Member Handbook

UNM HEALTH
Insurance Plan



UNMH Employee Health Plan Member Handbook

Healthcare administration and member access guide

Effective Date	January 1, 2027
Plan Year	2027
Plan Name	UNM Health Insurance Plan
Plan Sponsor	University of New Mexico Hospital (UNMH)
Plan Type	Self-Insured Employee Health Plan

Administered by Community Care Plan

Member Services 1-866-602-1751 | TTY 711

How to Use This Handbook

This handbook explains how to access and use healthcare services administered by Community Care Plan for the UNMH Employee Health Plan. It includes information about participating providers, authorizations, claims, pharmacy services, member rights and responsibilities and the steps to follow when a service or claim is denied.

This handbook does not establish eligibility or replace the official plan documents. Questions about employee or dependent eligibility, enrollment, payroll contributions, qualifying life events, continuation of coverage, or termination of coverage should be directed to UNMH Human Resources, Benefits Department.

The official plan documents contain the complete terms governing covered services, exclusions, limitations, copayments, deductibles, coinsurance, and benefit maximums. If this handbook conflicts with an official plan document, the official plan document controls.

For more information on your coverage benefits please refer to the following documents on our website ccpcares.org/for-members/unmh-employees/:

- Plan Documents
- Summary of Benefits
- Summary of Benefits and Coverage (SBC)

This handbook and other plan information are available in alternative formats and languages upon request. Interpreter and translation services are available at no cost.

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1. Plan Administration and Important Contacts

The UNMH Employee Health Plan is sponsored by UNMH. Community Care Plan performs designated administrative functions for the plan. Other organizations may administer specific benefits or services.

Who Does What

Organization	Primary responsibility	Contact
UNMH Human Resources Benefits Department	Eligibility, enrollment, dependents, employee contributions, qualifying life events, continuation coverage, and coverage termination.	933 Bradbury Drive SE HOPE Ste 3002 Albuquerque, NM 87106 (505) 272-2325
Community Care Plan	Member services, provider network support, medical claims, authorizations, care management, complaints, grievances, and medical appeals.	1-866-602-1751 | TTY 711 CCPcares.org ccp.customerservice@ccpcares.org Mon-Fri 8 AM – 5 PM MST 1643 Harrison Parkway, Suite H-200 Sunrise, FL 33323
Prime Therapeutics	Participating pharmacies, formulary, medication prior authorization, specialty pharmacy, mail order, and pharmacy appeals.	Member Service: 833-559-5676 Pharmacy Help Desk: 833-716-2523 PrimeOne.com/Member 24/7
Telehealth vendor	Non-emergency virtual medical and behavioral health services, as covered by the plan.	Teladoc Health www.Teladoc.com 24/7
Behavioral health administrator	Behavioral health and substance use access, authorizations, crisis support, and claims questions, as applicable.	CCP administers all behavioral health and substance use services for the plan. Behavioral Health can also be obtained via Teladoc

Important Contact Information

Need	Contact information
Medical emergency	Call 911 or go to the nearest emergency department
Mental health or substance use crisis	Call or text 988; call 911 for an immediate life-threatening emergency
Member Services	1-866-602-1751 | TTY 711 | Mon-Fri 8AM – 5PM MST
UNMH Benefits	505-272-2325
Pharmacy benefits	Member Service: (833) 559-5676
Care management	1-866-602-1751 | ccp.carecoordination@ccpcares.org
Telehealth	1-800-TELADOC (1-800-835-2362)
Compliance or fraud reporting	FWA Hotline: 855-843-1106 Compliance Officer 954-622-3482 ccp.compliance@ccpcares.org
New Mexico Office of Superintendent of Insurance	1-855-427-5674 | www.osi.state.nm.us
Request to add a provider to the network	Members_UNMHealthInsPlan@salud.unm.edu

2. Getting Started

Confirming Your Coverage

Members may contact Member Services or use the member portal, MyChart, to view coverage status, ID cards, claims and authorizations. Questions about why coverage began, changed, or ended must be directed to UNMH Benefits.

Member Portal – MyChart: Myplan.unmhealth.org

Reviewing Your Services

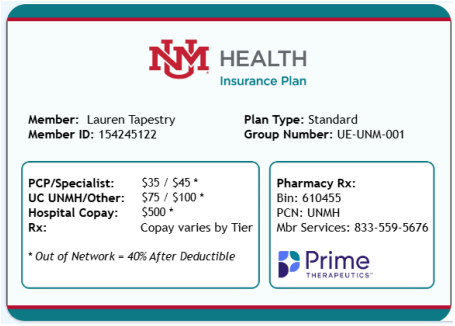
Members can visit the UNMH Patient Portal for upcoming appointments, lab and test results, medical notes, provider messaging feature, and more.

