Blue Cross Community Centennial™
A Centennial Care Plan

2016 Member Handbook
A Guide to Your BCBSNM Managed Care Plan

ADMINISTERED BY:

Blue Cross Blue Shield of New Mexico

CENTENNIALCARE
Dear Blue Cross Community Centennial Care Member,

Welcome to the Centennial Care Managed Health Care Program, administered by Blue Cross and Blue Shield of New Mexico (BCBSNM). We look forward to working with you and your health providers to help you get the health care you need.

BCBSNM has contracts with providers all over New Mexico and along its borders in Texas, Arizona, and Colorado. When a provider has a contract to provide services to Centennial Care members, those providers are in the BCBSNM Centennial Care network. Centennial Care members can choose to see any provider in the BCBSNM Centennial Care network. To see a provider that is not in the BCBSNM network, you may need to get prior authorization from us. There are exceptions to this rule. The exceptions are explained in Section 4: Covered and Non-Covered Benefits of this handbook.

For more information about our company (such as its structure or operations), or to find out more about our provider network and any questions you may have about our provider incentive plans, please call Member Services at 1-866-689-1523.

Please take some time to review this handbook and any other materials you received in your welcome packet. Learning how your program works can help you make the best use of your health care benefits.

Note: The State of New Mexico Human Services Department (HSD) may change the benefits described in this handbook. If that happens, BCBSNM will notify you within 30 calendar days. Benefit changes and the names of Primary Care Providers (PCPs) leaving the program will also appear in your Member Newsletter. This handbook is updated on a yearly basis and the most updated version will be mailed to you.

Sincerely,

Sharon Huerta
Centennial Care CEO, Blue Cross and Blue Shield of New Mexico

PO. Box 27838 • Albuquerque, New Mexico 87125-7838
1-866-689-1523 • bcbsnm.com /medicaid
### Table of Contents

**Member Assistance** ........................................... 3
  24/7 Nurseline ........................................... 3
  Non-Emergency Transportation ................................ 3
  BCBSNM Website, Internet Help and Email ..................... 3
  What to Do in an Emergency ................................ 4
  Interpreter Services ....................................... 4
  Contacting Member Services ................................ 4
  Writing to Member Services ................................ 4
  How We Can Help ........................................ 5
  After-Hours Help .......................................... 5
  Ombudsman Specialist ..................................... 5
  Community Social Services ................................ 6
  Health Education and Health Literacy ....................... 6
  Member Feedback ......................................... 6
  Member Advisory Board ................................ 7

**Member Rights and Responsibilities** ..................... 8
  Member Rights ........................................... 8
  Member and Member Representative Responsibilities .... 10

**Section 1: Enrollment** .................................... 11
  Managed Care Program Participation .......................... 11
  Selecting a Managed Care Organization (MCO) .............. 11
  Auto Assignment ......................................... 11
  Lock-In Period .......................................... 11
  Re-enrollment ........................................... 11
  Coverage Due to Being Pregnant ............................. 11
  Newborns .................................................. 11
  ID Cards ................................................... 12
  Change in Eligibility and/or Address ......................... 12
  When to Contact your ISD Case Worker ...................... 12

**Section 2: Native Americans** ............................. 13
  Prior Authorizations ..................................... 13
  Copayments ............................................... 13
  Care Coordinator ........................................ 13
  Native American Advisory Board ............................ 13

**Section 3: Providers** ................................... 14
  Provider Directory and Online Provider Finder® ........... 14
  Primary Care Physicians (PCPs) ...................................... 15
  Choosing a PCP ......................................... 15
  Changing PCPs .......................................... 16
  Medicare PCP Selection ................................ 16
  PCP Lock-In ............................................. 16
  Specialists ............................................... 16
  Specialist PCP .......................................... 16
  PCP Terminations ....................................... 16
  Referrals ................................................ 17
  Out-of-Network Providers ................................ 17
  Filing Claims for In-Network Providers ..................... 17
  Filing Claims for Out-of-Network Providers ............... 18
  Itemized Bills ........................................... 18

  Making an Appointment ...................................... 18
  Transportation to Appointments ................................ 19
  Second Opinions ......................................... 19
  Cancelling an Appointment ................................. 19
  Always Talk to Your Doctor ................................ 20

**Section 4: Covered and Non-Covered Benefits** .......... 21
  Prior Authorization ....................................... 21
  Children’s Health Insurance Program (CHIP) ............... 21
  Working Disabled Individuals (WDI) ........................ 21
  Copayments ............................................... 22
  Other Times You May Have to Pay for Services ............ 22
  Annual Member Copayment Maximum ......................... 22
  Other Insurance ......................................... 23
  Outside New Mexico ...................................... 24
  Duplicate (Double) Coverage ................................ 24
  Experimental, Investigational, or Unproven Services .... 24
  No Effect on Treatment Decisions ........................... 25
  Medically Unnecessary Services ............................ 26
  No Legal Payment Obligation ................................ 26

**Section 4A: Physical Health Benefits** .................. 27
  Preventive Services ....................................... 27
  Well-Child Visits ....................................... 27
  Early and Periodic Screening, Diagnostic and Treatment (EPSDT) ...................................... 27
  Adults ..................................................... 28
  Medical/Surgical Services ................................ 28
  Non-Covered Medical Services .............................. 29
  Family Planning Services ................................ 29
  Pregnancy-Related and Maternity Services .................. 30
  Prenatal Care ............................................ 31
  Special Beginnings® ..................................... 31
  Infant Car Seat and Portable Crib and Diaper Programs .......... 31
  Birthing Options Program ................................ 32
  Urgent Care Services .................................... 32
  Emergency Services ....................................... 33
  What to Do in an Emergency ............................... 33
  What is Not an Emergency ................................ 33
  Emergency Room and Ambulance Services ................... 33
  Observation Stays in the Hospital ............................ 34
  Follow-Up Care ......................................... 34
  What is Not Covered for Emergency Care .................... 34

**Section 4B: Behavioral Health Benefits** ............... 35
  What is Not Covered for Behavioral Health Benefits ....... 36

**Section 4C: Long-Term Care and Community Benefits** .... 37
  Agency-Based Community Benefit ........................... 37
  What is Not Covered for Agency-Based Community Benefit Services ...................................... 37
# Table of Contents

- **Self-Directed Community Benefit** .................................. 37
- **Your Participation** .................................................. 38
- **Recruiting, Hiring, Supervising, and Firing Providers** ........ 38
- **What is Not Covered for Self-Directed Community Benefit Services** .................................. 38

### Section 4D: Prescription Drug Benefits

- **Drug List** .......................................................... 40
- **Exceptions** ....................................................... 40
- **Covered Medications and Other Items** .................. 41
- **Retail Pharmacy Program** ..................................... 41
- **Member Copayments under WDI and CHIP** ........ 42
- **Drug Plan Supply Limits** ..................................... 42
- **90-Day Supply** .................................................. 42
- **Mail-Order Program** .......................................... 42
- **What is Not Covered for Prescription Drugs and Other Items** .................................. 43
- **Brand-Name Exclusion** ..................................... 44
- **Pharmacy Lock-In** ............................................ 44

### Section 4E: Vision Benefits

- **What is Not Covered for Vision Care** .................... 45

### Section 4F: Dental Benefits

- **Covered Dental Services** ..................................... 46
- **What is Not Covered for Dental Services** ............ 46
- **Finding a Dentist** ............................................ 46
- **Urgent Dental Care** .......................................... 46
- **Non-Urgent Dental Care** .................................. 46
- **Routine Dental Checkup** .................................. 46

### Section 4G: Transportation Benefits

- **What Is Not Covered for Transportation Services** .... 48
- **Scheduling Transportation for Routine Care** ....... 49
- **Transportation Services Needing Prior Authorization for Long Distance Travel** .......... 49
- **Meals and Lodging** .......................................... 49
- **Payment for Mileage** ....................................... 50
- **Address for Expense Reports and Mileage** .......... 51
- **Transportation Services for Rides to PCP Offices Requiring Authorization** .......... 51
- **Rides to Out-of-Network Providers** .................... 51
- **Accompanying Persons or Family Members** .......... 51
- **Picking Up Medical Supplies and Prescriptions** .... 51

### Section 4H: Value-Added Services

- **Value-Added Services** ...................................... 55
- **Covered and Non-Covered Services** .................... 56

### Section 6: Care Coordination

- **Considering Your Needs** .................................. 59
- **Care Coordination Levels** ............................... 59
- **Care Coordination** .......................................... 59
- **Getting Help with Special Health Care Needs** .... 60
- **Community Social Services** ........................... 61
- **Utilization Management** .................................. 61

### Section 7: Grievances (Complaints) & Appeals

- **Grievance (Complaint)** ..................................... 62
- **Filing a Grievance** ........................................... 62
- **Grievance Addresses and Phone Numbers** ........ 62
- **Time Limits for Filing a Grievance** .................... 62
- **Time Frame for an Answer to a Grievance** .......... 62
- **People Who Can File a Grievance** ..................... 63
- **Process to Follow if You Disagree with the Final Grievance Decision** .................. 63
- **Appeal** ....................................................... 63
- **Time Limits for Filing an Appeal** ....................... 63
- **Filing an Appeal** ............................................ 63
- **Appeals Addresses and Phone Numbers** ............ 64
- **How Your Appeal is Handled** ........................... 64
- **Keeping Your Services During an Appeal** ........... 64
- ** Expedited Appeal** ........................................ 64
- ** Expedited Appeal Request Denials** .................. 65
- ** Fair Hearing** .............................................. 65

### Section 8: Disenrollment

- **Annual Choice Period** .................................... 66
- **Moving out of State** ......................................... 66
- **Member Disenrollment Requests** ....................... 66
- **HSD Reasons for Disenrolling Members** ........... 66
- **BCBSNM Reasons for Disenrolling Members** .... 66
- **Disenrolling During a Hospital Stay or While in a Nursing Facility** .................. 67
- **How to Disenroll** ......................................... 67

### Section 9: General Information

- **Changes to Handbook or Benefits** ..................... 68
- **Disclosure and Release of Information** ............... 68
- **Advance Directives** ....................................... 68
- **Mental Health Advance Directives** .................... 68
- **Major Disasters** ........................................... 68
- **Women’s Health and Cancer Rights Act of 1998** .... 69
- **Health Care Fraud and Abuse** .......................... 69
- **How You Can Help** ....................................... 69
- **Reporting Fraud and Abuse** ............................ 69
- **Medical Policy** ............................................ 70
- **Privacy of Your Information** ............................ 70
- **Independent Companies** ................................ 71
BCBSNM’s Medicaid plan is called Blue Cross Community Centennial™. When you have a question about Centennial Care, you may call us at 1-866-689-1523, or you may visit our office in Albuquerque. When visiting our office, an appointment is not needed.

Telephone Hours: Monday through Friday from 6 a.m. to 8 p.m.
Office Hours: Monday through Friday from 8 a.m. to 5 p.m.
Saturdays and most holidays from 8 a.m. to 5 p.m.
Location: 4373 Alexander Blvd. NE, Albuquerque, NM 87107

If you need help after hours, you may call Member Services at 1-866-689-1523 and leave a message. We will return your call by 5 p.m. the next business day.

24/7 Nurseline
If you can’t reach your Primary Care Provider (PCP), the free 24/7 Nurseline will connect you with a nurse who can help you decide if you need to go to the emergency room or urgent care center, or if you should make an appointment with your PCP. If you think you have an urgent problem and your provider cannot see you right away, call the Nurseline for advice. Call toll-free: 1-877-213-2567.

We also have a phone library of more than 1,000 health topics available through the Nurseline. More than 600 of these topics are available in Spanish.

Non-Emergency Transportation
To request a ride to a scheduled appointment, call the LogistiCare® Reservation Line at 1-866-913-4342. Call at least three working days before your visit, Monday through Friday from 8 a.m. to 5 p.m. To return home or to arrange a ride after hours (such as for urgent care), call the Ride Assist phone line. You can call 1-866-418-9829 toll-free 24 hours a day, 7 days per week. For more information, see Section 3: Providers.

BCBSNM Website, Internet Help and Email
Do you need to find a provider, download the Member Handbook, view the drug list, or find forms and other plan information? Visit the BCBSNM website at bcbsnm.com/medicaid. You can also email Member Services from the website (go to Contact Us).

If you have Internet access, BCBSNM has online programs and tools you can use. Blue Access for Members™ (BAM) is our secure member portal that allows you to:

- Read your Member Handbook
- Search for health care providers that participate with BCBSNM for Centennial Care - doctors, hospitals, others
- Read frequently asked questions about your health plan
- Find health and wellness information
- Search a list for drugs that are covered by your health plan and learn about generic drugs
- Print a temporary ID
- Download forms
- Find Internet links to other services, important phone numbers, and email addresses
- Email BCBSNM a question or comment via secure messaging
To check out our online features and programs, log in to BAM. If you have never logged in to BAM before, click “Register Now” in the login box. Then follow the steps to register for BAM.

If you need help getting into BAM, call the Blue Access Help Desk toll-free at 1-888-706-0583 (TTY: 711). The Help Desk is available Monday through Friday 7 a.m. to 9 p.m., and Saturday 6 a.m. to 2:30 p.m. Mountain Time.

We encourage you to enroll in BAM and use the online features. Programs and program rules may change or end without notice as new programs are designed and/or as your needs change.

If you have questions about your Blue Cross Community Centennial health plan, call Member Services at 1-866-689-1523.

What to Do in an Emergency

If there is a need for cardiopulmonary resuscitation (CPR), or there is an immediate threat to your life or limb, call 911. If there is no need to call 911, go to the nearest hospital or emergency room. Prior authorization is not needed for emergency services. You should call your PCP as soon as possible after receiving care to arrange follow-up services.

See Section 4A: Physical Health Benefits for details on getting emergency care. Do not use the emergency room in a non-emergency situation. If you are a member receiving services at a Core Service Agency (CSA), you may also use your crisis plan for further instructions and contact your CSA crisis line. Before an emergency arises, please contact your assigned Care Coordinator and ask about a personal crisis plan.

Interpreter Services

Tell your provider’s office when making an appointment if you need an interpreter for any language other than English, or for sign language. The provider should have an interpreter there during your appointment. During your visit, if your provider cannot offer you translation services, please call Member Services.

If you need oral interpretations in any language, please call Member Services. Written materials will also be translated into Spanish or another format if needed.

Deaf, hard-of-hearing, and speech-disabled callers may use the New Mexico Relay Network. Dialing 711 connects the caller to the Human Services Department/Medical Assistance Division (HSD/MAD) transfer relay service for TTY and voice calls.

Contacting Member Services

When you have questions about Centennial Care, you may call, write, or email us. You may also visit our office in Albuquerque. We are here to help you. Call us at 1-866-689-1523. For help at any time, you can access our telephone number, which is listed on the back of your ID card.

Writing to Member Services

Send your question to:
Blue Cross Community Centennial
P.O. Box 27838
Albuquerque, NM 87125-7838
Member Assistance

How We Can Help
Whether you call, write, email, or visit BCBSNM, Member Services Advocates can help with the following:

• Picking a PCP or finding other Centennial Care network providers
• Arranging transportation to provider appointments
• Prior authorization requests
• Checking on a claim status
• Ordering a replacement ID card, provider directory, handbook, or member forms
• Any questions about what is covered and what is not covered under the Centennial Care program

After-Hours Help
If you need help or want to file a complaint outside normal business hours, you may call Member Services. Your call will be answered by our automatic phone system. You can use this system to:

• Leave a message for us to call you back on the next business day
• Leave a message saying you have a complaint or appeal
• Talk to a nurse at the 24/7 Nurseline right away if you have a health problem

Ombudsman Specialist
The Ombudsman Specialist is available to all Centennial Care members at no cost. The Ombudsman explores problems and deals with them fairly. The Ombudsman advocates for your rights. This is done by using Medicaid guidelines and BCBSNM resources to help you. The Ombudsman wants to help you receive the benefits of your Blue Cross Community Centennial health plan.

The Ombudsman can:

• Review and address your concerns regarding services
• Address your concerns about benefits you feel should be covered but were denied
• Help you understand or clarify your rights and responsibilities
• Help you understand the covered services that are available to you
• Help you reach appropriate BCBSNM personnel
• Help you understand the pros and cons of your possible options
• Help you understand BCBSNM policies and procedures
• Help you get the most out of your health care benefits

You can reach the Ombudsman Specialist by phone or email:

Toll Free: 1-888-243-1134
TTY: 711
Email: NMCentennialCareOmbudsman@bcbsnm.com
Community Social Services
The Community Social Services program is available to all Centennial Care members. This service is to help you find community resources to help keep you healthy and safe. We are the connectors between you and the many nonprofit organizations helping people in the community. Call us at 1-866-689-1523, option 6, between 8 a.m. to 5 p.m., Monday through Friday. We can help you find resources such as the following:
- Food pantries
- Benefit coordinators
- Early Head Start Program for your child
- Food stamp, TANF, or WIC office
- Help with your electric bill
- Information regarding local support groups/services
- Other community resources

Health Education and Health Literacy
We offer many ways to access information about health promotions, maintenance, and prevention for you and your children. Listed below are the ways to get this information. Visit our website at bcbsnm.com/medicaid where you can:
- Read the health newsletter
- Find answers to regularly asked questions
- Sign up for text messages to be sent to your cell phone and email. These messages will give you information about diabetes, weight loss, and other important topics
- Access health education trainings
- Find information about how to talk to your provider or nurse during your visits

- Find Centennial Care on Facebook and Twitter to learn more about health education topics and community events
- Find information about joining in special programs such as Special Beginnings, Diabetes Lifestyle Coaching, and Care Management
- Call Member Services at 1-866-689-1523 for more information

To help you connect with community resources, we participate at community health fairs and outreach events. When an event is scheduled in your area, you will receive a mailing to let you know which health topics will be discussed and what screenings will take place.

