor (only the same charges that would be eligible to extract the egg from a covered Employee are allowed for the donor; prescription medications taken by a donor are not allowable charges)
- Storing and preserving sperm, ovum and embryos for up to two years

6.5. Prescription Drugs for Infertility Treatments

Prescription drugs related to infertility are covered under the Prescription Drug Program. Prescription drugs obtained through the Prescription Drug Program and used for infertility treatment may require a diagnosis of infertility. The cost of these drugs is not applied to the

$30,000 infertility maximum if received through the Prescription Drug Program.

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

6.5.1. *Injections in Physician's Office*

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

- Blue Preferred Plus Network/ BCBS PPO Network:
  1. Allergy shots – You pay 10 / 20% of Covered Charges, after the Deductible
  2. Immunizations/vaccines – no cost to You as outlined under Preventive Care
  3. All other injections (e.g., cortisone, etc.) – 10 / 20% of CoveredCharges, after the Deductible
- For out-of-network services, You pay 40% of Covered Charges, after the Deductible.

6.5.2. Inpatient Care

Note: Pre-authorization is required before receiving services. Refer to Prior Authorization Requirements for Medical Services for more information. If Prior Authorization is notreceived, benefits may be denied.

Inpatient services in a hospital are covered as follows:

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

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

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

If You are admitted to a hospital on an Emergency basis that is not in the network and servicesare covered, BCBS PPO Network benefits will be paid until You are stabilized (Blue Preferred Plus Network level of benefits will be paid only if services are received from a Blue Preferred PlusNetwork provider). Once stabilized, You must be moved to a network hospital to continue in- network benefits. You may elect to remain in the out-of-network hospital and receive out-of- network benefits, as long as BCBSNM confirms the treatment to be Medically Necessary.

6.5.3. *Maternity Services*

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

longer than those mentioned above require Prior Authorization. If PriorAuthorization is not received, benefits may be reduced.

Maternity services are covered as follows:

- Initial visit to the physician to determine pregnancy status
- Pre-natal and post-natal visits
- Charges related to delivery
- Charges for newborn delivery services, paid as follows:
    1. Charges billed for well-baby care are paid under the newborn but at the mother's level of benefit, subject to her Deductible and Out-of-Pocket Limit(e.g., if mom has met her Out-of-Pocket Limit, well-baby charges will be reimbursed as if the newborn's Out-of-Pocket Limit was met as well)
    2. Charges billed for the newborn under any other non-well baby ICD-10 code arepaid under the newborn and subject to the newborn's Deductible and Out-of- Pocket Limit

Note: The Programs will pay for Covered Health Services for the newbornfor the first 31 calendar days of life. This is regardless of the newborn's condition or whether You enroll the eligible child within the applicable time frame as referenced in the Employee H&W Plan Summary Plan Description or the Post-Employment H&W Plan SPD for continued coverage. If You submit enrollment paperwork prior to the 61st calendar day from the date of birth, the coverage effective date will be retroactive to newborns date of birth. This coverage does not apply to third-generation Dependents.

The Programs will pay for maternity services for You, Your coveredSpouse, and Your covered children.

Licensed birthing centers are covered to include charges from the birthing center, physician, midwife, surgeon, assistant surgeon (if Medically Necessary), and anesthesiologist. Benefits for birthing services rendered in the home will be paid according to the network status of the physician with whom the licensed nurse midwife is affiliated. If the licensed nurse midwife isnot affiliated with a physician and is not a part of the network, reimbursement will be paid onan out-of-network level. If You are admitted to a hospital, You must notify BCBSNM if Your hospital stay will be longer than 48 hours following a normal vaginal delivery or longer than 96 hours following a cesarean section. Refer to the beginning of this section for additional information regarding when Prior Authorization is required.

Refer to Preventive Care for information on preventive services related to maternity.

Extended Stay Newborn Care

You must ensure that BCBSNM is called regarding the newborn's extended stay before themother is discharged from the hospital. If You do not, benefits for the newborn's covered facility services will be reduced. The baby's services will be subject to a separate Deductible and Coinsurance and a separate Out-of-Pocket Limit.

6.5.4. *Medical Supplies*

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

- Ostomy supplies

- Up to 6 pair or 12 individual, Medically Necessary, surgical or compression stockings,per calendar year
- Aero chambers, aero chambers with masks or nebulizers (You can obtain these eitherunder the medical benefits or the Prescription Drug Program but not both)
- Breast pumps, accessories, and supplies (Refer to Women's Additional Preventive Services.)

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

Contact the BCBS Onsite Healthcare Ambassador or Members Services to verify if any services you are seeking are covered prior to receiving them.

6.5.5. Nutritional Counseling

Nutritional counseling services provided by a dietitian (a licensed health professional) to develop a dietary treatment plan to treat and/or manage conditions including, but not limited to, diabetes, heart failure, kidney failure, high cholesterol, anorexia, and bulimia are covered health services when both of the following are true:

•Nutritional education is required for a disease in which member self-management is a part of treatment.

•There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefit Limitations and Exclusions:

•Non-disease specific, nutritional education such as general good eating habits, calorie control, or dietary preferences (e.g., vegetarian, macro-biotic) is excluded from coverage.

Diet counseling for adults at higher risk for chronic diseases is covered under the preventivebenefits. Refer to Preventive Care in this section.

6.5.6. *Obesity Surgery*

Note: Prior Authorization is required before receiving these services. Refer to Prior Authorization Requirements for Medical Services for more information. If PriorAuthorization is not received, benefits may be denied or reduced.

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

- Body Mass Index (BMI) of 35 to 39.9 with one or more obesity related co-morbidmedical conditions, OR
- BMI equal or greater than 40.

Note: While You can select any in-network or out-of-network provider/facility for Your surgery, the Blue Distinction Centers for Bariatric Surgery® program can help You find the program that meets Your needs. For more information call BCBSNM Health Services at 800- 325-8334 or visit their website at http://www.bcbsnm.com/sandia/providers/blue_distinction.html.

6.5.7. *Office Visits*

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

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

6.5.8. Organ Transplants

IMPORTANT: Prior Authorization must be requested in writing from BCBSNM. Authorization must be obtained from BCBSNM before a pre-transplant evaluation is scheduled. A pre-transplant evaluation is not covered if Prior Authorization is not obtained from BCBSNM. If authorized, a BCBSNM case manager will be assigned to You (the transplant recipient candidate), and You must contact the case manager with the results of the evaluation. If You are approved as a transplant recipient candidate, You must ensure that PriorAuthorization for the actual transplant is received. If Prior Authorization is not received, benefits may be denied or reduced.

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

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

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

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

6.5.9. *Outpatient Surgical Services*

Outpatient Surgery and related services are covered as follows:

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

Benefits for professional fees are described under Professional Fees for Surgical Procedures in this section. Also, see the list of procedures in the Prior Authorization Requirements for Medical Services section that require Prior Authorization.

6.5.10. *Prescription Drugs (other than those dispensed by Express Scripts)*

Primary source and/or Inborn Error of Metabolism:

Administered orally, as a primary source/Inborn Errors of Metabolism are a group of disorders that causes a block in a metabolic pathway leading to clinically significant consequences. Examples include: phenylketonuria (PKU), phenylketonuria, maple syrup urine disease, homocystinuria, methylmalonic acidemia, propionic acidemia, isovaleric acidemia, and other disorders of leucine metabolism; glutaric aciduria type I and tyrosinemia types I and II; and urea cycle disorders Note: Medication obtained through a mail order service is not eligible for reimbursement under BCBSNM. It may be eligible for reimbursement under Express Scripts on an out-of- network basis.

You can receive coverage for intravenous medications, enteral nutrition or nutritional supplements through either BCBSNM or Express Scripts, but not both. Refer Prescription Drug Program for information on coverage of prescription drugs not mentionedabove.

6.5.11. Preventive Care

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

See Prescription Drug Program for information about covered preventivemedications.

Preventive care benefits are covered as described below.

IMPORTANT: In order to ensure that You receive the preventive care benefit, the service must be submitted with a preventive ICD-10 diagnostic code. If it is submitted with a non- preventive ICD-10 diagnostic code, the service may be reimbursed at the non-routine, diagnostic benefit level. It is solely up to the provider as to whether the service is coded as preventive or diagnostic. Neither NTESS nor BCBSNM can direct the provider to bill a servicein any particular way. The issue as to how it is billed is between You and Your provider.

6.5.12. Well-Baby Care (ages 0-2 years)

The Programs provide preventive care coverage at 100% of the CoveredCharges for covered Blue Preferred Plus Network/ BCBS PPO Network services and at 60% of the Covered Charges, after the Deductible, for covered out-of-network services.

Covered Health Services include:

Routine physical exams (including height and weight) at birth and at one, two, four,six, nine, 12, 15, 18, and 24 months

Autism screening at 18 and 24 months

Behavioral assessment as needed

Congenital Hypothyroidism screening for newborns

Development screening – surveillance throughout childhood as needed

Gonorrhea preventive medication for the eyes of all newborns

Hearing screenings as needed

Hematocrit or hemoglobin screening as needed

Hemoglobinopathies or sickle cell screening for newborns

Lead screening as needed

Phenylketonuria (PKU) screening in newborns

Thyroid screening as needed

Tuberculin testing for children at higher risk of tuberculosis

Vision screening as needed (screening does not include an eye exam, refraction, orother test to determine the amount and kind of correction needed.)

Refer to Immunizations/Vaccines/Flu Shot Services for information on these covered services.

6.6. Well-Child Care (ages 3-10 years)

The Programs provide preventive care coverage at 100% of the CoveredCharges for covered Blue Preferred Plus Network/BCBS PPO Network services and at 60% of the Covered Charges, after the Deductible, for covered out-of-network services.

Covered Health Services include:

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

- Lead screening as needed
- Obesity screening and counseling as needed
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening as needed (A screening does not include an eye exam, refraction, orother test to determine the amount and kind of correction needed.)

Refer to Immunizations/Vaccines/Flu Shot Services for information on these covered services.

6.7. Well-Adolescent Care (ages 11-18 years)

The Programs provide preventive care coverage at 100% of the CoveredCharges for covered Blue Preferred Plus Network/BCBS PPO Network services and at 60% of the Covered Charges, after the Deductible, for covered out-of-network services.

Covered Health Services include:

- One routine physical/annual exam (including height, weight, and body mass index measurements) is allowed each calendar year regardless of the date of the previous routine physical/annual exam, but no more frequently than one per calendar year. Allowable exams include routine preventive physicals, including annual exams.
- Alcohol and drug use assessment as needed
- Behavioral assessment as needed
- Chlamydia infection screening as needed
- Cervical dysplasia screening as needed for sexually active females
- Development screening – surveillance throughout childhood as needed
- Dyslipidemia screening for children at higher risk of lipid disorders
- Hematocrit or hemoglobin screening as needed
- HIV screening as needed for adolescents at higher risk
- Lead screening as needed
- Obesity screening and counseling as needed
- Rubella screening (once per lifetime)
- Sexually transmitted infection prevention counseling for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening as needed (A screening does not include an eye exam, refraction, orother test to determine the amount and kind of correction needed.)
- Hearing screenings as needed

Refer to Immunizations/Vaccines/Flu Shot Services for information on these covered services.

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

The Programs provide preventive care coverage at 100% of the CoveredCharges for covered Blue Preferred Plus Network/BCBS PPO Network services and at 60% of the Covered Charges, after the Deductible, for covered out-of-network services.

Covered Health Services include:

- One routine physical/annual exam (including height, weight, and body mass index measurements) is allowed each calendar year regardless of the date of the previous routine physical/annual exam, but no more frequently than one per calendar year. Allowable exams include routine preventive physicals, including annual exams.
- Abdominal aortic aneurysm one-time screening for men between the ages of 65 and 75
- Alcohol misuse screening and counseling as needed
- Blood pressure screening as needed
- Breast Cancer (BRCA) genetic counseling and testing for women at higher risk
- Breast cancer chemoprevention counseling for women at higher risk
- Cervical cancer screening for sexually active women
- Chlamydia infection screening as needed
- Depression screening as needed
- Diet counseling for adults at higher risk for chronic disease
- Gonorrhea screening for women at higher risk
- HIV screening and counseling as needed for adults at higher risk
- FDA-approved preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons at high risk of HIV acquisition, (when prescribed by a Plan provider), including the following baseline and monitoring services for the use of PrEP.
- Obesity screening and counseling as needed
- Osteoporosis screening (once per 3 years at age 50 and older)
- Rubella screening (once per lifetime)
- Sexually transmitted infection prevention counseling for adults at higher risk
- Syphilis screening as needed for adults at higher risk
- Tobacco use screening as needed and cessation interventions for tobacco users
- Well woman/man exam annually
- Hearing screenings as needed – up to and through age 21

Refer to Immunizations/Vaccines/Flu Shot Services, Laboratory Services, Cancer Screening Services, and Bone Density Testing later in this section for information on these covered services.