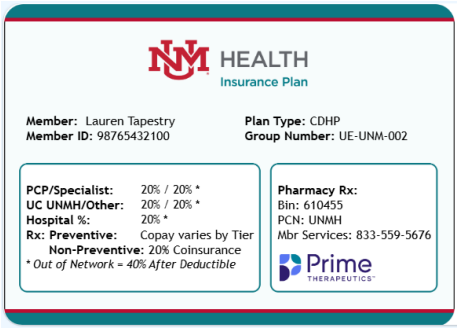
Patient Portal – MyHealthUNM: UNM Health Patient Portal

Member Identification Card

Present your member ID card whenever you receive healthcare services or prescription medications. Review the card when it arrives and contact Member Services if the information is incorrect. A replacement card may be requested through Member Services or the member portal. Sample ID cards below are for illustrative purposes only; your ID card may look slightly different.

- Keep the card with you.
- Do not allow another person to use your card.
- Show both your medical and pharmacy information when requested.
- Notify UNMH Benefits of demographic or dependent changes using its required process.





Understanding Your Benefits and Costs

Your Schedule of Benefits and Summary of Benefits and Coverage describe the services covered by the plan and the amounts you may owe. Member Services can explain how the plan processed a claim but cannot change benefits established by the official plan documents.

Before non-emergency care, ask whether the provider and facility participate in the plan network and whether prior authorization is required. Provider participation and authorization do not guarantee payment. Coverage also depends on eligibility on the date of service, medical necessity, benefit limitations, and other plan requirements.

3. Participating Providers and Network Access

Participating providers are healthcare professionals, facilities, and organizations contracted to provide services at negotiated rates. Using participating providers generally reduces your financial responsibility.

To find a participating provider visit our directory at ccpcares.org/find-a-provider.

Provider directory information can change frequently. Confirm participation with both the plan and the provider before receiving non-emergency services. Confirm the participation of the facility and each professional who may be involved, such as an anesthesiologist, radiologist, pathologist, assistant surgeon, or laboratory.

If You Cannot Find an Available Participating Provider

Contact Member Services if the directory does not show an appropriate participating provider who can provide the covered service within the required timeframe or geographic area. The plan will review available network options for your plan and determine whether you can see an out-of-network provider or if a network exception or other arrangement is appropriate under the plan terms.

Member Services: (866) 602-1751

Out of Network Services

Except for emergencies and other circumstances protected by law or approved by the plan, services from an out-of-network provider may not be covered or may result in higher member responsibility. An out-of-network provider may also bill you for amounts not paid by the plan unless balance-billing protections apply.

To confirm out-of-network member responsibility please review the Summary of Benefits for your plan on our website: CCPcares.org

If you would like UNM Health Insurance Plan to consider adding a provider to our network of participating providers, please email us at Members_UNMHealthInsPlan@salud.unm.edu. Referring a provider for participation is not a guarantee the provider will join the network. Providers become in-network providers upon completion of all of the required contracting and credentialing activities.

4. Primary Care and Specialty Care

Choosing a Primary Care Provider

A primary care provider helps coordinate preventive care, treatment, referrals, diagnostic testing, and follow-up care. Use the provider directory to identify participating providers accepting new patients.

You are not required to choose a Primary Care Physician (PCP) to manage your health care, but it's recommended that you see your PCP before a specialist to ensure that you are directed to the appropriate services. Some specialists may require a referral before they will schedule an appointment with you.

PCP services are also available through Teladoc. Visit Teladoc.com to connect with a provider and learn more about your options and services available through Teladoc.

Specialists and Referrals

If you need care that your Primary Care Provider (PCP) cannot provide, your PCP may suggest seeing another, more suitable in-network specialist or facility. However, you do not need a referral from your PCP to receive care from any in-network facility, specialist, or other health care provider. Under the Standard Network, you may go directly to any Network Provider you choose.

Although a referral from your Primary Care Provider (PCP) is not required before receiving Covered Services from another in-network provider, it is still best to consult your PCP when possible. Your PCP understands your medical history and may recommend a treatment plan or specialist better suited to your needs. In addition, many specialists and facilities prefer to see patients who have been referred by a physician.

Note: Please refer to your Summary of Benefits for copayment details.

Preventive Care

Certain recommended preventive services may be covered without member cost sharing when provided by a participating provider and billed as preventive care. Services performed to diagnose or treat symptoms may be subject to the applicable cost sharing.

The preventive services listed in this provision are not limited by the number of times you may receive them or by the age of the patient, unless a service is clearly inappropriate for a particular age group (for example, administering a pediatric immunization to an adult). You and your Physician should work together to decide how often and when you should receive preventive exams and tests. Coverage will be provided according to your Health Care Plan's benefits and limitations. Any recommended Preventive Service that is considered Medically Necessary will be covered regardless of an individual's sex assigned at birth, gender identity, or the gender recorded by CCP.

These Preventive Services are covered in full, without Coinsurance, Deductible, Copayments, or benefit maximums, when received from an In-Network Provider, according to the quantities and timeframes permitted under applicable law. Out-of-Network services will be subject to normal Out-of-Network Deductible, Coinsurance, and Out-of-Pocket Limits. Some services are required by state regulations to be covered at no cost to the member.