Centennial Care gives information about health literacy at events in your community and brochures at your provider’s office. The goal is to assist you to be an informed member and to receive the full benefit of all the services Centennial Care offers. If you need any other materials, just call our Member Services Department at 1-866-689-1523 and ask a Member Advocate to help you.

Member Feedback
BCBSNM needs your help to improve our service to you. Please email, call, or write to Member Services with ideas on how BCBSNM can improve service to you.
Member Advisory Board

BCBSNM also holds several Member Advisory Board (MAB) meetings. The MAB is a team of Blue Cross Community Centennial members and BCBSNM staff who meet to talk about ways to improve the services we provide. You may get a notice in the mail or a phone call asking you to join us for a meeting. You can also call or write us and let us know you want to join. To learn more about MAB or to make a reservation, please call **505-816-4316** (TTY: **711**) or email bccc_ab@bcbsnm.com. Meeting dates will be printed in the member newsletter. You can also visit our website at [bcbsnm.com/medicaid](http://bcbsnm.com/medicaid) for the most current information.
Member Rights

It is the policy of BCBSNM to make sure that you know you have the below rights.

As a member of Centennial Care, you have the right to:

- Health care when medically necessary as determined by a medical professional or BCBSNM; 24 hours per day, 7 days per week for urgent or emergency care services, and for other health care services as defined in the member handbook
- Receive health care that is free from discrimination
- Be treated with respect and recognition of your dignity and right to privacy
- Choose a PCP or provider from the BCBSNM network and be able to refuse care from certain providers (a prior authorization may be necessary to see some providers)
- Receive a copy of, as well as make recommendations about BCBSNM’s member rights and responsibilities policy
- Be provided with information about BCBSNM’s member rights and responsibilities, policies, and procedures regarding products, services, providers, appeals procedures, and other information about the company and get information about how to access covered services and the providers in our network
- Receive a paper copy of the official Privacy Notice from the Human Services Department upon request
- Receive information in compliance with the Americans with Disabilities Act (ADA)
- Be given the name and professional background of anyone involved in your treatment and the name of the person primarily responsible for your care
- Choose a surrogate decision-maker to be involved and assist with care decisions as appropriate; this can be done by you or your legal guardian
- Have an interpreter present when you do not speak or understand the language that is being spoken
- Participate with your provider in all decisions about your health care, including gaining an understanding of your physical and/or behavioral condition, being involved in your treatment plan, deciding on acceptable treatments, and knowing your right to refuse health care treatment or medication after possible consequences have been explained in a language you understand. Family members, legal guardians, representatives or decision-makers also have this right, as appropriate
- Talk with your provider about treatment options, risks, alternatives, and possible results for your health conditions, regardless of cost or benefit coverage and have this information documented in your medical record. If you cannot understand the information, the explanation will be provided to your family, guardian, representative, or surrogate decision-maker
- Give informed consent for physical and/or behavioral health medical services
- Decide on advance directives for your physical and/or behavioral health care. These decisions can be made by you or your legal guardian as allowed by law
Member Rights and Responsibilities

- Access your medical records in accordance with the applicable federal and state laws, which means that you have the right to receive communications about your private records, request a change or addition if you feel they are incomplete or wrong, and request restricted disclosure of your medical records, and the right to be notified if accidental disclosure occurs. If the member has a legal guardian, the legal guardian has the right to access the member’s medical records.

- Request a second opinion from another BCBSNM provider. This can be done by you or your legal guardian.

- File a grievance or appeal about BCBSNM or the care that you received and receive an answer within a reasonable time. Complaints can be filed with BCBSNM and/or the New Mexico Human Services Department (HSD) without fear of retaliation. You can also request a Fair Hearing with HSD.

- Receive prompt notification of termination or changes in benefits, services, or provider network.

- Be free from harassment from BCBSNM or its network providers in regard to contractual disputes between BCBSNM and providers.

- Select a health plan and exercise switch enrollment rights without threats or harassment.

- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal or New Mexico regulations on the use of restraints and seclusion.

- Exercise rights without concern that care will be negatively affected.

- Receive information on available treatment options and alternatives in an understandable manner.
Member Rights and Responsibilities

**Member and Member Representative Responsibilities**

It is the policy of BCBSNM to make sure that you know about the below responsibilities.

As a member of Centennial Care, you have these responsibilities:

- Give complete health information to help your provider give you the care you need
- Follow your treatment plan and instructions for medications, diet, and exercise as agreed upon by you and your provider
- Do your best to understand your physical, long-term care, and/or behavioral health conditions and take part in developing treatment goals agreed upon by you and your provider
- Make appointments ahead of time for provider visits
- Keep your appointment or call your provider to reschedule or cancel at least 24 hours before your appointment
- Tell your providers if you don’t understand explanations about your health care
- Treat your provider and other health care employees with respect and courtesy
- Show your ID card to each provider before receiving medical services (or you may be billed for the service)

- Know the name of your PCP and have your PCP provide or arrange your care
- Call your PCP or the 24/7 Nurseline before going to an emergency room, except in situations that you believe are life threatening, or that could permanently damage your health, or if you are having thoughts of harm to yourself or others
- Provide information to New Mexico HSD and BCBSNM of your:
  - Current mailing address
  - Current phone number, including any land line and cell phone, if available
  - Current emergency contact information
  - Current email address, if available
- Tell New Mexico HSD and BCBSNM about changes to your phone number or address
- Tell BCBSNM if you have other health insurance, including Medicare
- Give a copy of your living will and advance directives regarding your physical, long-term care, and/or behavioral health to your PCP to include in your medical records
- Read and follow the *Member Handbook*
Section 1: Enrollment

Managed Care Program Participation
When you apply for Medicaid coverage at your Income Support Division (ISD) office, you will need to pick a managed care plan. All members have to pick a managed care plan except for Native American members who are not receiving a nursing facility level of care. If you are Native American and receiving a nursing facility level of care, or have both Medicare and Medicaid, you will have to enroll in a managed care plan.

Selecting a Managed Care Organization (MCO)
You can choose an MCO when you apply for Medicaid coverage at your local ISD office.

Auto Assignment
If you do not pick an MCO when you are filling out your Medicaid application, you will automatically be assigned to one. You will randomly be assigned to an MCO unless one of the following occurs:
- If you were covered by an MCO for less than two months since your coverage terminated; if you re-enroll in Medicaid during this period, you will be automatically assigned back to same MCO
- Family members will be assigned to the same household MCO
- Newborns will be covered by the same MCO as their mother’s MCO

Lock-In Period
Within the first 90 calendar days of your effective date with Centennial Care, you can choose a new MCO. After 90 days, you cannot choose a new MCO until your next 12-month redetermination period with HSD.

Re-enrollment
Most members have to renew Medicaid coverage every 12 months. This can be done through the ISD office, or in some cases, by calling HSD at 1-888-997-2583.

Coverage Due to Being Pregnant
Some women are eligible for Medicaid because they are pregnant. Coverage for these members lasts for two months after the pregnancy has ended.

Newborns
Medicaid-eligible newborns have coverage for 12 months starting with the month of birth. If the mother is enrolled in an MCO, the child is enrolled in the same MCO. Up to 90 calendar days after the newborn’s birth, the baby’s MCO can be changed if the mother (or legal guardian) requests it.

During your prenatal visits, be sure to let your provider know the name of the PCP you want for your baby. After your baby is born, the hospital will complete the Notice of Birth form, which is sent to your MCO. It is very important to tell your ISD case worker right away that your baby has been born. They will work with your MCO to get your newborn enrolled and mail ID cards to you.

Remember, the sooner your ISD case worker knows your baby is born, the sooner you can arrange medical services for your baby. This includes shots and well-baby checkups. If you have any questions about enrolling your baby, call your Care Coordinator at 1-877-232-5518, option 3.
Section 1: Enrollment

ID Cards
Your Centennial Care ID card gives you the information needed for covered health care. Show your ID card to your provider when you receive services. This ID card can be used to get prescription drugs, physical health, behavioral health, long-term care, dental, and vision services. You can also show your blue Medicaid plastic card that you received from your ISD office. If you have Medicare, also remember to show that card. Do not let anyone (other than you) use your Centennial Care ID card. If you do this, you could lose your Medicaid eligibility.

If you need to order a replacement Centennial Care ID card, call Member Services at 1-866-689-1523. Your replacement ID card will be sent to you within 10 calendar days of ordering it. If you need services before your ID card arrives, you can go to bcbsnm.com, log in to Blue Access for Members (BAM), and print a temporary ID. If you have never logged in to BAM before, follow the steps to register for BAM. If you need help getting in to BAM, call the Blue Access Help Desk toll-free at 1-888-706-0583.

Change in Eligibility and/or Address
A lot of important information is mailed to the address you gave to the ISD office. If you change your address or phone number, it is very important to call your ISD office right away and give them your new information. Medicaid eligibility is determined based on how many people are in your family. If you have a change in family size, it is important to report this to the ISD office right away.

When to Contact your ISD Case Worker
You need to call your county ISD case worker if you:
- Change your name
- Move to another address
- Change your phone number
- Have a new child, adopt a child, or place your child up for adoption
- Get other health insurance, including Medicare
- Move out of New Mexico
- Have any questions about your Medicaid eligibility
Prior Authorizations
Native American members do not need prior authorizations to visit any Indian Health Service, tribal health provider, or urban Indian provider (all together referred to as “I/T/U”). This also applies to Tribal 638 facilities. Even if these facilities and providers are not contracted in the Centennial Care provider network, you can still see them. We understand the importance of your relationship with your I/T/U provider. Our Care Coordinators will help you coordinate your care with these providers.

You can receive services directly from any I/T/U provider, including facilities that are operated by Native American/Alaskan Indian tribes. You can also get prescriptions at I/T/U facilities that are not on the Drug List without obtaining prior authorization from BCBSNM.

Copayments
Native American members do not pay any copayments under the Centennial Care plan.

Care Coordinator
You can ask to be assigned to a Native American Care Coordinator. If there is a time when the Native American Care Coordinator is not available, a Community Health Worker will be present for all in-person meetings with you and a non-Native American Care Coordinator.

Native American Advisory Board
The Native American Advisory Board (NAAB) is a team of Blue Cross Community Centennial members. The members on the NAAB play a key role in advising BCBSNM how to improve its services. NAAB meets four times a year at different locations. All Native American members are invited to attend.

You may get a notice in the mail or a phone call asking you to join us for a meeting. You can call or write us and let us know you want to join. To learn more about NAAB or to make a reservation, please call 505-816-2210 (TTY: 711) or email bccc_ab@bcbsnm.com. Meeting dates will be printed in the member newsletter. You can also visit our website at bcbsnm.com/medicaid for the most current information.
All of the places and people you can receive covered services from are called providers. Examples of providers are PCPs, specialists, nurses, counselors, hospitals, urgent care centers, and pharmacies.

If you want to know more about your provider, such as where he or she went to medical school or performed their residency, their qualifications, their special expertise, or board certification status, call Member Services at 1-866-689-1523.

Centennial Care helps manage health care costs by asking you to have your care coordinated by a PCP and to stay within a “network” of Centennial Care providers. These are independent providers that have agreed by contract to see Centennial Care members and follow the rules of the BCBSNM Centennial Care program. In this handbook, we call these independent providers “in-network” or “Centennial Care providers” or “Centennial Care network providers.”

Under your Centennial Care plan, you must get services from network providers. Services from providers who are not in the Centennial Care network are called out-of-network providers, and services from them will not be covered, except in the following cases:

- Urgent care or emergency care described in Section 4A: Physical Health Benefits
- Family planning services
- Native Americans visiting any I/T/U providers or Tribal 638 facilities
- When prior authorization is received from BCBSNM (such as when there is no Centennial Care provider that can give you the care you need)

If you are a new member of the Centennial Care program, we may need to plan for you to switch to a Centennial Care network provider. For example, you may already be using a home health service or seeing a provider that is not in our Centennial Care network. We will approve you to continue to see this provider while we help you change to a Centennial Care provider. Just call or email Member Services. We are here to help you.

**Provider Directory and Online Provider Finder®**

To find a Centennial Care provider in your area, please visit Provider Finder on our website at bcbsnm.com/medicaid. The Provider Finder has a list of PCPs and other network providers. You can also request a printed copy of the provider directory by calling Member Services at 1-866-689-1523. We will send one to you free of charge within 10 calendar days of your request. The directory lists all providers in the local Centennial Care network. The directory will not include any transportation providers. You must call LogistiCare to set up all non-emergency transportation. You can read about LogistiCare in Section 4G: Transportation Benefit.

The directory will tell you the provider’s specialty, what languages are spoken in the office, what the office hours are, telephone numbers, and other information. To find this information on the website directory, click on the provider’s name. The website directory will also give you a map to the provider’s office.
Section 3: Providers

Some providers are listed as taking established patients only. This means that if you are not already a patient of that provider, you cannot choose him or her as your PCP. Some of these providers may open or close their practices to new patients after a directory has already been printed. You may want to ask the PCP if he or she is accepting new patients before seeing the provider.

Primary Care Physicians (PCPs)

The role of a PCP is to take care of you and help you stay healthy. Your PCP is the most important person to help you with your health care needs. They will provide most of your health care. This is who you will go to first when you are sick or need a check-up. Your PCP will keep a record of your health and your health care. Your PCP will deliver your health care services or send you to other providers when you need specialty care. You and your PCP should work as a team to take care of your health. You should be able to talk to your PCP about all of your health care needs, including your medical, behavioral health, and long-term care needs.

PCPs have signed a special Primary Care Provider agreement with BCBSNM. You can find a provider directory on the online Provider Finder. PCPs are located in New Mexico and along the New Mexico border of neighboring states. PCPs include:

- Family and general practice
- Internal medicine
- Gerontology
- Obstetrics (OB)/gynecology
- Pediatric health care providers
- Certified nurse practitioners and midwives
- Physician assistants

Centennial Care providers know when to request authorizations for certain services and how to work with us when you need special care. They will also help you when they believe you need hospital care.

Choosing a PCP

You must select a PCP from the Centennial Care provider network. When you enroll in Centennial Care, we will give you information on how to choose a PCP or we can help assign you a PCP.

If you have a new PCP, you should make an appointment for a physical exam as soon as possible so that you can get to know each other. You can tell your new PCP about your health conditions and talk about any concerns you have.

If you are a new member of Centennial Care and your provider is not in our network, you can continue your care with your current provider for at least 30 days while you find a new PCP in our network. If you are more than six months pregnant when you enroll with us, you can keep seeing your current OB provider for the rest of your pregnancy. You can call Member Services to help you with your PCP needs.

When you enroll, please let us know if you need to continue services, such as:

- Medical equipment
- Home health services
- Case management
- Surgery that has already been scheduled
Section 3: Providers

- Pregnancy care
- Other ongoing care, such as radiation, chemotherapy, dialysis, diabetic care, or pain management

Please also let us know if you see I/T/U providers or if you are pregnant.

Changing PCPs
You may select a new PCP at any time by calling or writing Member Services. Tell us the name of the PCP you want. If the PCP is taking new patients, we will make the change.

- If you call on or before the 20th of the month, the PCP change will be effective the 1st day of the next month.
- If you call on or after the 21st of the month, the PCP change will be effective the 1st day of the second following month.
- We will mail you a new ID card showing the new PCP’s name. Your legal guardian or representative can request this change as well. You can begin seeing your new PCP right away. You do not have to wait for your new ID card.

Medicare PCP Selection
If you are eligible for both Medicare and Medicaid, you do not have to pick a new PCP. You can continue to see your Medicare PCP. You must take your Medicare ID card and your Centennial Care ID card with you any time you see a provider, including your PCP.

PCP Lock-In
If you get services that are not needed or are getting the same services from multiple providers, Centennial Care can lock you into one PCP. We will need to get approval from your PCP or the provider you are getting care from to do this. If needed, a PCP lock-in can be done for more than one provider.

Specialists
There may be times when you need to see a provider who can treat a special medical problem. A provider who takes care of specific health problems (such as heart problems, asthma, cancer, etc.), is called a specialist. These providers don’t usually see patients for routine care or minor health problems.

If your PCP thinks you should see a specialist or go to another provider for medical tests, he or she may make the appointment for you. A referral is not required. Sometimes you will have to make the appointment yourself. This is called “direct access,” or the ability to self-refer. You may also call Member Services if you need help seeing a specialist or getting an appointment for X-rays or other tests.

Specialist PCP
A specialist may be able to act as your PCP. A PCP may help you get the treatment for all of your medical problems. BCBSNM and the specialist have to agree with the treatment. If you think you need a specialist as your PCP, please call Member Services. We will work with you and your provider to help make this change.

PCP Terminations
If your PCP tells us they are leaving the Centennial Care network, we will send you a letter telling you at least 30 days before your PCP leaves. We will give you a new list of PCPs and help you select a new one.
Section 3: Providers

If your PCP is terminated or suspended from the network for potential quality or fraud and abuse reasons, you must select another PCP within 15 days of the termination. If you do not select another PCP, we will choose one for you and notify you in writing of the PCP’s name, location, and office telephone number. If you need help, we will help you find a new PCP.

Referrals

BCBSNM does not require a referral when you see any in-network medical, behavioral, or long-term care provider. A referral is not needed for emergency services, Early Periodic Screening, Diagnosis and Treatment (EPSDT) services, women’s services, or any service, such as vision and dental.

When you need to go to a specialist, remember that your PCP knows you and your medical history. They may be able to suggest a treatment or a provider that is better for you. Please talk to your PCP if you can before making an appointment with a specialist. Some providers may not accept you as a patient if you have not received a written referral by another provider. This is sometimes referred to as a physician-to-physician referral. BCBSNM does not need to be told when this happens.

