Benefit Booklet

BlueEdge℠ Individual for HSA

A Guide to Your Individual/Family Preferred Provider Option (PPO) Health Care Plan

To be used in conjunction with the BlueEdge HSA Plan for Individuals

Underwritten by:

Blue Cross and Blue Shield of New Mexico

NM 80009 - 05/09

Customer Assistance

Customer Service — When you have questions or concerns, call BCBSNM Monday through Friday from 6 A.M.– 10 P.M. and 8 A.M.– 5 P.M. on weekends and holidays. (If you need assistance outside normal business hours, you may call the Customer Service telephone number and leave a message. A Customer Service representative will return your call by 5:00 P.M. the next business day.) You may call toll-free at: **1-866-236-1702.**

Send all **written inquiries** to:

Blue Cross and Blue Shield of New Mexico
Hallmark Services Corporation
P.O. Box 3235
Naperville, IL 60566-7235

Claims Submission and Prior Approval Requests — For admission review and other prior approval requests, call a Health Services representative in Albuquerque, Monday through Friday, between 8 a.m. and 5 p.m., Mountain Time. Written requests should be sent to the mailing address given below. **Note:** If you need prior approval assistance between 5 P.M. and 8 A.M. or on weekends, call Customer Service. If you call after normal Customer Service hours, you will be asked to leave a message.

(505) 291-3585 or 1-800-325-8334

Submit **medical/surgical claims*** and send all **written prior approval requests** to:

Blue Cross and Blue Shield of New Mexico
P.O. Box 3235
Naperville, IL 60566-7235

Web Site — For provider network information, a copy of the BCBSNM Drug List, claim forms, and other information, or to e-mail your question to BCBSNM, visit the BCBSNM Web site at:

www.bcbsnm.com

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*Exceptions to Claims Submission Procedures Above — Claims for health care services received outside New Mexico from providers that do not contract **directly** with BCBSNM, should be sent to the Blue Cross Blue Shield Plan in the state where services were received. **Note: Do not submit claims for items covered under the drug plan to BCBSNM.** The name and address of the drug plan claim administrator is in a separate brochure. See *Section 6* for details on submitting claims.

Welcome to BlueEdge Individual for HSA

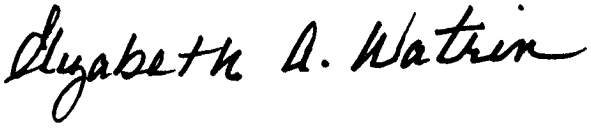
Welcome to BlueEdge Individual, underwritten by Blue Cross and Blue Shield of New Mexico (BCBSNM), your partner in health care. BCBSNM is pleased to provide you with health care coverage that allows you choice and flexibility for your health care. Our goal is to provide you with the health care coverage and service that you expect. By encouraging physicians, hospitals, other providers, and members to work together, BCBSNM manages health care costs while providing you with a comprehensive and affordable health care plan.

Please take some time to get to know your BlueEdge Individual health care plan coverage, including its benefit limits and exclusions, by reviewing this important document and any enclosures. This plan is designed to be used along with the **BlueEdge Health Savings Account (HSA)** program. Learning how your plan works can help you make the best use of your health care benefits.

Note: BCBSNM may change the benefits described in this booklet. If that happens, BCBSNM will notify you of those changes.

Thank you for selecting BCBSNM for your health care coverage. We look forward to working with you to provide personalized and affordable health care now and in the future.

Sincerely,



Elizabeth A. Watrin
President
Blue Cross and Blue Shield of New Mexico

This booklet includes information presented in the following endorsements, amendments, or riders and replaces the following documents:

BlueEdge Individual HSA Benefit Booklet (NM80009; 01/05); and
25/50 Percent Drug Plan Rider (M616; 06/05)
2005 Benefit and Eligibility Changes for Fully Insured BCBSNM Individual Plans (end_mega2005; 07/01/05);
Amendment to 25/50 Percent Drug Plan Rider (AMD-NM80009; 01/01/06);
and *Administrative Address Changes* (end_address_hmk; 06/01/09).

Be sure to read this booklet carefully and refer to your Summary of Benefits.

Endorsement:

2007 Benefit Changes for Fully Insured BCBSNM Individual Plans

(Excluding BlueTransitions and Medicare Supplements)

Blue Cross and Blue Shield of New Mexico

This *2007 Benefit Changes for Fully Insured BCBSNM Individual Plans* endorsement is made a part of your Blue Cross and Blue Shield of New Mexico (BCBSNM) health care plan benefit booklet. If you have a question about these changes, please call your Customer Service Unit representative at the phone number printed on the bottom of the page or on the back of your identification card.

BY:

Elizabeth A. Watrin
President
Blue Cross and Blue Shield of New Mexico

Hearing Aids/Related Services for Children Under Age 21 (SB529)

Effective July 1, 2007, add the following text to *Section 3: Covered Services* of your benefit booklet:

For members under 21 years old, this plan covers the cost of hearing aids, the fitting and dispensing fees for hearing aids, and ear molds up to a maximum benefit payment of **$2,200 per hearing impaired ear every 36 months.** This 36-month benefit period begins on the date the first covered hearing aid-related service is received and payable under this provision and ends 36 months later. The next benefit period for the impaired ear begins 36 months after the first hearing aid-related service (e.g., fitting cost, ear mold, etc.) OR on the date of the next hearing aid-related service for that ear, whichever length of time is greater.

Benefits for hearing aid-related services payable under this provision are not subject to any deductible, coinsurance, or copayment amount. The hearing aid-related services will pay at 100 percent of covered charges. (Other services, such as hearing exams and audiometric testing related to a hearing aid need for members under 21 years old are subject to usual plan deductible, coinsurance, and copayment provisions for office services and diagnostic testing. Benefits for these additional services are not applied to the 36-month maximum benefit available for hearing aids. **Routine hearing exams and related services are not covered for members age 21 and older.)** Services received in- and out-of-network are combined to calculate whether or not the maximum benefit has been reached for a particular ear. If your plan does not provide benefits for out-of-network coverage, you must receive services from in-network providers in order to receive this benefit. **Exception:** Under BlueEdge HSA plans, all services must be subject to deductible and amounts applied to the deductible are considered benefits paid for purposes of determining when a maximum benefit has been reached.

Effective July 1, 2007, add the following line of text to your Summary of Benefits:

Hearing aids, fitting and dispensing fees for hearing aids, and ear molds for members under age 21: Plan pays 100 percent of covered charges up to a maximum benefit of $2,200 per ear during any 36-month benefit period. (Note: Deductible must be met before payment begins under BlueEdge HSA plans.)

Routine hearing exams and audiometric testing for members under age 21: Usual copayments and/or deductible and coinsurance based on type of service received (i.e., exam versus diagnostic testing).

General Anesthesia and Hospitalization for Dental Surgery (SB776)

Effective July 1, 2007, replace the "Facility Services for Dental-Related Services" provision (or similar provision addressing facility services for dental-related services) under "Dental-Related/TMJ Services and Oral Surgery" in Section 3: Covered Services in your benefit booklet with the following text:

Facility Charges and General Anesthesia for Dental-Related Services — This plan covers inpatient or outpatient hospital expenses (including ambulatory surgical centers) and hospital and physician charges for administration of general anesthesia for noncovered, medically necessary dental-related services if the patient requires hospitalization for one of the following reasons:

- Because of the **patient's** physical, intellectual, or medical condition(s), local anesthesia is not the best choice.
- Local anesthesia is ineffective because of acute infection, anatomic variation, or allergy to local anesthesia.
- The patient is a member age 19 or younger who is extremely uncooperative, fearful, or uncommunicative; his/her dental needs are too significant to be postponed; and lack of treatment will be detrimental to the child's dental health.
- Because oral-facial or dental trauma is so extensive, local anesthesia would be ineffective.
- There is a medically necessary dental procedure – not excluded by any *General Limitation or Exclusion* listed in the benefit booklet such as for work-related, pre-existing, or cosmetic services, etc. – that requires the patient to undergo general anesthesia or be hospitalized.

All hospital services for dental procedures must be **prior-approved** by BCBSNM. **Note:** Unless listed as a covered procedure in this section, the dentist's services for the procedure will not be covered. **Reminder:** If hospital services are recommended by any out-of-network provider, you are responsible for obtaining **admission review approval** for the admission or **prior approval** for outpatient services to receive maximum benefits. (See "Admission Review and Other Prior Approvals" in *Section 2*.)

This plan does **not** cover:

- surgeon's or dentist's charges for the noncovered dental-related service
- hospitalization or general anesthesia for the patient's or provider's convenience
- any service related to a dental procedure that is not medically necessary or that is excluded under this plan for reasons other than being dental-related, even if hospitalization and/or general anesthesia is medically necessary for the procedure being received (e.g., cosmetic procedures, experimental procedures, services received after coverage termination, services related to pre-existing conditions, work-related injuries, etc.)

Preventive Services (HB510 and SB407)

Effective June 15, 2007, add the following text to the list of services covered under the "Preventive Services" provision in Section 3: Covered Services in your benefit booklet:

- human papillomavirus vaccine (HPV) for members aged 9 through 26
- colorectal cancer screening tests

Note About Booklet Amendment: The statute requires that benefits for HPV be provided only to children ages 9 to 14; however, BCBSNM's coverage extends coverage for HPV to members through age 26. You and your physician are encouraged to determine how often and at what time you or your child should receive preventive tests and vaccinations.

Hospice Care

For members with a $7,500 lifetime benefit maximum for hospice care: Effective July 1, 2007, increase the maximum lifetime benefit for "Hospice Care" on your Summary of Benefits to $10,000 per member. (Health plans that limit hospice services to a maximum number of days per year or lifetime or that do not limit such benefits are not changing.)

Subrogation (Reimbursement)

Effective July 1, 2007, if your benefit booklet includes a "Subrogation" provision, replace it with the following "Reimbursement" provision:

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for covered services described in this benefit booklet, you agree:

BCBSNM has the 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 you or your legal representative as a result of that sickness or injury, in the amount of the total covered charges for covered services for which BCBSNM provided benefits to you or your dependents.

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 you, your covered dependents or your 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.

You are 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.

BlueExtras℠

Effective immediately, add the following text to your benefit booklet. Details of any such programs described here will be sent to you in the future as they become available to BCBSNM members.

Certain local and national retailers, outlets, and businesses offer BCBSNM health plan members an opportunity to save money on services that are not covered under the health plan. These discount offers and other services are not part of the medical/surgical health care plan benefits described in your benefit booklet and the entities making the offers and the providers of the services may not be affiliated or associated with BCBSNM or your health care plan. However, from time to time, BCBSNM will be announcing such offers by sending manufacturer or retail discount coupons to member households, inserting information into Member Newsletters, or mailing descriptions of various programs being offered to our members by businesses such as health clubs, pharmacies, vision care providers, hearing aid retailers, dentists, etc. These mailings may contain coupons or offers that enable you, at your discretion, to purchase the described product or enroll in a certain program at a discount or at no charge. The retailer, provider, or manufacturer may pay for and/or provide the content for this information. The discounts and services available to members may change at any time and BCBSNM does not guarantee that a particular discount or service will be available at a given time. For details of current discounts available, please contact a Customer Service representative by calling the phone number on the back of your ID card or by visiting our offices in Albuquerque at 4373 Alexander Boulevard NE.

Breast Reconstruction and Mastectomy Notification (WHCRA)

This is notice that your health care plan provides benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and treatment for complications resulting from a mastectomy (including lymphedema), when such benefits are required by the federal Women's Health and Cancer Rights Act of 1998. Check your benefit materials or call Customer Service for more information.

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

Endorsement:
Member Services

Blue Cross and Blue Shield of New Mexico

This *Member Services* endorsement is made a part of your Blue Cross and Blue Shield of New Mexico (BCBSNM) health care plan benefit booklet. If you have a question about these changes, please call your Customer Service Unit representative at the phone number printed on the bottom of the page or on the back of your identification card.

BY:

Elizabeth A. Watrin
President
Blue Cross and Blue Shield of New Mexico

Other Member Services

Effective immediately, add the following text to your benefit booklet. Details of any such programs described here will be sent to you in the future as they become available to BCBSNM members.

To help our members track claims payments, make health care choices, and reduce health care costs, BCBSNM maintains a flexible array of online programs and tools for health care plan members. Our online "Blue Access for Members" tool provides convenient and secure access to claims information and account management features and to various cost comparison tools. While online, members can also access a wide range of health and wellness programs and tools, including a health risk assessment and personalized health updates, and a program in which members can earn merchandise and gift cards for making healthy lifestyle choices and participating in various activities. To access these online programs, go to www.bcbsnm.com, log into Blue Access for Members (BAM) and create a user ID and password for instant and secure access. If you need help accessing the site, call the Blue Access Help Desk toll-free at 888-706-0583, Monday through Friday 7 A.M. to 9 P.M. MT; Saturday 6 A.M. to 2:30 P.M. MT. **Note:** Depending on your plan's coverage, you may not have access to all online features. Check with your benefits administrator or call Customer Service at the number on the back of your ID card. BCBSNM assesses the usefulness of various programs regularly, using data about program usage and member feedback to make changes to online tools as needed. Therefore, available programs and program rules are updated, added, or terminated and may change without notice as new programs are designed and/or as our members' needs change. We encourage you to enroll in Blue Access for Members and check the online features available to you – and check back in as frequently as you like. We are always looking for ways to add value to your health care plan and hope you will find our Web site helpful.

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

Endorsement:
2008 Benefit Changes for Fully Insured Individual Plans

Blue Cross and Blue Shield of New Mexico

This *2008 Benefit Changes for Fully Insured Individual Plans* endorsement is made a part of your Blue Cross and Blue Shield of New Mexico (BCBSNM) health care plan benefit booklet. If you have a question about these changes, please call your Customer Service Unit representative at the phone number printed on the back of your identification card.

BY:

Elizabeth A. Watrin

Elizabeth A. Watrin
President
Blue Cross and Blue Shield of New Mexico

PPO Plans Only: Appeals Process and Grievances

Effective July 1, 2008, replace any information about complaints, appeals, or grievances (sometimes referred to as "reconsiderations") in your benefit booklet or any prior amendment with the following text:

Grievances (Complaints)

If you have an inquiry or a concern about any prior authorization request, claims payment, claims that have been denied or only partially paid, the quality of care you receive, the cancellation of your coverage, or any other review decisions made by BCBSNM, call a BCBSNM Customer Service representative for assistance. Many complaints or problems can be handled informally by calling, writing, or e-mailing BCBSNM Customer Service. If you are not satisfied with the initial response, you can request internal review as described below.

If you make an oral grievance, a BCBSNM Customer Service representative will assist you. The Managed Health Care Bureau of the New Mexico Insurance Division is also available to assist you with grievances, questions, or complaints. Call:

1-888-427-5772 or (505) 827-3928

You may designate a representative to act for you in the internal review. Your designation of a representative must be in writing in order to protect against disclosure of information about you except to your authorized representative. You, your guardian or representative, or a provider acting on your behalf can contact a BCBSNM Customer Service representative in person, by letter, by e-mail, or by telephone if you have an inquiry or complaint about a prior authorization request, a claim payment or denial, or any other issue. If you make an inquiry or complaint or file a grievance under the following procedures, you will not be subject to retaliatory action by BCBSNM. **Note:** This is a summary of the procedures. You may request a more detailed written explanation of these procedures by calling BCBSNM Customer Service.

Grievance Procedures

If you are not satisfied with the initial decision made by BCBSNM, you can request internal review. Within **180 days** after you receive notice of a BCBSNM decision (payment, denial, or partial denial) on a claim or a prior authorization request, call or write BCBSNM Customer Service and explain your reasons

for disagreeing with the decision. If you do not submit the request for internal review within the 180-day period, you waive your right to internal review, unless you can satisfy BCBSNM that matters beyond your control prevented you from timely filing the request. You may also ask to see relevant documents and you may submit written issues, comments and additional medical information as part of the internal review.