The list of covered services is subject to change. For updates, please visit our website CCPcares.org or contact Member Services (866) 602-1751.

5. Prior Authorization and Medical Necessity

Prior authorization is the Plan's review of a proposed service, supply, or medication before it is provided. Prior authorization may be required for hospital admissions, outpatient procedures, advanced imaging, durable medical equipment, home health, skilled nursing, specialty medications, or other services identified by the plan.

The plan Prior Authorization list is located on our website: CCPcares.org

The ordering provider is responsible for submitting the clinical information needed for review. Members should still confirm that required authorization has been obtained before receiving non-emergency services.

Prior authorization is not a guarantee of payment. Payment depends on eligibility, benefits, medical necessity, coding, coordination of benefits, and other plan requirements on the date of service.

Checking Authorization Status

Members can view authorizations submitted to the plan by logging into MyChart and navigating to the Authorizations section. You can also obtain authorization status by calling Member Services (1-866-602-1751 | TTY 711).

Urgent Requests

If waiting for the standard review period could seriously jeopardize your life, health, ability to regain maximum function, or ability to manage severe pain, your provider may request an expedited review. Emergency services do not require prior authorization.

Request Type	Decision Timeframe
Urgent/Expedited Pre-Service	3 business days of receipt of the request with all pertinent clinical information. If sufficient relevant clinical information is not available to make a determination, the Plan may request an extension of the decision-making timeframe for an additional three (3) business days

6. Emergency Urgent and After-Hours Care

Medical Emergency

An emergency medical condition involves acute symptoms, including severe pain, that a prudent layperson could reasonably expect to result in serious jeopardy to health, serious impairment of bodily functions, or serious dysfunction of an organ or body part without immediate medical attention.

Call 911 or go to the nearest emergency department. Emergency services do not require prior authorization. If follow-up or continued inpatient care is needed, the facility or member should contact the plan as soon as reasonably possible so the plan can assist with care coordination. Failure to provide notice does not eliminate protections that apply to emergency services.

Urgent Care

Urgent care is appropriate for illnesses or injuries requiring prompt attention that are not emergencies, such as minor infections, sprains, minor cuts, flu symptoms, or ear infections. Use participating urgent-care facilities whenever reasonably possible, to reduce your financial responsibility.

To locate an in-network Urgent Care center visit the online Provider Finder: providerdirectory.unmh.ccpcares.org/

For virtual urgent care visits use: Teladoc.com.

After Hours Care and Telehealth

For non-emergency needs outside normal office hours, contact your provider's on-call service, use a participating urgent-care center, or use the plan's telehealth service when appropriate.

Your health plan provides convenient access to telehealth services for non-emergency medical needs. Telehealth allows you to connect with licensed providers from home, work, or on the go using your phone, tablet, or computer. Members may use our contracted telehealth vendor, Teladoc, for virtual visits including primary care consultations, behavioral health support, urgent care needs, dermatology services, and help with common conditions such as cough, flu, rashes, allergies, and

minor infections. Most services are available 24/7, and no appointment is needed. To begin, visit Teladoc.com or download the Teladoc mobile app. For new users, click "Register now". Follow the prompts and the app will link you to the plan based on your personal information. If you choose to use another in-network provider's telehealth platform, standard copayments or cost-sharing may apply based on your plan. Telehealth is also available after hours when your provider's office is closed, offering members accessible, convenient care wherever they are.

Teladoc services are available for primary care, urgent care, behavioral health and dermatology services: Teladoc.com

Please check Benefits and Limits on the Summary of Benefits: ccpcares.org/for-members/unmh-employees/

Care Outside the Service Area

Emergency services and certain urgent services may be covered when you are traveling. Routine out-of-area care may require advance approval or may not be covered. Contact Member Services before obtaining non-emergency care outside of the Albuquerque metro area. Members are encouraged to refer to the online provider directory or contacting customer service prior to scheduling out of area care.

7. Behavioral Health and Substance Use Services

The plan provides access to covered mental health and substance use disorder services in accordance with the official plan documents. Services may include outpatient therapy, medication management, intensive outpatient care, partial hospitalization, inpatient treatment, and substance use treatment.

Behavioral health services for UNM Health Insurance Plan members are administered by Community Care Plan (CCP). Members may contact Member Services for assistance with finding providers, understanding benefits, and obtaining authorization status by calling 1-866-602-1751. To locate an in-network behavioral health provider, members can access the online directory at providerdirectory.unmh.ccpcares.org/. Certain behavioral health services require prior authorization, including non-emergency inpatient mental health admissions, Intensive Outpatient Programs (IOP), Partial Hospitalization Programs (PHP), residential treatment, and Applied Behavior Analysis (ABA). Routine outpatient therapy services typically do **not** require prior authorization, and **referrals are not required** for members to receive in-network behavioral health care.

Crisis Support

For behavioral health crises, members and providers may contact:

The New Mexico Crisis & Access Line (NMCAL) at 1-855-NMCRISIS (1-855-662-7474). NMCAL is staffed by trained behavioral health professionals who can provide crisis intervention, assessments and referrals to local resources. NMCAL is a free and confidential service available to anyone in New Mexico.