Out-of-Network Providers

Providers and facilities not listed in our provider directory or in our online Provider Finder are considered out-of-network providers. If you have Medicare, your Medicare PCP is not considered out-of-network. Services from an out-of-network provider are not covered without first getting prior authorization from BCBSNM, except in the situations listed below:

- Emergency care (life-threatening) from a hospital and emergency ambulance
- Urgent care received at an urgent care center
- Family planning such as education and counseling about birth control and pregnancy, lab tests, follow-up care, birth control pills, and devices such as IUDs and condoms, tubal ligation, and vasectomies
- Native Americans visiting I/T/U providers or Tribal 638 facilities

If your out-of-network service is preauthorized and that provider recommends another out-of-network service, it is your responsibility to make sure you have prior authorization for the new service. If you do not get prior authorization before you receive out-of-network services, you may have to pay the provider. Call BCBSNM for help or prior authorization at 1-866-689-1523.

If BCBSNM provides prior authorization to see an out-of-network provider, you will not have to pay more than you would have if you had received services from an in-network provider.

Filing Claims for In-Network Providers

All Centennial Care providers file claims to BCBSNM. BCBSNM makes payments directly to your providers. Be sure these providers
know you have Centennial Care coverage. Do not file claims for in-network services yourself. Centennial Care providers may not bill you if they do not meet the timely filing limit they have agreed to (usually 90 days).

**Filing Claims for Out-of-Network Providers**

If you have to pay for out-of-network services or an out-of-network provider does not file a claim for you, you must submit receipts or itemized medical bills to BCBSNM. This needs to be done as soon as possible. We will then file the claim for you. You may be responsible for charges not covered by Centennial Care.

If you have questions, call Member Services and we will be happy to help you. Centennial Care does not cover services outside the United States.

Mail receipts and itemized medical bills for covered services of out-of-network providers to:

Blue Cross and Blue Shield of New Mexico
P.O. Box 27838
Albuquerque, NM 87125-7838

Most claims will be processed, and the provider will be notified of BCBSNM’s benefit decision within 30 days of receiving the claim.

**Itemized Bills**

Claims for covered services must be itemized on the provider’s billing forms or letterhead stationery and must show:

- Member’s Centennial Care ID number
- Member’s name and address
- Member’s date of birth
- Name and address of health care provider, including tax ID number or social security number
- Date of service or purchase, diagnosis, type of service or treatment, procedure, and amount charged for each service (each service must be listed separately)
- Accident or surgery date (when applicable)
- Amount paid by you (if any), along with receipt, canceled check, or other proof of payment

Itemized bills are necessary for your claim to be processed. The only acceptable bills are those from health care providers. Do not file bills you prepared yourself, canceled checks, balance due statements, or cash register receipts. Make a copy of all itemized bills for your records before you send them as the bills are not returned to you. All information on the claim and itemized bills must be readable. If information is missing or is not readable, BCBSNM will return it to you.

**Making an Appointment**

To make an appointment, please follow these steps:

- For routine visits or sudden illnesses, call your provider’s office and tell them you are a Centennial Care member. Your provider’s office will help you.
- When you get to the provider’s office, show your Centennial Care ID card. If you have a Medicare ID card, please be sure to show that as well.
- You may contact your Core Service Agency (CSA) or other behavioral health provider for an appointment for routine or urgent needs.
Section 3: Providers

- You may also contact your assigned Care Coordinator if you need assistance.
- If you need a ride to your provider’s office or behavioral health appointment please call LogistiCare.

If you go to a provider’s office without an appointment, the provider may not be able to see you. Please call your provider before you go to his or her office.

We do not guarantee that a certain type of room or service will be available at any hospital or other facility within the Centennial Care provider network, or that the services of a particular hospital, provider, or other provider will be available.

Transportation to Appointments

If you do not have a car or anyone to give you a ride, you may be eligible for transportation to help you get to your non-emergency medical, behavioral, and long-term care appointments. LogistiCare coordinates all non-emergency transportation for Centennial Care members. This includes food and lodging expenses when you have to travel a long distance to get covered medical care. Call LogistiCare at least three working days before your routine appointment to schedule a ride. More information about LogistiCare is provided in the section regarding non-emergency transportation services. See Section 4: Covered and Non-Covered Benefits for more information on transportation services.

Second Opinions

Getting a second opinion means seeing another provider about your illness or your treatment after your own PCP or specialist has seen you. You have a right to see another provider if:
- You disagree with your PCP or specialist
- You have more concerns about your illness
- You want another provider to approve your treatment plan
- You need more information about treatment than your provider has suggested
- Your PCP or specialist does not want to give you a referral to another provider who requires that you have a referral

You must get your second opinion from providers who are in the Centennial Care network or get a prior authorization from BCBSNM to see a provider outside the network. We will cover a second opinion from a qualified provider outside the network at no cost to you only if one is not available in our network. You must have prior authorization from BCBSNM before getting a third or fourth opinion.

Cancelling an Appointment

If you need to cancel a visit, tell your provider’s office as soon as possible. Try to tell them at least 24 hours before the appointment time. Working Disabled Individuals (WDI) and Children’s Health Insurance Program (CHIP) members may be charged up to $5 for a missed appointment.
If you are going to be late, please call your provider’s office. You may be asked to schedule a new time for your visit.

If you have arranged for a ride to your provider’s office, call LogistiCare and cancel or reschedule your ride. You need to cancel your ride at least two hours before you were supposed to be picked up.

**Always Talk to Your Doctor**

None of BCBSNM’s programs or services replace in any way the care you can get from your doctor or other health care providers. Always talk to your doctor or other health care providers about your health. None of the doctors and other health care providers mentioned in this handbook are employed by BCBSNM. They are all independent from BCBSNM.
Section 4: Covered and Non-Covered Benefits

Your Centennial Care plan covers medical, behavioral, long-term care, dental, vision, transportation and prescription services for eligible members. All members are covered for these services. The amount, duration, and scope of all covered and non-covered benefits are described in this section.

You must use Centennial Care network providers except for the below situations:

- Emergency care (see Section 4A) from a hospital or emergency ambulance service
- Urgent care received at an urgent care center
- Family planning, such as education and counseling about birth control and pregnancy, lab tests, follow-up care, birth control pills, devices such as IUDs and condoms, tubal ligations, and vasectomies
- Native Americans visiting I/T/U providers or Tribal 638 facilities

If you have to see an out-of-network provider for any other reason, you must first get prior authorization from BCBSNM.

Prior Authorization

To go outside of the Centennial Care network of providers, to be admitted to the hospital, or to receive certain services, such as home health care, you will need a prior authorization from BCBSNM. The Centennial Care network of providers will get approvals for you. BCBSNM may not approve the request. If the request for these types of services is denied by BCBSNM, you and your provider will be notified and the reason for the denial will be explained. Standard requests are reviewed as quickly as your health condition requires but no later than 14 days after BCBSNM receives the request from your provider. A 14-day extension may be granted if requested by your provider or if there is a reason that the delay would be in your best interest.

If you have other insurance besides Medicare, all Centennial Care prior authorization guidelines still apply.

Children’s Health Insurance Program (CHIP)

CHIP is part of the Medicaid program. The program covers health care for children up to the age of 19 who live with families who qualify.

Working Disabled Individuals (WDI)

Some members are in the Medicaid program under WDI. These members qualify for Medicaid because of disability and income level, but can also have a job.

If you are eligible for Medicaid through WDI or CHIP, you will have to pay a copayment to receive certain services. If so, your copayments will also be listed on your Centennial Care ID card. You must make copayments directly to providers at the time of service. You are always responsible for paying a provider’s full charges for non-covered services. You may be charged a copayment for missed appointments.
Section 4: Covered and Non-Covered Benefits

The copayments for CHIP and WDI member services are:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>CHIP Copayment</th>
<th>WDI Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office/Urgent Care Visit</td>
<td>$5 per visit*</td>
<td>$7 per visit*</td>
</tr>
<tr>
<td>Outpatient Visit</td>
<td>$5 per visit</td>
<td>$7 per visit</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$25 per admission</td>
<td>$30 per admission</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$2 per prescription (30-day supply or 120 pills, whichever is less)</td>
<td>$3 per prescription (30-day supply or 120 pills, whichever is less)</td>
</tr>
</tbody>
</table>

* No copay for approved second opinions

Applicable copayments may be charged for missed appointments. There are no copayments for routine or preventive care, prenatal care, family planning, emergency room visits, Native Americans, or if you have Medicare or a nursing facility level of care.

Copayments

A copayment is a charge you are responsible for paying for your service. You may have to pay a copayment for some services received under the Centennial Care plan. These services include the following:

- Use of the emergency room for non-emergencies has an $8 copay
- Getting a name-brand drug when a generic version of the same drug is available (exceptions are drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions or if you get a prior authorization for a special exception) has a $3 copay

If you are billed and do not pay your bill, the provider and/or Centennial Care may use legal action to collect payment from you. If you do not pay your copayments, you will not lose your Medicaid benefits.

Other Times You May Have to Pay for Services

There may be times when Centennial Care will not pay for services you received. You may have to pay for services in the following times:

- If you did not follow prior authorization guidelines and still received the service
- If you agree to pay for non-covered services in writing with your provider

Providers cannot bill you for them not following Centennial Care procedures. If you cannot pay for services that were not covered, you will not lose your Medicaid benefits.

Annual Member Copayment Maximum

When you are eligible for CHIP or WDI, BCBSNM determines your maximum quarterly copayment. Each quarter, we recalculate the amount of your out-of-pocket limit. If the amount changes, it will change on the next quarter.
Section 4: Covered and Non-Covered Benefits

If you reach the maximum copay amount during a quarter, you and your family do not pay copayments for the rest of the quarter (following the date that BCBSNM verifies you have paid the maximum amount). If you have met the quarterly maximum amount, we will let you know.

If you have questions, you can call Member Services at 1-866-689-1523.

Other Insurance

If you or your family have other medical or dental plan coverage, including Medicare, it is very important that you tell your ISD case worker. Also, tell your provider before your appointment. If you do not know how to contact your case worker, call HSD/MAD at 1-888-997-2583 to get information. You will need to tell BCBSNM about your other health insurance. This will help us coordinate your health care coverage so that your medical services get paid correctly. Please call Member Services at 1-866-689-1523.

Always show your Centennial Care ID card and other health insurance ID cards when you see a provider and go to the hospital. The other insurance plan needs to be billed for your health care services before Centennial Care can be billed. BCBSNM’s staff will work with the other insurance plan on payment for these services. One exception to this is if you also have Indian Health Services (IHS) coverage. Medicaid will pay before IHS does.

Please contact BCBSNM if you have been hurt in a car accident or if you receive services for an injury at work. This may involve insurance coverage through other companies and will help get your medical services paid. This is also called subrogation.

If this happens, BCBSNM has the following rights:

- Right to reimbursement for all benefits provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Member or the Member’s legal representative as a result of that sickness or injury, in the amount of the total Covered Charges for Covered Services for which BCBSNM has provided benefits to the Member.
- BCBSNM is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits BCBSNM provided for that sickness or injury.
- BCBSNM shall have the right to first reimbursement out of all funds the Member, the Member’s covered family Members, or the Member’s legal representative, are or were able to obtain for the same expenses for which BCBSNM has provided benefits as a result of that sickness or injury.
- The Member is required to furnish any information or assistance or provide any documents that BCBSNM may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.
If you have both Medicare and Medicaid, you have more than one insurance coverage. Medicare is considered your primary insurance and Centennial Care is your secondary insurance. Your Centennial Care benefits will not change your primary insurance benefits.

Your Care Coordinator will work with your primary insurance to help set up your health care. If you have both Medicare and Centennial Care, Medicare Part D will cover most of your drugs. You will still have to pay Medicare Part D copays unless you live in a nursing facility. If you have Medicare, you can use your current provider. You can get Medicare specialty services without approval from BCBSNM. We will work with your provider for the services you get. We can help you pick a provider if you do not have one. This provider can set up your Centennial Care and Medicare services. Centennial Care may cover some services that are not covered by Medicare.

**Outside New Mexico**

If you are outside of NM but within the United States and need emergency services, go to the nearest emergency room. Claims for covered emergency medical/surgical services received outside New Mexico from providers that do not contract as Centennial Care providers should also be mailed to BCBSNM. If a provider will not file a claim for you, ask for an itemized bill, and complete a claim form the same way that you would for services received from any other out-of-network provider. Please mail both forms to BCBSNM. If you would like to see an out-of-state provider for non-emergency services, you must first receive prior authorization from BCBSNM. If you do not get a prior authorization, the services will not be covered.

**Duplicate (Double) Coverage**

Centennial Care does not cover amounts already paid by other valid coverage or that would have been paid by Medicare as the primary carrier if you were entitled to Medicare, had applied for Medicare, and had claimed Medicare benefits. If you have any other health care coverage, you must let us know.

**Experimental, Investigational, or Unproven Services**

Centennial Care does not cover any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical practice, as defined below, or those considered experimental, investigational, or unproven. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted when services were administered, the service is experimental and will not be covered. To be considered experimental, investigational, or unproven, one or more of the following conditions must be met:

- The device, drug, or medicine cannot be marketed lawfully without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the device, drug, or medicine is furnished.
Section 4: Covered and Non-Covered Benefits

- Reliable evidence shows that the treatment, device, drug, or medicine is the subject of ongoing phase I, II, III, or IV clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its capability, or its capability as compared with the standard means of treatment or diagnosis.

- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug, or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

- The guidelines and practices of Medicare, the FDA, or other government programs or agencies may be considered in a determination; however, approval by other bodies will neither constitute nor necessitate approval by BCBSNM.

- Reliable evidence means only published reports and articles in authoritative peer-reviewed medical and scientific journals; the written protocol or protocols used by the treating facility, or the protocol(s) of another facility studying mainly the same medical treatment, procedure, device, or drug; or the written informed consent used by the treating facility or by another facility studying mainly the same medical treatment, procedure, device, or drug.

The service must be medically necessary and not excluded by any other contract exclusion.

Standard medical practice means the services or supplies that are in general use in the medical community in the United States, and:

- Have been demonstrated in standard medical textbooks published in the United States and/or peer-reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated

- Are appropriate for the hospital or other facility provider in which they are performed

- The physician or other professional provider has had the appropriate training and experience to provide the treatment or procedure

If you disagree with BCBSNM’s decision regarding any item or service, you may file an appeal. See Section 7: Grievances & Appeals.

No Effect on Treatment Decisions

Benefit decisions by BCBSNM (like prior authorizations) are different from treatment decisions by you and your health care providers. Regardless of any benefit decision, the final decision about your care and treatment is between you and your health care provider.
Section 4: Covered and Non-Covered Benefits

Medically Unnecessary Services
Centennial Care does not cover services that are not medically necessary. Medically necessary services are clinical and rehabilitative physical or behavioral health services that:

- Are necessary to prevent, diagnose, or treat medical conditions, or are needed to enable the patient to attain, maintain, or regain functional capacity
- Are delivered in the amount, duration, scope, and setting that is clinically appropriate to the specific health care needs of the patient
- Are provided within professionally accepted standards of practice and national guidelines
- Are required to meet the physical, behavioral, and behavioral health needs of the patient and are not primarily for the convenience of the patient, the provider, or BCBSNM

BCBSNM determines whether a service or supply is medically necessary, and whether it is covered. Because a provider prescribes, orders, recommends, or approves a service or supply, does not make it medically necessary, or make it a covered service, even if it is not specifically listed as an exclusion.

No Legal Payment Obligation
Centennial Care does not cover services for which you have no legal obligation to pay or that are free, including:

- Charges made only because benefits are available under this program
- Services for which you have received a discount that you have arranged
- Volunteer services
- Services provided by you or a family member for yourself, or by a person ordinarily residing in your household
Preventive Services

Preventive health care is for everyone. Preventive health care can keep you healthy and prevent illness. Below are some of the screenings and services available to you and your children.

Well-Child Visits

Well-child visits are for children from birth to age 21. Your child’s PCP can check your child’s health, growth, development, and provide immunizations. This can occur many times throughout childhood. Well-child visits can sometimes be done when your child sees the PCP for a sick visit.

Your PCP will guide you if more services are needed.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

EPSDT services are provided to every Medicaid-eligible child from birth to age 21. Centennial Care wants your child to be healthy. Centennial Care will provide checkups and preventive services through your child’s regular provider. A well-child checkup will be provided for your child. Your child should have exams at the ages shown on the chart below.

These exams may include vaccinations or shots. If your child has not had his or her checkup this year, call the provider and schedule one.

- **Lead Testing:** The provider will need to do a blood test to make sure your child does not have too much lead. Your child should be checked at 12 months and 24 months of age or if they have never been checked.

- **Dental Exam:** Your child should have their teeth cleaned and receive fluoride treatments every six months.

- **Private Duty Nursing:** When your child’s provider wants a nurse to provide care at home or at school.

- **Personal Care Services:** When your child’s provider wants a caregiver to help your child with eating, bathing, dressing, and toileting.

EPSDT also provides hearing services, vision services, school-based services, and more. If you have questions, please contact your Care Coordinator. If you need a Care Coordinator, call 1-877-232-5518, select option 3.

Health problems should be identified and treated as early as possible. If your child needs special services like Private Duty Nursing or Personal Care Services, they will be provided under EPSDT through Centennial Care.

Immunizations help keep you well. You can receive shots at a PCP visit. Many immunizations are needed before the age of two years. Yearly flu shots are important, too. Ask your PCP which shots you need. Teenage children will also need to receive some shots.
**Section 4A: Physical Health Benefits**

**Adults**

There are recommended health screenings for both men and women. Women age 40 through 74 should talk with their provider about having a mammogram every one to two years. Both men and women age 50 and older should be screened for colon cancer. These are just a few of the necessary screenings.