Adverse Determination Grievance — This is a summary of the grievance procedure that applies to "adverse determinations" made by BCBSNM regarding a request for a health care service.

Adverse determination – An "adverse determination" means a decision made either pre-service or post-service by BCBSNM that a health care service requested by a provider or member has been reviewed and, based upon the information available, does not meet the requirements for coverage or medical necessity and the requested health care service is either denied, reduced, or terminated.

If your request for a health care service has been denied in whole or in part, you may request internal review of the adverse determination. The internal review will be either "expedited" or "standard."

If required by the medical exigencies of the request, BCBSNM will conduct an "Expedited Review" and will render a decision as soon as practicable, but not later than **72 hours** from receipt of the request.

If not medically exigent, BCBSNM will conduct a "Standard Review." If the request for internal review is made **before** you receive the health care service ("pre-service request for review"), the **entire** internal review process shall be completed within **20 working days** of receipt of the request for internal review. If the request for internal review is made **after** you receive the health care service ("post-service request for review"), the **entire** internal review shall be completed within **40 working days** of the request for internal review. BCBSNM may extend the review period **10 working days** in pre-service cases and **20 working days** in post-service cases.

If the BCBSNM medical director or the appropriate designee of the medical director upholds the adverse determination, BCBSNM will notify you of that decision by telephone (if available) and by mail and will ask whether you want to pursue an "internal panel review" of the decision. If you elect to pursue internal panel review, BCBSNM will notify you of the date, time, and location that the panel will convene and will make arrangements for you to participate by phone or in person, if necessary. BCBSNM will not unreasonably deny your request for a postponement. The internal panel decision will be provided to you by telephone and in writing within the time frames set forth above, subject to any extensions or postponements.

Administrative Grievance — This is a summary of the grievance procedure followed by BCBSNM for any oral or written complaint about any aspect of the benefit plan other than a request for health care service including, without limitation:

- administrative practices of BCBSNM that affect the availability, delivery or quality of health care services;
- claims payment, handling, or reimbursement for health care services; and
- termination of coverage.

If you are dissatisfied with a decision, action, or inaction of BCBSNM, you have the right to request an initial internal review of the administrative grievance orally or in writing. A BCBSNM representative will complete the internal review and mail a written decision to you within **15 working days** of receipt of the administrative grievance. The decision will be binding unless you request reconsideration of the internal review within **20 working days** of your receipt of the initial decision.

Upon receipt of your request for reconsideration of the internal review, BCBSNM will appoint a reconsideration committee to schedule and hold a hearing. Arrangements will be made for you to participate in

the hearing in person or by telephone. The hearing shall be held within **15 working days** after receipt of your request for reconsideration and the committee's decision will be provided to you in writing within **7 working days** after the hearing. BCBSNM will not unreasonably deny your request for a postponement.

BCBSNM Contacts — For more information, contact:

BCBSNM Appeals Unit
P.O. Box 27630
Albuquerque, NM 87125-9815

Telephone (toll-free): (800) 205-9926
e-mail: See Web site at www.bcbsnm.com
Fax: (505) 816-3837

External Appeals

If you are still not satisfied after having completed the BCBSNM inquiry, appeals, and grievance procedures, you have the option of taking one or more of the following steps. (You may not take legal action to recover benefits under this Plan until 60 days after BCBSNM has received the claim or prior authorization request in question. Also, you may not take any legal action after three years from the date that the claim in question must be filed with BCBSNM.)

Review by the NM Superintendent of Insurance — If you are dissatisfied with the BCBSNM internal review of your grievance or appeal decision, you have the right to request an external review by the New Mexico Superintendent of Insurance by filing a written request **within 20 working days** of receipt of the written decision from BCBSNM. You may file your request by:

- Mail to the Superintendent of Insurance, Attention: Managed Health Care Bureau - External Review Request, New Mexico Public Regulation Commission, P.O. Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269;
- Fax to Managed Health Care Bureau-External Review Request at (505) 827-4734;
- E-mail to mhcb.grievance@state.nm.us (subject: "External Review Request");
- Online by using a Division of Insurance Complaint Form at http://www.nmprc.state.nm.us; or
- If required by the medical exigencies of the case, by telephone at 1-888-427-5772 or (505) 827-3928.

You will need to provide a copy of the BCBSNM decision; a fully executed release form authorizing the Superintendent to obtain any necessary medical records from BCBSNM or other health care provider; and any other supporting documentation. You may contact the Managed Health Care Bureau to assist you in this process by calling toll-free at 1-888-427-5772.

General Limitations and Exclusions

Effective July 1, 2008, add the following exclusion to your benefit booklet:

Medical Policy Determinations — Any technologies, procedures, or services for which medical policies have been developed by BCBSNM are either limited or excluded as defined in the medical policy (see "Medical policy" in the *Glossary).*

Effective July 1, 2008, remove the following bulleted item from the "Noncovered Providers of Service" exclusion in your benefit booklet:

- pain clinic or any provider primarily in the practice of pain management or treatment

Effective January 1, 2009, replace the "Weight Management" (or similar) exclusion in your benefit booklet with the following exclusion:

Weight Management — **This Plan does not cover** weight-loss or other weight-management programs, dietary control, or medical obesity treatment**. This Plan does not cover** any and all surgical treatments of obesity including, without limitation, gastric bypass or other type of bariatric surgery, under any circumstance. This is true regardless of the presence or absence of other medical conditions that can be either directly or indirectly attributed to obesity. Obesity means any diagnosis of obesity including morbid obesity.

Glossary

Effective July 1, 2008, add the following definition to your benefit booklet:

Medical policy — A coverage position developed by BCBSNM that summarizes the scientific knowledge currently available concerning new or existing technology, products, devices, procedures, treatment, services, supplies, or drugs and used by BCBSNM to adjudicate claims and provide benefits for covered services. Medical policies are posted on the BCBSNM Web site for review or copies of specific medical policies may be requested in writing from a Customer Service representative.

Basic Blue Members Only

Effective July 1, 2008, the maximum annual calendar year benefit payment is increased to $100,000. Please update your Summary of Benefits to reflect this change.

BlueDirect Plan C Only: Out-of-Network Coverage

Effective January 1, 2009, BlueDirect Plan C, in which members used the PPO network exclusively (there was only limited coverage of out-of-network services), is being amended to include out-of-network coverage for all services other than transplant-related services. Like Plans A and B, BlueDirect Plan C is now a standard "PPO" health plan. For this reason, remove any information in your benefit booklet or on the Summary of Benefits that indicates out-of-network services are excluded under Plan C (except in the case of transplants) and remove any references to an "Exclusive Provider Organization" or "EPO."

Your in-network coverage is not changing under Plan C. In-network copayments continue to apply to the Plan C in-network out-of-pocket limit. In-network and out-of-network amounts do not cross-apply (that is, coinsurance under out-of-network coverage is not applied to the in-network deductible or out-of-pocket limit or vice versa).

Plan C out-of-network coverage is the same coverage currently available under BlueDirect Plans A and B (including a $1000 maximum out-of-network benefit for durable medical equipment/home medical supplies and a $1000 maximum out-of-network benefit for prosthetics/orthotics). Note the following payment rules for out-of-network services:

- **out-of-network deductible is twice the in-network amount chosen by you; and**
- **out-of-network out-of-pocket limit is twice the in-network amount chosen by you; and**
- **out-of-network coinsurance (the percentage you pay) is 50 percent of covered charges after the out-of-network deductible is met for the calendar year.**

You will receive a new summary and benefit booklet in 2009.

Benefit Limitations

Unless otherwise indicated on your *Summary of Benefits,* when services are limited as to the number or amount of services payable in a calendar year, a lifetime, or any other period of time, the maximum benefit is a combination of both in-network and out-of-network services.

Customer Service Hours

Effective July 1, 2008, telephone customer service hours are changing. Replace the first sentence about customer service hours on the inside front cover of your benefit booklet with the following:

The 24/7 Nurseline can help when you have a **health problem** or concern. The 24/7 Nurseline is staffed by registered nurses who are available 24 hours a day, 7 days a week.

Toll-free telephone number: 1-800-973-6329

When you have a **non-medical** benefit information question or concern, call BCBSNM Monday through Friday from 7 A.M.– 5 P.M. or visit the BCBSNM Customer Service department in Albuquerque.(If you need assistance outside normal business hours, you may call the Customer Service telephone number and leave a message. A Customer Service representative will return your call by 5 P.M. the next business day.) You may either call toll-free or visit the BCBSNM office in Albuquerque at:

Street address: 4373 Alexander Blvd. NE
Toll-free telephone number: (866) 236-1702

Breast Reconstruction and Mastectomy Notification (WHCRA)

This is notice that your health care plan provides benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and treatment for complications resulting from a mastectomy (including lymphedema), when such benefits are required by the federal Women's Health and Cancer Rights Act of 1998. Check your benefit materials or call Customer Service for more information.

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

Endorsement:
2009 Drug Plan Benefit Changes for Fully Insured Plans

Blue Cross and Blue Shield of New Mexico

This *2009 Drug Plan Benefit Changes for Fully Insured Plans* endorsement is made a part of your Blue Cross and Blue Shield of New Mexico (BCBSNM) health care plan benefit booklet. If you have a question about these changes, please call your Customer Service Unit representative at the phone number printed on the bottom of the page or on the back of your identification card. (Disregard this endorsement if your drug plan is through Medicare Part D or is for "mandated coverage" only. Your drug plan is not changing.)

BY:

Elizabeth A. Watrin
President
Blue Cross and Blue Shield of New Mexico

Prescription Drugs and Other Items

Effective January 1, 2009, replace the first bulleted item under the list of covered drugs and medications in either your separately issued *Drug Plan Rider* or under "Prescriptions Drugs and Other Items" in the *Covered Services* of your benefit booklet with the following item:

- prescription drugs and medicines (includes prescriptive oral agents for controlling blood sugar levels and prescription contraceptive medications), insulin, glucagon, and prescription contraceptive devices purchased from a participating pharmacy, unless listed as an exclusion **(Note:** Prescription contraceptive devices fitted or inserted by, and purchased directly from, a physician are payable under the "Family Planning" benefit, if any, of your medical/surgical plan.)

Effective January 1, 2009, add the following exclusion to your drug plan benefits:

- non-commercially available compounded medications, regardless of whether or not one or more ingredients in the compound requires a prescription (Non-commercially available compounds are those made by mixing or reconstituting ingredients in a manner or ratio that is inconsistent with United States Food and Drug Administration-approved indications provided by the ingredients' manufacturers.)

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

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Notes

1 How to Use This Benefit Booklet

This benefit booklet describes the coverage available to members of this health care plan and benefit limits and exclusions.

Other Benefit-Related Materials

In addition to this booklet you should have the following benefit-related documents:

Summary of Benefits — Throughout this booklet, you are asked to refer to the separately issued *Summary of Benefits* that shows specific member cost-sharing amounts and coverage limitations of your plan. If you do not have a *Summary of Benefits*, please contact a BCBSNM Customer Service representative (the phone number is at the bottom of each page of this booklet). You will receive a new *Summary of Benefits* if changes are made to your health care plan.

ID Card — Your BCBSNM identification (ID) card shows that you are a member of a plan provided by BCBSNM. It shows the individual Preferred Provider deductible and out-of-pocket limit and the drug plan you selected. The ID card provides the information needed when you require health care services or prescription drugs or other items covered under the drug plan, or when you are contacting a Customer Service representative. Carry it with you. Have your ID card handy when you call for an appointment and show it to the receptionist when you sign in for an appointment.

This card is part of your coverage. Do not let anyone who is not named in your coverage use your card to receive benefits. If you want additional cards or need to replace a lost card, contact a Customer Service representative.

Drug Plan Brochure — In addition to this benefit booklet, you should have received a drug plan brochure and mail-order claim form from the drug plan administrator. These documents provide important information about your drug plan benefits, which also includes coverage for specified diabetic supplies. (BCBSNM has contracted with a separate program for administration of outpatient drug plan benefits.)

Provider Network Directory — The provider network directory is available through the BCBSNM Web site. It lists all providers in the BCBSNM preferred provider network and participating pharmacies. (If you want a paper copy of a directory, you may request one from Customer Service and it will be mailed to you free of charge.) **Note:** Although provider directories are current as of the date shown at the bottom of each page, they can change without notice.

BlueEdge Individual HSA Brochure and Other Materials — Participants in the Health Savings Account (HSA) program receive additional materials describing how the Health Savings Account works with this BlueEdge Individual PPO coverage. Your identification card will indicate “BlueEdge Indiv Basic,” “BlueEdge Indiv Enhanced,” or “BlueEdge Indiv Premier” (depending on which deductible option you chose). The deductible and out-of-pocket limit amount for

each plan will vary depending on whether you have Individual or Family Coverage.

Note: This benefit booklet describes only the medical/surgical plan benefits that are available to you. You can ask the bank chosen by you to be the administrator of your account about the details of your Health Savings Account, your banking arrangement, the amount of money you add to the account, account administration fees, and the rules regarding the use of the account to pay for medical expenses not paid under this plan.

BlueCard Brochure — As a member of a PPO health plan administered by BCBSNM, you take your health care plan benefits with you – across the country and, for emergency services, around the world. The BlueCard Program gives you access to preferred providers almost everywhere you travel or live. Almost 90 percent of physicians in the United States contract with Blue Cross Blue Shield Plans, so members can receive the Preferred Provider level of benefits – even when traveling or living outside New Mexico – by using health care providers that contract as preferred providers with their local BCBS Plan. You should have received a brochure describing this program in more detail. It's a valuable addition to your health care plan coverage. Instructions for locating a preferred provider outside New Mexico are in the brochure or can be found on the BCBSNM Web site at www.bcbsnm.com.

Using the Informational Graphics

Graphic symbols are used throughout this benefit booklet to call your attention to certain information and requirements. Some commonly used symbols are:

Preferred Provider Benefit Only

The services listed below are eligible for benefits **only** when received from preferred providers:

- transplant services (Services must be received at a facility that contracts with BCBSNM, the local BCBS Plan, or the national BCBS transplant network, for the transplant being provided.)
- outpatient cardiac and pulmonary rehabilitation
- physical, occupational, and speech therapy
- skilled nursing facility services
- preventive services
- spinal manipulation and acupuncture

Definitions

This symbol calls attention to definitions of important terms throughout the booklet. More definitions are in the *Glossary*.

Cross-References

Throughout this benefit booklet, cross-references direct you to read other sections of the booklet or to refer to your ID card or separately issued *Summary of Benefits* when necessary. You will see this symbol next to such references in *Section 3*.

Limitations and Exclusions

Each subsection in *Section 3* not only describes what is covered, but may list some limitations and exclusions that specifically relate to a particular type of service. *Section 4: General Limitations and Exclusions* lists limitations and exclusions that apply to *all* services. This symbol will be next to limitations or exclusions listed in *Section 3*.

Admission Review or Other Prior Approval Required

To receive full benefits for some nonemergency admissions and other specified services, you or your provider must call the BCBSNM Health Services department **before** you receive treatment. This symbol is a reminder to do so. Call Monday through Friday, 8 A.M. to 5 P.M., Mountain Time. See "Admission Review and Other Prior Approvals" in *Section 2* for details. **Note:** Call Customer Service if you need prior approval assistance after 5 p.m.

Call Within 48 Hours
(505) 291-3585
(800) 325-8334

Emergency Admission Notification — To ensure that benefits are correctly paid and that an admission you believe is emergency-related will be covered, you or your physician or hospital should notify BCBSNM within 48 hours or as soon as reasonably possible following admission. Call BCBSNM's Health Services department, Monday through Friday, 8 A.M. to 5 P.M., Mountain Time.