If there is an immediate risk to life or safety, Members should seek immediate attention at the nearest emergency room or call 911.

Confidentiality

Behavioral health and substance use information is protected by applicable privacy laws. The plan uses and discloses this information only as permitted or required by law and plan administration requirements.

8. Prescription Drug Coverage

Prime Therapeutics administers your prescription drug benefits. Review the Pharmacy Benefits Guide to learn about your pharmacy benefits, coverage, and available services.

Important Pharmacy Contacts

- Member Services: (833) 559-5676
- Pharmacy Help Desk: (833) 716-2523
- Express Scripts Home Delivery: (833) 247-8963
- Accredo Specialty Pharmacy: (833) 275-4894

Formulary and Prescription Resources

Starting January 1, 2027, members can visit PrimeOne.com/Member to:

- **Review the Preferred Drug List (Formulary)** for covered prescription medications and any applicable coverage requirements
- **Find In-Network Pharmacies** in your area and **understand prescription costs**
- Access pharmacy benefit resources

Specialty Pharmacy

Accredo Specialty Pharmacy provides certain specialty medications to UNM Health Insurance Plan members. Learn about specialty medication support, home delivery services, refill options, and how to get started with Accredo.

Mail Order Pharmacy Services

90DayMyWay is a program offered through your pharmacy benefits. It gives you 90-day supplies of your long-term medicines. Learn more about 90DayMyWay at PrimeOne.com/Member.

Copay Level	Type of Prescription (must be on Drug List)
	Retail Pharmacy (up to a 30-day supply) **Mail-Order Pharmacy** (up to a 90-day supply)
Tier 1	**Preferred Generic Drug**
Tier 2	**Non-Preferred Generic Drug**
Tier 3	**Preferred Brand-Name Drug**
Tier 4	**Non-Preferred Brand-Name Drug**
Tier 5	**Preferred Specialty Drug** (not available through mail-order)
Tier 6	**Non-Preferred Specialty Drug** (not available through mail-order)
All Tiers	**Nonprescription Enteral Nutritional Products and Special Medical Foods** (brand-name or generic): Products must be **prior-approved.**
All Tiers	**Prescription Drug Out-of-Pocket Limit**

For further benefit details, refer to the Summary of Benefits on the Documents page of our website: ccpcares.org/for-members/unmh-employees/

Prime Therapeutics periodically reviews and updates its formulary and typically makes formulary changes quarterly. If a change is made, Prime pulls the utilization for each drug and sends a letter to the impacted members 90 days prior to the effective date.

Pharmacy Exceptions and Appeals

You, your prescriber, or an authorized representative, may request an exception when a medication is not covered, or a coverage rule is not clinically appropriate. You may request an expedited appeal if waiting for a standard decision could seriously jeopardize your health or your ability to regain maximum function.

Members can call, write, or fax an exception request or appeal a decision. You can also access the coverage decision process through our website: PrimeOne.com/Member

Toll-Free Phone: (833) 559-5676
Call 24 hours a day, 7 days a week.
TTY 711

Fax: (877) 898-6093

Mail: UNMH Health Insurance Plan
Clinical Review Department,
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

9. Care Management and Transition of Care

Continuity of Care

Continuity of Care (COC) helps prevent disruptions in your medical care when you are receiving an ongoing course of treatment from a provider who is not, or is no longer, part of the Plan's network. If you meet the Plan's Continuity of Care requirements, you may be able to continue receiving covered services from your current provider for up to 90 days, or until your course of treatment can be safely transitioned to an in-network provider, whichever occurs first.

Continuity of Care may apply in certain circumstances, such as ongoing course of treatment for a serious or complex condition, pregnancy, scheduled surgery, or other qualifying treatment already in progress. COC is subject to Plan requirement and approval and does not guarantee coverage of all services from an out-of-network provider.

Contact Member Services if you believe you may qualify for Continuity of Care or need assistance with the COC process.

10. Claims, Explanations of Benefits, and Reimbursement

How Claims Are Submitted

Using the information below participating providers generally submit claims directly to the plan. Members may need to submit a claim when a provider does not bill the plan or when reimbursement is permitted under the plan's terms.

Electronic Claims Submission:

EDI Claims Clearinghouse – Availity
Submitter ID# 59064
Phone: 1-800-282-4548
Claims Reconsideration Fax: 954-417-7187

Explanation of Benefits

An Explanation of Benefits, or EOB, shows how the plan processed a claim. It is not a bill. Review the EOB for the services billed, amount charged, allowed amount, amount paid by the plan, amount applied to deductible or other cost sharing, denial reason, and appeal information.

Compare the EOB with any bill you receive from your provider. Contact Member Services if you do not recognize the services, are the bill does not match your EOB, or you believe the claim was processed incorrectly.