During PCP visits, talk with the provider about exercise, eating right, and safety issues for children and adults. Your PCP can measure height and weight to ensure you and/or your child is at a healthy weight.

**Medical/Surgical Services**

In the chart below, it says that prior authorization is dependent on the exact service. That means you will need to call Member Services to find out if the exact service you are checking on requires prior authorization.

The following services are covered when medically necessary:

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits to PCPs or specialists, including dieticians, nurse practitioners, and physician assistants</td>
<td>No</td>
</tr>
<tr>
<td>Allergy care, including tests and serum</td>
<td>Dependent on exact service</td>
</tr>
<tr>
<td>Diabetes self-management services</td>
<td>Dependent on exact service</td>
</tr>
<tr>
<td>Injections</td>
<td>Dependent on exact service</td>
</tr>
<tr>
<td>Podiatry (foot and ankle) services</td>
<td>Yes</td>
</tr>
<tr>
<td>Minor surgeries</td>
<td>Dependent on exact service</td>
</tr>
<tr>
<td>Therapies</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine physicals, children's preventive health programs and Tot-to-Teen checkups</td>
<td>No</td>
</tr>
<tr>
<td>Medical supplies; durable medical equipment</td>
<td>All medical supplies costing $2,500 or more require prior authorization. Please call Member Services and ask to speak with a Care Coordinator/Case Manager for more information.</td>
</tr>
<tr>
<td>Hospital services (in-patient, outpatient, and skilled nursing)</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing facilities and swing bed hospital services</td>
<td>Yes</td>
</tr>
<tr>
<td>Dialysis services</td>
<td>No</td>
</tr>
<tr>
<td>Surgery, including pre-and post-operative care: Organ transplants</td>
<td>Dependent on surgery; all transplants and pre-transplant evaluation require prior authorization</td>
</tr>
<tr>
<td>Emergency dental care</td>
<td>Yes</td>
</tr>
<tr>
<td>Special rehabilitation services, such as: Physical therapy Occupational therapy Speech therapy Cardiac rehabilitation Pulmonary rehabilitation</td>
<td>Yes</td>
</tr>
<tr>
<td>Laboratory, X-ray, EKGs, medical imaging services, and other diagnostic tests</td>
<td>Dependent on exact service</td>
</tr>
<tr>
<td>Home health care and intravenous services</td>
<td>Yes</td>
</tr>
<tr>
<td>Personal care services and private duty nursing (home- or school-based) for children under age 21, who qualify under the EPSDT program</td>
<td>Yes If your child is disabled, he or she may qualify for more services. Please call Member Services and ask to speak with a Care Coordinator/Case Manager for more information.</td>
</tr>
<tr>
<td>Hearing services</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Section 4A: Physical Health Benefits

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second opinions</td>
<td>No</td>
</tr>
<tr>
<td>Chemotherapy and radiation therapy</td>
<td>Yes</td>
</tr>
<tr>
<td>Nutritional counseling services</td>
<td>Dependent on exact service</td>
</tr>
<tr>
<td>Covered services provided in school-based health clinics</td>
<td>No</td>
</tr>
<tr>
<td>Pregnancy-related and maternity services</td>
<td>No</td>
</tr>
<tr>
<td>Ground and air ambulance</td>
<td>Ground - No Air - Yes</td>
</tr>
<tr>
<td>PET, MRA, MRI, and CT scans</td>
<td>Yes</td>
</tr>
<tr>
<td>Hospice</td>
<td>Yes</td>
</tr>
<tr>
<td>Home birthing</td>
<td>Yes</td>
</tr>
<tr>
<td>Nutritional products and special medical foods</td>
<td>Yes</td>
</tr>
<tr>
<td>Breast Pumps and replacement supplies</td>
<td>Electric Breast Pumps - No Manual Breast Pumps - No</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td>Yes</td>
</tr>
</tbody>
</table>

- Personal care items, like toothbrushes, or television sets in hospital rooms
- Services received outside the United States, including emergency services
- Medical services provided to a person who is an inmate of a public institution
- Infertility services and treatments
- Private room expenses, unless your medical condition requires isolation and charges are preauthorized by BCBSNM
- Some durable medical equipment and supplies (Centennial Care suppliers of these services know what is covered by Medicaid and what needs prior authorization)
- Duplicate equipment
- Temporomandibular joint or craniomandibular joint treatment

Family Planning Services

Family planning or birth control helps you decide when you are ready to have a baby. To get help with your decision, you can see your PCP, any qualified family planning center, or other provider. This includes an OB/GYN provider or going to Planned Parenthood. You can get family planning services in or out-of-network. You can do this without asking your PCP. This includes adolescents. Female members have the right to refer themselves to a contracted women’s health specialist for routine and preventive women’s health services.

Centennial Care offers the following family planning services and related services to all members. You have the right to receive these services when you need them:

Non-Covered Medical Services

Centennial Care does not cover the following medical services:

- Acupuncture, massage therapists, hypnotherapy, rolfing, biofeedback, naprapathy, or chiropractic services
- Reversal of a voluntary sterilization
- Cosmetic services, including plastic surgery, wigs, hairpieces, or medications for hair loss

All services received from an out-of-network provider must have a prior authorization except for the examples listed in Section 3: Providers.
Section 4A: Physical Health Benefits

- Family planning counseling and health education, so you will know which birth control method, if any, is best for you
- Lab tests if you need them to help you decide which birth control you should use
- Follow-up care for trouble you may have from using a birth control method that a family planning provider gave you
- Birth control pills
- Pregnancy testing and counseling

Centennial Care also offers the following FDA-approved devices and other procedures:
- Injection of Depo-Provera for birth control purposes
- Diaphragm, including fitting
- IUDs or cervical caps, including fitting, insertion, and removal
- Surgical sterilization procedures, such as vasectomies and tubal ligations

You do not need to get prior authorization from BCBSNM if you wish to visit Planned Parenthood or other out-of-network providers for family planning services. If you need a ride to the provider’s office, please contact LogistiCare for prior authorization.

Pregnancy-Related and Maternity Services

Once you are sure you are pregnant, you may choose either your PCP or another Centennial Care network provider to provide maternity care. The provider is then responsible for notifying BCBSNM of any admissions or home birth plans.

If you are pregnant or think you may be pregnant, you or your provider should call BCBSNM right away. The care of a pregnant mother is important and the mother’s health can affect the health of her newborn. When you call, we will:

- Help you choose a primary OB/GYN provider or certified nurse midwife for your pregnancy
- Have you enroll in our special program for pregnant members, Special Beginnings®
- Help you choose a PCP for your baby (if your baby is eligible for Centennial Care coverage)

You may self-refer to any Centennial Care provider for your maternity care. If there is no Centennial Care maternity services provider in your area, you or your provider may request prior authorization from BCBSNM to go to an out-of-network women’s health care provider.

Centennial Care covers all medically necessary hospitalizations, including up to 48 hours of inpatient care following a vaginal delivery and 96 hours following a C-section delivery. If you need emergency services and must go to a hospital outside the network (such as while you are traveling), call Member Services within 48 hours or as soon as possible so we can help coordinate your care and arrange for follow-up services.

If you are pregnant on the date you become a Centennial Care member and you are already seeing a provider, please call Member Services so that we can approve your visits to the provider if she or he is outside our network. If you are in your first or second trimester, in most cases you will be allowed to continue your care with that provider for at least 30 days. If you are six months or more than six months pregnant, you can continue seeing your provider for the rest of your pregnancy.
Section 4A: Physical Health Benefits

Prenatal Care

Early and regular prenatal care is very important for you and your baby’s health. Your provider or midwife will:

- Give you information about childbirth classes
- Tell you how often you need to visit your provider or midwife after your first visit. Usually you will visit your provider or midwife every four weeks until you are about six months pregnant. Then you will visit your provider or midwife every two weeks until your last month. You will continue visiting your provider or midwife every week during the last month
- Schedule you for routine lab work and other tests that will check the health of you and your baby
- Let you know about good nutrition and exercise, about the dangers of smoking, alcohol/drug use, and other behavior, and give you information about vitamins, breast feeding, infant safety car seats, and cribs
- Ask you to return to see your provider for a postpartum visit between 21 to 56 days after you have your baby
- Help you in the future with family planning (such as birth control)
- Talk to you about preventing sexually transmitted diseases (STDs), flu shots during pregnancy, and whether or not to get a rubella shot after delivery

Special Beginnings®

This maternity program is for Centennial Care members whenever you need it. It can help you better understand and manage your pregnancy, so you should enroll in the program within three months of becoming pregnant. When you enroll, you’ll receive a questionnaire to find out if there may be any problems during your pregnancy to watch for, information on nutrition, newborn care, and other topics helpful to new parents. You will also receive personal and private phone calls from an experienced nurse all the way from pregnancy to six weeks after your child is born. To learn more or to enroll, call toll-free at 1-888-421-7781 (TTY: 711).

Infant Car Seat and Portable Crib and Diaper Programs

If you are pregnant, you can receive a car seat, portable crib, and a box of diapers for your infant from Centennial Care. To get the car seat you will need to:

- Visit your provider during the first 12 weeks of pregnancy or within 42 days of enrollment in Blue Cross Community Centennial
- See your provider for 8 prenatal visits

To get the portable crib, you will need to do all of the above, plus:

- Enroll and participate in our free Special Beginnings program
- Learn about the Safe Sleep Program by contacting BCBSNM Health Services at 1-888-421-7781 (TTY: 711)
Section 4A: Physical Health Benefits

To get the box of diapers you will need to complete your postpartum checkup with your provider between 21 to 56 days after you have your baby.

See the Special Beginnings flier and the free car seat and portable crib form in your enrollment packet for more information. Or you can call 1-888-421-7781 (TTY: 711).

Birthing Options Program

You can choose to have your pregnancy-related services provided at home or in a birthing center by a licensed certified nurse-midwife (CNM) or by a licensed direct-entry midwife (DEM). These services will be covered only if they are provided by health care providers who have an approved Provider Agreement with HSD/MAD. If you are planning to have your baby at home or in a birthing center, you must have prior authorization from BCBSNM. This will help us make sure you are seeing a provider or midwife that can provide such services under the Centennial Care program.

If you are interested in having a midwife, call us and ask for a midwife packet, and follow the instructions. If you choose a midwife for at-home or birthing center delivery, it is your right and responsibility to:

- Ask the midwife if he or she has malpractice insurance
- Receive the confirmation or release statement from the midwife
- Sign the confirmation release or statement sent to you by the midwife
- Receive an “informed consent” or “informed choice” agreement from the midwife about complications that may or may not occur

If the midwife does not have malpractice insurance, you are assuming all risks of damage and injury.

Urgent Care Services

Urgent care is needed for sudden illnesses or injuries that are not life-threatening. If you can wait a day or more to receive care without putting your life or a body part in danger, you may not need urgent care. If you think you need urgent care, you can choose any of the following steps:

- Call your PCP or behavioral health provider’s office and say you need to see a provider as soon as possible, but there is no emergency. If your provider 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, please call our free 24/7 Nurseline at 1-877-213-2567 for advice.
- Ask your provider to recommend another provider if your provider is not able to see you within 24 hours.
- Contact your Core Service Agency (CSA) or other behavioral health provider if you feel you need urgent behavioral health care.
- Visit the nearest urgent care center in the Centennial Care network.
- If there is not an in-network Centennial Care center nearby, go to the closest urgent care center.
- If you are outside New Mexico and need urgent care, call Member Services for help or go to a local urgent care center.
- If you do not know if your condition is urgent, you can call the 24/7 Nurseline for advice.

BCBSNM does not cover follow-up care from out-of-network providers without prior authorization.
Emergency Services

An emergency is a medical or behavioral condition that has symptoms so severe (including severe pain), that if you do not receive care right away, your health might seriously suffer (in the case of a pregnant woman, the health of the unborn child.) An emergency might also be when you believe you might ruin a bodily function, lose an organ, or lose a body part if you do not get medical attention right away.

To find out if you have an emergency, you should ask yourself:

- Do you have a severe medical or behavioral condition (including severe pain)?
- Do you believe your health could be seriously harmed if you don’t get health care right away?
- Do you believe your life or the lives of others could be seriously harmed if you don’t get health care right away?
- Do you believe a bodily function, body part, or organ can be damaged if you don’t get health care right away?

If you answered “yes” to one or more of these questions, you may have an emergency. Here are some examples of emergencies:

- Bad chest pain or other pain
- Hard time breathing
- Bleeding you cannot stop
- Loss of consciousness (passing out)
- Seizures
- Poisoning or drug overdose
- Severe burns
- Serious injury from an accident or fall, such as a broken bone
- Injured eye
- Feelings of wanting to hurt yourself or others

If you have an emergency, you do not need to call BCBSNM before going to the emergency room or calling 911 for emergency ambulance services. In an emergency, you do not have to worry about whether or not the emergency room or ambulance is in the Centennial Care network.

What to Do in an Emergency

If CPR is necessary, or if there is an immediate threat to your life or a limb, call 911. If you do not call 911, go to the nearest medical facility or trauma center.

What is Not an Emergency

Do not go to an emergency room if you are not having a true emergency. The emergency room is for patients who are very sick or injured and 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 may be responsible for paying emergency room charges.

You should not go to the emergency room for the following problems:

- Flu
- Sore throat
- Earache
- Runny nose or cold
- Rash
- Stomach ache

If you have one of the above illnesses or problems, call your PCP first. If you cannot get in touch with your PCP, call the free 24/7 Nurseline at 1-877-213-2567. One of our nurses will help you decide what to do to get better on your own or where you should go.
to get the kind of care you need. Our nurse may tell you to go to your PCP or an urgent care center. If your PCP’s office is closed, our nurses can also help you decide what you should do.

If you know that your illness is not serious or life-threatening and you go to the emergency room or call an ambulance anyway, you may be billed. If you are billed and do not pay your bill, the provider and/or Centennial Care may use legal action to collect payment from you.

Emergency Room and Ambulance Services
If you have an emergency, you do not need to call BCBSNM before going to the emergency room or calling 911 for emergency ambulance services. In an emergency, you do not have to worry about whether or not the emergency room or ambulance is in the Centennial Care network.

Observation Stays in the Hospital
If you are admitted to the hospital after an emergency room visit and you only need to stay a few days, your care could be covered as an observation stay instead of an inpatient stay. Your provider will be notified when your illness qualifies as an observation stay.

Follow-Up Care
After a visit to the emergency room, you may need follow-up care. The health care you receive will either keep your health stable or improve or resolve your health problem. This is called post-stabilization care. This type of care may require prior authorization from BCBSNM. You may receive post-stabilization care in a hospital or other facility. Centennial Care covers this care. For other follow-up care, such as medicine refills or having a cast removed, go to your PCP’s office. For help on how to find post-stabilization providers and get to their locations, call Member Services at 1-866-689-1523.

What is Not Covered for Emergency Care
- Follow-up care outside New Mexico if you could return to New Mexico to receive care without medically harmful results
- Follow-up care received from an out-of-network provider if it is not preauthorized by BCBSNM
- Services received outside the United States
Section 4B: Behavioral Health Benefits

Behavioral health services help to support people facing emotional problems, mental illness, and/or substance abuse. Sometimes, behavioral health conditions may occur in combination with each other, or in addition to a physical condition. Covered services are services paid for by Centennial Care. The type of service you may need depends on your situation. A Care Coordinator can help you find out what services are covered for you and whether the service will need to be preauthorized. If you need a Care Coordinator, call 1-877-232-5518 and select option 3. A list of the services available for the behavioral health benefit is included in the table below:

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Age Applies To</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Inpatient Hospital Services</td>
<td>All ages</td>
<td>Yes</td>
</tr>
<tr>
<td>Inpatient Professional Services</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>All ages</td>
<td>Yes</td>
</tr>
<tr>
<td>Hospital Outpatient Services</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Evaluation</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>All ages</td>
<td>Yes</td>
</tr>
<tr>
<td>Assessment</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Counseling</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Therapy (Services beyond core coverage may need prior authorization)</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Comprehensive Community Support Service</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>(Services beyond core coverage may need prior authorization)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telehealth Services</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Intensive Outpatient for Substance Abuse and Co-occurring Disorders</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Behavior Support Consultation</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Recovery Services</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>All ages</td>
<td>May be required based upon the drug prescribed</td>
</tr>
<tr>
<td>Applied Behavior Analysis (Autism Spectrum Disorder)</td>
<td>12 months up to 21 years of age</td>
<td>Yes</td>
</tr>
<tr>
<td>Residential Treatment Center (RTC)</td>
<td>Under age 21</td>
<td>Yes</td>
</tr>
<tr>
<td>(Services beyond core coverage may need prior authorization)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Home Services</td>
<td>Under age 21</td>
<td>Yes</td>
</tr>
<tr>
<td>Treatment Foster Care</td>
<td>Under age 21</td>
<td>Yes</td>
</tr>
<tr>
<td>(Services beyond core coverage may need prior authorization)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day Treatment Services</td>
<td>Under age 21</td>
<td>No</td>
</tr>
<tr>
<td>Multi-Systematic Therapy</td>
<td>Under age 21</td>
<td>No</td>
</tr>
<tr>
<td>Behavioral Management Skills Development Services</td>
<td>Under age 21</td>
<td>No</td>
</tr>
<tr>
<td>School-Based Counseling</td>
<td>Under age 21</td>
<td>No</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation Program (PSR)</td>
<td>Age 21 and older</td>
<td>No</td>
</tr>
<tr>
<td>Assertive Community Treatment</td>
<td>Age 21 and older</td>
<td>No</td>
</tr>
<tr>
<td>Psychiatric Emergency Room Services</td>
<td>Age 21 and older</td>
<td>No</td>
</tr>
</tbody>
</table>
Section 4B: Behavioral Health Benefits

You do not need a referral from your PCP to get behavioral health services. You can call Member Services at 1-866-689-1523 to get more information. If you are not sure what kind of help you need, call Member Services and they will help you find a provider or help you speak to a Care Coordinator. You may need to complete an assessment with the help of your Care Coordinator and meet certain conditions to get behavioral health services. A licensed clinician may need to determine that the services are medically necessary.