Written Request Required — If a **written request** for prior approval is required in order for a service to be covered, the provider should send the request, along with appropriate documentation, to:

Blue Cross and Blue Shield of New Mexico
Attn: Health Services Department
P.O. Box 27630
Albuquerque, NM 87125-7630

Please ask your health care provider to submit your request early enough to ensure that there is time to process the request before the date you are planning to receive services.

Customer Service

For your convenience, the toll-free customer service number for BCBSNM is printed at the bottom of every page in this booklet. See the inside front cover for Web site and mailing address information.

2 How Your Plan Works

Benefit Choices

Preferred providers — Health care professionals and facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, or another BCBS Plan as "preferred" or "PPO" providers. These providers have agreed to provide health care for PPO plan members and accept the plan's payment for a covered service plus the member's share of the covered charge (i.e., deductible, coinsurance, penalty amount, if any) as payment in full.

Nonpreferred providers — Providers that have not contracted with BCBSNM, either directly or indirectly, to be part of the "preferred" or "PPO" provider network. (These providers may have "participating" provider agreements, but are **not** considered preferred. See "Filing Claims" in *Section 6* for more information.)

BlueEdge Individual is a Preferred Provider Option (PPO) health care plan that gives you the opportunity to save money, while providing you choice and flexibility when you need medical/surgical care and preventive services. When you need health care, you have two choices: Preferred Provider or Nonpreferred Provider Services. It's important to understand the differences between them. Your choice can make a difference in the amount you pay and the benefits available to you. The advantages of choosing a **preferred provider** when you need medical care are listed on the table below:

Your Choice

Preferred Provider Services	Nonpreferred Provider Services
▪ You pay an annual deductible and a lower percentage of covered charges (coinsurance) after the deductible is met. ▪ You have a lower annual out-of-pocket limit to meet (includes Preferred Provider benefit level coinsurance only and covered drug plan copayments and/or coinsurance amounts). ▪ The preferred provider files claims for you to the local BCBS Plan. ▪ If the covered charge* is less than the billed amount, the provider will write off the difference. You pay only deductible, coinsurance, noncovered expenses, and penalty amounts, if any. ▪ Preferred providers that contract directly with BCBSNM are responsible for requesting all necessary approvals on your behalf. (Providers that contract with another BCBS Plan may call for approval on your behalf, but you will be responsible for making sure that approval is obtained when required.)	▪ You pay a higher percentage of covered charges after the deductible is met. ▪ You have a higher annual out-of-pocket limit to meet for Nonpreferred Provider benefit level coinsurance. ▪ You may have to pay the provider in full and submit your own claims; the decision is up to the provider. ▪ You may have to pay the provider any amounts above the covered charge.* ▪ Nonpreferred providers may call for prior approvals on your behalf, but you are responsible for making sure that all approvals are obtained when required. ▪ Some benefits (preventive care, physical rehabilitation, transplants, cardiac and pulmonary rehabilitation, acupuncture, spinal manipulation, and skilled nursing facility services) are not available unless services are received from a preferred provider.

*** Note:** The "covered charge" is the amount that BCBSNM determines is a fair and reasonable allowance for a particular covered service. After your share of a covered charge (e.g., deductible, coinsurance, penalty amount) has been calculated, BCBSNM pays the remaining amount of the covered charge, up to maximum benefit limits, if any. **The covered charge may be less than the billed charge.** Your choice of provider will determine if you will also have to pay the difference between the covered charge and the billed charge.

Plan Features — The BlueEdge HSA health care plan includes these special features:

- You can choose at the time that care is needed whether to see a preferred provider or another provider.
- If you choose to visit a preferred provider from an extensive network of preferred providers that contract with BCBSNM and other Blue Cross Blue Shield (BCBS) Plans throughout the United States, you will receive the higher, Preferred Provider (PPO) benefit level for covered services.
- If you receive covered services from providers outside the preferred provider network, benefits will be paid at the Nonpreferred Provider benefit level. You may also be responsible for any amount above covered charges. (Some services are **not covered** unless received from a preferred provider.)

When you receive treatment or schedule a surgery or admission, ask each of your providers if he/she is a preferred provider. (A physician's or other provider's contract may be separate from the facility's contract.)

Selecting a Provider — When you need medical care in New Mexico (or along the border of neighboring states), check the BCBSNM Web site or use a printed *BCBSNM Preferred Provider Network Directory* to choose a preferred provider. Whichever method you use, the directories also list participating pharmacies.

To verify a provider's current status or if you have any questions about how to use the directory, contact a BCBSNM Customer Service representative or visit the BCBSNM Web site at www.bcbsnm.com.

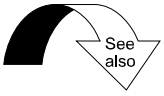
Note: Although provider directories are current as of the dates shown at the bottom of each page, they can change without notice. If you do not have a current directory, ask a BCBSNM Customer Service representative to send you one or visit our Web site.

Outside New Mexico — When outside New Mexico, you can still receive the Preferred Provider level of benefits by using providers that contract with their local Blue Cross and/or Blue Shield Plan. These out-of-state providers also accept covered charges as payment in full and file claims for you. **Note:** Providers who have a "participating-only" contract are **not** "preferred" providers and you will not receive Preferred Provider benefits when receiving services from participating-only providers – unless listed under the "Benefit Payment Exceptions" provision later in this section; otherwise, you must use **preferred** providers in order to obtain the higher benefit under this PPO Plan.

For a list of contracting providers outside New Mexico, call the BlueCard Doctor and Hospital Information Line at 1-800-810-BLUE (2583). When you call, a BlueCard representative will give you the name and telephone number of a local provider who will be able to call Customer Service for eligibility information and will submit a claim to the local BCBS Plan for the services provided.

If you have an Internet connection, you may visit the BCBSNM Web site at www.bcbsnm.com and be linked to the national provider location system, the Blue Cross Blue Shield Association's BlueCard Doctor and Hospital Finder. You can also connect to the national provider location system at www.bcbs.com.

Cost-Sharing Features



See "Prescription Drugs and Other Items" for more information about amounts you pay under the drug plan.

Annual Deductibles

Deductible — The amount of covered charges that you must pay in a calendar year before this plan begins to pay its share of the covered charges you incur during the rest of the same calendar year. If the deductible amount remains the same during the calendar year, you pay it only once each calendar year, and it applies to all covered services you receive during that calendar year.

See your ID card or separately issued Summary of Benefits for your deductible amount.

Individual Deductible — Once a member's deductible payments reach the individual deductible amount specified on your separately issued *Summary of Benefits,* this plan will begin paying its share of that member's covered charges.

When you enrolled in BlueEdge Individual for HSA, you chose either Individual Coverage or Family Coverage. The deductible amount you (or your family) must satisfy depends on whether you have Individual or Family Coverage. An Individual Coverage member must meet the applicable "Individual Coverage" deductible before the plan begins to pay his/her covered charges.

An entire family must meet the "Family Coverage" deductible before the plan begins to pay benefits for covered services for any covered family member. The deductible is met when the total deductible amounts paid by all family members combined reach the amount specified on the *Summary of Benefits*. **Note:** There is no "individual" deductible to meet for a member under "Family Coverage." An entire family must first meet the Family Coverage deductible and one family member may satisfy the entire amount for the whole family.

The first $400 you incur in covered adult preventive services, and routine/preventive services from preferred providers for dependent children through age 17 are **not** subject to a deductible.

Admissions Spanning Two Benefit Periods — If a deductible has been met while you are an inpatient and the admission continues into a new year, no additional deductible is applied to that admission's covered services. However, all other services received during the new year are subject to the deductibles for the new year.

Timely Filing Reminder — Most benefits are payable only after BCBSNM's records show that an applicable deductible has been met. If you file your own claims for services from nonparticipating providers, you must file them within **12 months** of the date of service. Preferred providers and providers that have "participating" provider agreements with BCBSNM will file claims for you and must submit them within a specified amount of time, usually within 90 days. If a claim is returned for further information, resubmit it **within 45 days.** See "Filing Claims" in *Section 6* for details.

Coinsurance and Copayments

Coinsurance — The percentage of covered charges that you must pay for most covered services after the annual deductible, if applicable, has been met.

Copayment — The minimum or maximum fixed-dollar amount of a covered charge that is paid by the member for prescription drugs and other items payable under the outpatient prescription drug plan benefit after the annual deductible is met (some copayments are based on a percentage of covered charges).

See your Summary of Benefits for coinsurance percentages, copayments, and out-of-pocket limit amounts.

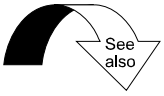
Drug Plan Coinsurance and Copayments — When you purchase covered prescription drugs and other items through the drug plan, your copayment may be either a fixed-dollar amount or a percentage of the covered charge. (You may also have to pay the difference between the cost of a brand-name drug and its generic equivalent.)

Drugs and other items purchased through the drug plan *are* subject to the annual deductible; coinsurance or copayment amounts you pay for covered items under the drug plan are also applied to the Preferred Provider out-of-pocket limit each year. See “Prescription Drugs and Other Items” in *Section 3* for more information about copayments under the drug plan.

Medical/Surgical Plan Coinsurance — For most covered services, you must pay a percentage of covered charges as “coinsurance.” After your share has been calculated, this plan pays the rest of the covered charge, up to maximum benefit limits, if any. You pay a lower percentage of covered charges when you visit a preferred provider. **Remember:** The covered charge may be less than the billed charge for a covered service. Preferred providers may not bill you more than the covered charge; nonpreferred providers may.

Out-of-Pocket Limits

Out-of-pocket limits — The maximum amount of deductible, drug plan copayments, and coinsurance amounts that you pay for most covered services in a calendar year. After an out-of-pocket limit is reached, this plan pays 100 percent of most of your preferred or nonpreferred provider covered charges for the rest of that calendar year, not to exceed any benefit limits.



See your Summary of Benefits for out-of-pocket limit amounts.

Out-of-Pocket Limits — Your out-of-pocket limit depends on whether you have Individual or Family Coverage. Unlike the deductible provision, there are two separate out-of-pocket limits for preferred provider and nonpreferred provider services. The higher Nonpreferred Provider limit must be met before this plan pays 100 percent of most of the member’s (or family’s) covered charges for nonpreferred provider services. Coinsurance for preferred provider services is not applied to the Nonpreferred Provider out-of-pocket limit, nor vice versa.

Individual Coverage Limits — An Individual Coverage member must meet the applicable “Individual Coverage” out-of-pocket limit before the plan begins to

pay 100 percent of his/her covered charges for preferred provider or nonpreferred provider services, as applicable, for the rest of the calendar year.

Family Coverage Limits — An entire family must meet the "Family Coverage" out-of-pocket limits before the plan begins to pay 100 percent of preferred provider or nonpreferred provider covered charges for any covered family member. The applicable limit is met when the total coinsurance for all family members reaches the amount specified on the family's *Summary of Benefits*. **Note:** There are no "individual" limits to meet for a member under "Family Coverage." An entire family must first meet the out-of-pocket limit(s) and one family member may satisfy an entire preferred provider or nonpreferred provider limit for the whole family.

What is Not Included in the Limits — The following amounts are **not** applied to the out-of-pocket limits and are not eligible for 100 percent payment under this provision: penalty amounts; amounts in excess of covered charges (including amounts in excess of annual or lifetime benefit limits); noncovered expenses (including services in excess of annual or lifetime day/visit limitations).

Benefit Payment Exceptions

Services of nonpreferred providers will be paid at the Preferred Provider benefit level in the following instances only. Except as described below, the Preferred Provider benefit level is **not** available for nonemergency services when received from a nonpreferred provider — even if a preferred provider is not available in your area to perform the services.

Emergency Care Exception — If you visit a nonpreferred provider for emergency medical/surgical services, the Preferred Provider deductible and coinsurance is applied only to the initial treatment, which includes emergency room services and, if you are hospitalized within 48 hours of an emergency, the inpatient hospitalization. (Office/urgent care facility services are not considered "emergencies" for purposes of this provision.)

For follow-up care (which is no longer considered an emergency) and for all other nonemergency care, you will receive the Nonpreferred Provider benefit for the services of a nonpreferred provider, even if a preferred provider is not available to perform the service. (See "Emergency and Urgent Care" in *Section 3* for more information.)

Unsolicited Providers — In some states, the local BCBS Plan does not offer preferred provider contracts to certain types of providers (e.g., home health care agencies, chiropractors, ambulance providers). These provider types are referred to as "unsolicited providers." The types of providers that are unsolicited varies from state to state. If you receive covered services from an "unsolicited provider" outside New Mexico, you will receive the Preferred Provider benefit level for those services. However, the unsolicited provider may still bill you for amounts that are in excess of covered charges. You will be responsible for these amounts, in addition to your deductible and coinsurance.

Ancillary Provider Exception — Once you have obtained prior approval for an inpatient admission to a preferred hospital or treatment facility for a covered

service, your preferred physician or hospital will make every effort to ensure that you receive ancillary services from other preferred providers. If you receive covered services from a **preferred** physician for outpatient surgery or inpatient medical/surgical care in a preferred hospital or treatment facility, services of a nonpreferred radiologist, anesthesiologist, or pathologist will be paid at the Preferred Provider level and you will not be responsible for any amounts over the covered charge (these are the only three specialties covered under this provision).

If a **nonpreferred** surgeon provides your care or you are admitted to a non-preferred hospital or other treatment facility, you **will** be responsible for amounts over the covered charge for any services received from nonpreferred providers during the admission or procedure.

Changes to the Cost-Sharing Amounts

Coinsurance percentage amounts, deductibles, and out-of-pocket limits may change during a calendar year. If changes are made, the change applies only to services received after the change goes into effect (for inpatient services, benefits are determined based on the date you are admitted to the facility for purposes of this provision). You will receive a revised *Summary of Benefits* and/or a new ID card if changes are made to this plan.

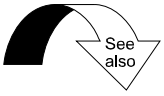
Changes to the Deductible — You can change your deductible or switch to a different product currently offered by BCBSNM. In all cases, you must complete a new *Application*. The change may not be approved. If you decrease your deductible, you will not receive a refund for any amounts applied to the higher deductible and out-of-pocket limit during the previous deductible period. If you increase the deductible during a calendar year, you will not receive benefit payments until the increased deductible is met and will not have claims paid at 100 percent of the covered charge until the increased out-of-pocket limit is met.

Changing Coverage Types — If you must change from Individual Coverage to Family Coverage because you must add a dependent to coverage, you and your new dependent must meet the higher Family Coverage deductible and out-of-pocket limit. **Exception:** If you must switch to Family Coverage because of adding an eligible newborn child within the time limits specified in *Section 7,* you will not be required to meet the Family Coverage deductible and out-of-pocket limits for covered hospital services related to **routine** newborn nursery care. However, the newborn's pediatrician services for routine newborn care *will* be subject to Family Coverage deductible and out-of-pocket provisions.

If you lose a dependent and must switch from Family to Individual Coverage, you will be given credit for all amounts applied to both the Family Coverage deductible and the Family Coverage out-of-pocket limit. However, you will not be given a refund for any amounts that are in excess of the new Individual Coverage amount.

Benefit Limits

Calendar year — January 1 through December 31 of the same year. The initial calendar year benefit period is from a member's effective date of coverage through December 31 of the same year, which may be less than 12 months.

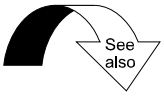


There is no general lifetime maximum benefit under this plan. However, certain services have separate benefit limits per admission, per calendar year, etc. **See the *Summary of Benefits* for details.**

Generally, benefits are determined based upon the coverage in effect on the day a service is received, an item is purchased, or a health care expense is incurred. For inpatient services, benefits are based upon the coverage in effect on the date of admission, except that if you are an inpatient at the time your coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date.

Admission Review and Other Prior Approvals

Prior approval — A requirement that you or your provider must obtain authorization from BCBSNM *before* you are admitted as an inpatient (admission review approval) or receive certain types of services (other prior approvals).