6.9. Immunizations/Vaccines/Flu Shot Services

The Programs will pay 100% of the Eligible Expenses in-network and 60%of the Eligible Expenses, after the Deductible, if done out-of-network for non-travel related immunizations, vaccines, and flu shots. Flu shots and some immunizations/vaccines are available at no cost to You at an in-network retail pharmacy. Immunizations for personal travelwill pay 100% of the Eligible Expenses in-network and 60% of the Eligible Expenses, after the deductible.

IMPORTANT: Immunizations for NTESS-business-related travel must be given at the Sandia Onsite Clinic; however, if Sandia Onsite Clinic directs the Employee to obtain immunizations offsite for NTESS-business-related travel, You will be reimbursed at 100% of the charge, regardless of whether You obtain the immunizations in- or out-of-network. Contactthe BCBSNM Dedicated Advocate if this exception is required to ensure proper reimbursement.

6.10. Laboratory Services

The Programs provide preventive care coverage at 100% of the CoveredCharges for covered Blue Preferred Plus Network/BCBS PPO Network services and at 60% of the Covered Charges, after the Deductible, for covered out-of-network services for services rated A and B the United States Preventive Services Task Force (USPSTF). In addition, NTESS will cover the following laboratory services for those age 19 and older:

Covered Health Services include:

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

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

6.11. Cancer Screening Services

The Programs provide preventive care coverage at 100% of the CoveredCharges for covered Blue Preferred Plus Network/BCBS PPO Network services and at 60% of the Covered Charges, after the Deductible, for covered out-of-network services.

Covered Health Services include:

Service	Allowed Frequency	Allowable Age
Pap Test	As needed	Age 11 and older
Prostrate Antigen Test	Annual	Upon turning 50
Mammogram*	Baseline/ Annual	N/A if preventive care service
Fecal Occult Blood Test	Annual	Upon turning 50
Sigmoidoscopy**	Once every five years	Upon turning 50
Colonoscopy**	Once every ten years	Upon turning 44
Barium Enema**	Once every five years	Upon turning 50

*The mammogram preventive benefit also includes the computer-aided detection test. The preventive benefit also includes the charge by the provider for interpreting the test results.

**You are entitled to the following:

A sigmoidoscopy once every five years, OR

A colonoscopy once every 10 years, OR

A sigmoidoscopy or colonoscopy under age 44 or more frequently if You have an immediate family history (mother, father, sister, brother only) of colorectal cancer or You have a personal history of colonic polyps. Polyp removal during a preventive colonoscopy will be covered under the preventive colonoscopy benefit.

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

6.12. Pregnancy-Related Preventive Care Services

The Programs provide preventive care coverage for the following pregnancy-related services, on an as needed basis, at 100% of the Covered Charges for covered Blue Preferred Plus Network/BCBS PPO Network services and at 60% of the Covered Charges,after the Deductible, for covered out-of-network services.

- Multiple marker screening between weeks 15 and 18 for pregnant women aged 35 andolder
- Serum alpha-fetoprotein between weeks 16 and 18 based on personal risk factors
- Chorionic villus sampling before week 13 or amniocentesis between weeks 15 and 18in women who are 35 and older and at risk for passing on certain chromosomal disorders
- Hemoglobiopathy screening if at risk for passing on certain blood disorders
- Screening for gestational diabetes
- Screening for Group B strep between 35 and 37 weeks
- Anemia screening on a routine basis
- Bacteriuria urinary tract or other infection screening
- Hepatitis B screening at first prenatal visit
- Rh incompatibility screening and follow-up testing for women at higher risk
- Syphilis screening
- Tobacco use screening and counseling as needed

6.13. Women's Additional Preventive Services

New guidelines expanded on the coverage of women's preventive services without costsharing, including:

- Human papillomavirus (HPV) DNA testing for women 30 years and older
- Sexually transmitted infection counseling
- Human immunodeficiency virus (HIV) screening and counseling
- FDA-approved contraception methods (generic prescriptions)
- Breastfeeding support, supplies, and counseling
- The Women's Preventive Services Initiative recommends comprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and the postpartum period to ensure the successful initiation and maintenance of breastfeeding. Personal double electric breast pumps/supplies at no cost

share from a network doctor or an approved DME provider. Hospital grade breast pumps/supplies (rental only) covered at deductible/coinsurance.

- Interpersonal and domestic violence screening and counseling

6.14. Bone Density Testing

The Programs provide preventive care coverage for bone density testing once every three years upon turning age 50 at 100% of the Covered Charges for covered BluePreferred Plus Network/BCBS PPO Network services, and at 60% of the Covered Charges, after the Deductible, for covered out-of-network services.

6.14.1. Professional Fees for Surgical Procedures

The Programs pay professional fees for surgical procedures and othermedical care received from a physician in a hospital, Skilled Nursing Facility, inpatient rehabilitation facility, or Outpatient Surgery facility.

The Program will pay the following surgical expenses:

- Only one charge is allowed for the operating room and for anesthesia.
- A surgeon will not be paid as both a co-surgeon and an assistant surgeon.
- Expenses for certified first assistants are allowed.
- Incidental procedures are those services carried out at the same time as a more complex, primary procedure. The incidental procedure may be a part of the primary procedure and require little or very little additional time and resources; therefore, theyare usually not covered.
- A surgical procedure that is performed and not considered incidental to the primary procedure will be reimbursed at half of the allowable. For example: When bilateral surgical procedures are performed by one or two surgeons, the Programs will consider the first procedure at the full allowed amount, and the secondprocedure will be considered at half of the allowed amount of the listed surgical unit value
- Foot surgery – for a single surgical field/incision or two surgical fields/incisions on thesame foot, the Programs will allow the full amount for the procedure commanding the greatest value; half of the full amount for the second procedure; half of the full amount for the third procedure; and a quarter of the full amount for each subsequent procedure.

6.14.2. Prosthetic Devices/Appliances

The Programs cover prosthetic devices and appliances that replace a limbor body part or help an impaired limb or body part work. Examples include:

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

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

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

6.14.3. *Reconstructive Procedures*

IMPORTANT: Prior Authorization is required before receiving services. Refer to Prior Authorization Requirements for Medical Services for more information. If Prior Authorization is not received, benefits may be denied or reduced.

The Programs cover certain Reconstructive Procedures where a physical impairment exists, and the expected outcome is a restored or improved physiological functionfor an organ or body part.

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

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

6.14.4. Rehabilitation Services (Outpatient Therapies)

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

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

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

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

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

6.14.5. *Skilled Nursing Facility/Inpatient Rehabilitation Facility Services*

IMPORTANT: Prior Authorization is required before receiving services. Refer to Prior Authorization Requirements for Medical Services for requirements. If Prior Authorization is not received, benefits may be denied or reduced.

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

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

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

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

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

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

The Program does not pay benefits for custodial care, even if ordered by a physician.

6.14.6. *Temporomandibular Joint (TMJ) Syndrome*

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

6.15. Urgent Care

The Programs will cover Urgent Care as follows:

- Urgent Care services obtained from a Blue Preferred Plus Network Urgent Care facilitywill be considered at the Blue Preferred Plus Network level of benefits.

- Urgent Care services obtained from an BCBS PPO Network Urgent Care facility will be considered at the BCBS PPO Network level of benefits.
- Urgent Care services obtained from an out-of-network Urgent Care facility within the United States will be considered at the out-of-network level of benefits.
- If You are traveling outside the United States, Your claim will be processed at the in-network benefit level for Urgent Care.

Follow-up care is covered as follows:

- Follow-up care while traveling outside the United States will be covered at the out-of-network level of benefit if You receive care from an out-of-network provider.
- Follow-up care while traveling outside the United States will be covered at the in-network level of benefit if You receive care from an in-network provider.
- Follow-up care while traveling within the United States will be covered at the in- network level of benefits if the place of care is not located within 30 miles of any in-network provider.

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

- Call Your doctor's office and tell them You need to see a doctor as soon as possible, butthat there is no Emergency. If Your doctor tells You to go to the Emergency room because he or she cannot see You right away and You do not believe You have an Emergency, call the 24/7 Nurseline toll-free at 800-973-6329 for advice, or utilize the virtual visit benefit through the MD Live portal at mdlive.com/sandia. You will needYour member ID number located on Your BCBSNM insurance card to register Your account. Services apply to the Blue Preferred Plus Network Deductible, Coinsurance,and out of pocket.
- Ask Your doctor to recommend another provider if he/she is unable to see You within24 hours.
- Visit the nearest Urgent Care Center, Blue Preferred Plus Network Provider, or in-network Provider, for in-network benefit.
- Visit any Urgent Care Center, out-of-network, for out-of-network benefit.

Note: If You are traveling within the United States and there are no Blue Preferred PlusNetwork or in-network facilities available within a 30-mile radius, Your claim will be processed at the in-network benefit level.

7. PRESCRIPTION DRUG PROGRAM

The Prescription Drug Program, although part of the Programs, is administered separately by Express Scripts. For information on filing claims, claim denials, and appeals, refer to How to File a Claim and How to File an Appeal.

IMPORTANT: Generally claims must be submitted within one year after the date of service in orderto be eligible for consideration of payment. This one-year requirement will not apply if You are legally incapacitated.

Note: Although the Programs generally cover the same services, there are several differences between the prescription drug coverage provided under the Programs.

For the Total Health PPO Plan, the following chart summarizes Your Coinsurance responsibility as well as coverage for purchases under the Smart90 Anywhere Retail & Mail-Order Program and the Express Scripts networkand out-of-network retail pharmacies.

TOTAL HEALTH PPO PLAN			
Express Scripts Smart90 Anywhere Retail/Mail-Order Pharmacy (for maintenance prescription drugs)		**Express Scripts Network Retail Pharmacies**	**Out-of-Network Retail Pharmacies**
Refer to Specialty Drug Management Program section for information on coverage for specialty drugs.			
Generic prescription drugs	Coinsurance of 20% of a Smart90 Anywhere Pharmacy/mail order discount price with a $12.50 minimum and $25 maximum for generic prescription drugs	Coinsurance of 20% of retail discount price with a $5 minimum and $10 maximum for generic prescription drugs	50% reimbursement
Preferred brand name prescription drugs (formulary)	Coinsurance of 30% of a Smart90 Anywhere Pharmacy/mail order discount price with a $75 minimum and $112.50 maximum for preferred brand name prescription drugs	Coinsurance of 30% of retail discount price with a $30 minimum and $45 maximum for preferred brand name prescription drugs	50% reimbursement
Non-preferred brand name prescription drugs (non- formulary	Coinsurance of 40% of a Smart90 Anywhere Pharmacy /mail order discount price with a $125 and $187.50 maximum for non-preferred brand name prescription drugs	Coinsurance of 40% of retail discount price with a $50 minimum and $75 maximum for non-preferred brand name prescription drugs	50% reimbursement
Days' Supply	Maximum of 90-day supply	30-90-day supply	Maximum of 30-day supply File claims with Express Scripts
Out-of-Pocket Limit	For Pharmacy Only: Out-of-Pocket Limit is $1,500 per person per year or $5,950 per family). There is not an Out-of-Pocket limit for Out-of-Network prescription drugs or Smart90 eligible prescription drugs purchased outside of the Smart90 program		Out-of-Pocket Limit does not apply
If a multi-source generic drug is reclassified as a single-source brand name, the Coinsurance will change from 20% to 30% or 40% with the applicable minimum and maximum copays. For the Total Health PPO Plan, there is no prescription drug Deductible; the Coinsurance does not apply towards the medical Deductible and medical Out-of-Pocket Limit. Reimbursement for prescriptions purchased outside the United States will be reimbursed at the applicable retail Coinsurance, limited to a maximum of a 30-day supply.			

For the Health Savings Plan (HDHP for Pre-Medicare Retirees, Surviving Spouses, and LTD Terminees), the following chart summarizes Your Coinsurance responsibility as well as coverage for purchases under the Smart90 Anywhere Retail & Mail-Order Program and the Express Scripts networkand out-of-network retail pharmacies.