Members can view EOBs in the Claims section of the MyChart Member Portal: myplan.unmhealth.org

Requesting Member Reimbursement

To request reimbursement:

1. **Contact Member Services.** Call 1-866-602-1751 (TTY 711) to initiate a reimbursement request. A Member Services representative will explain the information and documentation needed to submit your request.
2. **Submit your documentation.** Submit all required documentation by fax or email to Member Services using the contact information provided when you initiated your reimbursement request.
3. **Keep copies of all documents** submitted for your records.

Processing Time: Reimbursement requests that meet plan guidelines will be processed within **30 calendar days of the Plan receiving all required supporting documentation.**

Reimbursement is subject to the Plan's applicable coverage, exclusions, limitations, prior authorization requirements, and cost-sharing provisions. Submission of a reimbursement request does not guarantee payment.

If You Receive a Provider Bill

Always compare your EOB with your provider bill. If you do not recognize a service, notice a difference between the bill and your EOB, or believe there is an error with your claim, contact Member Services for assistance.

11. Other Insurance and Third-Party Responsibility

Coordination of Benefits

If you have other health coverage, coordination-of-benefits rules determine which plan pays first. To ensure claims are processed correctly, promptly report any other medical, pharmacy, Medicare, Medicaid, automobile, or workers' compensation coverage and respond to requests for updated information. Member Services may require updated details at any time, and claims may be delayed or denied when required information is missing. If you have other coverage, contact Member Services as soon as possible to provide or update your information so the Plan can coordinate benefits accurately and avoid interruptions in claim processing.

Member Services: (866) 602-1751

Injuries Caused by Another Party

Notify the plan if care is related to an accident, workplace injury, automobile incident, or another person's actions. The plan may request information about other coverage or responsible parties and may have recovery or reimbursement rights under the official plan documents.

Subrogation, Recovery and Right of Reimbursement

Benefits are payable only upon the Member's acceptance of the terms of the Plan. As a condition to receiving benefits under this Plan, a Member agrees:

1. To serve as a constructive trustee, and to hold in constructive trust such money or property resulting from any payments or settlement proceeds and agrees that they will not dissipate any such money or property without prior written consent of the Plan, regardless of how such money or property is classified or characterized, from any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, other insurance policies for funds; and
2. To restore to the Plan any such benefits paid or payable to, or on behalf of, the Member when said benefits are paid or established by any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, other insurance policies for funds; and
3. To refrain from releasing any party, person, corporation, entity, insurance company, insurance policies or funds that may be liable for or obligated to the Member for the injury or condition without obtaining the Plan's written approval; and
4. Without limiting the preceding, to subrogate the Plan to any and all claims, causes of action or rights that they have or that may arise against any person, corporation and/or other entity and to any coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, other insurance policies or funds ("Coverage") for which the Member claims an entitlement to benefits under this Plan, regardless of how classified or characterized.

In the event a Member settles, recovers, receives, or is reimbursed by any third party or Coverage, the Member agrees that they are a constructive trustee, and shall hold any such funds received in constructive trust for the benefit of the Plan, and to transfer title to the Plan for all benefits paid or that will be paid as a result of said injury or condition. The Member acknowledges that the Plan has a property interest in the Member's settlement, recovery, or reimbursement, and that the Plan's subrogation rights shall be considered a first priority claim and shall be paid before any other claims for the Member as the result of the illness or injury, regardless of whether the Member is made whole. If the Member fails to reimburse

the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any recovery or reimbursement received, the Member will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Member.

The Member shall execute and return a Subrogation Agreement to the Plan Administrator and shall supply other reasonable information and assistance as requested by the Plan Administrator regarding the claim or potential claim. If the Subrogation Agreement is not executed and returned or if information and assistance is not provided to the Plan Administrator upon request, no benefits will be payable under the Plan with respect to costs incurred in connection with such illness or injury.

If the Member (or guardian or estate) decides to pursue a third party or any coverage available to them as a result of the said injury or condition, the Member agrees to include the Plan's subrogation claim in that action and if there is failure to do so the Plan will be legally presumed to be included in such action or recovery. In the event the Member decides not to pursue any and all third parties or coverage, the Member authorizes the Plan to pursue, sue, compromise or settle any such claims in their name, to execute any and all documents necessary to pursue said claims in their name, and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Member (or guardian or estate) agrees to take no prejudicial actions against the subrogation rights of the Plan or to in any way impede the action taken by the Plan to recover its subrogation claim. Such cooperation shall include a duty to provide information, execute and deliver any acknowledgment and other legal instruments documenting the Plan's subrogation rights and take such action as requested by the Plan to secure the subrogation rights of the Plan.

The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Member pursuing a claim against any coverage or third party. The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of the Plan document. This right of subrogation shall bind the Member's guardian(s), estate, executor, personal representative, and heir(s).

Rights of Recovery

In the event of any overpayment of benefits by this Plan, the Plan will have the right to recover the overpayment. If a Member is paid a benefit greater than allowed in accordance with the provisions of this Plan, the Member will be requested to refund the overpayment. If payment is made on behalf of a Member to a Hospital, Physician or other provider of health care, and that payment is found to be an overpayment, the Plan will request a refund of the overpayment from the provider first. If the provider does not honor the Plan's request for a refund, the Plan will then request the overpayment from the Member. If the refund is not received from the provider or Member, the amount of the overpayment will be deducted from future benefits.