See "Important Note About Filing Claims" on page 58. *In order to receive benefits, services must be listed as covered and medically necessary, services must not be excluded, and the procedures described in this section must be followed regardless of where services are rendered or by whom.*

These approval requirements will provide you with assurance that you are being treated in the most efficient and appropriate health care setting and can help manage the rising costs of health care. Please note:

Prior Approval Does Not Guarantee Payment or Validate Eligibility

Prior approval determines only the medical necessity of a specific service and/or an admission and an allowable length of stay. Prior approval does not guarantee your eligibility for coverage, that benefit payment will be made, or that you will receive the highest level of benefits. Eligibility and benefits are based on the date you receive the services. Services not listed as covered, excluded services, services received after your termination date under this plan, and services that are not medically necessary will be denied.

When You Have Other Coverage

Even when this plan is not your primary coverage, these approval procedures must be followed. **Failure to do so may result in a reduction or in a denial of benefits.**

Retroactive Approvals Not Given

Retroactive approvals will not be given and you may be responsible for the charges if approval is not obtained **before** the service is received.

BCBSNM-Preferred Providers — If the attending physician is a preferred provider that contracts **directly** with BCBSNM, obtaining prior approval is not

your responsibility — it is the provider's. BCBSNM-preferred providers must obtain **prior** approval from BCBSNM in the following circumstances:

- when recommending any nonemergency admission, readmission, or transfer
- when a covered newborn stays in the hospital longer than the mother (the mother's services are not covered under this BlueEdge Individual health plan)
- before providing a service listed under "Other Prior Approvals," on the next page

Note: Providers that contract with other Blue Cross Blue Shield Plans are not familiar with the prior approval requirements of BCBSNM. Unless a provider contracts directly with BCBSNM as a preferred provider (i.e., is listed in your BCBSNM provider network directory as a preferred provider), the provider is not responsible for being aware of this plan's admission review and other prior approval requirements. See below.

Nonpreferred Providers or Providers Outside New Mexico — If any provider outside New Mexico (except for those contracting directly with BCBSNM as preferred providers) or any nonpreferred provider recommends an admission or a service that requires prior approval, the provider is **not** obligated to obtain the prior approval for you. In such cases, it is **your** responsibility to ensure that approval is obtained.

If approval is not obtained **before** services are received, **you will incur a penalty for a covered admission or, for some services, be entirely responsible for the charges.** The provider may call on your behalf, but it is **your responsibility** to ensure that BCBSNM is called.

Admission Review Approval

Admission review is required for most admissions **before** you are admitted to the hospital or skilled nursing, physical rehabilitation, or other treatment facility. If you do not obtain admission review approval within the time limits indicated in the table below, benefits for covered facility services will be **reduced or denied** as explained in the table on the next page.

Type of inpatient admission, readmission, or transfer	When to obtain admission review approval:
Nonemergency	**Before the patient is admitted.**
Emergency, nonmaternity (maternity services are not covered under this plan)	**Within 48 hours of the admission.** If the patient's condition makes it impossible to call within 48 hours, call as soon as possible.
Routine newborn care (the mother's maternity services are not covered under this plan)	**Before the mother's maternity due date,** soon after pregnancy is confirmed. However, you should always call within 48 hours of the admission or as soon as possible.
Extended stay, newborn (an eligible newborn stays in the hospital longer than the mother; the mother's maternity services are not covered under this plan)	**Before the newborn's mother is discharged.**

How the Approval Procedure Works — When you or your provider call, BCBSNM's Health Services staff will ask for information about your medical condition, the proposed treatment plan, and the estimated length of stay. The Health Services staff will evaluate the information and notify the attending physician and the facility (usually at the time of the call) if benefits for the proposed hospitalization are approved. If the admission is not approved, you may appeal the decision as explained later in this section and in *Section 6*.

Penalty for Not Obtaining Approval — If you or your provider does not call, or if you call and do not receive approval for inpatient benefits, but you choose to be hospitalized anyway, no benefits may be paid or partial payment may be made, as indicated in the table below:

If, based on a review of the claim:	Then:
The admission was **not for a covered service.**	Benefits for the facility and all related services will be **denied.***
The admission was for an item listed under **"Other Prior Approvals,"** below.	Benefits for the facility and all related services will be **denied.***
The admission was for any other covered service but hospitalization was **not medically necessary.**	Benefits will be **denied** for **room, board,** and **other charges** that are not medically necessary.*
The admission was for **a medically necessary covered service** (nonemergency).	Benefits for the facility's covered services will be **reduced by $300.***

* The admission review penalty of $300 and charges for noncovered and denied services are **not** applied to any deductible or out-of-pocket limit. You are responsible for paying this amount.

Admission review requirements may affect the amounts that this plan pays for inpatient services, but they do not deny your right to be admitted to any facility and to choose your services.

Other Prior Approvals

In addition to admission review for all inpatient services, prior approval is required for certain other services. Most prior approvals may be requested over the telephone. If a *written* request is needed and you call, a Health Services representative will give you instructions for filing a written request for prior approval.

If prior approval is not obtained for the following services, **benefits will be denied** for all related services:

- **air ambulance** services (unless during a medical emergency)
- **alcoholism** or **drug abuse** services
- **cardiac** or **pulmonary rehabilitation**
- **chemotherapy** (high-dose)
- **dental-related** services in a hospital or other facility (the procedure may not be covered even if benefits for the hospitalization are approved as medically

necessary; see *Section 3)*; treatment of **accidental injuries to teeth** (except initial treatment); treatment of **orthognathism**

- **diabetes self-management** educational programs; **insulin pumps; diabetic supplies** and **equipment** costing $500 or more
- **durable medical equipment,** medical supplies, and prosthetic devices costing **$500** (or more) or requiring **long-term rental; orthopedic appliances, orthotics,** and **surgically implanted prosthetics,** regardless of total cost
- **enteral nutritional products, special medical foods,** and **certain drugs** purchased through the drug plan; prescription **refills** before the supply should have been exhausted (See "Prescription Drugs and Other Items" in *Section 3.)*
- **home health, hospice, home IV, injections**
- **cardiac CT scans**
- **orthotics**
- **PET scans**
- **private room charges**
- **rehabilitative services** (outpatient physical, occupational, and speech therapy, including acupuncture, chiropractic services, and therapy services of a doctor of oriental medicine)
- certain **surgical procedures,** including:
  - **breast reduction**
  - **breast surgery following a mastectomy** (Note: This is the only cosmetic procedure covered under this plan.)
  - **cochlear implants**
  - **dental-related/oral surgery** services in a hospital or other facility (the procedure may not be covered even if benefits for the hospitalization are approved as medically necessary); surgical treatment of **accidental injuries to teeth** (except initial treatment); and **orthognathic surgery**
  - **orthotripsy**
  - **reconstructive surgical procedures**
  - **transplants,** including pretransplant evaluations

The services listed above may not be approved for payment (for example, due to being experimental, investigational, or unproven, or not medically necessary). It is strongly recommended that you request prior approval for high-cost services in order to reduce the likelihood of benefits being denied *after* charges are incurred. The complete list of services requiring prior approval is subject to review and change by BCBSNM. BCBSNM-contracted providers have a list of all procedures and services, including individual surgical procedures and injectable drugs, that require prior approval. If you need a copy of this list, call a Customer Service representative.

Appeal Procedure for Pre-Service Denial — If your request for prior approval has been denied in whole or in part, you may appeal the decision and have your request for services reviewed. Within **180 days** after you receive notice of the decision, call or write to BCBSNM Customer Service and explain your reasons for disagreeing with the adverse determination. Requests for review received more than 180 days following notification will not be considered unless you can satisfy BCBSNM that matters beyond your control prevented an earlier request for review. See "Reconsideration Requests" in *Section 6* for details.

Advance Benefit Information

If you want to know what benefits will be paid before receiving services or filing a claim, BCBSNM may require a written request. BCBSNM may also require a written statement from the provider identifying the circumstances of the case and the specific services that will be provided. An advance confirmation of benefits **does not guarantee** benefits if the actual circumstances of the case differ from those originally described. When submitted, claims are reviewed according to the terms of this benefit booklet, your eligibility, or any other coverage that applies on the date of service.

Utilization Review/Quality Management

Medical records, claims, and requests for covered services may be reviewed to establish that the services are/were medically necessary, delivered in the appropriate setting, and consistent with the condition reported and with generally accepted standards of medical and surgical practice in the area where performed and according to the findings and opinions of BCBSNM's professional consultants. Utilization management decisions are based only on appropriateness of care and service. BCBSNM does not reward providers or other individuals conducting utilization review for denying coverage or services and does not offer incentives to utilization review decision-makers to encourage underutilization.

Health Care Fraud Information

Health care and insurance fraud results in cost increases for health care plans. You can help; always:

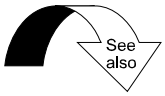
- Be wary of offers to waive copayments, deductibles, or coinsurance. These costs are passed on to you eventually.
- Be wary of mobile health testing labs. Ask what your health care insurance will be charged for the tests.
- Review the bills from your providers and the *Explanation of Benefits* (EOB) you receive from BCBSNM. Verify that services for all charges were received. If there are any discrepancies, call a BCBSNM Customer Service representative.
- Be very cautious about giving information about your health care insurance over the phone.

If you suspect fraud, contact the BCBSNM Fraud Hotline at:

1-888-841-7998.

3 Covered Services

This section describes the services and supplies covered by this health care plan, subject to the limitations and exclusions in *Sections 2* and *4*. All payments are based on covered charges as determined by BCBSNM.



See your Summary of Benefits for specific member cost-sharing amounts and benefit limitations for each type of service.

Medically Necessary Services

Medically necessary — A service or supply is medically necessary when it is provided to diagnose or treat a covered medical condition, is a service or supply that is covered under the plan, and is determined by BCBSNM's medical director to meet all of the following conditions:

- it is medical in nature; and
- it is recommended by the treating physician; and
- it is the most appropriate supply or level of service, taking into consideration:
  - potential benefits;
  - potential harms;
  - cost, when choosing between alternatives that are equally effective; and
  - cost-effectiveness, when compared to the alternative services or supplies; and
- it is known to be effective in improving health outcomes as determined by credible scientific evidence published in the peer-reviewed medical literature (for established services or supplies, professional standards and expert opinion may also be taken into account); and
- it is not for the convenience of the member, the treating physician, the hospital, or any other health care provider.

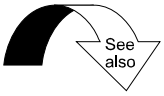
All services must be eligible for benefits as described in this section, not listed as an exclusion, and must meet all of the conditions of "medically necessary" as defined above in order to be covered.

Note: Because a health care provider prescribes, orders, recommends, or approves a service does not make it medically necessary or make it a covered service, even if it is not specifically listed as an exclusion. (BCBSNM, at its sole discretion, will determine medical necessity based on the criteria above.)

This plan does not cover pregnancy-related services, mental health services, or services related to chemical dependency rehabilitation (i.e., alcoholism or drug abuse).

Ambulance Services

Ambulance — A specially designed and equipped vehicle used only for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an ambulance.



Also see "Emergency and Urgent Care," later in this section, if applicable.

This plan covers ambulance services in an emergency (e.g., cardiac arrest, stroke). When you cannot be safely transported by any other means in a nonemergency situation, medically necessary ambulance transportation to a hospital with appropriate facilities, or from one hospital to another, is also covered.

Air Ambulance — Ground ambulance is usually the approved method of transportation. This plan covers air ambulance only when terrain, distance, or your physical condition requires the use of air ambulance services, or for high-risk newborn transport to tertiary care facilities. To be covered, nonemergency air ambulance services require **prior approval** from BCBSNM.

BCBSNM determines on a case-by-case basis when air ambulance is covered. If BCBSNM determines that ground ambulance services could have been used, benefits are limited to the cost of ground ambulance services.

Exclusions — This plan does **not** cover:

- commercial transport, private aviation, or air taxi services
- services not specifically listed as covered, such as private automobile, public transportation, or wheelchair ambulance
- services ordered only because other transportation was not available or for your convenience

See Section 4: General Limitations and Exclusions

Dental-Related/TMJ Services and Oral Surgery

Accidental injury — A condition that is not the result of illness but is caused solely by external, traumatic, and unforeseen means. Accidental injury does not include disease or infection. Dental injury caused by chewing, biting, or malocclusion is **not** considered an accidental injury.

Dental-related services — Services performed for the treatment of conditions related to the teeth or structures supporting the teeth.

Sound natural teeth — Teeth that are whole, without impairment, without periodontal or other conditions, and not in need of treatment for any reason other than the accidental injury. Teeth with crowns or restorations (even if required due to a previous injury) are **not** sound natural teeth. Therefore, injury to a restored tooth will not be covered as an accident-related expense. (Your provider must submit x-rays taken *before* the dental or surgical procedure in order for BCBSNM to determine whether the tooth was "sound.")

The following services are the only dental-related services and oral surgery procedures covered under this plan. When alternative procedures or devices are available, benefits are based upon the least costly, medically appropriate procedure or device available.

Dental and Facial Accidents — Benefits for covered services for the treatment of accidental injuries to the jaw, mouth, face, or sound natural teeth are generally subject to the same limitations, exclusions, and member cost-sharing provisions that would apply to similar services when not dental-related (e.g., x-rays, medical supplies, surgical procedures).

To be covered, *initial* treatment for the injury must be sought **within 72 hours** of the accident. Any services required after the initial treatment must receive **prior approval,** requested **in writing,** from BCBSNM and be received **within 12 months** of the date of accident in order to be covered. (For treatment of TMJ or CMJ injuries, see "TMJ/CMJ Services," below.)

Facility Charges — This plan covers inpatient or outpatient hospital expenses for dental-related procedures **only** if the patient is under age six or has a nondental, hazardous physical condition (e.g., heart disease or hemophilia) that makes hospitalization medically necessary. All hospital services for dental-related services must be **prior-approved** by BCBSNM. Unless listed as a covered procedure in this section, the dentist's services for the procedure will not be covered.

Also, if hospital services are recommended by a nonpreferred provider, you are responsible for obtaining **admission review approval** for an inpatient admission and **prior approval** for outpatient services to receive maximum benefits. See "Admission Review and Other Prior Approvals" in *Section 2*.

Oral Surgery — This plan covers the following oral surgical procedures only:

- medically necessary orthognathic surgery if **prior approval** for the service is received from BCBSNM
- external or intraoral cutting and draining of cellulitis (not including treatment of dental-related abscesses)
- incision of accessory sinuses, salivary glands, or ducts
- lingual frenectomy
- removal or biopsy of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of mouth when pathological examination is required

TMJ/CMJ Services — This plan covers standard diagnostic, therapeutic, surgical, and nonsurgical treatments of temporomandibular joint (TMJ) and craniomandibular joint (CMJ) disorders or accidental injuries. Treatment may include orthodontic appliances and treatment, crowns, bridges, or dentures **only if** required because of an accidental injury to sound natural teeth involving the TMJ or CMJ.

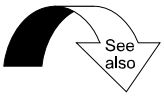
Exclusions — **This plan does not cover** oral or dental procedures not specifically listed as covered such as, but not limited to:

- services that have not been **prior-approved** by BCBSNM (except initial emergency treatment of accidental injuries)
- nonstandard services (diagnostic, therapeutic, or surgical)
- removal of tori, exostoses, or impacted teeth

- dental services that may be related to, or required as the result of, a medical condition or procedure (e.g., chemotherapy or radiation therapy)
- procedures involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for dentures
- duplicate or "spare" appliances
- personalized restorations, cosmetic replacement of serviceable restorations, or materials (such as precious metals) that are more expensive than necessary to restore damaged teeth
- dental treatment or surgery, such as extraction of teeth or application or cost of devices or splints, unless required due to an accidental injury and covered under "Dental and Facial Accidents" or "TMJ/CMJ Services"
- artificial devices and/or bone grafts for denture wear

See Section 4: General Limitations and Exclusions

Diabetic Services



For insulin and over-the-counter diabetic supplies, see "Prescription Drugs and Other Items."