HEALTH SAVINGS PLAN For Active Employees (HDHP for Pre-Medicare Retirees, Surviving Spouses, and LTD Terminees)			
Express Scripts Smart90 Anywhere Retail/Mail-Order Pharmacy (for maintenance prescription drugs)		**Express Scripts Network Retail Pharmacies**	**Out-of-Network Retail Pharmacies**
Refer to Specialty Drug Management Program section for information on coverage for specialty drugs.			
Generic prescription drugs	After the Deductible is met, Coinsurance of 20% of a Smart90 Anywhere Pharmacy /mail order discount price with a $12.50 minimum and $25 maximum for generic prescription drugs	After the Deductible is met, Coinsurance of 20% of retail discount price with a $5 minimum and $10 maximum for generic prescription drugs	50% reimbursement
Preferred brand name prescription drugs (formulary)	After the Deductible is met, Coinsurance of 30% of a Smart90 Anywhere Pharmacy /mail order discount price with a $75 minimum and $112.50 maximum for preferred brand name prescription drugs	After the Deductible is met, Coinsurance of 30% of retail discount price with a $30 minimum and $45 maximum for preferred brand name prescription drugs	50% reimbursement
Non-preferred brand name prescription drugs (non- formulary	After the Deductible is met, Coinsurance of 40% of a Smart90 Anywhere Pharmacy /mail order discount price with a $125 and $187.50 maximum for non-preferred brand name prescription drugs	After the Deductible is met, Coinsurance of 40% of retail discount price with a $50 minimum and $75 maximum for non-preferred brand name prescription drugs	50% reimbursement
Days' Supply	Maximum of 90-day supply. The minimum days' supply for Express Scripts Mail order is 35 days. Some exclusions may apply	30-90-day supply	Maximum of 30-day supply File claims with Express Scripts
Out-of-Pocket Limit	Combined medical and prescription drug: Out-of-Pocket Limit is $3,200 per person per year or $9,450 per family)		There is no Out-of-Pocket limit for Out-of-Network prescription drugs or Smart90 eligible prescription drugs purchased outside of the program
If a generic drug is reclassified as a single-source brand name, the Coinsurance will change from 20% to 30% or 40% with the applicable minimum and maximum copays. For the Health Savings Plan (HDHP for Pre-Medicare Retirees, Surviving Spouses, and LTD Terminees), the Out-of-Pocket limit aggregates medical and prescription drug costs. Reimbursement for prescriptions purchased outside the United States will be reimbursed at the applicable retail Coinsurance, limited to a maximum of a 30-day supply.			

7.1. Eligibility

If You are eligible for coverage under the Programs, then You are eligible for the Prescription Drug Program. If You have primary prescription drug coverage under another group healthcare plan or Medicare, You are not eligible to use the Mail-Order Programor purchase drugs from retail network pharmacies at the Coinsurance benefit.

Coordination of Benefits applies. If You or Your Dependent has primary prescription drug coverage elsewhere, file the claim first with the appropriate plan, and then file with ExpressScripts, attaching a copy of the EOB. Express Scripts will allow 50% of the price submitted,with no days-supply limit, up to the amount You pay Out-of-Pocket.

7.2. Covered Prescriptions

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

Only licensed providers authorized to prescribe medications in the United States may issue Your prescription(s). To be covered, the prescription must be considered Medically Necessary. Consideration of Medical Necessity occurs when a clinician's request falls outside standard criteria. Medical Necessity is a case-by-case assessment based upon substantiated justificationas documented by the treating healthcare professional. It must be in accordance with standard medical practice and clinical appropriateness to include but not limited to off-label and non- indicated uses. The Prescription Drug Program covers the following categories of drugs:

- Federal Legend Drugs – A medicinal substance that bears the legend "Caution: FederalLaw prohibits dispensing without a prescription"
- State Restricted Drugs – A medicinal substance that, by state law, may be dispensed by prescription only
- **Compound Medications.** A compound medication is a compoundedprescription in a customized dosage form that contains at least one federal legend drug. You should contact Express Scripts at 877-817-1440 to determineif a compound medication is covered before You fill the prescription.
- The U.S. Food and Drug Administration (FDA) defines a compound medication as one that requires a licensed pharmacist to combine, mix or alterthe ingredients of a medication when filling a prescription. The FDA does notverify the quality, safety and/or effectiveness of compound medications.
- Pharmacies must submit all ingredients in a compound prescription as part ofthe claim for both online and paper claim submissions. All ingredients submitted with the compound prescription claim must be covered and at leastone of the ingredients must require a physician's prescription for reimbursement.
- The following prescription devices/supplies:
    - Insulin auto-injectors
    - Lancet auto-injectors
    - Glucagon auto-injectors
    - Epi-Pens

- Aero-chambers, aero-chambers with masks, nebulizer masks (You may receive coverage under either the medical portion with BCBSNM or the Prescription Drug Program but not both)

Note: Medicare covers lancets and test strips. Continuous Glucose Monitoring Systems (CGMS), Insulin Pumps, and supplies for CGMS and Insulin Pumps are not covered underthe Prescription Drug Program. Please refer to Accessing Care for coverage information.

- The following over the counter (OTC) medications/supplies:
  - Nutritional supplements (requires Prior Authorization)
  - Insulin and Diabetic Supplies – Supplies, including lancets, alcohol swabs, ketone test-strips (both blood and urine), and syringes, can be purchased at theappropriate Coinsurance level, in-network with a prescription, or in-network without a prescription by paying the full price and submitting the claim to Express Scripts for reimbursement. (You will be reimbursed at the appropriateCoinsurance level.) The Mail-Order Program is also available for insulin and diabetic supplies purchased with a prescription.

Note: The Prescription Drug Program covers immunizations obtained and/or administered at retail network pharmacies at no cost to You. In addition, Express Scripts maintains a programin which certified pharmacists within the U.S. are licensed to prescribe and administer certainvaccinations. To inquire about this Program, contact Express Scripts at 877-817-1440.

7.2.1. Covered Preventive Medications

All benefits are subject to the definitions, limitations, and exclusions. Certain preventive drugs are covered at 100% of the cost by the Programs;please check coverage and pricing details before ordering any prescription!

Existing Members: Please check the coverage and pricing details prior to filling any prescription by registering and logging in at express-scripts.com. Select Price a Medication from the Prescriptions menu. Enter Your drug's name and view cost and coverage informationon the results page. Or You can contact Member Services at 877-817-1440.

Prospect Members: To find coverage and pricing details, please log in at express-scripts.com/sandia. Select Price a Medication, follow the prompt and enter Your drug's nameand view cost and coverage information on the results page. Or You can contact Member Services at 877-817-1440.

7.2.2. List of Consumer Directed Healthcare (CDH) preventive drugs (standard plus generic only) that may be covered by the Plan:

- Asthma/COPD
- Bone Disease and Fractures
- Cavities
- Colonoscopy Preparation*
- Depression
- Diabetes
- Heart Disease and Stroke
- Cholesterol Lowering
- High Blood Pressure

- Malaria
- Obesity
- Smoking-Cessation*
- PreP for HIV Prevention

Please check with the Claims Administrator for more details about the drugs that may be covered by the Plan. Your cost share will be determined by Your plan's drug coverage and formulary plan.

*Please note that some of these medications are also subject to the Affordable Care Act (ACA) and may be covered by Your plan at 100%.

Note: All preventive medications require a prescription, whether they are over the counter ornot. You can find a comprehensive list for 2024 when You visit the NTESS dedicated site, express-scripts.com/sandia. There choose Your plan, the PDF is located under the right menu.

7.3. National Preferred Formulary

The Programs utilize the Express Scripts' National Preferred Formulary. Preferred Drugs are selected according to safety, efficacy (whether the drug works for the indicated purpose), therapeutic merit (how appropriate the drug is for the treatment of a particular condition), current standard of practice, and cost. Non-Preferred drugs are also on the Formulary, but at a higher cost sharing tier. Drugs that are excluded from Formulary are not covered by the prescription drug program unless approved through a Formulary exception process managed by Express Scripts. If approved through the process, the non-preferred copayapplies.

The Formulary is the same for both the Mail-Order Pharmacy and the retail network pharmacies and is comprehensive for all major categories of acute and maintenance medications. To compare drug prices, check formulary status of a drug or switch to a covered alternative, please log on to express-scripts.com or call Express Scripts at 877-817-1440.

If, for some reason, You are unable to take any of the preferred alternatives, You, Your pharmacist or Your physician can initiate an exception request by contacting Express Scripts directly and requesting a Prior Authorization (PA) for the medication. Refer to the informationbelow for PA information. Express Scripts will contact Your doctor and request the information necessary for a non-preferred brand name drug. Express Scripts will review the letter and make the decision as to whether You will be able to receive the non-preferred drug for the preferred brand name Coinsurance amount or excluded drugs at the non-preferred Coinsurance amount.

7.4. Prescriptions Requiring Prior Authorization

A Prior Authorization (PA) is a clinical program that ensures appropriate use of prescription medications. You, Your pharmacist or Your physician can initiate a PA for the medication by contacting Express Scripts Prior Authorization department directly at 800-417-8164 and requesting a PA for the medication. Medications subject to a PA require a clinical review and pre-approval from the Express Scripts Prior Authorization Team before they can qualify for coverage under this Program. Medications requiring Prior Authorization are subject to change.Therefore, if You have questions about a particular drug, please contact Express Scripts customer service at 877-817-1440.

7.5. Prescriptions Subject to Quantity Limits

Drug Quantity Management (DQM) is a program in Your pharmacy benefit that's designed tomake the use of prescription drugs safer and more affordable. It provides You with medicinesYou need

for Your good health and the health of Your family, while making sure You receive them in the amount – or quantity – considered safe. Medications included in this program aresubject to change. Therefore, if You have questions about a particular drug or this program, please contact Express Scripts customer service at 877-817-1440.

7.6. Smart90 Anywhere Retail Program

Express Scripts offers the Smart90 Anywhere Program for members taking long-term prescriptions to receive them in a 90-day supply at lower cost than the cost of three 30-day supply from participating providers in the Express Script network of pharmacies.

Smart90 Anywhere offers two options to receive medications:

- Prescriptions may be filled and delivered by Express Scripts Pharmacy Home Delivery, or
- Filled by a participating Express Scripts Pharmacy

You can request that Your provider submit an e-prescription for a 90-day supply of medication with exact information for daily dosage, strength, quantity (e.g., number of pills, inhalers, tubes), and number of refills to the network Pharmacy or Express Scripts mail order Pharmacy, if electronic prescribing is available. If medication is needed right away, request a second prescription of a 30-day supply be sent to a participating retail in-network pharmacy for pickup. The Program provides two months of courtesy refills of a 30-day supply at a retail in-network pharmacy before requiring the prescription to be moved to the Smart90 Program.

If e-prescribing is not available, providers may also call in the prescriptions to Express Scripts at 877-817-1440 or fax it to 888-327-9791. Prescriptions preferred to be filled at participating Express Scripts Pharmacy can be called in or hand carried.

See the Mail Order Program below on more information about Home Delivery from Express Scripts Pharmacy.

Note: For medications that are eligible for the Smart90 Anywhere Program, You will receive two months of courtesy fills at the retail coinsurance amount at any In-Network retail pharmacy.

However, if You do not elect one of the two Smart90 Anywhere options listed above, You will be responsible to pay 100% of the cost of the prescription(s) after the two courtesy refills. These costs do not apply to the prescription drugs Out-of-Pocket limit. The Smart90 Anywhere Retail Program does not apply to controlled substances, narcotic medications, or specialty medications dispensed through Accredo Pharmacy. See Specialty Drug Management Program for more details.

7.7. Mail Service Program

Express Scripts partners with Express Scripts Pharmacy to offer a Mail Service Benefit. Express Scripts Pharmacy is a licensed pharmacy specializing in filling prescription drug orders for maintenance prescriptions. Maintenance prescription drugs are those taken routinelyover a long

period of time for an ongoing medical condition. Let Your physician know that you are planning to use the Mail Service Program and request a 90-day prescription (with up to three refills). Verify that the prescription specifies the exact information for daily dosage, strength, quantity (e.g., number of pills, inhalers, tubes), and number of refills.

Registered pharmacist and technicians are available 24 hours a day, seven days a week, at 877-817-1440, to answer medication-related questions. Prescriptions are delivered to Your home. (You are not responsible for shipping and handling fees unless You request special shipping arrangements.) To obtain a maintenance prescription through the Mail Service Program, You pay the appropriate Coinsurance for each prescription for a 90-day supply. If Express Scripts receives a script for less than a 35-day supply, they will contact the doctor's office for a 90-day prescription.

If You send in a prescription through the Express Scripts Mail Service Program and Express Scripts Mail Service does not carry the medication or if it is out of stock and Express Scripts Mail Service does not anticipate getting the medication in a timely manner, You will be able to receive a 90-day supply at a retail network pharmacy for the applicable mail-order Coinsurance. Contact Express Scripts at 877-817-1440 for assistance.

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

7.7.1. *Steps for Ordering and Receiving Mail Order Prescriptions (other than SpecialtyMedications)*

You can request that Your provider submit an e-prescription for a 90-day supply of medicationwith exact information for daily dosage, strength, quantity (e.g., number of pills, inhalers, tubes), and number of refills to Express Scripts Pharmacy at the time of the appointment, if electronic prescribing is available. If medication is needed right away, request a second prescription of a 30-day supply be sent to a local in-network pharmacy of Your choice for pickup.