If you do not have a personal crisis plan, please talk to your behavioral health provider or call the 24/7 Nurseline at 1-877-213-2567. It is important that you make a plan in advance that may help you prevent crisis or relapse.

In an emergency, (such as if you feel like hurting yourself or others, or if you are not able to take care of yourself), call 911 or go to the nearest hospital emergency room.

What is Not Covered for Behavioral Health Benefits

Non-covered services are the services not paid for by Centennial Care. These services would be paid for by you. Call Member Services at 1-866-689-1523 for more information about if a service is covered or not covered.

Centennial Care does not cover the following behavioral health services:

- Hypnotherapy
- Biofeedback
- Services that do not meet the standard of medical necessity as defined in Centennial Care rules
- Treatment for personality disorders for adults age 21 and older without a diagnosis indicating medical necessity for treatment
- Treatment provided for adults age 21 and older in alcohol or drug residential centers
- Educational or vocational services related to traditional academic subjects or vocational training
- Experimental or investigational procedures, technologies, or non-drug therapies and related services
- Activity therapy, group activities, and other services that are primarily recreational in nature
- Services provided by non-licensed counselors, therapists, or social workers
- Treatment of mental retardation alone

You can call Member Services to receive helpful information on how to contact a behavioral health peer support specialist or wellness center.
Your Centennial Care plan covers long-term care services. Long-term care includes medical and non-medical care for people who have disabilities or long-lasting illnesses. Long-term care helps meet health or personal needs. Most long-term care is to help people with support services such as activities of daily living like dressing, bathing, and using the bathroom. Long-term care can be provided in the home, in the community, in assisted living, or in the nursing home. It is important to remember that you may need long-term care at any age.

If your care requires it, coverage is available for nursing facilities and swing bed hospital services. Prior authorization is required. If you live in a nursing home and want to move out, we want to help you find a place that is right for you. Please call your Care Coordinator to learn more about the Community Benefit. This benefit offers the same needed care services at home for members who are eligible for nursing facility services.

You may be eligible for the Community Benefit based on Medicaid eligibility requirements or through eligibility based on medical need as determined on program availability through HSD/MAD.

To determine if you meet the Medicaid eligibility requirements, your Care Coordinator will do an assessment of your level of care. If the assessment shows you need a nursing facility level of care, you will be eligible for the Community Benefit.

If you are eligible for the Community Benefit, you will have the option to select either the Agency-Based Community Benefit (ABCB) or the Self-Directed Community Benefit (SDCB).

### Agency-Based Community Benefit

You will need to work with your Care Coordinator, based on your comprehensive needs assessment, to coordinate your care. The following services are covered for members who are eligible under the ABCB plan:

- Adult day health
- Assisted living
- Behavior support consultation
- Community transition services
- Emergency response
- Employment supports
- Environmental modifications
- Home health aide
- Personal care services
- Private duty nursing for adults
- Respite
- Skilled maintenance therapy services

### What is Not Covered for Agency-Based Community Benefit Services

Certain procedures, services, or miscellaneous items are not covered under the ABCB plan. To get more information on what is not covered, please contact your Care Coordinator for more information.

### Self-Directed Community Benefit

The SDCB is certain Home and Community-Based Services that are available to eligible members meeting nursing facility level of care. Self-direction gives you the opportunity to have choice and control over how your Community Benefits services are provided.
You can also choose who provides the services and how much providers are paid in accordance with SDCB-approved rates.

The following services are covered for members who are eligible under the SDCB plan:

- Behavior support consultation
- Emergency response
- Employment supports
- Environmental modifications
- Home health aide
- Homemaker
- Nutritional counseling
- Customized community supports
- Related goods
- Respite
- Skilled maintenance therapy services
- Specialized therapies
- Transportation (non-medical)
- Private duty nursing

Your Participation

If you choose to participate in the SDCB you will need an employer of record (EOR), Care Coordinator, and a Support Broker. You can be the EOR or designate someone on your behalf. The EOR (or Support Broker) and the Care Coordinator will be responsible for the following activities:

- Managing a self-directed budget
- Recruiting, hiring, and supervising providers
- Developing job descriptions for direct supports
- Completing employee forms
- Approving timesheets and purchase orders
- Getting quotes for services
- Completing all required documentation
- Developing a back-up plan
- Attending training

- Reporting incidents, such as fraud and abuse

A Support Broker will be available to help you make sure you meet all of the requirements. To get a Support Broker, call a Care Coordinator at 1-877-232-5518.

Recruiting, Hiring, Supervising, and Firing Providers

The EOR is the person responsible for directing the work under the SDCB. The EOR will recruit, hire, and fire all employees. The EOR will make all work schedules and assign tasks. The EOR will supervise and give training to all employees.

When the EOR works with employees, they will set how much employees will be paid. The payment rates must stay within the set range of rates. The EOR must:

- Track money spent on paying employees
- Track money spent on goods and services
- Approve employee time sheets

The EOR cannot be paid for doing the EOR tasks.

What is Not Covered for Self-Directed Community Benefit Services

Centennial Care does not cover the following SDCB services:

- Services covered by the Medicaid state plan (including EPSDT), MAD school-based services, Medicare, and other third parties
- Any service or good that would violate federal or state statutes, regulations, or guidance
- Formal academic degrees or certification-seeking education
Section 4C: Long-Term Care and Community Benefits

- Food and shelter expenses, including property-related costs
- Experimental or investigational services, procedures, or goods
- Any goods or services a household not including a person with a disability, would be expected to pay for as a regular expense
- Any goods or services to be used primarily for recreational purposes
- Personal goods or items not related to the disability
- Animals and costs of maintaining animals, with the exception of training and certification for service dogs
- Gas cards and gift cards; items that are purchased with SDCB program funds may not be returned for store credit, cash, or gift cards
- Purchase of insurance
- Purchase of a vehicle and long-term lease or rental of a vehicle
- Purchase of recreational vehicles
- Firearms, ammunition, or other weapons
- Gambling, games of chance, alcohol, tobacco, or similar items
- Vacation expenses, including airline tickets, cruise ship or other means of transport, guided tours, meals, hotel, lodging, or similar recreational expenses
- Purchase of usual and customary furniture and home furnishings, unless adapted to the eligible recipient’s disability or use, or of specialized benefit to the eligible recipient’s condition; requests for adapted or specialized furniture must include a doctor’s order from a member’s health care provider and when appropriate a denial of payment from any other sources
- Regularly scheduled upkeep, maintenance, and repairs of a home and addition of fences, storage sheds, or other outbuildings
- Regularly scheduled upkeep, maintenance and repairs of a vehicle, or tire purchase or replacement, except upkeep and maintenance of medications or alterations to a vehicle or van, which is an accommodation directly related to the SDCB member’s qualifying condition or disability; request must include documentation that the adapted vehicle is the SDCB member’s primary means of transportation
- Clothing and accessories
- Training expenses for paid employees
- Conference or class fees may be covered for eligible recipients or unpaid caregivers, but costs associated with such conferences or classes cannot be covered, including airfare, lodging, or meals
- Consumer electronics such as computers, printers, and fax machines, or other electronic equipment that does not meet criteria
- Cell phone services that include fees for data, or more than one cell phone line per eligible recipient; SDCB may cover the cost of text messaging if it is documented and determined that the need for texting is related to the member’s disability
Centennial Care covers drugs and other items listed in this section only when bought at a participating pharmacy (unless required in an emergency), or ordered through the Mail-Order Service.

**Drug List**

The Blue Cross Community Centennial Drug List is a list of drugs that are covered under Centennial Care. HSD approves the Drug List for all Medicaid managed care plans and it is updated quarterly. BCBSNM will send a copy of the Drug List if you request one. You can also see the Drug List on our website, [bcbsnm.com/medicaid](http://bcbsnm.com/medicaid).

Centennial Care will usually cover only the drugs on the Drug List. When there is a brand-name drug and a generic version of the same drug, only the generic drug is covered. If you want the brand-name drug instead, you may need to pay a copay. This copay will not apply to some members, including Native Americans. Requests to pay for a brand-name drug instead of the generic drug may be denied because:

- Brand-name drugs and generic drugs are made exactly the same.
- Generic drugs usually cost less.
- Generally, a trial of at least two covered generic drugs is required before a brand-name drug will be covered. In some cases, all available generic therapeutic alternatives must be tried first.

**Exceptions**

To make sure you do not have any problems filling your prescriptions, always ask your provider to check the Drug List. If your provider prescribes a drug that is not on the list or that is not already approved to treat your condition, the provider must have prior authorization from BCBSNM before you can get that medicine. A prior authorization is sometimes called an “exception.” Without prior authorization, the pharmacy will not be able to fill your prescription. We will look at your provider’s request and give approval only if we find the drug is medically necessary. Most of the time, we give approval for two reasons:

- A similar drug on the list does not improve your health as much as the drug you are asking for
- A similar drug on the list is harmful to your health.

In an emergency, BCBSNM will respond to your provider’s request within 24 hours. You may use the appeals process (see **Section 7: Grievances & Appeals**) if your request is denied.

There are exceptions to having to pay an additional copayment for brand-name drugs. Your provider may submit a request to waive the additional copayment on a brand-name drug when there is written information that multiple generic products have not worked for you.

Native Americans receiving prescriptions from I/T/U providers may receive drugs that are not on the Drug List without getting prior authorization from BCBSNM.
Section 4D: Prescription Drug Benefits

Covered Medications and Other Items

Centennial Care covers the following drugs, supplies, and other products when purchased from a participating pharmacy and prescribed by a Centennial Care network provider:

- Prescription drugs and medicines on the Drug List, unless listed as an exclusion
- Certain vaccines that can be given at a pharmacy (such as flu shots)
- Specialty pharmacy drugs such as self-administered injectable drugs. Most injectable and high-cost drugs require prior authorization from BCBSNM. Some self-administered drugs, whether injectable or not, are specialty pharmacy drugs and you must order them through a participating specialty pharmacy provider in order to be covered
- Insulin, insulin needles, syringes, and other diabetic supplies (e.g., glucagon emergency kits, autolet, injection aids, lancets, blood glucose and visual reading urine and ketone test strips)
- Non-prescription medications and birth control items on the Drug List and prescribed by your provider. These will not be covered if a prescription is filled anywhere other than at a participating pharmacy. Non-prescription medications are subject to quantity limits (usually 1 package size per 30 days). Some over-the-counter products will not be covered for members under the age of 4 or over the age of 18
- Non-prescription intestinal nutritional products only when medical criteria are met. These products must be prescribed by a Centennial Care network provider and must have prior authorization from BCBSNM to be covered
- Two 90-day courses of treatment, of preauthorized prescription or over-the-counter drugs to help you quit tobacco use or smoking. Starting this drug to help you quit smoking counts as one of your two allowable drug treatments. If you stop taking the drugs during the 90-day period, this still counts as one complete drug therapy treatment. For example, if you receive a one-month supply of a prescription drug to quit smoking and do not keep taking the drug beyond one month, you will have used up one of your two calendar year treatments with the 30-day supply. A smoking cessation support program must be used in combination with this drug therapy treatment. If you are not enrolled in a support program, we will enroll you in the BCBSNM program

Retail Pharmacy Program

All items must be purchased from a participating retail pharmacy. Some drugs must be purchased from a participating specialty pharmacy provider to be covered. See your provider directory for a list of participating pharmacies and specialty pharmacy providers. If you do not have a directory, call Member Services for a list or visit the BCBSNM website at bcbsnm.com/medicaid.

You must present your ID card to the pharmacist at the time of purchase to receive this benefit. If you have both Medicare and Centennial Care, Medicare Part D will cover your drugs. You will still have to pay Medicare Part D copays, unless you live in a nursing facility. If you have other insurance, make sure to show that card too.
Section 4D: Prescription Drug Benefits

You do not receive a separate prescription drug ID card. Use your Centennial Care ID card to receive all services covered under this program.

If you do not have your Centennial Care or your blue Medicaid plastic ID card with you, or if you purchase your prescription or other covered item from an out-of-network pharmacy in an emergency, you may have to pay for the purchase in full and then submit the pharmacy receipts. If possible, you should ask the pharmacy to call BCBSNM before filling the prescription so that we can make payment directly to the pharmacy.

If you are leaving the country and need a larger supply of medication, call Member Services at least two weeks before you plan to leave. In some cases, you may be asked to provide proof of continued eligibility under Centennial Care.

**Member Copayments under WDI and CHIP**

For covered prescription drugs, insulin, diabetic supplies, and nutritional products, some members pay a copayment for each prescription filled or item purchased. These cannot exceed supply limits described below. These copayments are included in your quarterly out-of-pocket limit and you will no longer have to pay them for the rest of the quarter once the out-of-pocket limit is reached.

**Drug Plan Supply Limits**

You can get up to a 30-day supply of a single covered prescription drug or other item or up to 120 pills, whichever is less. For commercially packaged items (such as an inhaler, a tube of ointment, or a blister pack of tablets or capsules), you will receive one package as a 30-day supply. You may need to pay a copayment for each package. For example, if two inhalers are purchased, two copayments will apply for some members.

**90-Day Supply**

Any drug you have never taken before will be limited to a 30-day supply the first time you buy it. After you have taken it for three or four weeks, your provider will make sure that you are going to be able to take the drug without getting sick or having some other side effect. After this, you can have your provider prescribe a 90-day supply that can be filled through the Mail-Order Program (see below).

Native American members accessing pharmacy services at I/T/U facilities may receive a 90-day supply of most (but not all) prescription drugs without being limited to a 30-day supply on the first fill.

**Mail-Order Program**

You can use the mail-order program to order a 90-day supply of a medication that you use regularly for a long-term or chronic condition. This program is called PrimeMail®. To use the mail-order program, call Member Services. We will help you fill out a mail-order form so you will get your medication in the mail.
Section 4D: Prescription Drug Benefits

What is Not Covered for Prescription Drugs and Other Items

Centennial Care does not cover the following prescription drugs and other items:

- Prescription, nonprescription, and over-the-counter drugs that are not listed as covered on the Drug List, including herbal or homeopathic preparations
- Drugs or other items purchased from an out-of-network pharmacy or any other provider that does not contract with BCBSNM, unless in an emergency
- Refills needed earlier than expected if you had taken the number of pills each day the provider indicated. Call Member Services for instructions on obtaining a greater supply if you are leaving home for more than a 30-day period of time
- Replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced
- Infertility medications
- Drugs or other items for treatment of any sexual dysfunction
- Medications or preparations for cosmetic purposes, such as for hair growth or medicated cosmetics, including tretinoin (sold under such brand names as Retin-A) for cosmetic purposes
- Non-prescription enteral nutritional products taken by mouth or delivered by a temporary naso-enteric tube (e.g., nasogastric, nasoduodenal, or nasojejunal tube), unless you have a genetic inborn error of metabolism and the product is preauthorized by BCBSNM
- Shipping, handling, or delivery charges, unless preauthorized by BCBSNM
- Drugs required for international travel or work
- Food, diet supplements, or special medical foods. Coverage does not include commercially available food alternatives, such as low- or sodium-free foods, low- or fat-free foods, low- or cholesterol-free foods, low- or sugar-free foods, low- or high-calorie foods for weight loss or weight gain, or alternative foods due to food allergies or intolerance
- Drugs, medicines, drug combinations, or devices not approved by the FDA and any products experimental, investigational, or unproven
- Methadone used in drug treatment programs
- Personal care items, such as nonprescription shampoo or soap
- Probiotics
- Weight loss or weight control drugs
- Cough and cold products for members under the age of 4
Section 4D: Prescription Drug Benefits

- Drug Efficacy Study Implementation (DESI) drugs; compounded drugs that use a product that has not been approved by the FDA for the intended use; compound drugs that do not have a national drug code and have not been approved by the FDA for use in humans; repackaged drug products

- The following over-the-counter products for members over the age of 21:
  - Pain relievers/fever reducers
  - Ear, nose, and throat products (except sodium chloride inhalation solution)
  - Stomach products (to treat heartburn, constipation, diarrhea)
  - Eye products (except eye lubricants)
  - Cough/cold products
  - Benzoyl peroxide
  - Antibiotics for use on the skin
  - Supplements (except oral electrolyte replacement and prenatal vitamins)
  - MCT Oil
  - Neutra-Phos, Neutro-Phos K

**Brand-Name Exclusion**

Some drugs are sold under more than one brand name. Centennial Care may cover only one of the brand names being sold for a single drug. If you do not accept the brand that is covered under Centennial Care, the brand name drug you want will not be covered.

**Pharmacy Lock-In**

In some special cases, we may tell a member that he or she must purchase drugs only from a certain pharmacy. This is known as “pharmacy lock-in.” We will tell you and/or your representative before you are placed on pharmacy lock-in. You will have the chance to file a grievance against BCBSNM’s decision to place you on a pharmacy lock-in. See Section 7: Grievances & Appeals. Only one pharmacy can be a lock-in pharmacy.

You will be removed from pharmacy lock-in when the problems have been fixed.
Section 4E: Vision Benefits

Centennial Care covers the following routine vision care, eyeglasses, and eye checkups through a program administered by Davis Vision.