For durable medical equipment, see "Supplies, Medical Equipment, and Prosthetics."

For educational services and diabetes management services, see "Physician Visits/Medical Care."

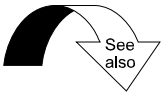
Diabetes is not excluded and diabetic persons are entitled to the same benefits for medically necessary covered services as are other members under the health care plan. For special coverage details, such as for insulin, glucose monitors, and educational services, see the above topics. **Note:** The health care plan will also cover items not specifically listed as covered when new and improved equipment, appliances, and prescription drugs for the treatment and management of diabetes are approved by the United States Food and Drug Administration.

See Section 4: General Limitations and Exclusions

Emergency and Urgent Care

Emergency care — Covered services required after the sudden onset of a medical condition manifesting itself by acute symptoms that are severe enough that a reasonable person believes that immediate attention is required and that a lack of such immediate medical attention may place the person's health in jeopardy, or may result in impairment of bodily functions or dysfunction of any organ or part. Initial treatment must be sought within 48 hours of the accident or onset of symptoms to qualify as an emergency.

Urgent care — Medically necessary medical or surgical procedures, treatments, or services received for an unforeseen condition that is *not* life-threatening. The condition does, however, require prompt medical attention to prevent a serious deterioration in your health (e.g., high fever, cuts requiring stitches).



For accidental injury to the mouth, jaw, teeth, or TMJ, see "Dental-Related/TMJ Services and Oral Surgery."

Also see other subheadings when applicable (such as "Hospital/Other Facility Services").

Emergency Care

Acute medical emergency care is available 24 hours per day, 7 days a week. If services are received in an emergency room or other trauma center, the condition must meet the definition of an "emergency" in order to be covered. Services received in an emergency room that do not meet the definition of an "emergency" may be reviewed for appropriateness and may be denied.

If you visit a nonpreferred provider for emergency services, the Preferred Provider deductible and coinsurance is applied only to the initial treatment, which includes emergency room services and, if you are hospitalized within 48 hours of an emergency, the related inpatient hospitalization. Once you are discharged, covered follow-up care from a nonpreferred provider is paid at the Nonpreferred Provider benefit level. (Office/urgent care facility services are not considered "emergencies" for purposes of this provision.)

For all follow-up care (which is no longer considered an emergency) and for all other nonemergency care, you will receive the Nonpreferred Provider benefit for the services of a nonpreferred provider, even if a preferred provider is not available to perform the service.

Member Copayments — If you are directly admitted as an inpatient, the copayment for emergency room services is waived. The inpatient hospital benefit will apply in such cases.

Call Within 48 Hours
(505) 291-3585
(800) 325-8334

Admission Notification Within 48 Hours — **Remember:** If you are admitted because of a medical emergency, you should notify BCBSNM **within 48 hours** of the admission with hospital admission information in order to ensure that benefits will be paid correctly. (See "Admission Review" in *Section 2*.)

Use of an emergency center for nonemergency services is NOT covered. However, services will not be denied if you, in good faith and possessing average knowledge of health and medicine, seek care for what reasonably appears to be an emergency — even if your condition is later determined to be nonemergency.

Urgent Care

Care received in an urgent care facility is covered as any other type of service. However, if services are received in an emergency room or other trauma center, the condition must meet the definition of an "emergency care," as described on the previous page, in order to be covered.

See Section 4: General Limitations and Exclusions

Family Planning and Infertility-Related Services

For oral contraceptive drug coverage and devices purchased from a pharmacy, see "Prescription Drugs and Other Items." Other contraceptive devices are paid as any other medical supply and are listed below.

Family Planning — Covered family planning services include FDA-approved devices and other procedures such as:

- 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

Infertility-Related Services — This plan covers the following infertility-related treatments when **prior approval** is received from BCBSNM (note that the following procedures only *secondarily* also treat infertility):

- surgical treatments such as opening an obstructed fallopian tube, epididymis, or vas when the obstruction is **not** the result of a surgical sterilization
- replacement of deficient, naturally occurring hormones **if** there is documented evidence of a deficiency of the hormone being replaced

The above services are the **only** infertility-related treatments that will be considered for benefit payment.

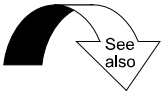
Infertility *testing,* when **prior approval** is received from BCBSNM, is covered only to diagnose the cause of infertility. Once the cause has been established and the treatment determined to be noncovered, no further testing is covered. For example, this plan will cover lab tests to monitor hormone levels following the hormone replacement treatment listed as covered above. However, daily ultrasounds to monitor ova maturation are **not** covered since the testing is being used to monitor a noncovered infertility treatment.

Exclusions — In addition to services not listed as covered, above, this plan does **not** cover pregnancy- or maternity-related services or:

- contraceptive devices that do not require a prescription, including over-the-counter contraceptive products such as condoms and spermicide
- sterilization reversal for males or females
- infertility treatments and related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization; Gamete Intrafallopian Transfer (GIFT) or Zygote Intrafallopian Transfer (ZIFT); cost of donor sperm
- artificial conception or insemination; fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such as in-vivo or in-vitro ("test tube") fertilization, and embryo transfer; drugs for induced ovulation; or other artificial methods of conception

See Section 4: General Limitations and Exclusions

Home Health Care/Home I.V. Services



For oxygen, ostomy supplies, and medical equipment, see "Supplies, Equipment, and Prosthetics."

Conditions and Limitations of Coverage — If you are homebound (unable to receive medical care on an outpatient basis), this plan covers home health care and home I.V. services for up to the number of visits specified on the *Summary of Benefits.* Services must be provided under the direction of a physician and nursing management must be through a home health care agency approved by BCBSNM. A *visit* is one period of home health service of up to four hours. **Hospice visits are included in the maximum benefit.**

Prior Approval Required — Before you receive home health care or home I.V. therapy, you, your physician, or home health care agency must obtain **prior approval** from BCBSNM. **This plan does not cover home health care or home I.V. services without prior approval.**

Covered Services — This plan covers the following services, subject to the limitations and conditions above and on the previous page, when provided by an approved home health care agency during a covered visit in your home:

- skilled nursing care provided on an intermittent basis by a registered nurse or licensed practical nurse
- physical, occupational, or respiratory therapy provided by licensed or certified physical, occupational, or respiratory therapists
- speech therapy provided by an American Speech and Hearing Association certified therapist

- intravenous medications and other prescription drugs ordinarily not available through a retail pharmacy if **prior approval** is received from BCBSNM (If drugs are *not* provided by the home health care agency, see "Prescription Drugs and Other Items" to find out if these medications are covered.)
- drugs, medicines, medical supplies, and laboratory services that would have been covered during an inpatient admission
- parenteral and enteral nutritional products that can only be legally dispensed by the written prescription of a physician and are labeled as such on the packages (If *not* provided by the home health care agency or if products do not require a prescription, see "Prescription Drugs and Other Items" to find out if these products are eligible for coverage.)
- skilled services by a qualified aide to do such things as change dressings and check blood pressure, pulse, and temperature

Exclusions — This plan does **not** cover:

- care provided primarily for your or your family's convenience
- homemaking services or care that consists mostly of bathing, feeding, exercising, preparing meals for, moving, giving medications to, or acting as a sitter for the patient (See the "Custodial Care" exclusion in *Section 4*.)
- services provided by a nurse who ordinarily resides in your home or is a member of your immediate family
- nonprescription enteral nutritional products (See "Prescription Drugs and Other Items" to find out if these products are eligible for coverage.)

See Section 4: General Limitations and Exclusions

Hospice Care

Hospice benefit period — The period of time during which hospice benefits are available. It begins on the date the attending physician certifies that the member is terminally ill and ends six months after the period began (or upon the member's death, if sooner). The benefit period must begin while the member is covered for these benefits, and coverage must be maintained throughout the benefit period.

Skilled nursing care — Care that can be provided only by someone with at least the qualifications of a licensed practical nurse (L.P.N.) or registered nurse (R.N.).

Terminally ill patient — A patient with a life expectancy of six months or less, as certified in writing by the attending physician.

Conditions and Limitations of Coverage — This plan covers inpatient and home hospice services for a terminally ill member received during a hospice benefit period when provided by a hospice program approved by BCBSNM. Hospice care benefits are limited as specified on the *Summary of Benefits*. If you need an extension of the hospice benefit period, the hospice agency must provide a new treatment plan and the attending physician must recertify your condition to BCBSNM. No more than two hospice benefit periods will be approved. **Note:** An extension of the hospice benefit period does **not** increase the total amount of benefits payable under this provision. **Home health care/home I.V. services are included in the maximum benefit.**

Covered Services — This plan covers the following services, subject to the conditions and limitations above, under the hospice care benefit:

- visits from hospice physicians
- skilled nursing care by a registered nurse or licensed practical nurse
- physical and occupational therapy by licensed or certified physical or occupational therapists and speech therapy provided by an American Speech and Hearing Association certified therapist
- medical supplies (If supplies are *not* provided by the hospice agency, see "Supplies, Equipment, and Prosthetics.")
- drugs and medications for the terminally ill patient (If drugs are *not* provided by the hospice agency, see "Prescription Drugs and Other Items" to find out if these medications are eligible for coverage.)
- medical social services provided by a qualified individual with a degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training, and experience (Such services must be recommended by a physician to help the member or his/her family deal with a specified medical condition.)
- services of a home health aide under the supervision of a registered nurse and in conjunction with skilled nursing care
- nutritional guidance and support, such as intravenous feeding and hyperalimentation
- respite care for a period not to exceed 5 continuous days for every 60 days of hospice care and no more than two respite care periods during each hospice benefit period (*Respite care* provides a brief break from total care-giving by the family.)

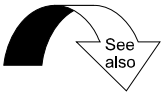
Exclusions — This plan does **not** cover:

- food, housing, or delivered meals
- medical transportation
- homemaker and housekeeping services; comfort items
- private duty nursing
- pastoral, spiritual, or bereavement counseling; supportive services provided to the family of a terminally ill patient when the patient is not a plan member

These services are **not** hospice care benefits but may be covered elsewhere under this plan: acute inpatient hospital care for curative services, durable medical equipment, physician visits unrelated to hospice care, and ambulance services.

See Section 4: General Limitations and Exclusions

Hospital/Other Facility Services



If applicable, see:
"Dental-Related/TMJ Services and Oral Surgery"
"Emergency and Urgent Care"
"Hospice Care"

For inpatient physician medical visits, see "Physician Visits/Medical Care."

For physical rehabilitation and skilled nursing facility services, see "Rehabilitation and Other Therapy."

See other subheadings in this section that apply to the type of services required during an admission, such as "Surgery and Related Services" or "Transplant Services."

Blood Services

This plan covers the processing, transporting, handling, and administration of blood and blood components. This plan covered directed donor or autologous blood storage fees only when the blood is used during a scheduled surgical procedure. This plan does **not** cover blood replaced through donor credit.

Inpatient Services

***Admission* —** The period of time between the dates when a patient enters a facility as an inpatient and is discharged as an inpatient. (If you are an inpatient at the time your coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date.)

***Routine newborn care* —** Care of a child immediately following his/her birth that includes: routine hospital nursery services; alpha-fetoprotein IV screening; routine medical care in the hospital after delivery; pediatrician standby care at a C-section procedure; and services related to circumcision of a male newborn.

See Section 7 for details about enrolling your newborn.

Admission Review Required — If hospitalization is recommended by a non-preferred provider, **you are responsible** for obtaining admission approval. If you do not follow the admission review procedures outlined in *Section 2,* benefits for covered facility services will be **reduced or denied** as explained under "Admission Review and Other Prior Approvals" in *Section 2*.

Covered Services — For acute inpatient medical or surgical care received during a covered hospital admission, this plan covers semiprivate room or special care unit (e.g., ICU, CCU) expenses and other medically necessary services provided by the facility. (If you have a private room for any reason other than isolation, covered room expenses are limited to the average semiprivate room rate, whether or not a semiprivate room is available. BCBSNM must give **prior approval** for medically necessary private room charges to be covered.)

Medical Detoxification — This plan also covers medically necessary services related to medical detoxification from the effects of alcoholism or drug abuse. Detoxification is the treatment in an acute care facility for withdrawal from the physiological effects of alcoholism or drug abuse, which usually takes about three days in an acute care facility. Benefits for detoxification services are the same as for any other acute medical/surgical condition.

This plan does not cover rehabilitation from the effects of alcoholism or other chemical dependency or any long-term care.

Newborn Care — If you have coverage for your newborn child, the initial routine newborn care is covered. Coverage includes benefits for medically necessary treatment of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. A newborn who is enrolled for coverage within the time limits specified in *Section 7* is also covered if he/she stays in the hospital longer than the mother. **However, the mother's maternity-related services are not covered under this plan.** Also, see "Changes to Cost-Sharing Amounts," in *Section 2*. You must ensure that BCBSNM is called for admission review approval **before** the mother is discharged from the hospital. If you do not, benefits for the newborn's covered facility services will be reduced by **$300.**

Exclusions — This plan does **not** cover:

- private room expenses, unless your medical condition requires isolation for protection from exposure to bacteria or diseases (e.g., severe burns or conditions that require isolation according to public health laws)
- pregnancy-related services
- mental health services or rehabilitation from the effects of alcoholism or other chemical dependency
- admissions related to noncovered services or procedures (See "Dental-Related/TMJ Services and Oral Surgery" for an exception.)
- extended care facility admissions or admissions to similar institutions
- admissions for rehabilitative treatment, such as oxygen therapy (For physical rehabilitation benefits, see "Rehabilitation and Other Therapy: Short-Term Rehabilitation.")

Outpatient or Observation Services

Coverage for outpatient or observation services and related physician or other professional provider services for the treatment of illness or accidental injury depends on the type of service received (for example, see "Lab, X-Ray, Other Diagnostic Services") or on special circumstances (for example, see "Emergency and Urgent Care").

See Section 4: General Limitations and Exclusions

Lab, X-Ray, Other Diagnostic Services

Diagnostic services — Procedures such as laboratory and pathology tests, x-rays, and EKGs that do *not* require the use of an operating and/or recovery room, and that are ordered by a provider to determine a definite condition or disease.

For services received during a covered inpatient admission, see "Hospital/Other Facility Services."

For allergy testing benefits, see "Physician Visits/Medical Care."

If applicable, also see these topics:
"Dental-Related/TMJ Services and Oral Surgery"
"Preventive Services"
"Emergency and Urgent Care"
"Transplant Services"

For invasive diagnostic procedures such as biopsies and endoscopies or any procedure that requires the use of an operating or recovery room, see "Surgery and Related Services."

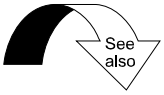
This plan covers diagnostic services, including preadmission testing, that are related to an illness or injury. Covered services include:

- x-ray and radiology services, ultrasound, and imaging studies
- laboratory and pathology tests
- EKG, EEG, and other electronic diagnostic medical procedures
- limited infertility-related testing, with **prior approval** from BCBSNM (See "Family Planning and Infertility-Related Services.")
- PET (Positron Emission Tomography) scans and cardiac CT scans, with **prior approval** from BCBSNM
- home sleep disorder studies, with **prior approval** from BCBSNM
- audiometric (hearing) and vision tests for the diagnosis and/or treatment of an accidental injury or an illness

Note: All services, including those for which prior approval is required, must meet the standards of medical necessity criteria established by BCBSNM and will not be covered if excluded for any reason under this health care plan. **Some services requiring prior approval will not be approved for payment** (for example, due to being experimental, investigational, unproven, or not medically necessary).