If e-prescribing is not available, providers may also call in the prescriptions to Express Scriptsat 877-817-1440 or fax it to 888-327-9791.

If You would prefer to mail in Your original prescription, follow the steps for ordering andreceiving below:

Step	Action	
1	Forms	Obtain an Express Scripts Mail Service Registration & Prescription Order Form from www.express-scripts.com.
2	Ordering Original Prescriptions	Complete the Express Scripts Mail Service Registration & Prescription Order Form. Attach Your original written prescription (with Your Member Identification number and address written on the back). Make sure Your physician has written the prescription for a 90-day supply with applicable refills. Enclose the required Coinsurance using a check or money order or complete the credit card section on the form. Mail all to Express Scripts Mail Service, PO Box 66568, St. Louis, MO 63166-9819. Your physician may also call in the prescription to Express Scripts at 877-817-1440 or fax it to 888-327-9791. **Note:** If You need medication immediately, ask Your doctor for two (2) separate prescriptions – one for a 30-day supply to be filled at a network retail pharmacy, and one to be filled by mail service. If the member has less than a 14 day supply on hand they should obtain a 30-day prescription for retail and a 90-day prescription for mail order to ensure there's no disruption in therapy.
3	Delivery	Expect delivery to Your home by first-class mail. A physical street address is needed. There are additional charges for requesting express shipping.
4	Refills	Refilling a mail service order prescription can be done by phone, mail, or through the web. It is recommended that You order three weeks in advance of Your current mail service prescription running out. **Refill-by-Phone:** Call 877-817-1440 to order refills. You may use the automated refill system 24 hours a day. Customer service representatives are available Monday through Sunday 24/7. **Refill-by-Fax:** Have Your physician contacts Express Scripts for the Fax Order Form. The physician (not You) must fax the number on the form. **Note:** Schedule II prescriptions cannot be faxed. **Refill-by-Mail:** Complete the Prescription Order Form (attached at the bottom of Your customer receipt), making sure You adhere the refill label provided or write the prescription number in the space provided. Mail in the self-addressed, postage-required envelope. **Refill through the Web:** Go to www.express-scripts.com. Log on to this site. On the left-hand side of Your screen, select “Order Prescriptions”. From there, follow the instructions to place Your refill order. You will need to use one of the accepted credit cards for payment. **Refill-by-Mobile App:** Download the free app, log in with Your www.express-scripts.com username and password. If You haven’t yet registered with www.express-scripts.com, You can create a username and password right from the app – and use the same username and password to access the website.

7.7.2. *Brand-To-Generic Substitution*

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

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

Many drugs are available in generic form. Generic drugs offer substantial cost savings overbrand names; therefore, the Mail-Service Program has a generic substitution component.

Unless Your doctor has specified that the prescription be dispensed as written, Your prescription will be filled with the least expensive acceptable generic equivalent when available and permissible by law. If You receive a generic medication in place of the brand name medication, and You want the brand name medication, You will need to obtain a new prescription stating, "no substitution" or "dispense as written" and resubmit it along with therequired Coinsurance.

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

7.8. Retail Pharmacies

This section does not apply to Smart90 Anywhere Retail Program eligible medications filled at a participating network pharmacies

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

7.8.1. *Using the Network Retail Pharmacies*

Express Scripts has contracted with specific retail pharmacies across the nation that will provide prescriptions to NTESS at discounted rates. These pharmacies are known as retail network pharmacies. To locate the pharmacy nearest You, call Express Scripts at 877-817-1440or visit www.express-scripts.com.

To obtain a medication through a retail network pharmacy, You will need a written prescriptionfrom Your physician. Present the prescription and Your Express Scripts ID card to the pharmacist. The card is required to identify that You are covered under the Program in order to be charged the appropriate Coinsurance.

If You request a prescription to be filled in a retail network pharmacy for more than a 30-day supply, the pharmacist will fill only 30 days for the appropriate Coinsurance of 20%, 30%, or40% and hold the rest as refills. When You need a refill, return to the pharmacy, pay another Coinsurance amount, and receive another maximum 30-day supply (or up to the amount prescribed by the physician).

7.8.2. *Using the Out-of-Network Retail Pharmacies*

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

7.9. Specialty Drug Management Program

Specialty medications must be purchased through the Express Scripts' Specialty Pharmacy, Accredo Specialty Pharmacy (Accredo), in order to be eligible for coverage under the Program. Specialty drugs are prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions such as cancer, hepatitis C, multiple sclerosis, rheumatoid arthritis, etc. To find out if Your prescription falls into this category, call Express Scripts at 877-817-1440.

Under this Program, Your prescription will be limited to a 30-day supply and will be subject tothe retail Coinsurance level of benefits. Any amounts over a 30-day supply will be denied.

There is no additional cost to You above Your required Coinsurance. In addition to Your medication, You will also receive the necessary supplies for administration such as alcohol swabs and syringes at no additional cost. The Specialty Pharmacy is staffed by experienced pharmacists who are specially trained in complex health conditions and the latest therapies toprovide support, counseling and assistance with medication management.

Steps for Ordering and Receiving Specialty Prescriptions through Accredo:

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

7.10. SaveonSP Specialty Drug Program:

For the Total Health PPO Plan, NTESS partners with Express Scripts' SaveonSP program tohelp You save money on certain specialty medications.

The SaveonSP Drug list that contains medications eligible for the program can be found at www.saveonsp.com/sandia.

If Your specialty medication is noted on the SaveonSP Drug List, You may participate in the SaveonSP program to receive Your medications free of charge ($0). This program utilizes benefit design and manufacturer copay assistance to achieve this level of discount. Your prescriptionswill still be filled through Accredo, Your current specialty pharmacy.

Note: To maintain eligibility to make/receive HSA contributions under IRS rules, participants who are enrolled in the Health Savings Plan or High Deductible Health Plan are not eligible for the SaveonSP program.

Contact SaveonSP at 800-683-1074 to enroll or confirm enrollment participation. These medications will not count towards Your applicable deductible or Out-of-Pocket Limits. Although thecost of the Program drugs will not be applied towards satisfying Your accumulators, the cost ofthe Program drugs will be reimbursed by the manufacturer.

Express Scripts, through their exclusive relationship with SaveonSP, reduces the Plan's coston specialty pharmacy drugs while lowering Your cost to $0. This is an important factor in helping to keep Your benefit premiums from increasing due to rising drug costs.

8. WHAT'S NOT COVERED – EXCLUSIONS

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

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

Exclusions	Examples
Administrative fees, penalties, and limits	Charges that exceed what the claims administrator determines are Covered Charges, as defined. Insurance filing fees, attorney fees, physician charges for information released to claims administrator, and other service charges and finance orinterest charges. Amount You pay as a result of failure to contact BCBSNM for Prior Authorization, including unauthorized care. Charges incurred for services rendered that are not within the scope of a provider's licensure. Charges for missed appointments.
Ambulance	Non-Emergency ambulance services (e.g., home to physician for an officevisit).
Behavioral Health Services	Family therapy, including marriage counseling and bereavement counseling, unless otherwise covered. Family therapy, marriage counseling, and bereavement counseling are covered for Employees and their Dependents only through the Employee Assistance Program. Religious, personal growth counseling or marriage counseling including Services and treatment related to religious, personal growth counseling or marriage counseling unless the primary patient has a mental health diagnosis. Conduct disturbances unless related to a coexisting condition or diagnosis otherwise covered. Educational, vocational, and/or recreational services as Outpatientprocedures. Biofeedback for treatment of diagnosed medical conditions. Treatment for insomnia, other sleep disorders, dementia, neurological disorders, and other disorders with a known physical basis (except certain treatments for sleep apnea that are covered as listed under medical services). Psychiatric or psychological exams, testing, or treatments that are otherwise covered under the Plan when related to judicial or administrative proceedings or orders. However, this exclusion does not apply to services that are determined to be Medically Necessary.

Exclusions	Examples
Behavioral Health Services, cont.	Services to treat conditions that are identified by the most current edition ofthe Diagnostic and Statistical Manual of Mental Disorders as not being attributable to a mental disorder. Any services or supplies that are not Medically Necessary.Custodial Care. Pastoral Counseling Developmental Care that is otherwise not covered as a Mental Health Disorder. Non-abstinence-based or nutritionally based treatment for Chemical Dependency. Services, treatments, or supplies provided as a result of a Worker's Compensation law or similar legislation, or obtained through, or required by,any government agency or program, whether federal, state, or any subdivision, or caused by the conduct or omission of a third party for which You have a claim for damages or relief, unless You provide BCBSNM Behavioral Health Unit with a lien against the claim for damages or relief in a form and manner satisfactory to BCBSNM Behavioral Health Unit. Non-organic erectile dysfunction (psychosexual dysfunction). Treatment for conduct and impulse control disorders, personality disorders, paraphilias (unusual sexual urges), and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by BCBSNM. Services or supplies that: Are considered Unproven, Experimental or Investigational drugs,devices, treatments, or procedures. Result from or relate to the application of such Experimental orInvestigational drugs, devices, treatments, or procedures. Services billed by a school, halfway house or group home, or their staff members; foster care; or behavior modification services. Services or supplies that are primarily for Your education, training, or development of skills needed to cope with an Injury or Illness unless the primary patient has a mental health diagnosis.
Biofeedback	Biofeedback is not a Covered Health Service.
Congenital Heart Disease (CHD)	CHD services other than as listed under Coverage Details.
Dental Procedures	Dental procedures are not covered under the Programs except for Injuries to Sound, Natural Teeth, the jawbone, or surrounding tissue, or birth defects. Treatment must be initiated within one year of Injury. Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not covered.
Drugs	In addition to the clinical guideline limitation imposed by Express Scripts (see Covered Prescriptions), the Program

Exclusions	Examples
Drugs, cont.	excludes coverage for certain drugs, supplies, and treatments, which include, but are not limited to, the following: Over-the-counter medications unless specifically included. Fluoride preparations (other than for ages 6 months to 5 years) and dental rinses. Drugs labeled “Caution: Limited by Federal Law to Investigational use or Experimental drugs” Experimental drugs are defined as “a therapy that has not been or isnot scientifically validated with respect to safety and efficacy.” Investigational drugs are defined as “those substances in any of the clinical stages of evaluation which have not been released by the Foodand Drug Administration (FDA) for general use or cleared for sale in interstate commerce. It also includes those drugs that are in any of theclinical stages of evaluation (Phase I, II, and III) which have not been released by the FDA for general use or cleared for sale in interstate commerce.” Glucose tablets. Drugs used for cosmetic purposes. Prescription drugs that may be properly received without charge under local, state, or federal programs, including Workers Compensation. Refills of prescriptions in excess of the number specified by the physician. Refills dispensed after one year from the date of order by the physician. Prescription Drugs purchased for those who are ineligible for coverage under the Programs. Prescription Drugs taken by a donor who is not insured under the Programs. Medicine not Medically Necessary for the treatment of a disease or an Injury The following are excluded by the Prescription Drug Program but may be covered by BCBSNM if Medically Necessary: Ostomy supplies Blood glucose meters Implantable birth control devices such IUDs Allergy serum External Insulin pumps and supplies Continuous glucose monitoring systems and supplies Medication that is dispensed and/or administered by a licensed facility or provider such as a hospital, home healthcare agency, or physician’s office,and the charges are included in the facility or provider bill to BCBSNM.
Equipment	Exercise equipment (e.g., exercycles, weights, etc.). Hearing aids for hearing loss except for Dependents up to age 21 and forIllness or Injury (see benefit under hearing aids for more details). Braces prescribed to prevent injuries while You are participating in athletic activities. Household items, including, but not limited to Air cleaners and/or humidifiers Bathing apparatus Scales or calorie counters

Exclusions	Examples
Equipment, cont.	Blood pressure kits Water beds Personal items, including, but not limited to Support hose, except Medically Necessary surgical or compressionstockings Foam cushions Pajamas Equipment rental fees above the purchase price, with the exception of oxygenequipment.
Experimental or Investigative or Unproven Treatment	Experimental or Investigational Services or Unproven Services, unless the Programs have agreed to cover them in Covered Medical Plan Services / Limitations. **Note:** This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices, or pharmacological regimens are the only available treatment option for Your condition. **Note:** This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which benefits are provided as described under clinical trials.
Gender Affirmation Services	Gender Affirmation related services listed below: Reversal of genital surgery or surgery to revise secondary sexcharacteristics Penile and Uterine transplants Other surgeries which have no medically necessary role in genderaffirmation services and are considered cosmetic in nature. Services received outside US.
Genetic Testing/ Counseling	Experimental or Investigational or Unproven genetic testing is not covered. In addition genetic counseling, including service for evaluation and explaining the implications of genetic or inherited disease, whether provided by physicians or non-physician health professionals, for the interpretation of family and medical histories to assess the risk of disease occurrence or recurrence, and for assisting in making treatment decisions based upon the risk of disease occurrence or recurrence is not covered. Refer to Genetic Testing and Preventive Care for covered services.
Hospital Fees	Expenses incurred in any federal hospital, unless You are legally obligated to pay. Hospital room and board charges in excess of the semi-private room rate. Unless Medically Necessary and approved by BCBSNM. In-hospital personal charges (e.g., telephone, barber, TV service, toothbrushes, slippers).