Right to Receive and Release Necessary Information

For the purposes of implementing the terms of this Plan, the Claims Administrator retains the right to request any medical information from any insurance company or provider of service it deems necessary to properly process a claim. The Claims Administrator may without consent of the Member, release or obtain any information it deems necessary. Any person claiming benefits under this Plan shall furnish to the Claims Administrator such information as may be necessary to implement this provision.

Reimbursement Rights

The Member, by accepting benefits under this Plan, agrees to hold in constructive trust any money or property resulting from any recovery, insurance payments or settlement proceeds, third party payments, settlement proceeds or judgment for the Plan's benefits under this provision. If a Member fails to reimburse the Plan for all benefits paid or to be paid, as a result of their illness or injury, out of any recovery or reimbursement received, the Member will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Member. This right of reimbursement shall bind the Member's guardian(s), estate, executor, personal representative, and heir(s).

12. Grievances, Appeals, and External Review

You may raise a concern or challenge a decision without retaliation. Interpreter services and reasonable accommodations are available at no cost. You may appoint an authorized representative to act for you, subject to the plan's authorization requirements.

Grievances

A member may submit a complaint or grievance regarding dissatisfaction with the Plan, its services, or a healthcare provider. Grievable concerns may include, but are not limited to:

- Customer service or communication
- Access to care or services
- Provider conduct or communication
- Quality of care or services received
- Appointment availability or wait times
- Network access or availability of participating providers
- Utilization management practices or processes
- Plan operations or administrative services
- Discrimination or accessibility concerns

Grievances may be submitted by:

- Calling Member Services at 866-602-1751 | TTY 711
- Submitting a written grievance via email or fax to:

  Community Care Plan – Grievance & Appeals Coordinator
  Email: grievancesandappeals@ccpcares.org
  Fax: 954-251-4848

Once your grievance is submitted, CCP will send an acknowledgement letter within three (3) business days. Cases are resolved within 30 calendar days.

Appeals

An appeal asks the plan to reconsider an adverse benefit determination. The denial notice explains the reason for the decision, the information needed to appeal, the filing deadline, and whether expedited or external review is available.

How to File an Appeal

4. Review the denial notice and the deadline for filing an appeal.
5. Explain the decision you are appealing and why you believe it should be changed.
6. Include the member's name, member ID, provider, date of service, claim or authorization number, and any supporting documentation.
7. Submit the appeal using the instructions provided below and keep a copy for your records.
8. If your situation is urgent and meets the criteria for an expedited appeal, you may request an expedited review.
9. Appeals must be filed within 180 calendar days of the Notice of Remittance Adverse/Provider Benefit Determination.

Members may file an appeal by:

Submitting a written appeal to:

Community Care Plan – Grievance & Appeals Coordinator
Email: grievancesandappeals@ccpcares.org
Fax: 954-251-4848

CCP will confirm receipt within three (3) business days, and resolve within 30 calendar days, unless an extension is permitted under regulatory guidelines.

CCP's Medical Director team will review and make determinations for appeals requiring medical judgment, ensuring all clinical reviews are completed by appropriately licensed personnel.

IMPORTANT: You have 180 calendar days from the date you receive CCP's decision to contact CCP Member Services by phone or in writing and explain why you disagree with the decision. If you do not request an internal review within this 180-day period, you forfeit your right to an internal review as described in this section, unless you can show CCP that circumstances beyond your control prevented you from submitting your request on time.

Authorized Representatives and Access to Records

You may authorize another person, including a provider, family member, or attorney, to act on your behalf. The plan may require a signed authorization form. You may request relevant documents, records, clinical criteria, and other information used in making the decision, as permitted by law and the plan terms.

Members may designate an authorized representative to act on their behalf when filing an appeal of an Adverse Benefit Determination.

Key points:

- The designation must be in writing to prevent unauthorized disclosure of your information.
- You or your authorized representative may review your claim file, submit evidence, and receive documents used in determining the claim.

Expedited Appeals and Continued Services

An expedited appeal may be available when waiting for the standard timeframe could seriously jeopardize life, health, the ability to regain maximum function, or the ability to manage severe pain. Special rules may apply when previously approved ongoing services are reduced or terminated.

Members may file an expedited appeal by:

Submitting a written appeal to:

Community Care Plan – Grievance & Appeals Coordinator
Email: grievancesandappeals@ccpcares.org
Fax: 954-251-4848

Request Type	Decision Timeframe
Urgent Appeal	If an appeal is approved as urgent by CCP Medical Director: CCP will confirm receipt within one (1) business day. CCP will provide resolution disposition within 72 hours, unless an extension is permitted under regulatory guidelines.