See Section 4: General Limitations and Exclusions

Physician Visits/Medical Care



If applicable, see these topics:
"Dental-Related/TMJ Services and Oral Surgery"
"Emergency and Urgent Care"
"Family Planning and Infertility-Related Services"
"Preventive Services"
"Rehabilitation and Other Therapy" for cardiac and pulmonary rehabilitation, chemotherapy, radiation therapy, and dialysis, physical, occupational, speech therapy and skilled nursing facility visits, acupuncture, and spinal manipulation
"Surgery and Related Services" or "Transplant Services"

Benefits for medically necessary services for treatment of an illness or injury and received in a physician's or other provider's office are based on the type of service received while in the office. **Your choice of provider can make a difference in the amount you pay.** (See *Section 2*.)

This section describes benefits for therapeutic injections, allergy care and testing, and other nonsurgical, nonroutine medical visits to a health care provider for evaluating your condition and planning a course of treatment. See the topics referenced above for more information regarding a particular type of service.

Office Visits and Consultations

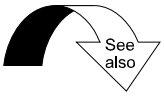
Services covered under this provision include allergy care, therapeutic injections, office visits, consultations (including second or third surgical opinions), and examinations, and other nonroutine medical procedures — when not related to hospice care or payable as part of a surgical procedure. (See "Hospice Care" or

"Surgery and Related Services" if the medical visits are related to either of these services.)

Allergy Care — This plan covers direct skin (percutaneous and intradermal) and patch allergy tests, radioallergosorbent testing (RAST), covered charges for allergy serum, and appropriate FDA-approved allergy injections administered in a provider's office or in a facility.

Diabetes Self-Management — This plan covers diabetes self-management training if you have diabetes or an elevated blood glucose due to pregnancy. Training must be prescribed by a health care provider and given by a certified, registered, or licensed health care professional with recent education in diabetes management. For services to be covered, you must receive **prior approval** from BCBSNM. If approved, covered services are limited to:

- medically necessary visits upon the diagnosis of diabetes
- visits following a physician diagnosis that represents a significant change in your symptoms or condition that warrants changes in your self-management
- visits when re-education or refresher training is prescribed by a health care provider
- medical nutrition therapy related to diabetes management



See "Prescription Drugs and Other Items" for benefits for insulin and oral agents to control blood glucose levels, needles, syringes, and test strips; see "Supplies, Equipment, and Prosthetics" for other covered supplies and equipment required due to diabetes.

Genetic Inborn Errors of Metabolism — This plan covers medically necessary expenses related to the diagnosis, monitoring, and control of genetic inborn errors of metabolism (as defined in the *Glossary).* Covered services include medical assessment, including clinical services, biochemical analysis, medical supplies, prescription drugs (see "Prescription Drugs and Other Items"*),* corrective lenses for conditions related to the genetic inborn error of metabolism, nutritional management, and **prior-approved** special medical foods (as defined and described in "Prescription Drugs and Other Items"). In order to be covered, services cannot be excluded under any other provision of this booklet and are paid according to the provisions of the plan that apply to that particular type of service (e.g., special medical foods are covered under "Prescription Drugs and Other Items," medical assessments under "Physician Visits/Medical Care," and corrective lenses under "Supplies, Equipment, and Prosthetics").

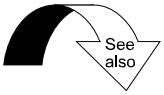
To be covered, you must be receiving medical treatment provided by licensed health care professionals, including physicians, dieticians, and nutritionists, who have specific training in managing patients diagnosed with genetic inborn errors of metabolism.

Injections and Injectable Drugs — This plan covers most FDA-approved therapeutic injections administered in a provider's office. However, this plan covers some injectable drugs only when **prior approval** is received from BCBSNM. Your BCBSNM provider has a list of those injectable drugs that require prior approval. If you need a copy of the list, contact a BCBSNM Health Services representative. (When you request prior approval, you may be directed

to purchase the self-injectable medication through a pharmacy, which may not be covered under your plan.)

BCBSNM reserves the right to exclude any injectable drug currently being used by a member. Proposed new uses for injectable drugs previously approved by the FDA will be evaluated on a medication-by-medication basis. Call a BCBSNM Health Services representative if you have any questions about this policy.

Inpatient Medical Visits



Please see "Adding Dependent Children" in Section 7 for details on newborn coverage.

With the exception of dental-related services (see "Dental-Related/TMJ Services and Oral Surgery"), benefits are available for the following services when received on a covered inpatient hospital day:

- visits for a condition requiring **only** medical care, unless related to hospice care (See "Hospice Care.")
- consultations (including second opinions) and, if surgery is performed, inpatient visits by a provider who is not the surgeon and who provides medical care **not** related to the surgery (For the surgeon's services, see "Surgery and Related Services" or "Transplant Services.")
- medical care requiring two or more physicians at the same time because of multiple illnesses
- initial routine newborn care (routine care of a child immediately following his/her birth that includes pediatrician standby care at a C-section) for a newborn added to coverage within the time limits specified in *Section 7* (See "Hospital/Other Facility Services" for information about nonroutine, extended stays for newborns and see "Changes to Cost-Sharing Amounts," in *Section 2.*)

See Section 4: General Limitations and Exclusions

Prescription Drugs and Other Items

Brand-name drug — A drug that is available from only one source, or when available from multiple sources, is protected with a patent.

Enteral nutritional product — A product designed to provide calories, protein, and essential micronutrients by the enteral route (i.e., by the gastrointestinal tract, which includes the stomach and small intestine only).

Generic drug — The chemical equivalent of a brand-name prescription drug. According to United States Food and Drug Administration (FDA) regulations, brand-name and generic drugs must meet the same standards for safety, purity, strength, and quality. A generic drug is usually available from multiple sources and is not protected by a patent.

Genetic inborn errors of metabolism — A rare, inherited disorder that is present at birth; if untreated, results in mental retardation or death, and requires that the affected person consume special medical foods.

Maintenance medications — Prescription drugs taken regularly to treat a chronic health condition, such as high blood pressure or diabetes.

Participating pharmacy — A retail supplier that has contracted with BCBSNM or its authorized representative to dispense covered prescription drugs and medicines, insulin, diabetic supplies, and nutritional products to plan members, and that has contractually accepted the terms and conditions as set forth by BCBSNM and/or its authorized representative. Some participating pharmacies are contracted with BCBSNM to provide specialty pharmacy drugs to plan members; these pharmacies are called "specialty pharmacy providers" and some drugs must be dispensed by these specially contracted pharmacy providers in order to be covered (see below).

Prescription drugs, medicines, and devices — Those that are taken at the direction and under the supervision of a provider, that require a prescription before being dispensed, and are labeled as such on their packages. All drugs, medicines, and devices must be approved by the FDA, and must not be experimental, investigational, or unproven. (See the "Experimental, Investigational, or Unproven Services" in *Section 4.)*

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

Specialty pharmacy drugs — Specialty pharmacy drugs must meet at least two of the following criteria: a) they are high cost, b) they are for use in limited patient populations or indications, c) they are typically self-injected, d) they have limited availability, require special dispensing, or delivery and/or patient support is required and, therefore, they are difficult to obtain via traditional pharmacy channels, e) complex reimbursement procedures are required, and/or f) a considerable portion of the use and costs are frequently generated through office-based medical claims.

Covered Medications and Other Items — This plan covers the following drugs, supplies, and other products only when dispensed by a participating pharmacy under the Retail Pharmacy Program or Specialty Pharmacy Drug Program (unless required as the result of an emergency, as defined in your benefit booklet) or ordered through the Mail Order Service:

- prescription drugs and medicines (including compounded medications of which at least one ingredient is a prescription drug, prescriptive oral agents for controlling blood sugar levels, insulin, and glucagon, and prescription contraceptive medications), and prescription contraceptive devices purchased from a participating pharmacy), unless listed as an exclusion **(Note:** Prescription contraceptive devices fitted or inserted by, and purchased directly from, a physician are payable under "Family Planning.")
- specialty pharmacy drugs (such as, but not limited to, self-administered injectable drugs such as growth hormone, Copaxone, Avonex) (Specialty pharmacy drugs are typically injectable drugs and require **prior approval** from BCBSNM. Some self-administered drugs, whether injectable or not, are identified as specialty pharmacy drugs and must be acquired through a participating specialty pharmacy provider in order to be covered.)

- insulin needles, syringes, and diabetic supplies (e.g., glucagon emergency kits, autolets, lancets, lancet devices, blood glucose and visual reading urine and ketone test strips) (There is a separate copayment for each item purchased. These items are not covered as a supply or medical equipment expense under your medical/surgical plan benefits.)
- nonprescription enteral nutritional products and special medical foods only when either: 1) delivered through a medically necessary enteral access tube that has been surgically placed (e.g., gastrostomy, jejunostomy) or 2) meeting the definition of special medical foods used to treat and to compensate for the metabolic abnormality of members with genetic inborn errors of metabolism in order to maintain their adequate nutritional status (Nonprescription nutritional products, which includes both enteral products and special medical foods, must be **prior-approved** by BCBSNM.)

Prior Approval — Certain prescription drugs, injectable medications, and specialty pharmacy drugs may require prior approval from BCBSNM. A list of drugs requiring prior approval is available on the BCBSNM Web site at www.bcbsnm.com. Your physician can request the necessary prior approval.

Member Percentages — For covered prescription drugs (including specialty pharmacy drugs), insulin, diabetic supplies, enteral nutritional products, and special medical foods, you pay a percentage amount, not to exceed the actual retail price, for each prescription filled or item purchased (not to exceed supply limitations described on the next page). Covered charges are subject to the medical plan deductible and Preferred Provider out-of-pocket limit provisions. Once you reach your Preferred Provider out-of-pocket limit (see your *Summary of Benefits),* covered charges under the drug plan will also be payable at 100 percent for the rest of the calendar year.

When the percentage amount for an item purchased under the drug plan is greater than the covered charge for the supply being purchased from a participating pharmacy, you pay the **lesser** of: 1) your percentage amount, or 2) the pharmacy's retail price. For claims submitted to the drug plan administrator for reimbursement, you are paid the **lesser** of: 1) the sum of the drug ingredient cost, the dispensing fee that would be payable to a participating pharmacy, and any sales tax minus the applicable percentage amount, or 2) the pharmacy's retail price minus the applicable percentage amount.

Retail Pharmacy/Specialty Pharmacy Program

All items covered under this provision of the plan must be purchased from a participating retail pharmacy. **Some drugs must be purchased from a participating specialty pharmacy provider in order to be covered.** (See your provider directory, call a Customer Service representative for a list of participating pharmacies and specialty pharmacy providers, or visit the BCBSNM Web site at www.bcbsnm.com.) **You must present your BCBSNM health care plan identification (ID) card to the pharmacist at the time of purchase to receive this benefit.** (You do not receive a separate drug plan ID card; use your health care plan ID card to receive all covered medical/surgical and drug plan services.)

You can use your ID card to purchase covered items only for yourself and covered family members. When coverage for you or a family member ends under this health care plan, the ID card may not be used to purchase drugs or other items for the terminated member(s). If you do not have your ID card with you or if you

purchase your prescription or other item from a nonparticipating provider in an emergency, you must pay for the purchase in full and then submit a claim directly to the BCBSNM drug plan administrator. (You should have received the address of the administrator among the materials you received upon enrollment. If you did not, call Customer Service for the address and a claim form or visit the BCBSNM Web site at www.bcbsnm.com.) If you are leaving the country or need an extended supply of medication, call Customer Service at least **two weeks** before you intend to leave. (Extended supplies or vacation overrides are not available through the Mail Order Service and may be approved through the Retail Pharmacy Program only. In some cases, you may be asked to provide proof of continued enrollment eligibility under the Retail Pharmacy Program.)

When you need to fill a prescription, simply go to a participating pharmacy and show the pharmacist your member ID card and pay the necessary percentage amount. The percentage amount you pay at the retail pharmacy and specialty pharmacy are as follows:

Type of Prescription	Percentage of Covered Charge	Minimum Percentage Amount	Maximum Percentage Amount
Generic Drug	**25%**	**$20**	**$75**
Brand-Name Drug	**50%**	**$40**	**$125**
Nonprescription Enteral Nutritional Products and Special Medical Foods	**50%** of covered charge with no minimum or maximum amount; both brand-name and generic products require prior approval		

Supply Limitations — During any 30-day period, for each percentage amount listed above, you can obtain up to a 30-day supply or 180 units (e.g., pills), whichever is less, of a single prescription drug or other item covered under this plan. If more than 180 units are needed to reach a 30-day supply, prior approval is required. For oral contraceptives the supply is limited to one menstrual cycle (normally 28 days). For commercially packaged items (such as an inhaler, a tube of ointment, or a blister pack of tablets or capsules), you will pay the applicable percentage amount for a 30-day supply (usually one packaged item).

Minimums and Maximums — The following is an example of how the minimum and maximum percentage amounts work when you purchase a generic drug through the retail pharmacy program:

- **Medication A** costs less than $20. You pay the actual retail cost of the prescription.
- **Medication B** costs $40. Since 25% is less than $20, you pay the minimum percentage amount of $20.
- **Medication C** costs $120. Since 25% is greater than $20 and less than $75, you pay 25% (or $30)
- **Medication D** costs $700. Since 25% is greater than $75, you pay the maximum percentage amount of $75.

Filing Claims — Claims for items covered under the drug plan must be sent to the drug plan administrator — **not** to BCBSNM. If not included in your enrollment materials, you can obtain the name and address of the administrator and the necessary claim forms from a Customer Service representative or on the BCBSNM Web site.

Mail Order Service

Except for supply limitations and nutritional products, all items that are covered under the Mail Order Service are the same items that are covered under the Retail Pharmacy Program and are subject to the same limitations and exclusions. **Items covered through a specialty pharmacy provider may not be covered through the Mail Order Service.** To use the Mail Order Service, follow the instructions outlined in the materials provided to you in your enrollment packet. (If you do not have this information, call a Customer Service representative.) N**ote:** Prescription drugs and other items may **not** be mailed outside the United States. Extended supplies or vacation overrides required when you are outside the country may be approved through the Retail Pharmacy Program only.

The mail order program offers you the convenience of home delivery at a lower cost, per 30-day supply, than what you would pay through the retail pharmacy. The percentage amount for up to a 90-day supply of medication through the mail-order program are as follows:

Type of Prescription	Percentage of Covered Charge	Minimum Percentage Amount	Maximum Percentage Amount
Generic Drug	25%	$40	$150
Brand-Name Drug	50%	$80	$250

Supply Limitations — During any 90-day period, for each percentage amount listed above, you can obtain up to a 90-day supply or 540 units (e.g., pills), whichever is less, of a single prescription drug or other item covered under the mail-order portion of this plan. If less than a 90-day supply is ordered, percentage amounts will still apply. If more than 540 units are needed to reach a 90-day supply, prior approval is required. For commercially packaged items (such as an inhaler, a tube of ointment, or a blister pack of tablets or capsules), you will pay the applicable percentage amount for a 90-day supply (usually three packaged items).

Minimums and Maximums — The following is an example of how the minimum and maximum percentage amounts work when you purchase a generic drug through the mail order program:

- **Medication A** costs less than $40. You pay the actual cost of the prescription.
- **Medication B** costs $50. Since 25% is less than $40, you pay the minimum percentage amount of $40.
- **Medication C** costs $175. Since 25% is greater than $40 and less than $175, you pay 25% (or $75)
- **Medication D** costs $700. Since 25% is greater than $150, you pay the maximum percentage amount of $150.