Exclusions	Examples
Hypnotherapy	Hypnotherapy is not a Covered Health Service
Infertility, Reproductive, and Family Planning	Services related to or provided to anonymous donors, Services provided by adoula (labor aide), Storing and preserving sperm beyond two (2) years, Donorexpenses related to donating eggs/sperm (including prescription drugs); however, charges to extract the eggs from a covered Employee or dependent for a donor are allowed, Expenses incurred by surrogate mothers (including members as surrogates), Artificial reproductive treatments done solely for genetic or eugenic (selective breeding) purposes unless medically necessary, Over-the-counter medications for birth control/prevention unless notated otherwise, Parenting, pre-natal, or birthing classes. Sperm procurement and storage in anticipation of future Fertility,unless covered under Fertility Services Benefit. Gamete preservation and storage in anticipation of future Fertility,unless covered under Fertility Services Benefit. Cryopreservation of fertilized embryos in anticipation of futureFertility, unless covered under Fertility Services Benefit.
Miscellaneous	Eye exams except as outlined under Covered Medical Plan Services / Limitations. Eyeglasses or contact lenses prescribed, except as outlined under Covered Medical Plan Services / Limitations. Contact lenses are not considered a prosthetic device. Modifications to vehicles and houses for wheelchair access. Health club memberships and programs or spa treatments. Treatment or services Incurred when the patient was not covered under the Programs even if the medical condition being treated began before the date Your coverage under the Program ends. For Illness or Injury resulting from Your intentional acts of aggression, including armed aggression, except for injuries inflicted on an innocent bystander (e.g., You did not start the act of aggression). For job-incurred Injury or illness for which payments are payable under any Workers Compensation Act, Occupational Disease Law, orsimilar law. While on active military duty. That are reimbursable through any public program other thanMedicare or through no-fault automobile insurance. Charges for blood or blood plasma that is replaced by or for thepatient. Conditions resulting from insurrection, except for injuries inflicted on an innocent bystander who is covered under the Programs. Unlicensed Christian Science practitioners and facilities. Food of any kind unless it is the only source of nutrition, there is a diagnosis of dysphagia (difficulty swallowing), in case of terminal cancer, or in cases of PKU or RH factor. Enteral feedings and other nutritional and electrolyte formulas, including infantformula and donor breast milk unless listed as covered. Oral vitamins and minerals (with the exception of certain prescription vitamins) as outlined in Prescription Drug Program. Herbs and over-the-counter medications except as specifically allowed under the Programs. Charges prohibited by federal anti-kickback or self-referral statutes.

	Chelation therapy, except to treat heavy metal poisoning. Diagnostic tests that are: Delivered in other than a physician's office or healthcare facility. Self-administered home-diagnostic tests, including, but not limited and pregnancy tests. Domiciliary care. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for ten seconds or longer). Appliances for snoring are always excluded. Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments when: Required solely for purposes of career, education, camp, employment, insurance, marriage or adoption; or as a result ofincarceration Conducted for purposes of medical research Required to obtain or maintain a license of any type ofPrivate duty nursing received on an inpatient basis. Respite care.Rest cures. Storage of blood, umbilical cord, or other material for use in a Covered HealthService, except if needed for an imminent surgery.
Not a Covered HealthService and/ or Not Medically Necessary	These health services, including services, supplies which are not: Provided for the purpose of preventing, diagnosing or treating Illness,Injury, mental illness, Chemical Dependency or their symptoms;
Not a Covered HealthService and/ or Not Medically Necessary cont.	Consistent with nationally recognized scientific evidence, as available, and prevailing medical standards and clinical guidelines; For the convenience of the covered person, physician, facility or anyother person; Included in Covered Medical Plan Services / Limitations. Provided to a Member who meets the applicable eligibility requirements; and Not identified in general Program exclusions.
Old Claims	Claims received one year after the date charges are incurred.
Physical Appearance	Breast reduction/augmentation surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which the claims administrator determines is required to treat a physiologic functional impairment or coverage required by the Women's Health and Cancer Right's Act of 1998. Any loss, expense, or charge that results from cosmetic or reconstructive surgery, except after breast cancer. Exceptions to this exclusion include: Repair of defects that result from surgery for which You were paidbenefits under the Program Reconstructive (not cosmetic) repair of a congenital defect thatmaterially corrects a bodily malfunction. When medically necessary as part of gender affirmation surgery for both binary and non-binary individuals. Liposuction. Pharmacological regimens. Tattoo or scar removal or revision procedures (such as Sal abrasion, chemosurgery, and other such skin abrasion procedures). Replacement of an existing intact breast implant unless there is documented

	evidence of silicon leakage. Physical conditioning programs, such as athletic training, body building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity (except that certain surgical procedures may be covered if the patient meets criteria listed in Covered Medical Plan Services / Limitations and has the procedure Prior Authorization approval by BCBSNM). Wigs regardless of the reason for hair loss.Treatments for hair loss. Face Lifts. Voice modification surgery. Blepharoplasty. Rhinoplasty. Abdominoplasty. Cosmetic Surgery – except as covered for Gender Dysphoria. Other electrolysis or laser hair removal not specified as covered Vaniqa.
Providers	Services: Performed by a provider who is a family member by birth or marriage, including Your Spouse, brother, sister, parent, or child A provider may perform on himself or herself Performed by a provider with Your same legal residence Provided at a diagnostic facility (hospital or otherwise) without awritten order from a provider Ordered by a provider affiliated with a diagnostic facility (hospital or otherwise) when that provider is not actively involved in Your medicalcare Prior to ordering the service or After the service is received This exclusion does not apply to mammography testing.
Services, supplies, therapy, or treatments	Charges that are: Custodial in nature Otherwise free of charge to You Furnished under an alternative medical plan provided by NTESS For aromatherapy or rolfing (holistic tissue massage) For Developmental Care after a maintenance level of care has beenreached For Maintenance Care For massage therapy unless performed by a licensed chiropractor,physical therapist, or physician as a manual therapy technique for lymphatic drainage Educational therapy when not Medically Necessary Educational testing Smoking-cessation programs unless covered under Covered Medical Plan Services / Limitations Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia, and astigmatism,including but not limited to procedures such as laser and other refractive eye surgery and radial keratotomy

Exclusions	Examples

Surgical and nonsurgical treatmentfor obesity	The following treatments for obesity (Unless covered under the pharmacy benefit): Non-surgical treatment, even if for morbid obesity, and Surgical operations for the correction of morbid obesity determined by BCBSNM not to be Medically Necessary and/or not meeting the criteriaoutlined in Covered Medical Plan Services / Limitations.
Transplants	Health services for organ and tissue transplants except as identified under Organ Transplants in Covered Medical Plan Services / Limitations unless BCBSNM determines the transplant to be appropriate according to BCBSNM's transplant guidelines. Determined by BCBSNM to be Unproven procedures for the involved diagnoses. Not consistent with the diagnosis of the condition. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available) Donor costs for organ or tissue transplantation to another person unless the recipient is covered under the Programs.
Travel	Travel or transportation expenses, regardless of personal or business travel, even if ordered by a physician, except as identified under Blue Distinction Center for Specialty Care Programs in Accessing Care. Medical repatriation outside of the United States regardless of personal or business travel.
Vision-Hardware	Eyeglasses, lenses, contact lenses as prescribed to correct visual acuity.

9. COORDINATION OF BENEFTIS (COB)

Coordination of Benefits (COB) is the provision that allows families with different employergroup health plan coverage to receive up to 100% coverage for Covered Health Services.

Under COB Your health plan as the Employee provides primary coverage for You and Your Spouse's health plan through his or her employer provides primary coverage for him or her.

Refer to the Employee H&W Plan SPD or the Post-Employment H&W Plan SPD for more information onCOB policy and rules for determining which plan provides primary coverage.

The Programs contain a COB provision so that the benefits paidor provided by all employer group plans are not more than the total allowable expenses under thePrograms. The Programs will notpay more than 100% of the cost of the medical treatment, nor will it pay for treatment or services not covered under the Programs.

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

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

Refer to Section 3 of the Employee H&W Plan SPD NTESS Health Benefits Plan for Employees Summary Plan Description or the Post-Employment H&W Plan SPD for more information on

"Special Rules for Covered Medicare-Primary Members" and "Provisionfor Covered Members with End-Stage Renal Disease (ESRD)."

Beginning January 1 of every year or if You are a new enrollee, You are required to provide anupdate to BCBSNM on whether any of Your covered family members have other insurance.

This notification is also required if Your family member enrolls in another medical plan duringthe year. If You do not provide this information to BCBSNM, Your covered family members' claims may be denied. You may update Your other insurance information by calling BCBSNMat 877-498-7652.

Refer to Prescription Drug Program for information on eligibility to use the Prescription Drug Program, as well as how COB works, if Your covered family member hasother insurance coverage.

10. HOW TO FILE A CLAIM

This section provides an overview of how to file a claim and the receipt of benefit paymentsunder the Programs.

10.1. Filing an Initial Claim

Refer to Section 8 of the Employee H&W Plan Summary Plan Description or the Post-Employment H&W Plan SPD for claim definitions, time frames for disposition of Urgent Care, pre-service, concurrent care, andpost-service claims, and the information that You are entitled to receive from the claims administrator upon processing of Your claim.

IMPORTANT: All claims must be submitted within one year from the date of service in order to be eligible for consideration of payment. This one-year requirement will not apply ifYou are legally incapacitated. If Your claim relates to an Inpatient Stay, the date of service is the date Your Inpatient Stay ends. It is recommended that claims be submitted as soon as possible after the medical or prescription expenses are incurred. If You need assistance in filing a claim, call BCBSNM Customer Service at 877-498-7652 for medical claims or Express Scripts at 877-817-1440.

10.1.1. *Blue Preferred Plus Network/In-Network Claims Processing*

Generally, when You seek services through a Blue Preferred Plus Network or in-network provider, the provider verifies eligibility and submits the claims directly to the claims administrator for processing. There are generally no claim forms necessary to obtain BluePreferred Plus Network/ in-network benefits. Refer to section for Health Reimbursement Account and Health Savings Account for information on payments from Your HRA and Prescription Drug Program for information on how to use network retail and mailorder pharmacy benefits.

10.1.2. *Out-of-Network Claims Processing*

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

Submit the claim form to the claims administrator immediately after the expense is incurredbut no later than one year from the date of service. Completion and submission of the claimform does not guarantee eligibility for benefits.

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

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

- Patient's full name and relationship to the Primary Covered Member
- Primary Covered Member's name and BCBSNM identification number and groupnumber
- Date and place of treatment or purchase
- Diagnosis
- Type of service provided

- Amount charged
- Name and address of provider and tax identification number, if available
- If other insurance is primary, the EOB (from the primary insurer) attached to Yourclaim form

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

Blue Cross and Blue Shield of New Mexico

P.O. Box 660058

Dallas, TX 75266-0058

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

If a Qualified Medical Child Support Order (QMCSO) or a properly completed National Medical Support Notice (NMSN) is in effect and conforms to ERISA requirements, the QMCSO or NMSN provisions will be followed. Refer to the Employee H&W Plan SPD or the Retiree Health and Welfare Summary Plan Description for more information.

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

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

You will need to pay up front for care received from a **doctor**, a **participating Outpatient hospital,** and/or **a nonparticipating hospital.** Then, complete a Blue Cross Blue Shield Global Core International Claim Form and send it with the bill(s) to the Blue Cross Blue Shield Global Core Service Center (the address is on theform). The International Claim Form is available from BCBSNM, the Blue Cross Blue Shield Global Core Service Center, or online at https://www.globalcore.com

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

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

Blue Cross Blue Shield Global Core Service Center

P.O. Box 2048

Southeastern, PA 19399

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

If You have a prescription filled by an out-of-network pharmacy, complete a Direct Member Reimbursement Form, attach pharmacy receipts, and send Your claim to Express Scripts.

10.4. Benefits Payments

Refer to the Employee H&W Plan SPD or the Post-Employment H&W Plan SPD for general informationon benefits payments.

BCBSNM will pay benefits directly to You for all out-of-network providers.

Express Scripts will pay benefits to the provider when You use a network or mail order pharmacy. If You use an out-of-network provider, Express Scripts will pay any applicablebenefits to You.

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

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

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

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

For eligible prescription drug claims processed through a Direct Member ReimbursementForm, You will receive an EOB with the payment from Express Scripts.