13. Member Rights, Responsibilities, Privacy, and Nondiscrimination

Member Rights

- Receive information about the health plan, available services and how to access them in an understandable and accessible format.
- Be treated with dignity and respect without discrimination.
- Receive care that is free from discrimination based on race, color, national origin, age, disability, or sex
- Participate in healthcare decisions and discuss treatment options regardless of cost or benefit coverage and their right to refuse treatment.
- Appeal coverage decisions they disagree with
- Receive emergency services as required by law.
- Request interpreter services and reasonable accommodations.
- Have their healthcare information kept confidential in accordance with HIPAA and applicable state and federal laws
- Receive a copy of their medical records
- File complaints, grievances, and appeals if they are dissatisfied with care or services without fear of retaliation.
- Receive information about participating providers and applicable requirements for accessing care.
- Receive appropriate assistance with understanding health information and accessing services, consistent with appliable legal requirements
- Designate an authorized representative to act on their behalf.

Member Responsibilities

- Provide accurate information to their providers and health plan needed to administer benefits and coordinate care.
- Following the treatment plans agreed upon with their providers and disclosing any barriers that may affect care.
- Present your member ID card and coverage information when seeking services and protecting ID card from misuse.
- Understand your benefits and obtain required referrals or authorizations before receiving emergency services.
- Use participating providers whenever possible.
- Review EOBs and promptly report suspected errors or fraud.
- Report other insurance and accident information.
- Paying applicable cost-sharing amounts (copays, deductibles, coinsurance) at the time of service.
- Communicate changes in health status to their provider(s)
- Keep scheduled appointments or provide timely notice when cancellation or rescheduling is necessary.
- Treat providers, staff, and other members with courtesy and respect.

Privacy Practices

The plan and its administrators protect member information in accordance with HIPAA and other applicable laws. The Notice of Privacy Practices explains how protected health information (PHI) may be used and disclosed and describes your privacy rights.

Your privacy is important to us. CCP is committed to protecting the confidentiality of your medical and financial information in accordance with federal and state law. You have the right to have your privacy respected and to understand how your protected health information (PHI) is used and shared. This includes the right to request restrictions on certain uses or disclosures of your PHI, to ask for confidential communications, and to inspect, copy, or request corrections to your health information. You may also request an accounting of specific disclosures made by the Plan.

You may view CCP's Notice of Privacy Practices at CCPcares.org. The Notice of Privacy Practices is effective January 1, 2027.

You may request a paper copy of the Notice of Privacy Practices by contacting Member Services at (866) 602-1751 (TTY 711), Monday through Friday, 8:00 AM to 5:00 PM MST.

If you have a question or concern about the privacy of your health information of believe your privacy rights have been violated, you may contact Member Services or submit a written complaint to CCP's Compliance (Privacy) Officer. You may report a privacy concern without fear of retaliation.

Nondiscrimination and Language Assistance

Notice of Nondiscrimination

Community Care Plan complies with applicable federal civil rights laws and does not discriminate based on **race, color, national origin, sex, age, or disability**.

Community Care Plan does not exclude or treat people differently because of race, color, national origin, sex, age, or disability in the administration of its health programs and activities.

If you believe that Community Care Plan has discriminated against you on the basis of race, color, national origin, sex, age, or disability, you may file a civil rights grievance with:

Jennifer Nielsen, Civil Rights Coordinator
Community Care Plan
1643 Harrison Parkway, Suite H-200
Sunrise, FL 33323
Phone: (866) 899-4828
TTY: 711
Email: jnielsen@ccpcares.org

You may file a grievance by mail, fax, phone, or email.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Information about filing a complaint is available through the Office for Civil Rights.

Language Assistance
If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, contact Member Services for assistance: 1-866-602-1751

Fraud Waste and Abuse (FWA)

Report suspected fraud, waste, abuse, or identity theft, as well as any misuse of a member ID card. Reports may be made confidentially using the contact below. Do not include sensitive health information in unsecured email.

Providers must comply with all applicable federal and state FWA laws and regulations, including:

- False Claims Act (31 U.S.C. §§ 3729–3733)
- Anti-Kickback Statute
- Stark Law (Physician Self-Referral Law)
- HIPAA fraud and abuse provisions

To report suspected fraud, waste, or abuse, contact the CCP FWA Hotline:

FWA Hotline: 855-843-1106

Alternatively, they may contact the compliance officer by phone, 954-622-3482 or email, ccp.compliance@ccpcares.org.

Reports may be made anonymously. Retaliation against individuals who report suspected FWA in good faith is strictly prohibited.

14. Important Member Protections

Protection from Surprise Medical Bills

Federal law generally protects members from certain unexpected out-of-network bills for emergency services, non-emergency services furnished by out-of-network providers at participating facilities, and out-of-network air ambulance services. When these protections apply, the member generally pays no more than the applicable in-network cost sharing and the provider may not balance bill the member, except in circumstances where notice and consent are legally permitted.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as copayment, coinsurance, and/or deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You're also not required to receive care out-of-network. **You may choose a provider or facility in your plan's network.**

When balance billing isn't allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

- Cover emergency services without requiring prior authorization.
- Cover emergency services provided by out-of-network providers.
- Base your cost-sharing on what it would owe an in-network provider or facility and show that amount in your explanation of benefits (EOB).
- Count any amount you pay for covered emergency or out-of-network services toward your in-network deductible and out-of-pocket limit, as applicable

If you believe you've been wrongly billed, you may contact the Department of Labor at 1-866-4-USA-DOL or www.dol.gov. Visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for more information about your rights under federal law.