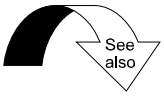
Drug Plan Exclusions — This plan does **not** cover:

- nonprescription and over-the-counter drugs unless specifically listed as covered, including herbal or homeopathic preparations, or prescription drugs that have over-the-counter equivalents (Equivalents have the same strength and cause similar action on bodily tissues.)
- replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced

- prescriptions or other covered items purchased from a nonparticipating pharmacy, nonparticipating specialty pharmacy provider, or other provider unless eligible for benefits in an emergency situation
- refills before the normal period of use has expired, in excess of the number specified by the physician, or requested more than one year following the physician's original order date (Prescriptions cannot be refilled until at least 75 percent of the previously dispensed supply will have been exhausted according to the physician's instructions. Call Customer Service for instructions on obtaining a greater supply if you are leaving home for more than a 30-day period of time.)
- infertility medications
- drugs or other items for smoking cessation purposes
- drugs or other items for the treatment of sexual or erectile dysfunction
- therapeutic devices or appliances, including support garments and other nonmedicinal substances
- medications or preparations used for cosmetic purposes (such as preparations to promote hair growth or medicated cosmetics), including tretinoin (sold under such brand names as Retin-A) for cosmetic purposes
- nonprescription enteral nutritional products that are taken by mouth or delivered through a temporary naso-enteric tube (e.g., nasogastric, nasoduodenal, or nasojejunal tube), unless the patient meets criteria for genetic inborn errors of metabolism and the product is prior-approved by BCBSNM or that have not been prior-approved by BCBSNM
- shipping, handling, or delivery charges
- prescription drugs required for international travel or work
- appetite suppressants or diet aids; weight reduction drugs; food or diet supplements and medication prescribed for body building or similar purposes

See Section 4: General Limitations and Exclusions

Preventive Services



For diabetic self-management education services, see "Physician Visits/Medical Care."

This plan covers the following routine physical examinations and associated testing in accordance with national medical standards, the state of New Mexico, the American Academy of Pediatrics, and/or the U.S. Preventive Services Task Force:

- routine physical, breast, pelvic, and annual gynecological examinations
- routine adult and pediatric immunizations
- low-dose mammogram screenings, Pap tests, and papillomavirus screening
- periodic blood hemoglobin, blood pressure, and blood glucose level tests
- periodic blood cholesterol or periodic fractionated cholesterol level including a low-density lipoprotein (LDL) and a high-density lipoprotein (HDL) level; periodic stool examination for the presence of blood; periodic left-sided colon examination of 35 to 60 centimeters; and periodic glaucoma eye tests
- well-child care as recommended by the American Academy of Pediatrics

- vision and hearing screenings in order to detect the need for additional vision or hearing testing in children through age 17 when received as part of a routine physical exam (A screening does *not* include an eye exam, refraction, or other test to determine the amount and kind of correction needed.)
- health education and counseling services if recommended by your physician, including an annual consultation to discuss lifestyle behaviors that promote health and well-being (Services must receive **prior approval** from BCBSNM in order to be covered.)

The services listed above are not limited as to the number of times you may receive the service in any given period or as to the age of the patient (except when a service is inappropriate for the patient's age group, such as providing a pediatric immunization to an adult). You and your physician are encouraged to determine how often and at what time you should receive preventive tests and examinations and you will receive coverage according to the benefits and limitations of your health care plan.

Your preventive services benefit pays covered preventive services at 100 percent of the covered charge, no deductible, for preferred provider services – up to a maximum annual payment amount of **$400.** After you have reached the $400 limit, benefits for covered preventive services are subject to deductible and coinsurance provisions.

No Non-PPO Provider Benefits

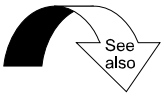
Preventive/routine services must be received from preferred providers in order to be covered.

Exclusions — This plan does **not** cover:

- employment physicals, insurance examinations, or examinations at the request of a third party (the requesting party may be responsible for payment); premarital examinations; sports or camp physicals; any other nonpreventive physical examination
- immunizations or medications required for international travel
- hepatitis B immunizations when required due to possible exposure during the member's work
- routine hearing or eye examinations, hearing aids, or any related service or supply; eye refractions; hearing or visual screening for members over age 17

See Section 4: General Limitations and Exclusions

Rehabilitation and Other Therapy



When billed by a facility as an ancillary services during a covered admission, therapy is covered in the same manner as the other ancillary services (see "Hospital/Other Facility Services").

Acupuncture and Spinal Manipulation

No Non-PPO Provider Benefits

This plan covers acupuncture and spinal manipulation services when administered by a licensed provider acting within the scope of licensure and when necessary for the treatment of a medical condition. Benefits for acupuncture and spinal manipulation are limited as specified on the *Summary of Benefits*.

Services must be received from a preferred provider in order to be covered. This plan does not cover these services when received from nonpreferred providers.

Cardiac and Pulmonary Rehabilitation

Call BCBSNM for Approval: (505)291-3585 or (800)325-8334

This plan covers outpatient cardiac rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services. **Prior approval** must be obtained from BCBSNM or benefits will be denied.

No Non-PPO Provider Benefits

Cardiac and pulmonary rehabilitation services must be received from a preferred provider in order to be covered. This plan does not cover these services when received from nonpreferred providers.

Chemotherapy and Radiation Therapy

Call BCBSNM for Approval: (505)291-3585 or (800)325-8334

This plan covers the treatment of malignant disease by standard chemotherapy and treatment of disease by radiation therapy.

High-dose chemotherapy treatments must receive prior approval from BCBSNM in order to be covered.

Call BCBSNM for Approval: (505)291-3585 or (800)325-8334

Cancer Clinical Trials — If you are a participant in a phase II, III, or IV approved "cancer clinical trial" (see *Glossary)* that is being conducted in New Mexico, you may receive coverage for certain "routine patient care costs" (see *Glossary)* incurred in the trial. The trial must be conducted as part of a scientific study of a new therapy or intervention for the prevention of reoccurrence, early detection, or treatment or palliation of cancer. In order to be considered for possible coverage, the persons conducting the trial must provide BCBSNM with notice of when the member enters and leaves a qualified clinical trial and must accept BCBSNM's covered charges as payment in full (this includes the health care plan's payment plus your share of the covered charge).

The routine patient care costs that are covered must be the same services or treatments that would be covered if you were receiving standard cancer treatment. Benefits also include FDA-approved prescription drugs that are not paid for by the manufacturer, distributor, or provider of the drug. (Member cost-sharing provisions described in "Prescription Drugs and Other Items" will apply to these benefits.)

If benefits for services provided in the trial are denied, you may contact the Superintendent of Insurance for an expedited appeal.

Dialysis

This plan covers the following services when received from a dialysis provider in a facility or, when **prior approval** is received from BCBSNM, in your home:

- renal dialysis (hemodialysis)
- continual ambulatory peritoneal dialysis (CAPD)
- apheresis and plasmapheresis
- the cost of equipment rentals and supplies for home dialysis

Short-Term Rehabilitation (Occupational, Physical, and Speech Therapy - Inpatient and Outpatient, Including Skilled Nursing Facility)

Home-based services — Physical rehabilitation services received in the home but not connected to a formal home health or hospice care treatment plan. (See "Home Health Care/Home I.V. Services" or "Hospice Care" if applicable.)

Short-term rehabilitation — A term used to describe inpatient and outpatient occupational, physical, and speech therapy techniques that are medically necessary to restore and improve lost bodily functions following illness or injury. Short-term rehabilitation does not include chemical dependency rehabilitation.

Prior Approval Required — To be covered, all outpatient, office, and home-based short-term rehabilitation treatments must receive **prior approval** from BCBSNM and be received from a **preferred provider**. Short-term rehabilitation required due to reinjury or aggravation of an injury is also covered but must receive a separate **prior approval** from BCBSNM, even if therapy was authorized for the original injury. **Remember:** All inpatient admissions, including admissions into a skilled nursing facility, require admission approval or benefits for covered services may be reduced by $300.

Covered Services — This plan covers the following short-term rehabilitation services when prescribed and/or provided by a **preferred provider** for the medically necessary treatment of accidental injury or illness:

- occupational therapy performed by a licensed occupational therapist
- physical therapy performed by a physician, licensed physical therapist, or other professional provider licensed as a physical therapist (such as a doctor of oriental medicine or chiropractor)
- speech therapy, including audio diagnostic testing, performed by a properly accredited speech therapist for the treatment of communication impairment or swallowing disorders caused by disease, trauma, congenital anomaly, or a previous treatment or therapy
- inpatient physical rehabilitation and skilled nursing facility services

Benefit Limits — Benefits for all inpatient, outpatient, office, and home-based services combined are limited as specified on the *Summary of Benefits*.

Conditions of Coverage — To be eligible for benefits, therapies must meet the following conditions:

- Services must be received from **preferred** providers and **prior-approved** by BCBSNM.
- There is a documented condition or delay in recovery that can be expected to measurably improve with therapy within two months of beginning active therapy.
- Improvement would not normally be expected to occur without intervention.

Exclusions

This plan does **not** cover:

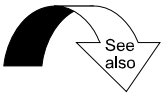
- long-term therapies, maintenance therapy, or care provided after you have reached your rehabilitative potential (Therapies are long-term if measurable improvement is not possible within two months of beginning active therapy.

This plan does **not** cover long-term therapy even if you have not yet used or exhausted maximum benefits. Also, if you have not reached your rehabilitative potential, this plan does **not** cover services that exceed maximum benefit limits. See the "Long-Term or Maintenance Therapy" exclusion in *Section 4.)*

- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay (Chronic conditions are conditions such as, but not limited to, autism, Down's Syndrome, and developmental delays. See "Early Developmental Delay and Disability" for reimbursement of certain services provided to eligible children by the Department of Health.)
- diagnostic, therapeutic, rehabilitative, or health maintenance services provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered provider
- therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights)
- private room expenses
- speech therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic; other speech services that can be carried out by the patient, the family, or caregiver/teacher
- herbs, homeopathic preparations, or nutritional supplements
- services of a massage therapist or rolfing

See Section 4: General Limitations and Exclusions

Supplies, Equipment, and Prosthetics



For contraceptive devices, see "Family Planning and Infertility-Related Services."
For diabetic supplies such as needles, syringes, and test strips, see "Prescription Drugs and Other Items."
*For supplies or equipment used during an inpatient or outpatient stay, see "Hospital/Other Facility Services." (Supplies or equipment that are dispensed by a facility for use outside of the facility **are** subject to the provisions of this "Supplies, Equipment, and Prosthetics" section.)*

If you have a question about durable medical equipment, supplies, prosthetics, or appliances not listed, please call the BCBSNM Health Services Department.

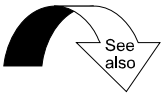
Prior approval from BCBSNM is required for:

- **specific items** listed in this section
- **long-term rental** of an item
- when total charges for an item equal **$500** or more *(Total charges* means either the total purchase price of the item or total rental charges for the estimated period of use.)

Diabetic Supplies and Equipment — Under this provision, this plan covers the following supplies and equipment for diabetic members and individuals with elevated blood glucose levels due to pregnancy (supplies are not to exceed a **30-day supply** purchased during any 30-day period) **Note:** Needles, syringes, and test strips are covered; see "Prescription Drugs and Other Items" for more information:

- insulin pump supplies
- injection aids, including those adaptable to meet the needs of the legally blind
- insulin pumps if **prior approval** is received from BCBSNM
- blood glucose monitors, including those for the legally blind

- medically necessary podiatric appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics that have been **prior-approved** by BCBSNM, custom molded inserts, replacement inserts, preventive devices, and shoe modifications



Reminder: Prior approval is required for items costing over $500 or requiring long-term rental. For additional diabetic supply coverage (e.g., insulin needles and syringes, autolet, test strips for glucose monitors, glucagon emergency kits), see "Prescription Drugs and Other Items." **Note:** The plan will also cover items not specifically listed as covered when new and improved equipment, appliances, and prescription drugs for the treatment and management of diabetes are approved by the United States Food and Drug Administration. This plan will: 1) maintain an adequate formulary to provide these resources to individuals with diabetes; and 2) guarantee reimbursement or coverage for the equipment, appliances, prescription drugs, insulin, or supplies described in this booklet within the limits of this plan.

Durable Medical Equipment and Appliances — This plan covers the following items **(prior approval is required for items costing over $500 or requiring long-term rental):**

- orthopedic appliances **(prior approval** is required, regardless of total cost)
- replacement of items only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- oxygen and oxygen equipment, wheelchairs, hospital beds, crutches, and other necessary durable medical equipment
- lens implants for aphakic patients (those with no lens in the eye) and soft lenses or sclera shells (white supporting tissue of eyeball)
- sphygmomanometer/blood pressure apparatus with cuff and stethoscope or automatic blood pressure monitor
- either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) when necessary to replace lenses absent at birth or lost through cataract or other intraocular surgery or ocular injury, to treat conditions related to genetic inborn errors of metabolism, or prescribed by a physician as the only treatment available for keratoconus (Duplicate glasses/lenses are not covered. Replacement is covered only if a physician or optometrist recommends a change in prescription due to a change in your medical condition.)
- cardiac pacemakers
- the rental of (or at the option of BCBSNM, the purchase of) durable medical equipment (including repairs to such purchased items), when prescribed by a covered health care provider and required for therapeutic use

Note: Benefits for durable medical equipment received from a **nonpreferred** provider are limited each year to the amount indicated on the *Summary of Benefits*. (The limitation does not apply to oxygen or oxygen equipment.) Benefits for durable medical equipment received from a preferred provider are not limited.

Medical Supplies — This plan covers the following medical supplies, not to exceed a **30-day supply** purchased during any 30-day period:

- colostomy bags, catheters
- gastrostomy tubes
- hollister supplies
- tracheostomy kits, masks
- lamb's wool or sheepskin pads
- ace bandages, elastic supports when billed by a physician or other provider during a covered office visit
- slings

Orthotics and Prosthetic Devices — When medically necessary and ordered by a provider, this plan covers the following items:

- surgically implanted prosthetics or devices, including penile implants required as a result of illness or injury, if **prior approval** for such items is received from BCBSNM
- externally attached prostheses to replace a limb or other body part lost after accidental injury or surgical removal; their fitting, adjustment, repairs, and replacement
- replacement of items only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- breast prosthetics when required as the result of a mastectomy and up to **four** mastectomy bras per calendar year
- functional orthotics only for patients having a locomotive problem or gait difficulty resulting from mechanical problems of the foot, ankle, or leg (A functional orthotic is used to control the function of the joints and is covered only when **prior-approved by BCBSNM** and prescribed by a physician or podiatrist.)
- up to **six pair** of support hose/calendar year when prescribed by a physician

When alternative prosthetic devices are available, the allowance for a prosthesis will be based upon the least costly item.

Note: Benefits for orthotics and prosthetics received from a nonpreferred provider are limited each year to the amount indicated on the *Summary of Benefits*. (The limitation does not apply to breast prosthetics.) Benefits for prosthetics and orthotics received from a preferred provider are not limited.