10.5. Pricing of Non-Contracted Provider Claims

The BCBSNM Covered Charge for some Covered Health Services received from Non- preferred Providers is the lesser of the provider's billed charges or the BCBSNM "Non- contracting Allowable Amount." The BCBSNM Non-contracting Allowable Amount is basedon the Medicare Allowable

amount for a particular service, which is determined by the Centers for Medicaid and Medicare Services (CMS). The Medicare Allowable is determined for a service covered under this medical plan using information on each specific claim and based on place of treatment and date of service, is multiplied by an "adjustment factor" to calculate the BCBSNM Non-contracting Allowable Amount. The adjustment factors for non-Emergency services are 100% of the base Medicare Allowable.

Certain categories of claims for Covered Health Services from Non-preferred Providers areexcluded from this non-contracted provider pricing method. These include:

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

10.6. BlueCard Program

Blue Cross Blue Shield of New Mexico (BCBSNM) provides access to a nationwide network of providers when traveling in the U.S. You have access to established PPO network of doctors, hospitals and other health care providers throughout the country called the Blue Card Program. UnderBlueCard, when You receive Covered Health Services outside of New Mexico from a PPO Provider that does not have a contract with BCBSNM, the amount You pay for Covered Health Services is calculated on the lower of:

- The billed charges for Your Covered Health Services, or
- The negotiated price that BlueCard passes on to BCBSNM.

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

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

Laws in a small number of states may require BlueCard to 1) use another method for, or 2) add a surcharge to, Your liability calculation. If any state laws mandate other liability calculation methods, including a surcharge, BCBSNM would calculate Your liability for anycovered services according to the applicable state law in effect when You received care.

Surcharges are not Your responsibility.

10.7. Independent Contractors

The relationship between BCBSNM and its network providers is that of independent contractors; physicians and other providers are not agents or employees of BCBSNM, and BCBSNM and its employees are not employees or agents of any network provider. BCBSNMwill not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by You while receiving care from any network provider. The relationship between BCBSNM and NTESS is that of independent contractors; the employer is not an agent or employee of BCBSNM, and BCBSNM and its employees are not employees or agents of NTESS.

10.8. Sending Notices

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

10.9. Membership Records

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

10.10. Disclosure and Release of Information

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

10.11. Research Fees

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

10.12. Recovery of Excess Payment

The claims administrator has the right at any time to recover any amount paid by the Programs for Covered Charges in excess of the amount that should have been paid under the provisions. Payments may be recovered from You, providers of service, and other medical care plans.

IMPORTANT: By accepting benefits under the Programs, You agree toreimburse payments made in error and cooperate in the recovery of excess payments.

11. HOW TO FILE AN APPEAL

This section outlines how to file an appeal with either BCBSNM or Express Scripts. The respective claims administrator will notify You of the decision regarding any appeal within theapplicable time frames. Refer to Section 8, Claims and Appeals section of the or the Post-Employment H&W Plan SPD for information on general appeal time frames under ERISA, as well as Your right to information that You are entitled to receive from the claims administrator upon the denial of an appeal.

11.1. Filing an Appeal

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

If a request for service or a claim for benefits is denied in part or in whole, You have the rightto appeal the denial. A request for further information (such as a diagnosis) from the providerof service is not a claim denial.

IMPORTANT: Regardless of the decision and/or recommendation of the claims administrator, NTESS, or what the Programs will pay, it isalways up to You and the doctor to decide what, if any, care You receive.

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

If You have a claim denied because of…	Then…
Eligibility (except for incapacitation determinations)	See Eligibility Appeals Procedure in the Employee H&W Plan Summary Plan Description or the Retiree Health and Welfare Plan Summary Plan Description
Eligibility based on incapacitation determinations	Contact the claims administrator for assistance
Benefit Determinations	Refer to the procedures noted below

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

If You are appealing an Urgent Care claim denial, please refer to Urgent Claims Appeals under BCBSNM or Expedited Appeal under Express Scripts.

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

- Patient's name and ID number as shown on the ID card
- Provider's name
- Date of service

- Reason You think Your claim should be paid
- Any documentation or other written information to support Your request

You, Your authorized representative (if You want someone to represent You in the appealprocess, You must submit written authorization to BCBSNM designating the name of theperson), or Your doctor can send the written appeal to:

11.1.1. Medical/Behavioral Health Appeals to:

BCBSNM Appeals Unit

PO Box 660058

Dallas, TX 75266-0058

Phone: 800-205-9926

Fax: 505-962-7541

11.1.2. Prescription Drugs Appeals to:

Express Scripts, Inc.

Attn: Pharmacy Appeals

Mail Route BL 0390

6625 West 78th Street

Bloomington, MN 55439

Fax: 877-852-4070

11.1.3. Prescription Administration Appeals to:

Express Scripts, Inc.

Attn: Administrative Appeals Department

PO BOX 66587

St. Louis, MO 63166-6587

Phone: 800-946-3979

11.1.4. Prescription Clinical Appeals to:

Express Scripts, Inc.

Attn: Clinical Appeals Department

PO BOX 66588

St. Louis, MO 63166-6588

Phone: 800-753-2851

11.1.5. BCBSNM Appeals Process

A qualified individual who was not previously involved in the claim decision being appealed will be appointed to decide the appeal. If Your appeal is related to clinical matters, the review will be done

in consultation with a healthcare professional with appropriate expertise in the field who was not previously involved in the prior determination. BCBSNM may consult with,or seek the participation of, medical experts as part of the appeal resolution process. Upon request and free of charge You have the right to reasonable access to and copies of, all documents, records, and other information relevant to Your claim appeal for benefits.

11.1.6. *Pre-Service and Post-Service Claim Appeals*

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

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

11.1.7. *Urgent Claims Appeals*

Your appeal of a Prior Authorization or concurrent review denial may require immediate action if a delay in treatment could significantly increase the risk to Your health or the ability to regain maximum function or cause severe pain. The appeal does not need to be submitted inwriting. You or Your physician should call BCBSNM at 877-498-7652 as soon as possible.

BCBSNM will provide You with a verbal or written determination within 72 hours followingreceipt by BCBSNM of Your request for review taking into account the seriousness of Your condition.

11.1.8. *Independent External Review Program*

You or Your authorized representative may make a request for a standard external review or expedited external review of an Adverse Benefit Determination of Final Internal Adverse Benefit Determination by an Independent Review Organization (IRO).

1. **Request for external review.** Within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from BCBSNM, You or Your authorized representative must file Your request for standard external review with BCBSNM's Appeal Unit. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example,if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or

federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

2. **Preliminary review.** Within five business days following the date of receipt of the external review request, BCBSNM must complete a preliminary review of the requestto determine whether:
    a. You are, or were, covered under the plan at the time the healthcare item or service was requested or, in the case of a retrospective review, was coveredunder the plan at the time the healthcare item or service was provided;
    b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to Your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
    c. You have exhausted BCBSNM's internal appeal process unless You are not required to exhaust the internal appeal process under the interim final regulations. Please read the Exhaustion section for additional information and exhaustion of the internal appeal process; and
    d. You or Your authorized representative have provided all the information and forms required to process the external review.
    e. You will be notified within one business day after BCBSNM completes the preliminary review if Your request is eligible or if further information or documents areneeded. You will have the remainder of the four-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If Yourclaim is not eligible for external review, BCBSNM will outline the reasons it is ineligible in the notice and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).
3. **Referral to Independent Review Organization.** When an eligible request for external review is completed within the time period allowed, BCBSNM will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally recognized accredited organization. Moreover, BCBSNM will take action against bias and to ensure independence. Accordingly, BCBSNM must contract with at least three IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may notbe eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

- Utilization of legal experts where appropriate to make coverage determinationsunder the plan.
- Timely notification to You or Your authorized representative, in writing, or the request's eligibility and acceptance for external review. This notice will includea statement that You may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to but may accept and consider additional information submitted after 10 business days.

- Within five business days after the date of assignment of the IRO, BCBSNM must provide to the assigned IRO the documents and any information considered making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by BCBSNM to timely provide the documents and information must not delay the conduct of the external review. If BCBSNM fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reversethe Adverse Benefit Determination of Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify BCBSNM and You or Your authorized representative.
- Upon receipt of any information submitted by You or Your authorized representative, the assigned IRO must within one business day forward the information to BCBSNM. Upon receipt of any such information, BCBSNM may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by BCBSNM must not delay the external review. The externalreview may be terminated as a result of the reconsideration only if BCBSNM decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, BCBSNM must provide written notice of its decision to You and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from BCBSNM.
- Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by adecisions or conclusions reached during BCBSNM's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available, and the IRO considers them appropriate, will consider the following in reaching a decision:
    - Your medical records;
    - The attending healthcare professional's recommendation;
    - Reports from appropriate healthcare professionals and other documentssubmitted by BCBSNM, You, or Your treating provider;
    - The terms of Your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicablelaw;
    - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelinesdeveloped by the federal government, national or professional medical societies, boards, and associations;
    - Any applicable clinical review criteria developed and use by BCBSNM,unless the criteria are inconsistent with the terms of the plan or with applicable law; and
    - The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available, and the clinical reviewer orreviewers consider appropriate.
- Written notice of the final external review decision must be provided within 45days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to BCBSNM and You or Your authorized representative.
- The notice of final external review decision will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the dateor dates of service, the healthcare provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
- The date the IRO received the assignment to conduct the externalreview and the date of the IRO decision;
- References to the evidence or documentation, including the specificcoverage provisions and evidence-based standards, considering in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standardsthat were relied on in making its decision;
- A statement that the determination is binding except to the extent thatother remedies may be available under state or federal law to either BCBSNM and You or Your authorized representative;
- A statement that judicial review may be available to You or Your authorized representative; and
- Current contact information, including phone number, for anyapplicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

- After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. AnIRO must make such records available for examination by the claims administrator, state, or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws, and You or Your authorized representative.

4. **Reversal of plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination of Final Internal Adverse Benefit Determination immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

11.2. Expedited External Review

1. **Request for expedited external review.** BCBSNM must allow You or Your authorized representative to make a request for an expedited external review with BCBSNM at the time You receive:
    a. An Adverse Determination if the timeframe for completion of an expedited internalappeal under the interim final regulations would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function and You have filed a request for an expedited internal appeal; or
    b. A Final Internal Adverse Benefit Determination, if the timeframe for completion ofa standard external review would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability or care, continued stay, or healthcare item or serve for which You received Emergency services, but have not been discharged from a facility.

2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, BCBSNM must determine whether the request meets the reviewability requirements set forth in the Independent External Review Program section on page 99. BCBSNM must immediately send You a notice of its eligibility determination that meets the requirements set forth in the "Standard External Review" section above.
3. **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, BCBSNM will assign an IRO pursuant to the requirements set forth in the Independent External Review Program section on page 99. BCBSNM must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.
    a. The assigned IRO, to the extent the information or documents are available, and the IRO considers them appropriate, must consider the information or documents describedabove under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during BCBSNM's internal claims and appeals process.
4. **Notice of final external review decision.** BCBSNM's contract with the assigned IRO must require the IRO to provide notice of final external review decision, in accordance with the requirements set forth in the Independent External Review Program section on page 99, as expeditiously as Your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO musts provide written confirmation of the decision to BCBSNM and You or Your authorized representative.

11.2.1. *Exhaustion*

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

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

External review may not be requested for an Adverse Benefit Determination involving a claimfor benefits for a healthcare service that You have already received until the internal review process has been exhausted.

11.2.2. *Other External Actions*

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

11.3. External Appeal for ERISA Plans

If You are still not satisfied after having completed the complaint, grievance, appeal, or reconsideration process administered by BCBSNM (described above), You may have a right tobring a civil action under ERISA section 502(a).

11.3.1. *Retaliatory Action*

BCBSNM shall not take any retaliatory action against You for making a complaint or filing anappeal under this medial plan.

11.3.2. *Appeals Process*

Two levels of appeal are permitted for each type of claim that is denied (called an Adverse Determination). Appeal determinations will be rendered as specified in How to File an Appeal, of the Employee H&W Plan SPD orthe Post-Employment H&W Plan SPD.