Women's and Family Health Protections

Federal and state laws may provide protections related to maternity stays, breast reconstruction following mastectomy, access to obstetrical and gynecological care, contraceptive services, and other preventive care. The official plan documents and required notices explain the protections that apply.

Under the Newborn's and Mothers' Health Protection Act, group health plans may not restrict hospital benefits for childbirth to less than 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. The attending healthcare provider may, after consulting with the mother, authorize an earlier discharge. The Plan does not require prior authorization for a hospital stay within these federally protected timeframes.

In accordance with the Women's Health and Cancer Rights Act of 1998, members receiving mastectomy-related benefits are entitled to coverage for breast reconstruction, surgery to achieve symmetry, prostheses, and treatment of physical complications, including lymphedema. Coverage is provided in consultation with the member and attending physician and is subject to applicable Plan cost-sharing requirements.

Newborns' and Mothers' Health Protection Act (NMHPA)

Hospital Stays Following Childbirth

Under the Newborns' and Mothers' Health Protection Act, coverage for a hospital stay related to childbirth cannot be limited to less than:

- 48 hours after a vaginal delivery; or
- 96 hours after a cesarean (C-section) delivery.

You and your health care provider may decide that an earlier discharge is appropriate. If so, benefits will continue to be provided for services covered under your health plan. Your provider's decision about discharge will not be influenced by financial incentives from the health plan

Women's Health and Cancer Rights Act (WHCRA)

Breast Reconstruction Following Mastectomy

Under the Women's Health and Cancer Rights Act, if this health plan covers a mastectomy, coverage is also available for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to create a balanced appearance;
- Breast prostheses; and
- Treatment of physical complications of a mastectomy, including lymphedema.

These services are subject to the same deductibles, copayments, coinsurance, and other plan requirements that apply to similar medical and surgical benefits under this health plan. Please contact Member Services for more information about these benefits.

Advance Directives

New Mexico law permits individuals to make decisions about future healthcare treatment through documents such as a living will or healthcare power of attorney. The plan does not discriminate based on whether a member has completed an advance directive.

If you have an advance directive, you are encouraged to provide a copy to your healthcare providers so that your healthcare preference can be documented in your medical records.

Your designated healthcare agent, authorized representative, family member, or other trusted individual may also assist in communicating the existence of your advance directive and providing a copy to your healthcare providers, as permitted by applicable law.

You are also encouraged to keep copies of your advance directive in an accessible location and share them with individuals who may be involved in your healthcare decision.

15. Glossary

Adverse benefit determination: A denial, reduction, termination, or failure to provide or pay for a benefit, including certain decisions involving eligibility for a benefit, medical necessity, experimental or investigational treatment, or a plan limitation.

Allowed amount: The maximum amount the plan recognizes for a covered service. The amount may be based on a contracted rate or another method described in the plan documents.

Appeal: A request for the plan to reconsider an adverse benefit determination.

Balance billing: Billing a member for the difference between a provider's charge and the amount recognized or paid by the plan, other than permitted member cost sharing.

Coinsurance: A percentage of the allowed amount that a member pays for a covered service.

Complaint: An expression of dissatisfaction about a service, experience, or other aspect of the Plan or its administration. A complaint may relate to customer service, communication, access, or another concern and may be resolved without becoming a formal grievance.

Copayment: A fixed amount a member pays for a covered service.

Deductible: The amount a member pays for covered services before the plan begins paying for services subject to the deductible.

Emergency medical condition: A condition with acute symptoms severe enough that a prudent layperson could reasonably expect serious harm without immediate medical attention.

Explanation of Benefits: A statement showing how the plan processed a claim. It is not a bill.

Formulary: The list of prescription medications covered by the plan, including applicable coverage rules and tiers.

Grievance: A formal expression of dissatisfaction about the Plan, a provider, the quality or availability of services, or another matter related to the member's health care experience that is submitted for review and resolution through the Plan's grievance process. A grievance does not include a request to overturn an adverse benefit determination.

Medical necessity: Clinical criteria used to determine whether healthcare services or supplies are appropriate under the terms of the plan.

Out of network: A provider or facility that does not have a participating agreement for the applicable plan network.

Out of pocket maximum: The most a member pays during the benefit period for covered services that count toward the maximum. Not all expenses apply towards the out-of-pocket maximum.

Participating provider: A provider or facility contracted to provide covered services under the applicable plan network.

Prior authorization: Review and approval required before certain services, supplies, or medications are provided.

Referral: A direction from one provider to another provider for evaluation or treatment. A referral does not necessarily constitute prior authorization.