The following services are covered under your Centennial Care plan:

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Time Limit</th>
<th>Age Applies To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor repairs to eyeglasses</td>
<td>Any time</td>
<td>All ages</td>
</tr>
<tr>
<td>Lens tinting if certain conditions are present</td>
<td>Any time</td>
<td>All ages</td>
</tr>
<tr>
<td>Lenses to prevent double vision</td>
<td>Any time</td>
<td>All ages</td>
</tr>
<tr>
<td>Eye exam for medical conditions (diabetes, cataracts, hypertension, and glaucoma)</td>
<td>Every 12 months</td>
<td>All ages</td>
</tr>
<tr>
<td>One routine eye exam</td>
<td>Every 12 months</td>
<td>Under age 21</td>
</tr>
<tr>
<td>Frames</td>
<td>Every 12 months</td>
<td>Under age 21</td>
</tr>
<tr>
<td>Replacement lenses, if lost, broken, or have deteriorated</td>
<td>Any time</td>
<td>Under age 21</td>
</tr>
<tr>
<td>Corrective lenses</td>
<td>1 set every 12 months</td>
<td>Under age 21</td>
</tr>
<tr>
<td>One routine eye exam</td>
<td>Every 36 months</td>
<td>Age 21 and older</td>
</tr>
<tr>
<td>Frames</td>
<td>Every 36 months</td>
<td>Age 21 and older</td>
</tr>
<tr>
<td>Replacement lenses for members with a developmental disability, if lost, broken, or have deteriorated</td>
<td>Any time</td>
<td>Age 21 and older</td>
</tr>
<tr>
<td>Corrective lenses</td>
<td>1 set every 36 months</td>
<td>Age 21 and over</td>
</tr>
</tbody>
</table>

Please call Member Services at **1-866-689-1523** for more information on prior authorizations.

You may receive more than the standard number of eye exams each year if you have diabetes or other diseases that could affect your eyesight.

If you are age 21 and older, additional benefits are available for eye exams, frames, and lenses as a value-added service. Please see **Section 4H: Value-Added Services** for more information.

What is Not Covered for Vision Care

Centennial Care does not cover the following vision care services:

- Eyeglass or contact lens insurance
- Orthoptic assessment and treatment
- Low vision aids
- Anti-scratch, anti-reflective, or mirror coating
- Photochromic lenses or tint, unless medically necessary
- Trifocals
- Laser vision correction
- Eyeglass cases
- Progressive lenses
- Ultraviolet (UV) lenses
Centennial Care covers services for eligible members through a program administered by DentaQuest®. Dental visits are necessary for good health. Regular dental checkups and cleanings are important for children as well as adults. Schedule a well-baby checkup with your dental provider by the time your baby is two years old.

If you need oral surgery or have an accident that injures your teeth, the services may be covered through Centennial Care as part of the medical/surgical program. Please call Member Services at 1-866-689-1523 before receiving such services so you know which providers will be approved for payment.

**Covered Dental Services**

The services listed in the chart on page 45 are covered under your Centennial Care plan.

**What is Not Covered for Dental Services**

Centennial Care does not cover the following dental services if for cosmetic reasons:

- Permanent fixed bridges for members 21 years of age and older
- Cosmetic services
- Desensitization, re-mineralization, or tooth bleaching
- TMJ disorders, bite openers, and orthotic appliances
- Implants and implant-related services

**Finding a Dentist**

If you need to find a dentist in your area, call Member Services or check the provider directory. A paper copy of the directory is available to you at no charge, or on our website at [bcbsnm.com/community-centennial](http://bcbsnm.com/community-centennial).

Member Services has information about handicap-accessible offices, other languages the dentist speaks, and if the dentist is an expert with children or individuals who have special health care needs. Once you choose a dentist, call the dentist to make an appointment and find out if the service will be covered by Centennial Care.

**Urgent Dental Care**

If you have an urgent dental problem, you should be seen within 24 hours. An urgent problem means you need to be seen that day, but it is not serious enough to go to an emergency room. Most dental problems are not considered emergencies under the medical/surgical plan. If you have an urgent dental problem and cannot find a dentist to see you within 24 hours, please call Member Services.

**Non-Urgent Dental Care**

If you have a non-urgent dental problem, you should be seen within 14 days. A non-urgent problem means you have symptoms, but you do not need to see a dentist that same day.

**Routine Dental Checkup**

If you need a regular dental checkup or have a dental condition that is not causing you problems or pain, you should be seen within
### Section 4F: Dental Benefits

60 days of your request. If your dentist cannot see you within 60 days, please call Member Services. We may be able to send you to another dentist who can see you sooner.

With any questions about your dental coverage, please call Member Services at **1-866-689-1523**.

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Time Limit</th>
<th>Age Applies To</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tooth extractions (pulling of teeth)</td>
<td>N/A</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Emergency services</td>
<td>No limit</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>One complete series of intraoral X-rays (with one added set of bitewing X-rays)</td>
<td>Every five years; Added set of bitewing X-rays once every 12 months</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>One complete oral exam</td>
<td>Every 12 months</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Fillings, stainless steel crown, resin crown, and one recementation of a crown or inlay or fixed bridge</td>
<td>N/A</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Periodontic scaling and root planning</td>
<td>N/A</td>
<td>All ages</td>
<td>Yes</td>
</tr>
<tr>
<td>Two denture adjustments</td>
<td>Every 12 months</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>Incision and drainage of an abscess</td>
<td>N/A</td>
<td>All ages</td>
<td>No</td>
</tr>
<tr>
<td>One cleaning and periodic exam</td>
<td>Every six months</td>
<td>Under age 21</td>
<td>No</td>
</tr>
<tr>
<td>One fluoride treatment</td>
<td>Every six months</td>
<td>Under age 21</td>
<td>No</td>
</tr>
<tr>
<td>One sealant for each permanent molar</td>
<td>Every five years</td>
<td>Under age 21</td>
<td>No</td>
</tr>
<tr>
<td>General anesthesia and IV sedation, including nitrous oxide</td>
<td>N/A</td>
<td>Under age 21</td>
<td>No</td>
</tr>
<tr>
<td>Therapeutic pulpotomy</td>
<td>N/A</td>
<td>Under age 21</td>
<td>No</td>
</tr>
<tr>
<td>Orthodontic services (braces)</td>
<td>N/A</td>
<td>Under age 21</td>
<td>Yes</td>
</tr>
<tr>
<td>Dental services in a hospital</td>
<td>N/A</td>
<td>Under age 21</td>
<td>No - Dentist Yes - Facility</td>
</tr>
<tr>
<td>Reimplantation of permanent tooth</td>
<td>N/A</td>
<td>Under age 21</td>
<td>No</td>
</tr>
<tr>
<td>Fixed space maintainers (passive appliances)</td>
<td>N/A</td>
<td>Under age 21</td>
<td>Yes</td>
</tr>
<tr>
<td>General anesthesia and IV sedation, not including nitrous oxide</td>
<td>N/A</td>
<td>Age 21 and older</td>
<td>No</td>
</tr>
<tr>
<td>One cleaning</td>
<td>Every 12 months; Every six months for members with developmental disabilities</td>
<td>Age 21 and older</td>
<td>No</td>
</tr>
<tr>
<td>One fluoride treatment</td>
<td>Every 12 months</td>
<td>Age 21 and older</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Note: Federally Qualified Health Center members will not need prior authorization on any dental service.
If you do not have a car or anyone to give you a ride, you may be eligible for transportation to help you get to your non-emergency medical, long-term care, or behavioral health appointments. If you have an emergency and you need help getting to an emergency room, call 911.

LogistiCare coordinates all non-emergency transportation for members, including food and lodging expenses, when you have to travel a long distance to get covered medical care. You can use these benefits only for medical needs. Transportation for any non-medical reason is not covered.

The following services are covered under your Centennial Care plan:

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Prior Authorization</th>
<th>Prior Notice to LogistiCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ride to routine appointment</td>
<td>No</td>
<td>3 working days up to two weeks</td>
</tr>
<tr>
<td>Ride to behavioral health</td>
<td>No</td>
<td>3 working days up to two weeks</td>
</tr>
<tr>
<td>Mass transit</td>
<td>No</td>
<td>4 working days</td>
</tr>
<tr>
<td>Mileage reimbursement</td>
<td>Yes</td>
<td>14 days prior up to the day of appointment</td>
</tr>
<tr>
<td>Meals</td>
<td>Yes</td>
<td>3 working days</td>
</tr>
<tr>
<td>Lodging</td>
<td>Yes</td>
<td>3 working days</td>
</tr>
</tbody>
</table>

What Is Not Covered for Transportation Services

Centennial Care does not cover the following transportation services:

- Transportation to a pharmacy to get prescriptions, or to a medical supply store to get medical supplies or durable medical equipment
- Transportation for non-medical needs
- Transportation to a provider who is 65 miles or farther away from where you live, without special authorization from BCBSNM
- Transportation to a provider who is outside BCBSNM’s network of contracted providers, without special authorization from BCBSNM
Section 4G: Transportation Benefits

Scheduling Transportation for Routine Care

Call the Reservation Line phone number to schedule a ride to your appointment from 8 a.m. to 5 p.m., Monday through Friday at 1-866-913-4342. When you call LogistiCare’s Reservation Line, tell them you are a Centennial Care member and give them your ID number. Give them the date and time of your appointment and tell them where you are going. Call LogistiCare at least three working days before your routine appointment to schedule a ride. Saturdays, Sundays, and holidays are not working days. If you do not call at least three working days before your appointment, your request may be denied. This three-day notice does not apply to urgent care. When you call for a ride on the same day as your appointment, LogistiCare must call your provider to verify you have an appointment, and your ride may take up to four hours to arrive. If you need to see a provider on a regular basis, you may schedule your ride two weeks (10 working days) ahead of time.

Call the Ride Assist phone line at 1-866-418-9829 to be picked up after seeing your provider, or after being discharged from a hospital, or if your ride is late. Drivers are required to wait only five minutes, so be sure you are ready to leave when the driver arrives. If you are not ready within five minutes, the driver will not wait longer because he or she has other people to transport.

LogistiCare can help transport you if you have a special health care need. LogistiCare will keep notes on any special transportation needs, and provide a driver trained in CPR, if needed. When you call LogistiCare, be sure to mention if you have special needs.

If your medical appointment is canceled and you have already made arrangements with LogistiCare, please call LogistiCare at least two hours before you were supposed to be picked up to cancel your ride.

If you live in an area with public transportation, LogistiCare may give you a mass transit pass to get to your medical, long-term care, or behavioral health appointments. You must request a mass transit pass four working days before your appointment. To find out about getting a mass transit pass, please call LogistiCare at 1-866-913-4342.

Transportation Services Needing Prior Authorization for Long Distance Travel

If you must travel more than 65 miles one way or must travel outside New Mexico to receive health care, you must call LogistiCare for approval to request transportation. If you have to travel to another city or state for an approved appointment, it is important to make plans for these trips as soon as possible and no later than three working days before the appointment.

Meals and Lodging

Through LogistiCare, Centennial Care may pay for your meals when you travel to another city or state for an approved appointment. If you go to an appointment and are away from home for eight hours or more, you can be repaid for your meals if you get authorization.
Section 4G: Transportation Benefits

from LogistiCare no fewer than three working days before you travel. You will be repaid up to $18 per day when you are away from home.

When a trip takes more than four hours one way and an overnight stay is medically necessary to receive covered services, you may call LogistiCare to arrange for lodging. All lodging expenses must be coordinated by LogistiCare. Do not arrange your own lodging for any expenses not coordinated and authorized in advance by LogistiCare. The lodging provider can be paid up to $58 per night on a weekday in New Mexico, and up to $81 per night on a weekend or for out-of-state travel any day.

If you need to get paid for lodging that was authorized by LogistiCare, you are required to fill out a LogistiCare Expense Report for lodging and meals, which is available on the BCBSNM website at bcbsnm.com/medicaid (under Member Resources, Forms, then click on View and Download Forms) or by calling Member Services.

When you call LogistiCare to approve meals and/or lodging, you will be given an authorization/job number if the travel is approved. You must include original receipts for each meal and lodging expense (not photocopies) and write your authorization/job number on the LogistiCare Expense Report you send in to LogistiCare. You will not be paid for meals or lodging if the form and receipts are received more than 30 days after you travel. Mail the form to the address shown on the form.

Payment for Mileage

You might be able to be repaid for mileage if you have to drive your own vehicle to a covered appointment. This must be authorized by LogistiCare. Do not expect to be paid for mileage if you do not call the LogistiCare Reservation Line first at 1-866-913-4342. LogistiCare will verify you have an appointment and will tell you the number of miles covered. You may call up to 14 days in advance, but no later than the day of the appointment. If LogistiCare authorizes your trip, you will be given a trip/job number. Please do not lose this trip/job number. You will need it to be paid for your mileage. If you cannot drive yourself, a friend or family member may drive you. He or she can get mileage reimbursement as well. The same procedures and authorization requirements apply.

After you receive approval, complete a Mileage Reimbursement Form and take it with you to your appointment. The provider’s office must sign the form and you must write the trip/job number given to you by LogistiCare in the area titled “trip/job #.” If the trip is approved and the provider has signed the form, you will be repaid for mileage costs based on the BCBSNM mileage reimbursement rate. This rate is for a round trip from your home to the provider’s office or to the hospital.

You will not be paid if the form is received more than 30 days after the appointment, or if the trip was not approved in advance by LogistiCare. Send the completed and signed form to LogistiCare within 30 days of the appointment.
Section 4G: Transportation Benefits

<table>
<thead>
<tr>
<th>Type of County</th>
<th>County Name</th>
<th>Distance Between PCP’s Office and Your Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>Bernalillo, Doña Ana, Los Alamos, Santa Fe</td>
<td>30 miles</td>
</tr>
<tr>
<td>Rural</td>
<td>Chaves, Curry, Eddy, Grant, Lea, Luna, McKinley, Otero, Rio Arriba, Roosevelt, Sandoval, San Juan, Taos, Valencia</td>
<td>45 miles</td>
</tr>
<tr>
<td>Frontier</td>
<td>Catron, Cibola, Colfax, DeBaca, Guadalupe, Harding, Hidalgo, Lincoln, Mora, San Miguel, Sierra, Socorro, Torrance, Quay, Union</td>
<td>60 miles</td>
</tr>
</tbody>
</table>

Address for Expense Reports and Mileage
LogistiCare Claims Department
New Mexico Mileage Reimbursement
2552 West Erie Drive, Suite 101
Tempe, AZ 85282-3100

Transportation Services for Rides to PCP Offices Requiring Authorization
If you choose a PCP who is farther from your home than the distances shown above (based on the county you live in), you will not be able to receive rides to and from the PCP’s office, unless you receive special authorization from BCBSNM. If there is a PCP closer to you, you may be asked to change PCPs, or you will have to arrange your own rides to and from your PCP’s office.

Rides to Out-of-Network Providers
You will have to call BCBSNM Member Services first, if you need a ride to any out-of-network provider (even for family planning and even if you already have prior authorization for the visit). The approval for a ride to an out-of-network provider is different from any prior authorization you might have received for the provider visit itself.

When you call BCBSNM, you will be issued a confirmation number that you must give to LogistiCare when you call them about arranging a ride. LogistiCare must call BCBSNM and make sure any ride to an out-of-network provider will be covered. LogistiCare will verify with BCBSNM that the confirmation number you gave over the phone is correct.

Only BCBSNM can authorize LogistiCare to give you a ride to an out-of-network provider.

Accompanying Persons or Family Members
Centennial Care will cover rides for one other person to ride with you to a provider’s appointments. If you must bring a child because you are unable to arrange for care while you are gone, the child must be in an approved car seat or booster seat. If you take an adult with you, it must be medically necessary for him or her to help you.

Picking Up Medical Supplies and Prescriptions
You must make your own arrangements to pick up prescriptions, medical supplies, and durable medical equipment. These items may also be delivered to your home, but you will have to make your own arrangements for delivery.
In addition to covering the services required by state law, your Blue Cross Community Centennial health plan offers extra services to help keep you and your family healthy. These are called “value-added services.”

Some value-added services are not always available all year and may have additional limits and steps. Call Member Services at 1-866-689-1523 for more details. Also, some services may change from year to year. These services include:

<table>
<thead>
<tr>
<th>Value-Added Service</th>
<th>Applies To</th>
<th>Members on Standard Medicaid Plan</th>
<th>Members on Alternative Benefit Plan (ABP)</th>
<th>Members on ABP-Exempt Plan</th>
<th>Prior Authorization Required for Value-Added Service?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Chemical Dependency Residential Treatment Center (RTC) Services</td>
<td>RTC services for members age 21 and older with severe medical disorders and patients with alcohol/substance abuse problems</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Routine Physicals and Related Testing</td>
<td>Members age 21 and older</td>
<td>✓</td>
<td>Not a value-added service; standard ABP benefits apply</td>
<td>Not a value-added service; standard ABP benefits apply</td>
<td>No</td>
</tr>
<tr>
<td>One Box of Baby Diapers</td>
<td>Newborn members</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Yes</td>
</tr>
<tr>
<td>Dental Varnish in a PCP’s Office</td>
<td>Birth to age three</td>
<td>✓</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>No</td>
</tr>
<tr>
<td>Electroconvulsive Therapy (ECT) (Treatment for Psychiatric Conditions)</td>
<td>Members who meet standard ECT medical necessity criteria</td>
<td>✓</td>
<td>Not a value-added service; standard ABP benefits apply</td>
<td>Not a value-added service; standard ABP benefits apply</td>
<td>Yes</td>
</tr>
<tr>
<td>Extended Adult Vision Benefits (One Vision Exam, Set of Frames, and Lenses Every 12 Months)</td>
<td>Members age 21 and older</td>
<td>✓</td>
<td>Not eligible</td>
<td>Extended 12-month benefits do not apply (Coverage every 36 months for members age 21 and older)</td>
<td>Yes</td>
</tr>
<tr>
<td>Extended Lodging for Homeless Members (Post-Hospitalization Lodging)</td>
<td>Homeless members</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Yes</td>
</tr>
<tr>
<td>Full Medicaid Benefits for Pregnant Women Categories of Eligibility (COE) 301 and 035 (Full Benefits Including Dental, Vision, Prescription Drugs, and Behavioral Health)</td>
<td>Certain pregnant members</td>
<td>✓</td>
<td>Not a value-added service; standard ABP benefits apply</td>
<td>Not a value-added service; standard ABP benefits apply</td>
<td>Only if a particular service should require one</td>
</tr>
<tr>
<td>Infant Car Seat</td>
<td>Pregnant members</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Yes</td>
</tr>
<tr>
<td>Infant Mental Health Program</td>
<td>Birth to age three</td>
<td>✓</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Yes</td>
</tr>
<tr>
<td>Inpatient Detox at Non-Hospital-Based Facilities</td>
<td>Chemically dependent members</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Yes</td>
</tr>
<tr>
<td>Portable Infant Crib</td>
<td>Pregnant members</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Yes</td>
</tr>
<tr>
<td>Traditional Healing Benefit (Reimbursement for Traditional Healing Practices Used to Treat Medical Conditions)</td>
<td>Native American members</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Yes</td>
</tr>
<tr>
<td>Transitional Living for Chemically Dependent/Psychiatrically Impaired Adults and Children</td>
<td>Members enrolled in outpatient substance abuse center or in active treatment for psychiatric issues</td>
<td>✓</td>
<td>Not eligible</td>
<td>Not eligible</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Section 4I: Member Rewards

Every member of Centennial Care is able to enroll in the Centennial Rewards Program. The Rewards Program allows you to earn “credits” by just taking part in certain healthy actions.