11.4. Pre-Service and Post-Service Claim:

1. An appeal may be filed by You, Your representative, or by a prescriber (on Your behalf).
2. You, Your representative or prescriber, on Your behalf, may submit written comments, documents, records and other information relevant to Your request for an appeal. All such information is taken into account during the appeal process without regard to whether such information was submitted or considered when making the initial Adverse Determination.
3. Upon initial receipt of an appeal, a clinical pharmacist will review the appeal (First-Level) and may overturn the initial Adverse Determination, if appropriate. If the initial Adverse Determination is overturned, You and the prescriber, if the prescriber filed the appeal on Your behalf, will be notified of the determination in writing.
4. If the clinical pharmacist does not overturn the Adverse Determination, Express Scripts will forward the appeal request to a physician (Second Level) in the same profession and in a similar specialty that typically manages the medical condition, procedure, or treatment as mutually deemed appropriate. The physician reviewer will make the appeal determination. The clinical pharmacist completing the review of the appeal and the reviewing physician must hold an active, unrestricted license and board certification, if applicable, by the American Board of Medical Specialties (Doctor of Medicine) or the Advisory Board of Osteopathic Specialists (Doctor of Osteopathic Medicine).
5. If You are not satisfied with the decision following completion of the second-level appeal process, You may request that Express Scripts forward Your appeal request to an independent review organization (IRO). You must submit this request within 120 calendar days of Your receipt of the Second-Level appeal review denial. The IRO will engage a physician in the same profession and in a similar specialty that typically

manages the medical condition, procedure, or treatment as mutually deemed appropriate. The physician reviewer will make the appeal determination.

6. As with any Adverse Determination, approved clinical criteria will be employed to evaluate the claim under review during an appeal.
7. If within 5 working days after the filing date of the appeal there is not sufficient information to process the appeal, You, Your representative or the prescriber, who filed the appeal on Your behalf, will be notified by written communication of the information required in order to process the appeal and directions on how to resubmit the appeal.
8. If any of the appeal reviews overturns the Adverse Determination, the benefit will be allowed.

11.4.1. Urgent Claims (Expedited) Appeal:

1. An expedited appeal may be filed by You, Your representative or a prescriber, acting on Your behalf. Contact Express Scripts customer service at 877-817-1440 to initiate an appeal.
2. The clinical pharmacist or physician reviewer, in discussion with You and/or independent third-party review organization, will determine whether the appeal constitutes an expedited appeal.
3. Upon initially receiving an expedited appeal, a clinical pharmacist will review the expedited appeal and may overturn the initial Adverse Determination, if appropriate. If the initial Adverse Determination is overturned, You and the prescriber, on Your behalf, will be notified of the outcome in writing.
4. If the clinical pharmacist upholds the Adverse Determination, Express Scripts will forward the appeal request to an external Independent Review Organization (IRO). The IRO will engage a physician in the same profession and in a similar specialty that typically manages the medical condition, procedure, or treatment as mutually deemed appropriate. The physician reviewer will make the Appeal determination. The clinical pharmacist completing the review of the appeal and the reviewing physician will each hold an active, unrestricted license and board certification, if applicable, by the American Board of Medical Specialties (Doctor of Medicine) or the Advisory Board ofOsteopathic Specialists (Doctor of Osteopathic Medicine).
5. If within 24 hours after the filing date of the expedited appeal, there is not sufficient information to process the appeal, You, Your representative or the prescriber, who filed the appeal on Your behalf, will be notified verbally with a follow up in writing of the information required in order to process the appeal and directions on how to resubmit the appeal.

The decision on an expedited appeal will be rendered and communicated verbally within 24hours of receipt of the appeal request.

12. ADMINISTRATIVE SERVICES

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

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

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

Inspira Financial is the claims administrator for Your Healthcare Flexible Spending Account (HCFSA) and Health Reimbursement Account (HRA).

Express Scripts is the claims administrator for Outpatient prescription drugs.

There are no claims associated with Your Employee Assistance Program, but the service isprovided by Magellan Health Services. Magellan Health is a subcontractor to BCBSNM.

12.1. BCBSNM Member Identification Cards

IMPORTANT: Always present Your current Member identification card when obtaining healthcare. You have a Member ID card for healthcare services from BCBSNM or a Member ID card for prescriptiondrugs from Express Scripts.

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

- Your name as the Primary Covered Member
- A unique subscriber (Primary Covered Member) ID number that has been assigned toYou by BCBSNM and is linked to the Primary Covered Member's Social Security number in the BCBSNM system
- Family members ID number
- The group number
- The claims filing address
- On the back of Your Member ID card You will find:
    - Customer Service phone numbers and website
    - Prior Authorization phone number for medical/surgical
    - Prior Authorization phone number for mental health/Chemical Dependency

- 24/7 Nurseline assistance phone number
- Blue Card Access phone number for national provider location
- EAP Magellan phone number for Prior Authorization, provider location, and assistance
- MD Live phone number for provider Virtual Visits
- Applicable plan deductibles
- Applicable Out-of-Pocket Limits

12.2. Express Scripts Member Identification Cards

If You are a new enrollee in the Programs, You will receive two ExpressScripts ID cards, with dependents listed (if covered). If You need additional identification cards, You may call Express Scripts Customer Service at 877-817-1440 and request them.

IMPORTANT: Always present Your Express Scripts Member ID card when obtaining prescriptions at a retail pharmacy.

12.3. Blue Access for Members (BAM) Website

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

- Learn about health conditions, treatments, and procedures
- Search for in-network providers and compare based on demographics, qualitydesignations, etc.
- Access information on wellness topics
- Complete a health risk assessment to identify health habits You can improve, learnabout healthy lifestyle techniques, and access health improvement resources
- Use the treatment cost estimator to obtain an estimate of the costs of over 300procedures nationwide
- Make real-time inquiries into the status and history of Your claims
- View eligibility and benefit information
- View and print EOB statements online
- Print a temporary ID card or request a replacement ID card
- Update coordination of benefits status

Note: If You have not already registered as a BAM Member, go to bcbsnm.com/sandia and click on **Register Now**. Have Your BCBSNM ID card ready for Your Group and Member IDnumbers.

12.4. Express Scripts Website

The Express Scripts Member website, www.express-scripts.com, provides information at Your fingertips anywhere and anytime You have access to the Internet. This website offers practical and personalized tools and information so You can get the most out of Your benefits. Log on to:

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

You can also access the above information on the Express Scripts Rx phone app from any smartphone. Simply enter Express-scripts.com into Your smartphone browser or download theapp by going to the Apple App Store, Google Play, Android Market, or Blackberry World.

12.5. Contact Telephone Numbers and Hours of Operation

Function	Telephone Numbers
Optum Ambassador Line – 505-262-7100 Lovelace Concierge Line – 505-727-2727	
BCBSNM – www.bcbsnm.com/sandia	
Customer Service Claims questions Check eligibility Benefit information Preferred (PPO) providers list Case management	**877-498-7652** **TTY 711 in New Mexico or outside NM call 800-746-7289** 6:00 a.m. - 8:00 p.m. MT, Monday – Friday8:00 a.m. – 5:00 p.m. MT Saturdays 4373 Alexander Blvd NEAlbuquerque, NM
Inspira Financial (FSA and HRA administrator)	**833-419-0287** https://openenrollment.inspirafinancial.com/inspira/Sandia_PayFlex
BCBSNM Health Services Medical/Surgical Prior Authorization	**Phone number: 800-325-8334** **Fax number: 866-589-8253** **8:00 a.m. - 5:00 p.m. MT, Monday – Friday** **BCBSNM Medical Claims Address: BCBSNM** **P. O. Box 660058** **Dallas, TX 75266-0058**
BCBSNM Behavioral Health Unit Mental health Prior Authorization Chemical Dependency Prior Authorization Claims Inquiries	**Phone number: 877-361-7659 ~~888-898-0070~~** **Fax number: 312-946-3737** **24 hours/day, 7 days/week** **BCBSNM Behavioral Health Claims Address:** **BCBSNM Behavioral Health** **P. O. Box 660058 Dallas, TX. 75266-0058 ~~92165 Albuquerque, NM 87199-2165~~**
BCBSNM Medical and Behavioral Health Appeals Address: BCBSNM Appeals Unit P. O. Box 660058 Dallas, TX. 75266-0058 **Phone:** 800-205-9926 **Fax: 918-551-2011**	

Function	Telephone Numbers
Optum Ambassador Line – 505-262-7100 Lovelace Concierge Line – 505-727-2727	
BCBSNM – www.bcbsnm.com/sandia	
Magellan Health Services Employee Assistance Program (EAP) PriorAuthorization Participating providers	**800-424-0320** 24 hours/day, 7 days/week
BCBSNM 24/7 Nurseline Advice on medical care	**800-973-6329** 24 hours/day, 7 days/week
Virtual Visits Diagnoses & treatment on low acuity conditions	Mdlive.com/bcbsnm or mobile app24 hours/day, 7 days/week
BCBSNM Onsite Ambassador Escalated issues which the BCBSNM Customer Service toll-free number is unable toresolve	**505-962-7059** 8:30 a.m. to 5:00 p.m. MTMondays - Friday sandia@bcbsnm.com
Ovia Health Program provides information about: nutrition newborn care	**888-421-7781** 8:00 a.m. - 5:00 p.m. MT Monday - Friday
Blue Distinction Centers for Specialty Care® Bariatric Surgery Cardiac Care Complex and Rare Cancers Knee and Hip Replacement Spine Surgery Transplants	**800-325-8334** http://www.bcbsnm.com/sandia/providers/blue_distinction.html
Blue365® Discount Program	http://www.bcbsnm.com/sandia/discounts.html
Blue Access for Members (BAM) Help Desk	**888-706-0583**
• Member website assistance	**7 a.m. to 9 p.m. MT, Monday – Friday 6 a.m. to 2:30 p.m. MT, Saturday**
BlueCard Access® • Preferred (PPO) provider search while on travel • BlueCard Doctor and Hospital Finder	**800-810-2583 (BLUE)** **www.bcbsglobalcore.com**
Express Scripts Prescription Drug Program– www.express-scripts.com	
Customer Service Refill a mail order prescription Determine if a pharmacy is in the pharmacynetwork Obtain information about Your benefits Speak with a pharmacist about a prescription Request additional ID cards	**877-817-1440** 24 hours/day, 7 days/week
Sandia National Laboratories – hr.sandia.gov	

Function	Telephone Numbers
Optum Ambassador Line – 505-262-7100 Lovelace Concierge Line – 505-727-2727	
BCBSNM – www.bcbsnm.com/sandia	
HR Solutions Forms General questions Benefit information Address changes	**505-284-4700** 8:00 a.m. to 5:00 p.m. MT
Via Benefits Pre-Medicare Retiree Assistance Enrollment/disenrollment in retiree plans Address changes	**888-598-7809** www.SandiaRetireeBenefits.com

12.6. When You Change Your Address

When You move, You must change Your address with Sandia. Active Employees canchange their address through NTESS's internal website. Retirees need to change their address with Via Benefits and Sandia HR Solutions.

13. DEFINITIONS

Term	Definition
Adverse Benefit Determination or Adverse Determination	A denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a service. An Adverse Benefit Determination includes a decision to deny benefits based on: • An individual being ineligible to participate in the Programs; • Utilization review; • A service being characterized as Experimental or Investigational ornot Medically Necessary or appropriate; • A concurrent care decision; and • For medical claims, certain retroactive terminations of coverage, • whether or not there is an adverse effect on any particular benefit at any time.
Chemical Dependency	Conditions defined by patterns of usage that continue despite occupational, marital, or physical problems that are related to compulsive use of alcohol or drugs. Chemical Dependency (alcoholism and drug abuse) may also be defined by significant risk of severe withdrawal symptoms if the use of alcohol or drugs is discontinued. Chemical Dependency does not include nicotine addiction or alcohol use.
Coinsurance	The percentage of a Covered Health Service, which the Member pays after You've met the Deductible.
Congenital Anomaly	A physical developmental defect that is present at birth
Cost Effective	A procedure, service, or supply that is an economically efficient use of resources with respect to cost, relative to the benefits and harms associated with the procedure, service, or supply. When determining cost effectiveness, the situation and characteristics of the individual patient are considered.
Cosmetic Procedures	Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the claims administrator. Reshaping a nose with a prominent bump is an example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function, such as in breathing.
Covered Charge (applicable to medical plan)	The amount that BCBSNM allows for Covered Health Services using a variety of pricing methods and based on generally accepted claim coding rules. The Covered Charge for services from "contracted providers" is the amount the provider, by contract with BCBSNM (or another entity, such as another BCBS Plan), will accept as payment in full under this medical program. For Medicare-covered services, the Covered Charge is Medicare'sApproved Amount for assigned claims, or the Medicare Limiting Charge (115% of the Medicare-Approved Amount) for non-assigned claims. Noncontracting Allowable Amount — The maximum amount, not to exceed billed charges that will be allowed for a covered service received froma noncontracted provider in most cases. The BCBSNM Noncontracting Allowable Amount is based on the Medicare Allowable amount for a particular service, which is determined by the Centers for Medicaid and Medicare Services (CMS). **Medicare Allowable —** The amount allowed by CMS for Medicare-participating provider services, which is also used as a base for calculating noncontracted providers' claims payments for some Covered Health Services of noncontracted providers under this medical plan. The Medicare Allowable

Term	Definition
Covered Charge Cont'd.	amount will not include any additional payments that are not directly tied to a specific claim, for example, medical education payments. If Medicare is primary over this medical plan, and has paid for a service, the Covered Charge under this medical plan may be one of the two following amounts: **Medicare-Approved Amount —** The Medicare fee schedule amount upon which Medicare bases its payments. When Medicare is the primary carrier, it is the amount used to calculate secondary benefits under this medical plan when no "Medicare limiting charge" is available. The Medicare-Approved Amount may be less than the billed charge. **Medicare Limiting Charge —** As determined by Medicare, the limit on the amount that a nonparticipating provider can charge a Medicare beneficiary for some services. When Medicare is the primary carrier and a Medicare Limiting Charge has been calculated by Medicare, this is the amount used to determine Your secondary benefits under this medical plan. **Note:** Not all Medicare-covered services from nonparticipating providers are restricted by a Medicare Limiting Charge.
Covered Member	See Member.
Covered Health Services (applicable to medical plan)	Covered Health Services are those health services and supplies that are: • Provided for the purpose of preventing, diagnosing, or treating Illness, Injury, mental illness, Chemical Dependency, or their symptoms • Provided to You, if You meet the eligibility requirements as described in theSummary entitled Employee H&W Plan Summary Plan Description or Post-Employment H&W Plan Summary Plan Description and have enrolled into the Program • Medically Necessary/appropriate
Custodial Care	Services or supplies, regardless of where or by whom they are provided, that a person without medical skills or background could provide or could be trained to provide or are provided mainly to help You with daily living activities, including (but not limited to): 1. Walking, getting in and/or out of bed, exercising and moving 2. Bathing, toileting, administering enemas, dressing, and assisting with any other physical or oral hygiene needs 3. Assistance with eating by utensil, tube, or gastrostomy 4. Homemaking, such as preparation of meals or special diets, and house cleaning 5. Acting as a companion or sitter 6. Supervising the administration of medications that can usually be self-administered, including reminders of when to take such medications 7. Provide a protective environment. Are part of a maintenance treatment plan or are not part of an active treatment plan intended to or reasonably expected to improve Your Illness, Injury, or functional ability, or Are provided for the convenience of You or the caregiver or are provided because Your own home arrangements are not appropriate or adequate.

Term	Definition
Deductible	Covered Charges incurred during a calendar year that You must pay in full before the Program pays benefits. Does not apply to covered, in-network Preventive Care or to Outpatient prescription drugs purchased through Express Scripts.
Developmental Care	Services or supplies, regardless of where or by whom they are provided, that: • Are provided to You if You have not previously reached the level of development expected for Your age in the following areas of major life activity: 1. Intellectual 2. Physical 3. Receptive and expressive language 4. Learning 5. Mobility 6. Self-direction 7. Capacity for independent living 8. Economic self-sufficiency • Are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to Injury or Illness) or are educational in nature
Emergency	See Medical Emergency
Emergency Services **Emergency Services Cont'd.**	1. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate an Emergency Medical Condition; 2. Within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and 3. Post stabilization services which are additional services covered under the Plan that are furnished by a Non-Participating Provider or Non-Participating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after a patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay, with respect to the visit in which the services described in subsections 1 and 2, above, are provided, until: • The provider or facility determines that the participant or dependent is (i) stable; (ii) able to travel using nonmedical transportation or nonemergency medical transportation to an available Participating Provider or Participating Facility within a reasonable travel distance, taking into account the individual's medical condition; and (iii) in a condition to receive the information and provide informed consent, as described herein; • The participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-Participating Provider with respect to the Plan, of the estimated charges for the treatment and any advance limitations that the Plan may put on such

Term	Definition
	treatment, of the names of any Participating Providers at the facility who are able to provide such treatment, and that the participant or dependent may elect to be referred to one of the Participating Providers listed; and The participant or dependent gives informed consent to continued treatment by the Non-Participating Provider, acknowledging that the participant or dependent understands that continued treatment by the Non-Participating Provider may result in greater cost to the participant or dependent.
Experimental or Investigational (applicable to medical plan)	Experimental or Investigational Services: medical, surgical, diagnostic, psychiatric, Chemical Dependency or other healthcare services, technologies, supplies treatments, procedures, drug therapies, medications or devices that, at the time BCBSNM makes a determination regarding coverage in a particular case, are determined to be any of the following: Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; Subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational); or The subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight **EXCEPTIONS**: Clinical trials for which benefits are available as described under clinical trials: If You have a life-threatening Illness or condition (one that is likely to cause death within one year of the request for treatment), BCBSNM may, at their discretion, consider an otherwise Experimental or Investigational service to be a Covered Health Service for that Illness or condition. Prior to such consideration, BCBSNM must determine that, although Unproven, the service has significant potential as an effective treatment for that Illness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.
Health Assessment	A Health Assessment is a confidential online questionnaire that asks You about health history, lifestyle behaviors (such as smoking and exercise habits) and Your willingness to make changes.
Health Care Facility	The term “Health Care Facility” (for non-Emergency Services) means each of the following: • A hospital (as defined in section 1861(e) of the Social Security Act); • A hospital outpatient department; • A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and • An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act

Term	Definition
Hospice	A program provided by a licensed facility or agency that provides home healthcare, homemaker services, emotional support services, and other service provided to a terminally ill person whose life expectancy is six months or less as certified by the person's physician.
Independent Freestanding Emergency Department	A health care facility (not limited to those described in the definition of Health Care Facility) that is geographically separate and distinct and licensed separately from a hospital under applicable State law and provides Emergency Services.
Illness	A disease, disorder, or condition that requires treatment by a physician. For female Member, Illness includes childbirth or pregnancy. The term Illness as used in this Benefit Summary does not include mental illness or Chemical Dependency, regardless of the cause or origin of the mental illness or Chemical Dependency.
Injury	Bodily damage from trauma other than Illness, including all related conditions and recurrent symptoms.
Inpatient Stay	An uninterrupted confinement of at least 24 hours following formal admission to a hospital, Skilled Nursing Facility or inpatient rehabilitation facility.
Intensive Outpatient Program	A program that provides 9 to 20 hours per week (less than four hours per day) of professionally directed evaluation and/or treatment.
Maintenance Care	Treatment beyond the point where material or significant improvement is to be expected. The treatment results in no measurable or objective improvement. For modality treatments, such as Nonsurgical Spinal Treatment or physical therapy, the treatment provides no evidence of lasting benefit; treatment provides only relief of symptoms.
Medical Emergency	An accidental Injury or a medical condition, including mental health condition or substance use disorder that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) serious jeopardy to his/her health (or, if pregnant, to the unborn child); 2) serious impairment to the bodily functions; or 3) serious dysfunction of any bodily organ or part.
Medically Necessary or Medically Appropriate (applicable to medical plan) **Medically Necessary or Medically Appropriate Cont'd.**	A service or supply that is ordered by a physician, the medical director, and/or a qualified party or entity selected by BCBSNM, and determined as: Provided for the diagnosis or direct treatment of an Injury or Illness Appropriate and consistent with the symptoms and findings or diagnosis and treatment of Your Injury or Illness Provided in accordance with generally accepted medical practice on a national basis The most appropriate supply or level of service that can be provided on a Cost-Effective basis including, but not limited to, inpatient vs. Outpatient care, electric vs. manual wheelchair, surgical vs. medical or other types of care Allowable under the provisions of the Programs as prescribed by Your physician. IMPORTANT: The fact that a physician may provide, prescribe, order, recommend, or approve a service or supply does not in itself make the service or supply Medically Necessary or make the charge for it allowable even though the service or supply is not specifically listed as an exclusion in the Programs.

Term	Definition
Medicare- Approved Amount	The Medicare fee schedule amount upon which Medicare bases its payments. This amount may be less than the actual amount charged by the provider. The out-of-network coverage for Covered Health Services under the medical plan is based on 100% of the Medicare-Approved Amount.
Member	An enrolled participant or enrolled family member. This term refers to a person only while enrolled under the Programs. References to "You" and "Your" throughout this document are references to a Member.
Non-preferred Provider	A provider that is not contracted with a BCBS Plan to be part of the BCBS Preferred Provider network.
Nonsurgical Spinal Treatment	Detection or nonsurgical correction (by manual or mechanical means) of a condition of the vertebral column, including distortion, misalignment, and subluxation to relieve the effects of nerve interference that results from or relates to such conditions of the vertebral column.
No Surprises Act	The federal No Surprises Act (Public Law 116-260, Division BB).
Out-of-Pocket Limit or Out- of-Pocket Limit	Your financial responsibility for covered expenses before the Programs reimburses additional Covered Charges at 100%, with no Deductible, for the remaining portion of that calendar year.
Outpatient	A person who visits an office, a clinic, Emergency room, or health facility and receives healthcare without being admitted as an overnight patient (under 24-hour stay).
Outpatient Surgery	Any invasive procedure performed in a hospital or surgical center setting when a patient is confined for a stay of less than 24 consecutive hours.
Partial (or day) Hospitalization	A program that provides Covered Health Services to persons who are receiving professionally directed evaluation or treatment and who spend only part of a 24-hour period (but at least four hours per day) or 20 hours per week in a hospital or treatment center.
Prior Authorization	The process whereby You and/or Your physician call to obtain prior approval for certain healthcare services and employee assistance program benefits.
Preferred Provider	Healthcare professionals and facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, the BCBS Association, or another BCBS Plan as "preferred" (PPO) providers. An "HMO" or a "participating-only" provider is not a Preferred Provider under the medical plan. When scheduling an appointment for "in-network" services, ask if the provider is a BCBS "Preferred Provider."
Primary Covered Member	The person to whom the coverage is issued; that is, NTESS Employee, Retiree, Surviving Spouse, Long Term Disability Terminee or the individual who is purchasing temporary continued coverage.
Recommended Clinical Review	A Recommended Clinical Review (Predetermination) is a voluntary, written request by a member or a provider to determine if a proposed treatment or service is covered under a patient's health benefit plan.
Residential Treatment Facility	A Residential Treatment Facility provides acute overnight services for the care of a Chemical Dependency disorder or overnight mental health services for those who do not require acute care.
Skilled Nursing Facility	A nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a hospital is considered a Skilled Nursing Facility for purposes of the medical plan.

Term	Definition
Sound Natural Teeth	Teeth that are whole or properly restored; are without impairment or periodontal disease and are not in need of the treatment provided for reasons other than dental Injury.
Specialist	Any physician who is devoted to a medical specialty.
Unproven Services (applicable to medical plan) **Unproven Services Cont'd.**	Health services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature. Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received. Well-conducted cohort studies are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group. BCBSNM has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, BCBSNM issues medical and drug policies that describe the clinical evidence available with respect to specific healthcare services. These medical and drug policies are subject to change without prior notice. Note: If You have a life-threatening Illness or condition (one that is likely to cause death within one year of the request for treatment), BCBSNM may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Illness or condition. Prior to such a consideration, BCBSNM must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Illness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health. BCBSNM may, in their discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Member with an Illness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met: • If the service is one that requires review by the U.S. Food and Drug Administration (FDA), • It must be FDA-approved • It must be performed by a physician and in a facility with demonstrated experience and expertise • You must consent to the procedure acknowledging that BCBSNM does not believe that sufficient clinical evidence has been published in peer- reviewed medical literature to conclude that the service is safe and/or effective • At least two studies must be available in published peer-reviewed medical literature that would allow BCBSNM to conclude that the service is promising but Unproven • The service must be available from a network physician and/or network facility • The decision about whether such a service can be deemed a Covered Health Service is solely at BCBSNM's discretion. Other apparently similar promising but Unproven Services may not qualify.

Term	Definition
Urgent Care	Treatment of an unexpected Illness or Injury that is not life threatening but requires Outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering such as high fever, a skin rash, or an ear infection.
Urgent Care Center	Can be attached to a hospital or be freestanding, staffed by licensed physicians and nurses, and providing healthcare services.

14. BLUE365

Blue365 is just one more advantage of being a Blue Cross and Blue Shield of New Mexico (BCBSNM) Member. With this program, You may save money on health and wellness products and services from top retailers that are not covered by insurance. There are no claimsto file and no referrals or pre-authorizations.

With discounts on health-related products, along with discounts on health and fitness clubs, weight-loss programs and so much more, You can decide what choices are right for You whilesaving money.

- **Receive discounts, promote Your health** – Discounts and offers from national andlocal health and wellness companies encourage mind and body wellness.
- **Share the health** – Blue365 can make living well a family activity, with deals for gym discounts, well-balanced meal ideas and more.
- **Be in the know** – After You register, You'll get weekly deals delivered straight to Your inbox, helping You focus on Your health.

Once You sign up for the Blue365 website at https://www.bcbsnm.com/sandia/health-and-wellness/blue365,You will receive weekly "Featured Deals," via email.

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