To use your credits, enrollment is required. You can enroll at centennialrewards.com or call Centennial Rewards Wellness Services at 1-877-806-8964. Credits can be used by making choices from a catalog. You can order catalog items through a website or by calling Centennial Rewards Wellness Services at 1-877-806-8964. Shipping costs will not apply.

You will get your Centennial Rewards Program catalog when you earn your first credits.

Below are the Healthy Actions and the Reward Benefits (also called “credits”). Check centennialrewards.com for any new Healthy Actions throughout the year.

If you would like to know more about this program, please call toll-free 1-877-806-8964.

<table>
<thead>
<tr>
<th>Healthy Action</th>
<th>Reward/Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete your Health Risk Assessment</td>
<td>$10 per year</td>
</tr>
<tr>
<td>Step-Up Walking Program</td>
<td>Earn up to $50 per year and a free pedometer</td>
</tr>
<tr>
<td>Asthma Controller Medication Compliance (children)</td>
<td>$15 for 1st, 3rd, 6th, 9th and 12th refill ($75 annual max)</td>
</tr>
<tr>
<td>Diabetes - annual recommended tests (A1C, LDL, eye exam, nephropathy exam)</td>
<td>$20 for each test ($80 annual max)</td>
</tr>
<tr>
<td>Prenatal Program (earned when signing up for the MCO’s program)</td>
<td>$100 per pregnancy</td>
</tr>
<tr>
<td>Treatment Compliance – Schizophrenia</td>
<td>$15 for 1st, 3rd, 6th, 9th and 12th refill ($75 annual max)</td>
</tr>
<tr>
<td>Treatment Compliance – Bipolar</td>
<td>$15 for 1st, 3rd, 6th, 9th and 12th refill ($75 annual max)</td>
</tr>
<tr>
<td>Osteoporosis Management in Elderly Women – females 65+</td>
<td>$35 per test, max of one per lifetime</td>
</tr>
<tr>
<td>Annual Dental Visit – adult</td>
<td>$25 per visit, max of one per year</td>
</tr>
<tr>
<td>Annual Dental Visit – child</td>
<td>$35 per visit, max of one per year</td>
</tr>
</tbody>
</table>

Note: Credits are for qualifying catalogue/store use only. The “$” symbol is for convenience only. Credits have no cash or monetary value and can never be exchanged or redeemed for cash. They are not transferable to other persons. They may not be combined with other member’s credits or with other rewards or incentive programs offered by Centennial Care.
The Alternative Benefit Plan (ABP) is a part of the New Mexico Medicaid Centennial Care program. The ABP offers coverage for Medicaid-eligible adults ages 19-64 who have income up to 138% of the Federal Poverty Level (FPL).

There are two kinds of ABP benefit packages.

**ABP Benefit Package**
If you are eligible for the ABP benefit package, all of the detail outlined in this member handbook applies to you except for some of the covered and non-covered services. Value-added services are also different. To find out if a service is covered, you can check the covered services in this section or call Member Services at 1-866-689-1523.

**ABP Exempt Benefit Package**
If you are an ABP member and have a physical or behavioral health condition that meets certain criteria, you may be eligible to move to the Expansion State Plan. This is also called ABP Exempt. Examples of the criteria are listed below:

- Individuals who qualify for medical assistance on the basis of being blind or disabled
- Individuals who are terminally ill and are receiving benefits for hospice care
- Pregnant women
- Individuals who meet Medically Frail Criteria

Your condition will be reviewed by a Care Coordinator to see if you meet these criteria. You can also call us to ask us to complete this review.

If you meet criteria and choose to move to the ABP Exempt benefit package, you will then have the same benefits and provider network as the standard Medicaid plan. This means that everything in this handbook about standard Medicaid, except value-added services, also applies to you. If you meet ABP Exempt criteria during the middle of the month, you will be moved to that plan the 1st of that same month.

Under the ABP Exempt benefit package, you can also access community benefits and nursing facility care when the requirements for those services are met. To determine if you meet the Medicaid eligibility requirements, your Care Coordinator can do an assessment of your level of care. If the assessment shows you need a nursing facility level of care, you will be also be eligible for the Community Benefit.
Section 5: Alternative Benefit Plan

ID Cards

ABP ID Cards

When you apply for Medicaid coverage, you will know that you are eligible for the ABP. Another way to know is by looking at the front of your Centennial Care ID card. Your ID card will say it. Please see the example below:

[Image of an ID card]

ABP Exempt ID Cards

When you move to ABP Exempt, you will also receive a new ID card. The front of your ID card will say Expansion State Plan. Please see the example below:

[Image of an ID card]

Copayments

ABP Copayments

The below copayments apply to some ABP members:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting a name-brand drug when a generic version of the same drug is available (exceptions are drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions or if you get a prior authorization for a special exception)</td>
<td>$3.00</td>
</tr>
<tr>
<td>Use of the emergency room for non-emergencies</td>
<td>$8.00</td>
</tr>
</tbody>
</table>

ABP Exempt Copayments

The below copayments apply to some ABP Exempt members. They are the same as the standard Medicaid plan.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting a name-brand drug when a generic version of the same drug is available (exceptions are drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions or if you get a prior authorization for a special exception)</td>
<td>$3.00</td>
</tr>
<tr>
<td>Use of the emergency room for non-emergencies</td>
<td>$8.00</td>
</tr>
<tr>
<td>You do not have any copayments if you have a Nursing Facility Level of Care.</td>
<td></td>
</tr>
</tbody>
</table>

Provider Network

The providers you are eligible to see are the same as the standard Medicaid plan for both of the ABP benefit packages. More information about providers can be found in Section 3: Providers of this handbook.

Value-Added Services

ABP Value-Added Services

See the table in Section 4H: Value-Added Services for a list of ABP value-added services.


### Covered and Non-Covered Services

#### ABP Covered and Non-Covered Services

Below are some of the covered and non-covered ABP services. Some of the limitations may not apply for members ages 19 and 20. All services may be subject to some limitations, including prior authorizations. Please call Member Services at **1-866-689-1523** for more information.

<table>
<thead>
<tr>
<th>ABP Plan Covered Services</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism Spectrum Disorder</td>
<td>Covered through age 22</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
<td>Limited to one per lifetime</td>
</tr>
<tr>
<td>Behavioral Health Professional Services: Outpatient Behavioral Health and Substance Abuse Services</td>
<td>None</td>
</tr>
<tr>
<td>Cancer Clinical Trials</td>
<td>None</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>Limited to 36 hours per cardiac event</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>None</td>
</tr>
<tr>
<td>Dental Services</td>
<td>See Section 4F for limitations</td>
</tr>
<tr>
<td>Diabetes Treatment, including Diabetic Shoes</td>
<td>None</td>
</tr>
<tr>
<td>Dialysis</td>
<td>None</td>
</tr>
<tr>
<td>Disease Management</td>
<td>None</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Certain items have set limitations</td>
</tr>
<tr>
<td>Educational Materials and Counseling for a Healthy Lifestyle</td>
<td>None</td>
</tr>
<tr>
<td>Emergency Services (including emergency room visits and psychiatric ER)</td>
<td>None</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)</td>
<td>For individuals age 19 and 20</td>
</tr>
<tr>
<td>Eye Exams and Treatment Related to Treatment and Testing of Eye Diseases Only</td>
<td>Refraction is not covered</td>
</tr>
<tr>
<td>Family Planning, Sterilization, Pregnancy Termination, Contraceptives</td>
<td>None</td>
</tr>
<tr>
<td>Glasses and Contact Lenses</td>
<td>Covered only for aphaoria (following removal of the lens)</td>
</tr>
<tr>
<td>Hearing Testing or Screening as part of a Routine Health Exam</td>
<td>Hearing aids not covered; hearing testing by an audiologist or hearing aid dealer is not covered</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Limited to 100 visits per year; a visit cannot exceed four hours</td>
</tr>
<tr>
<td>Hospice Services</td>
<td>Limited to $10,000 lifetime benefit</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>Certain items have set limitations</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>Certain items have set limitations</td>
</tr>
<tr>
<td>Immunizations</td>
<td>None</td>
</tr>
<tr>
<td>Inhalation Therapy</td>
<td>None</td>
</tr>
<tr>
<td>IV Infusions</td>
<td>None</td>
</tr>
</tbody>
</table>
## Section 5: Alternative Benefit Plan

<table>
<thead>
<tr>
<th>ABP Plan Covered Services</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory Services, including Diagnostic Testing and Other Age-Appropriate Tests</td>
<td>None</td>
</tr>
<tr>
<td>Mammography, Colorectal Cancer Screenings, Pap Smears, PSA Tests and Other Age-Appropriate Tests</td>
<td>None</td>
</tr>
<tr>
<td>Medical Supplies: Diabetic Supplies Only</td>
<td>None</td>
</tr>
<tr>
<td>Medication-Assisted Treatment for Opioid Dependence</td>
<td>Some limitations apply</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>None</td>
</tr>
<tr>
<td>Obstetric/Gynecological Care, Prenatal Care, Deliveries, Midwives</td>
<td>None</td>
</tr>
<tr>
<td>Orthotics</td>
<td>Foot orthotics, including shoes and arch supports, are only covered when an integral part of a leg brace or diabetic shoes</td>
</tr>
<tr>
<td>Physician and Most Practitioner Services and Visits, including Maternity Services, Surgeries, and Anesthesia</td>
<td>None</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>None</td>
</tr>
<tr>
<td>Prescription Drug Items</td>
<td>Over-the-counter drug items are not covered, except for prenatal drug items, low-dose aspirin as preventive for cardiac conditions, contraceptive drugs and devices, and items for treating diabetes</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>ABP preventive services include the A&amp;B recommendations of the United States Preventive Services Task Force (USPSTF)</td>
</tr>
<tr>
<td>Prosthetics</td>
<td>None</td>
</tr>
<tr>
<td>Pulmonary Rehabilitation</td>
<td>Limited to 36 hours per year</td>
</tr>
<tr>
<td>Radiology, including Diagnostic Imaging and Radiation Therapy, Mammography, and other Age-Appropriate Imaging</td>
<td>None</td>
</tr>
<tr>
<td>Reconstructive Surgery</td>
<td>None</td>
</tr>
<tr>
<td>Rehabilitation and Habilitation: Physical Therapy, Occupational Therapy, and Speech and Language Pathology</td>
<td>Short-term therapy only (significant and demonstrable improvement within a two-month period from the initial date of treatment); extension of short-term therapy may be extended for one period of up to two months; long-term therapy not covered</td>
</tr>
</tbody>
</table>
## Section 5: Alternative Benefit Plan

### ABP Plan Covered Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Inpatient Hospitalization: Step-Down Lower Level of Care from an Acute Care Hospital for not more than 14 Days</td>
<td>Extended care hospitals (also called long-term care hospitals) are not covered</td>
</tr>
<tr>
<td>Reproductive Health Services</td>
<td>None</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>None</td>
</tr>
<tr>
<td>Sleep Studies</td>
<td>None</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>None</td>
</tr>
<tr>
<td>Tobacco Cessation Counseling</td>
<td>None</td>
</tr>
<tr>
<td>Transplant Services</td>
<td>Limited to 2 per lifetime</td>
</tr>
<tr>
<td>Transportation Services (Emergency and Non-Emergency Medical), including Air and Ground Ambulance, Taxi, and Handivan</td>
<td>See Section 4G for more information</td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>None</td>
</tr>
</tbody>
</table>

### ABP Non-Covered Services

- Family Support Services
- Recovery Services
- Respite Services
- Agency-Based and Self-Directed Community Benefits
- Acupuncture
- Infertility Treatment
- Naprapathy
- Weight Loss Programs
- Temporomandibular Joint (TMJ) and Cranial Mandibular Joint (CMJ) Treatment

### ABP Exempt Covered and Non-Covered Services

ABP Exempt members have the same benefits as the standard Medicaid plan. Please see Section 4: Covered and Non-Covered Benefits of this handbook for more information.
**Section 6: Care Coordination**

**Considering Your Needs**
To give you extra help getting appropriate care when and where you may need it, we have a number of programs to help you. The first step is to work with you to perform a Health Risk Assessment sometimes called an HRA. We will call you on the phone to ask health questions. These questions help us assist you with any needs related to your health condition. Our goal is to work with you to develop a care plan based on your needs and preferences.

BCBSNM will look at your completed Health Risk Assessment, to identify your medical, long-term care, and behavioral health needs. BCBSNM will then assign you to the right Care Coordination level to help you.

**Care Coordination Levels**

**Level 2:** You will have a Care Coordinator who will work directly with you. Your Care Coordinator will be in contact with you to conduct a Comprehensive Needs Assessment, sometimes called a CNA. This assessment helps us make sure you are getting all the care you need from the right providers. It will happen in person in your home. Your Care Coordinator will be in contact with you often to monitor your care plan. You can talk to your Care Coordinator about any education you may need to help you with your illness. If you have a caregiver, you can also get information to help your caregiver provide you care.

If your medical health, behavioral health, or long-term needs change, or if you are in the hospital, please contact your Care Coordinator. This also referred to as reporting a change in health status. Keep in touch with your Care Coordinator and let them know if your phone number or address changes. This helps your Care Coordinator give you the assistance you need. If you do not have a Care Coordinator and need help with your care, please call Care Coordination at **1-877-232-5518** and select option 3.

**Care Coordination**
The role of the Care Coordinator is to help members with special health care needs, whether at home or in the hospital. Care is centered on the member, focused on the family, when needed, and sensitive to the member’s cultural background. Care coordination can help you make sure your medical needs are fully identified and necessary services are provided to you and are well coordinated. This includes care coordination among providers in the Centennial Care network as well as providers who contract with other Medicaid or Centennial Care plans. Your Care Coordinator can help you coordinate all your needs as a whole. This includes your physical, behavioral, and long-term needs.
If you have special needs, your Care Coordinator can help you by:

- Assigning a person at BCBSNM who is responsible for working with you to coordinate your health care services
- Giving you information about providers in BCBSNM’s network who may address those needs
- Helping with coordinating medical, behavioral, dental health, and long-term care services
- Assisting in coordinating care when you also have Medicare or other coverage
- Getting help with different appointments, transportation, or other needs; or getting community services not covered by Centennial Care
- Making sure care coordination is provided when needed

You can call your Care Coordinator at 1-877-232-5518, option 3, to discuss your medical, long-term care, and behavioral health care needs.

**Getting Help with Special Health Care Needs**

Some members need extra help with their health care. They may have long-term health problems and need more health care services than most members. They also may have physical, long-term care, or behavioral health problems that limit their ability to function. We have special programs to help members with special health care needs.

If you believe you or your child has special health care needs, please call a Care Coordinator at 1-877-232-5518 and select option 3. The Care Coordinator can provide you with a list of resources to help you with your special needs. We also provide education for members with special health care needs and their caregivers. Information is provided about how to deal with stress and/or a chronic illness. You can find information on managing stress while caregiving at www.besmartbewell.com/caregiving.
Section 6: Care Coordination

Community Social Services

The Community Social Service (CSS) program is designed to connect you to local resources necessary to improve your health. These social needs impact your overall health and wellness. This program can help you with your needs related to transportation issues, hunger, place of residence, and understanding your health.

Local community resources are available to help you. All staff members in the program make your cultural needs a priority. We contract with Core Service Agencies (CSA) and other providers throughout the state. These community-based agencies, via Community Health Workers (CHW) may conduct home visits, well checks, coordinate transportation to medical appointments, and provide some health education, among other tasks assigned to meet your needs.

If you have a community social need, CSS helps you by:

- Connecting with you through a local CHW either by phone or in person, if one is available in your area
- Providing you with the local contacts you may need to locate a food pantry, a public service agency for help with Women Infants and Children (WIC), food stamps, temporary assistance for families with young children (TANF), or a program that covers the costs of electricity

- Setting up a PCP for you so you have a medical or behavioral health home where you can get to know the staff as they learn to know more about you. These offices are called “homes” because they coordinate care among doctors, pharmacists, and therapists

You can call BCBSNM Community Social Services at 1-877-232-5518 and select option 6.

Utilization Management

Utilization Management means we look at medical records, claims, and prior authorization requests to make sure services are medically necessary, provided in the right setting, and consistent with the condition reported.

If this management is done before a service is received, it is part of the “prior authorization” process. If it is done while a service is still being received, it is part of the “concurrent review” process. If it is done after a service is received, it is called “retrospective review.”

Utilization Management decisions are based only on appropriateness of care and service. BCBSNM does not reward providers or persons conducting our programs for denying services and does not offer incentives to program decision-makers that would encourage them to approve fewer services than you need. We want to help you get the care you need in the best way possible.

The amount, duration, or scope of service will not be denied solely because of your specific condition, diagnosis, or illness.
There is a difference between a grievance and an appeal.

**Grievance (Complaint)**
A grievance is also known as a complaint. It is an expression of dissatisfaction about any matter or part of BCBSNM or its services. You can also file a grievance if you are not happy with a provider. For example, a grievance is a complaint about the quality of the provider network or any other service BCBSNM provides.

**Filing a Grievance**
If you have a grievance about BCBSNM or a provider, call our Member Services line at 1-866-689-1523 or call 711 for TTY service for help. Member Services can help you file a grievance by getting you in contact with the Centennial Care Appeals/Grievance Coordinator.

**Grievance Addresses and Phone Numbers**
To file a grievance, contact the Centennial Care Appeals/Grievance Coordinator by writing a letter to the address below. You can also call Member Services, email us on our website at bcbnm.com/community-centennial (click on Contact Us), or send a fax to the number below.

Centennial Care Appeals/Grievance Coordinator
P.O. Box 27838
Albuquerque, NM 87125-7838
Telephone (toll-free): 1-877-232-5520
Fax: 1-888-240-3004
Email: Go to bcbnm.com /community-centennial and click on Contact Us

**Time Limits for Filing a Grievance**
You may file a grievance either by phone or in writing within 30 calendar days of the problem. We will send you a letter within five business days after we receive your grievance to let you know we received it and are working to resolve it within 30 calendar days. If you have information that supports your grievance, please send that to us as well. We will add it to your file for consideration.

**Time Frame for an Answer to a Grievance**
BCBSNM has 30 calendar days to review and respond to your concerns or as fast as your health condition requires. Your grievance will be reviewed by someone who was not involved and can research the problem. We will send you another letter within 30 calendar days to let you know how your concerns were answered. In some cases, we may need an extra 14 calendar days and will ask the State of New Mexico for more time, if this is in your best interest. You will be sent a letter within 2 business days of the decision to extend the timeframe. You may also ask for more time if you need it to explain your grievance. This extra time is called an extension.
Section 7: Grievances (Complaints) & Appeals

People Who can File a Grievance

A member may file a grievance verbally or in writing. The legal guardian for children or incapacitated adults, a representative as stated in writing, an attorney, or a provider acting on the member’s behalf with the member’s written permission, can file a grievance on behalf of a member. All grievances are kept confidential. You may ask for a copy of your grievance. You can call the Centennial Care Appeals/Grievance Coordinator or Member Services for help in getting a copy. No negative action will be taken against you or your provider for filing.

Process to Follow if You Disagree with the Final Grievance Decision

You may also file a grievance with the State by writing to:

New Mexico Human Services Department
Medical Assistance Division
P.O. Box 2348
Santa Fe, NM 87504-2348
Telephone: 1-888-997-2583

Appeal

An appeal is defined by the State as a request for review of an “action” taken by BCBSNM about a service. For example, you can request an appeal when a service is denied, delayed, limited, or stopped. An appeal is a request for review of a BCBSNM decision or action. An action is when BCBSNM denies, delays, limits, or stops a service. We will tell you when we make a decision or action in writing. We will send you a letter to let you know when a service is denied, delayed, limited, or stopped. It will also give you the instructions for filing an appeal.

Time Limits for Filing an Appeal

You have to appeal within 90 calendar days from the date of receipt of the denial letter. You can start an appeal over the phone or in writing. You must also mail in your written request for an appeal within 13 calendar days from calling. You can call Member Services and get help with submitting your written appeal request. The Centennial Care Appeals/Grievance Coordinator will also send you an appeal form to fill out and return within 13 calendar days. BCBSNM then has 30 calendar days from the day of your initial request to resolve the appeal.

Filing an Appeal

You should send your written appeal to the Centennial Care Appeals/Grievance Coordinator to the following address or fax a copy of your appeal to the fax number. If you have any proof or information that supports your appeal, please send that to us as well. We will add it to your appeal file for consideration. You may also ask for copies of any documentation BCBSNM used to decide your case. BCBSNM will consider the member, the legal guardian for children or incapacitated adults, the member’s representative as stated in writing, or an estate representative of a deceased member, or the member’s attorney as parties to an appeal.
Section 7: Grievances (Complaints) & Appeals

Appeals Addresses and Phone Numbers
Centennial Care Appeal/Grievance Coordinator
P.O. Box 27838
Albuquerque, NM 87125-5520
Telephone (toll-free): 1-877-232-5520
Fax: 1-888-240-3004
Email: Go to bcbsnm.com/community-centennial and click on Contact Us

How Your Appeal is Handled
Within five business days of receiving your appeal request, BCBSNM will send you a notice confirming we have received it. We will send this notice to you even if you request your appeal over the phone. The notice will also tell you when BCBSNM expects to have an answer for you. If you or your provider believes an answer is needed more quickly from BCBSNM, you can request an “expedited” review and response.

If applicable, a provider who was not involved in the initial denial decision will review your case when you request an appeal. This provider can give another opinion about whether the request will be approved or denied again. An answer to your appeal will be provided within 30 calendar days. The resolution letter will explain the appeal decision. If we need more time to answer your appeal and believe it is in your best interest to take more time, we will ask the State if they will approve an extension of up to 14 calendar days. You may also ask for an extension. If we ask for an extension, we will call to let you know and also follow up in writing within two business days.

Keeping Your Services During an Appeal
You have the right to request continued services while your appeal with BCBSNM and/or the State Fair Hearing process is pending. You have the right to receive continued benefits only if these conditions are met:

- You must request an appeal within ten calendar days from the date on the denial letter
- The appeal involves a service you were receiving before the appeal
- The services were ordered by an approved provider
- The original period covered by the authorization has not expired
- You request extension of the service

Please be aware, if the result of the appeal is not in your favor, you will have to pay for the services received.

Expedited Appeal
If you think the normal 30 calendar day appeal time will put your health at risk, you can ask us to “expedite” your appeal (review it faster). Your Centennial Care plan automatically provides an expedited review for all requests related to a continued hospital stay or other health care services for a member who has received emergency services and is still in the hospital. You or your provider can file an expedited appeal by calling Member Services. We will tell you within one working day if we agree to expedite your appeal. If we agree, we will tell you and/or your provider the outcome over the phone within three calendar days. We will send a follow-up letter within two calendar days telling you and your provider the outcome.
Section 7: Grievances (Complaints) & Appeals

**Expedited Appeal Request Denials**

If an expedited appeal request is denied, it goes through the normal appeal process. It will be resolved within 30 calendar days. BCBSNM will call you within one working day to tell you the appeal is not going to be expedited. We will also follow up in writing within two business days.

**Fair Hearing**

You have the right to ask for a hearing with the State Fair Hearings Bureau if after exhausting your internal grievance/appeal process, you do not agree with the final decision. You or your representative must ask for a Fair Hearing from the State’s Fair Hearing Bureau within 30 calendar days of BCBSNM’s final appeal decision. You have the right to have someone represent you at the hearing. The parties who may attend the Fair Hearing include representatives from BCBSNM, as well as you and/or your representative, or attorney, or the representative of a deceased member’s estate. BCBSNM will send to the HSD/Fair Hearing Bureau Assistance Division, you, and/or your representative a summary of evidence used for your appeal decision after you request a Fair Hearing. Your case may be dismissed if you do not go to your scheduled hearing without a good reason. If you requested continuation of benefits, and the result of the fair hearing is not in your favor, you will have to pay for the services received.

You can request a Fair Hearing by calling or writing to:

New Mexico Human Services Department  
Fair Hearings Bureau  
37 Plaza La Prensa  
P.O. Box 2348  
Santa Fe, NM 87507

If you have any questions about Fair Hearings, call the Fair Hearing Bureau. You can call them at **1-800-432-6217**, then press option 6, or at **505-476-6213**.
Annual Choice Period
Within the first 90 calendar days after your effective date of Centennial Care, you are given one chance to change to another managed care plan. If you do not change during this time, you will have to wait 12 more months.

Moving out of State
If you move out of state, you are no longer eligible for Centennial Care coverage. It is very important to let your ISD case worker know if you move out of state right away.

Member Disenrollment Requests
You can switch to another managed care plan at any time if there is “good cause.” You or your representative must make the request in writing and send it to HSD. If you do not receive approval from HSD, you may ask for a Fair Hearing from HSD. See Section 7: Grievances & Appeals for details about requesting a Fair Hearing. Below are examples of when you may make a special request:
• Centennial Care does not cover the service because of moral or religious reasons
• Centennial Care has been given penalties by HSD
• Contracted providers are not available to perform multiple services at the same time
• You do not have access to contracted providers for your health care needs
• Moved out of state
• Poor quality of care

HSD Reasons for Disenrolling Members
HSD can also ask a member to disenroll from the Managed Care program. These reasons include:
• Loss of Medicaid eligibility
• At any time during the Fair Hearing process, HSD finds it would be best for the member or HSD for the member to disenroll

BCBSNM Reasons for Disenrolling Members
BCBSNM can also request a member disenrollment request from HSD. This can be done when the member’s continued enrollment could harm the Centennial Care plan’s ability to offer services to its members.
Disenrolling During a Hospital Stay or While in a Nursing Facility

If you change to another managed care plan while you are hospitalized, Centennial Care will be responsible for payment of all covered inpatient facility and related professional services until your discharge date. Once you are discharged, all services will be handled by your new managed care plan under Centennial Care.

If you change managed care plans while in a nursing facility, BCBSNM is responsible for payment of covered services until the discharge date or the date you change managed care plans, whichever comes first.

If your coverage ends as a result of being eligible for Centennial Care while you are hospitalized or in a nursing facility, you are responsible for all charges once you are found to be ineligible for Centennial Care.

How to Disenroll

To send a request to disenroll, call your local ISD office or HSD at 1-888-997-2583.

You need to call your county ISD case worker if you:

- Change your name
- Move to another address
- Change your phone number
- Get married or get divorced
- Know of a Centennial Care member who has died
- Have a new child, adopt a child, or place your child for adoption
- Get other health insurance, including Medicare
- Think you lost eligibility or must change your eligibility with HSD/MAD
- Move out of New Mexico
- Need a referral for community resources through Centennial Care
- Have any questions about your eligibility with Centennial Care

If you do not know how to reach your case worker, call HSD/MAD at 1-888-997-2583.
Changes to Handbook or Benefits
HSD/MAD reserves the right to add or delete benefits to the Centennial Care program.

Disclosure and Release of Information
BCBSNM will only disclose information, including medical records, as permitted or required under state and federal law.

Advance Directives
Advance directives are written documents (such as a Living Will, Health Care Treatment Directives, and Durable Power of Attorney) that give a person you select the responsibility for making your health care decisions if you cannot express your own wishes. These documents also describe the kind of treatment you do and do not want. Talk with your provider about advance directives. Keep a copy of your advance directives in your medical record at your PCP’s office. Members over age 18 or emancipated minors have the right to refuse or accept medical or surgical care and to make advance directives.

BCBSNM, in-network providers, and staff do not discriminate care based on whether you have signed any type of advance directive. If you have questions or concerns about advance directives, contact your PCP to discuss these issues.

Complaints about noncompliance with advance directive requirements may be filed with HSD/MAD Division of Health Improvement in the New Mexico Department of Health.

Federal law says hospitals, nursing homes, and other providers have to tell you about advance directives. They need to explain your legal choices about medical decisions. The law was made to give you more control during times when you may not be able to make health care decisions.

If you need help to get an advance directive, contact Member Services or your Care Coordinator. If you are speech or hearing impaired, call 711 for TTY service. You can also call the State of New Mexico Aging and Disability Resource Center at 1-800-432-2080.

Mental Health Advance Directives
New Mexico’s Mental Health Care Treatment Decisions Act allows you to put in writing your wishes for psychiatric treatment. This is called a Psychiatric Advance Directive (PAD). If you are unable to make a decision, mental health advance directives will describe your wishes. You can list a person you trust to make decisions for you. If you need help to get an advance directive, contact Member Services or your Care Coordinator.

Major Disasters
In the event of any major disaster, epidemic, or other circumstance beyond your control, BCBSNM will render or try to arrange covered services with participating providers as much as possible. BCBSNM will do this according to its best judgment and within the limitations of facilities, supplies, pharmaceuticals, and personnel available. Such events include, complete or partial disruption of facilities,
Section 9: General Information

war, riot, civil uprising, disability of BCBSNM personnel, disability of Centennial Care providers, or an act of terrorism.

**Women’s Health and Cancer Rights Act of 1998**

As required by the Women’s Health and Cancer Rights Act of 1998, BCBSNM provides benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and treatment of complications resulting from a mastectomy (including lymphedema). If you have any questions, please call, write, or email Member Services.

**Health Care Fraud and Abuse**

When health care fraud and abuse happens, it hurts everyone. It can make costs rise and creates mistrust of the health care system. Legal action may also be taken against people who commit fraud.

Abuse is when medical benefits are used wrongly such as having extra services performed that are not needed.

Fraud is when someone intentionally uses a dishonest method such as lying or cheating to get goods or services that he or she is not entitled to.

Below are some examples of health insurance fraud and abuse:

- Using someone else’s ID card
- Using fake pay stubs for proof of income
- Selling medications or durable medical equipment
- Providers billing for services that never happened
- Providers billing for services when they know the patient is not the person on the insurance card
- Changing claims to get paid more

**How You Can Help**

Always review the bills from your providers. Make sure that services for all charges are received. If you think there is a problem or that the Centennial Care program is being charged for services that you did not receive, call Member Services at **1-866-689-1523**.

- Be very careful about giving information about your health care insurance over the telephone
- Keep your Centennial Care ID card safe; do not let anyone else use it
- Report any suspicion of fraud and/or abuse to BCBSNM

**Reporting Fraud and Abuse**

If you feel health care fraud and abuse has happened, or will happen, report it right away. BCBSNM will look into the report and will work with any needed government, regulatory, or law enforcement agencies for both member and provider cases, as needed.
Section 9: General Information

You can file a report by contacting our toll-free Fraud and Abuse Hotline at 1-800-543-0867. All calls are confidential and you do not have to give your name. You can also go to our website at bcbsnm.com/sid/reporting.

Based on federal rules, the New Mexico Attorney General’s Office has a dedicated unit called the Medicaid Fraud & Elder Abuse Division (MFEAD). This unit investigates and prosecutes providers who commit health care fraud and abuse, neglect, and exploitation of Medicaid recipients. It also reviews complaints about abuse and neglect for persons receiving services in long-term care Medicaid-funded facilities. You can send fraud reports to the MFEAD at the following address:

Medicaid Fraud & Elder Abuse Division
111 Lomas NW, Suite 300
Albuquerque, NM 87102

Telephone (toll-free): 1-800-525-6519
In Albuquerque: 505-222-9079

Medical Policy
A medical policy is a medical coverage position developed by BCBSNM. It summarizes the scientific knowledge currently available for new or existing technology, products, devices, procedures, treatment, services, supplies, or drugs and used by BCBSNM to process claims and provide benefits for covered services. Medical policies are posted on the BCBSNM website at bcbsnm.com/medicaid. Specific medical policies may be requested in writing from Member Services.

Privacy of Your Information
As a Centennial Care member, HSD is responsible for providing you with a notice. This notice explains how your Protected Health Information (PHI) can be used and shared. PHI includes medical information. It also includes information about your Centennial Care benefits. PHI can be communicated by spoken word, in writing, or electronically.

BCBSNM manages a contract with HSD to provide the Blue Cross Community Centennial health plan to BCBSNM’s Centennial Care members. So that you may use the benefits of this plan, BCBSNM has access to your PHI in all its forms. Due to this fact, we wanted you to know how BCBSNM protects and secures your PHI.

How We Use or Share Your PHI
To operate the health plan and for you to receive services from your health care providers, BCBSNM uses your PHI. BCBSNM shares it with your providers and other organizations. We also share your PHI to help with the following:

- Public health
- Safety issues
- Other legal or law enforcement activities

Please know that BCBSNM only shares your PHI when allowed by law.
Section 9: General Information

Your Rights

- **Authorizations:** There may be times when BCBSNM requires your authorization to release your PHI. Sometimes we need to share your PHI. This may be with your legal guardian, legal representative, or others involved in making decisions about your care.

- **Access to your PHI:** You have the right to ask BCBSNM for a copy of your health information, claims records, or other PHI.

How we Protect Your PHI

BCBSNM has policies, procedures and strong security controls in place. These are in place to protect your PHI. BCBSNM protects your PHI whether it is spoken, written, or maintained electronically. Employees at BCBSNM have to take privacy and security training at least once a year. Employees are also required to comply with all privacy and security policies and procedures.

Information

For more information about this notice or your rights, please call Member Services at 1-866-689-1523 (TTY: 711) or contact HSD.

Independent Companies

Prime Therapeutics is a separate company that is the pharmacy benefit manager for the Blue Cross Community Centennial health plan. Davis Vision, DentaQuest, and LogistiCare are independent companies that provide certain administrative services for the Blue Cross Community Centennial health plan in the areas of vision, dental, and transportation, respectively. All of these companies are independent contractors.
Such services are funded in part with the State of New Mexico.

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