Exclusions — This plan does **not** cover, regardless of therapeutic value, items such as, but not limited to:

- air conditioners, biofeedback equipment, humidifiers, purifiers, self-help devices, or whirlpools
- items that are primarily nonmedical in nature such as Jacuzzi units, hot tubs, exercise equipment, heating pads, hot water bottles, or diapers
- nonstandard or deluxe equipment, such as motor-driven wheelchairs, chairlifts, or beds; external prosthetics that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing
- repairs to items that you do not own
- comfort items such as bedboards, beds or mattresses of any kind, bathtub lifts, overbed tables, or telephone arms
- repair costs that exceed the rental price of another unit for the estimated period of need, or repair or rental costs that exceed the purchase price of a new unit

- dental appliances (See "Dental-Related/TMJ Services and Oral Surgery" for exceptions.)
- accommodative orthotics (deal with structural abnormalities of the foot, accommodate such abnormalities, and provide comfort, but do not alter function)
- orthopedic shoes, unless joined to braces (Diabetic members may be eligible to receive benefits for these items. Call BCBSNM Health Services for details.)
- equipment or supplies not ordered by a health care provider, including items used for comfort, convenience, or personal hygiene
- duplicate items; repairs to duplicate items; or the replacement of items because of loss, theft, or destruction
- voice synthesizers or other communication devices
- eyeglasses or contact lenses or the costs related to prescribing or fitting of glasses or contact lenses, unless listed as covered; sunglasses, special tints, or other extra features for eyeglasses or contact lenses
- hearing aids or ear molds, fitting of hearing aids or ear molds, or related services or supplies (For surgically implanted devices for the profoundly hearing impaired, see "Surgery and Related Services.")
- syringes or needles for self-administering drugs (Coverage for insulin needles and syringes and other diabetic supplies not listed as covered in this section is described under "Prescription Drugs and Other Items.")
- items that can be purchased over-the-counter, including but not limited to dressings for bed sores and burns, gauze, and bandages
- contraceptive devices that do not require a prescription, including over-the-counter contraceptive products such as condoms and spermicide
- items not listed as covered
- costs for items received from a nonpreferred provider that exceed the maximum benefit listed on the *Summary of Benefits*

See Section 4: General Limitations and Exclusions

Surgery and Related Services

Surgical services — Any of a variety of technical procedures for treatment or diagnosis of anatomical disease or injury including, but not limited to: cutting; microsurgery (use of scopes); laser procedures; grafting, suturing, castings; treatment of fractures and dislocations; electrical, chemical, or medical destruction of tissue; endoscopic examinations; anesthetic epidural procedures; other invasive procedures. Benefits for surgical services also include usual and related local anesthesia, necessary assistant surgeon expenses, and pre- and post-operative care, including recasting.

For accidental injuries to the jaws, mouth, or teeth, oral surgery, or treatment of TMJ disorders or injuries, see "Dental-Related/TMJ Services and Oral Surgery."

If applicable, also see these topics:
"Hospital/Other Facility Services"
"Family Planning and Infertility-Related Services" for surgical sterilization and limited infertility-related treatments
"Transplant Services"

You are responsible for obtaining admission review and/or other prior approval when necessary (see *Section 2*).

Surgeon's Services

Covered services include surgeon's charges for a covered surgical procedure.

Cochlear Implants — This plan covers cochlear implantation of a hearing device (such as an electromagnetic bone conductor) to facilitate communication for the profoundly hearing impaired, including training to use the device. You must submit a **written request for prior approval** to BCBSNM before treatment begins. This plan does not cover cochlear implant services without prior approval.

Mastectomy Services — This plan covers medically necessary hospitalization related to a covered mastectomy (including at least 48 hours of inpatient care following a mastectomy and 24 hours following a lymph node dissection).

This plan also covers cosmetic breast surgery, when **prior-approved** by BCBSNM and received **within 12 months** of a mastectomy for breast cancer (unless a later procedure is approved as medically appropriate by BCBSNM). Coverage is limited to:

- cosmetic surgery of the breast/nipple on which the mastectomy was performed, including tattooing procedures; and
- the initial surgery of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications following the mastectomy, including treatment of lymphedema.

This plan does **not** cover subsequent procedures to correct unsatisfactory cosmetic results attained during the initial breast/nipple surgery or tattooing, or breast surgery that has not received prior approval from BCBSNM.

Reconstructive Surgery — Reconstructive surgery improves or restores bodily function to the level experienced before the event that necessitated the surgery, or in the case of a congenital defect, to a level considered normal. Such surgeries may have a coincidental cosmetic effect. This plan covers reconstructive surgery when required to correct a **functional** disorder caused by:

- an accidental injury
- a disease process or its treatment (For breast surgery following a mastectomy, see "Mastectomy Services," above.)
- a functional congenital defect (any condition, present from birth, that is significantly different from the common form; for example, a cleft palate or certain heart defects)

You or your physician must obtain **prior approval, requested in writing,** from BCBSNM **before** the reconstructive service is provided. If the procedure (including any reconstructive service listed under "Dental-Related/TMJ Services and Oral Surgery") has not received prior approval, **the surgery and all related charges will be denied.** Cosmetic procedures and procedures that are not medically necessary, including all services related to such procedures, will also be **denied.**

Exclusions — This plan does **not** cover:

- cosmetic or plastic surgery or procedures, such as breast augmentation, rhinoplasty, and surgical alteration of the eye that does not materially improve the physiological function of an organ or body part (unless covered under "Mastectomy Services," on the previous page)
- procedures to correct cosmetically unsatisfactory surgical results or surgically induced scars
- refractive keratoplasty, including radial keratotomy, or any procedure to correct visual refractive defect
- unless required as part of medically necessary diabetic disease management, trimming of corns, calluses, toenails, or bunions (except surgical treatment such as capsular or bone surgery)
- sex change operations or complications arising from transsexual surgery
- subsequent surgical procedures needed because you did not comply with prescribed medical treatment or because of a complication from a previous noncovered procedure (such as a noncovered organ transplant, sex change operation, or previous cosmetic surgery)
- any reconstructive procedure, orthognathic surgery, cochlear implant, breast reduction, orthotripsy, cosmetic breast surgery following a mastectomy, or any other procedure that could be considered cosmetic that has not received prior approval from BCBSNM (Remember: Breast surgery following a mastectomy, described under "Mastectomy Services" on the previous page, is the only cosmetic procedure covered under this plan.)
- the insertion of artificial organs, or services related to transplants not specifically listed as covered under "Transplant Services"
- standby services unless the procedure is identified by BCBSNM as requiring the services of an assistant surgeon and the standby physician actually assists

Anesthesia Services

This plan covers necessary anesthesia services, including acupuncture used as an anesthetic, when administered during a covered surgical procedure by a physician, certified registered nurse anesthetist (CRNA), a licensed doctor of oriental medicine (for acupuncture), or other practitioner as required by law. (See "Rehabilitation and Other Therapy" for information about acupuncture benefits.)

Exclusions — This plan does **not** cover local anesthesia. (Coverage for surgical procedures includes an allowance for local anesthesia because it is considered a routine part of the surgical procedure.)

Assistant Surgeon Services

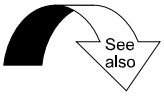
Covered services include services of a professional provider who actively assists the operating surgeon in the performance of a covered surgical procedure when the procedure requires an assistant.

Exclusions — This plan does **not** cover:

- services of an assistant only because the hospital or other facility requires such services
- services performed by a resident, intern, or other salaried employee or person paid by the hospital
- services of more than one assistant surgeon unless the procedure is identified by BCBSNM as requiring the services of more than one assistant surgeon

Transplant Services

Transplant-related services — Any hospitalizations and medical or surgical services related to a covered transplant or retransplant, and any subsequent hospitalizations and medical or surgical services related to a covered transplant or retransplant, and received within one year of the transplant or retransplant.



Covered cardiac surgeries, such as valve replacements and pacemaker insertions, are covered under "Surgery and Related Services."

Also see other subheadings in this section, such as "Hospital/Other Facility Services."

Prior Approval Required — **Prior approval, requested in writing,** must be obtained from BCBSNM **before** a pretransplant evaluation is scheduled. A pretransplant evaluation is **not** covered if prior approval is not obtained from BCBSNM. If approved, a BCBSNM case manager will be assigned to you (the transplant recipient candidate) and must later be contacted with the results of the evaluation.

If you are approved as a transplant recipient candidate, you must ensure that **prior approval** for the actual transplant is also received. None of the benefits described here are available unless you have this prior approval.

Facility Must Be in the Transplant Network — Benefits for covered services will be approved only when the transplant is performed at a facility that contracts with BCBSNM, another Blue Cross Blue Shield (BCBS) Plan, or the national BCBS transplant network, for the transplant being provided. Your BCBSNM case manager will assist your provider with information on the exclusive network of contracted facilities and required approvals. Call BCBSNM Health Services for information on these BCBSNM transplant programs.

Effect of Medicare Eligibility on Coverage — If you are now eligible for — or are *anticipating* receiving eligibility for — Medicare benefits, **you** are solely responsible for contacting Medicare to ensure that the transplant will be eligible for Medicare benefits.

Organ Procurement or Donor Expenses — If a transplant is covered, the surgical removal, storage, and transportation of an organ acquired from a cadaver is also covered. If there is a living donor that requires surgery to make an organ available for a covered transplant, coverage is available for expenses incurred by the donor for surgery, organ storage expenses, and inpatient follow-up care only.

This plan does **not** cover donor expenses after the donor has been discharged from the transplant facility. Coverage for compatibility testing prior to organ procurement is limited to the testing of cadavers and, in the case of a live donor, to testing of the donor selected.

Bone Marrow, Cornea, or Kidney

This plan covers the following transplant procedures if **prior approval** is received from BCBSNM:

- bone marrow transplant for a member with aplastic anemia, leukemia, severe combined immunodeficiency disease (SCID), or Wiskott-Aldrich syndrome, and other conditions determined by BCBSNM to be medically necessary and not experimental, investigational, or unproven
- cornea transplant
- kidney transplant

Covered services related to the above transplants are subject to the usual cost-sharing features and benefit limits of this plan (e.g., deductible, coinsurance, and out-of-pocket limits; annual home health care maximums).

Reminder: A transplant received at a facility that does not directly or indirectly contract with BCBSNM to provide transplant services is not covered.

Heart, Heart-Lung, Liver, Lung, Pancreas-Kidney

This plan also covers transplant-related services for a **heart, heart-lung, liver, lung, or pancreas-kidney** transplant. Services must be **prior-approved** in order to be covered. Also, all other limitations, requirements, and exclusions of this "Transplant Services" provision apply to these transplant-related services. In addition, the following provisions apply to this coverage for one year following the date of the actual transplant or retransplant. After one year, usual plan benefits apply and the services must be covered under other provisions of the plan in order to be considered for benefit payment:

Recipient Travel and Per Diem Expenses — If BCBSNM requires you (i.e., the transplant recipient) to temporarily relocate outside of your city of residence to receive a covered transplant, travel to the city where the transplant will be performed is covered. Also, a standard per diem benefit **($125)** will be allocated for food and lodging expenses for one additional adult traveling with you (the transplant recipient). If the transplant recipient is a dependent child under the age of 18, this plan covers travel and per diem expenses for **two** adults to accompany the child.

Travel expenses and standard per diem allowances are limited to a total combined lifetime maximum benefit of **$10,000** per transplant. Your case manager may approve travel and per diem food and lodging allowances based upon the total number of days of temporary relocation, up to the maximum $10,000 benefit.

Travel expenses are **not** covered and per diem allowances are **not** paid if you *choose* to travel to receive a transplant for which travel is not considered medically necessary by the case manager or if the travel occurs more than five days before or more than one year following the transplant or retransplant date.

Reminder: A transplant received at a facility that does not contract directly or indirectly with BCBSNM to provide transplant services is not covered.

Transplant Exclusions

This plan does **not** cover:

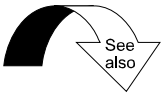
- any transplant or organ-combination transplant not listed as covered
- implantation of artificial organs or devices (mechanical heart); nonhuman organ transplants
- care for complications of noncovered transplants or follow-up care related to such transplants
- services related to a transplant that did not receive prior approval from BCBSNM
- services related to a transplant performed in a facility not contracted directly or indirectly with BCBSNM to provide the required transplant
- expenses incurred by a member of this plan for the donation of an organ to another person
- drugs that are self-administered or for use while at home (These services may be covered under "Prescription Drugs and Other Items.")
- donor expenses after the donor has been discharged from the transplant facility
- lodging, food, beverage, or meal expenses that are not covered by the per diem allowance, if available
- travel or per diem expenses:
  - incurred more than five days before or more than one year following the date of transplantation
  - if the recipient's case manager indicates that travel is not medically necessary
  - related to a bone marrow, cornea, or kidney transplant
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; telephone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- expenses charged only because benefits are available under this provision (such as transportation received from a member of your family, or from any other person charging for transportation that does not ordinarily do so)

See Section 4: General Limitations and Exclusions

4 General Limitations and Exclusions

These general limitations and exclusions apply to **all** services listed in this benefit booklet. *General Limitations and Exclusions* do not apply to services covered under the FIT program (see *Section 6)* that are provided to eligible children when not in excess of the maximum annual DOH reimbursement for such services.

This plan does not cover any service or supply not specifically listed as a covered service in this benefit booklet. If a service is not covered, then all services performed in conjunction with it are not covered.



Also see Section 3: Covered Services for specific benefit limits and exclusions.

This plan will not cover any of the following services, supplies, situations, or related expenses:

Alcoholism or Drug Abuse Rehabilitation — **This plan does not cover** services related to the rehabilitation from the effects of alcoholism or other substance or drug dependency.

Before Effective Date of Coverage — **This plan does not cover** any service received, item purchased, prescription filled, or health care expense incurred before your effective date of coverage. If you are an inpatient when coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date.

Biofeedback — **This plan does not cover** services related to biofeedback.

Blood Services — **This plan does not cover** directed donor or autologous blood storage fees when the blood is used during a nonscheduled surgical procedure. **This plan does not cover** blood replaced through donor credit.

Complications of Noncovered Services — **This plan does not cover** any services, treatments, or procedures required as the result of complications of a noncovered service, treatment, or procedure (e.g., due to a noncovered sex change operation, cosmetic surgery, transplant, or experimental procedure).

Convalescent Care or Rest Cures — **This plan does not cover** convalescent care or rest cures.

Cosmetic Services — Cosmetic surgery is beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic. **This plan does not cover** cosmetic surgery, services, or procedures

See additional exclusions related to specific types of covered services in *Section 3.*

for psychiatric or psychological reasons, or to change family characteristics or conditions caused by aging. **This plan does not cover** services related to or required as a result of a cosmetic service, procedure, or surgery, or subsequent procedures to correct unsatisfactory cosmetic results attained during an initial surgery.

Examples of cosmetic procedures are: dermabrasion; revision of surgically induced scars; breast augmentation; rhinoplasty; surgical alteration of the eye; correction of prognathism or micrognathism; excision or reformation of sagging skin on any part of the body including, but not limited to, eyelids, face, neck, abdomen, arms, legs, or buttock; services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body including, but not limited to, breast, face, lips, jaw, chin, nose, ears, or genitals; or any procedures that BCBSNM determines are not required to materially improve the physiological function of an organ or body part.

Exception: Cosmetic breast/nipple surgery required due to a mastectomy that occurred less than **12 months** before the planned cosmetic procedure may be covered. However, **prior approval, requested in writing,** must be obtained from BCBSNM for such services. Also, prior-approved reconstructive surgery, which may have a coincidental cosmetic effect, may be covered when required as the result of accidental injury, illness, or congenital defect. See *Section 3*.

Custodial Care — **This plan does not cover** custodial care, or care in a place that is primarily your residence when you do not require skilled nursing. **This plan does not cover** services to assist in activities of daily living (such as sitter's or homemaker's services), or services not requiring the continuous attention of skilled medical or paramedical personnel, regardless of where they are furnished or by whom they were recommended.

Dental-Related/TMJ Services and Oral Surgery — In addition to services excluded by the other general limitations and exclusions listed throughout this *Section 4,* see "Dental-Related/TMJ Services and Oral Surgery" in *Section 3* for additional exclusions.

Domiciliary Care — **This plan does not cover** domiciliary care or care provided in a residential institution, treatment center, halfway house, or school because your own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Duplicate (Double) Coverage — **This plan does not cover** amounts already paid by other valid coverage. See *Section 5* for more information. Also, if your prior coverage has an extension of benefits provision, **this plan will not cover** charges incurred after your effective date under this plan that are covered under the prior plan's extension of benefits provision.

Duplicate Testing — **This plan does not cover** duplicative diagnostic testing or overreads of laboratory, pathology, or radiology tests.

See additional exclusions related to specific types of covered services in *Section 3.*

Experimental, Investigational, or Unproven Services — **This plan 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.
- Reliable evidence shows that the treatment, device, drug, or medicine is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.
- 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 literature; the written protocol or protocols used by the treating facility, or the protocol(s) of another facility studying substantially the same medical treatment, procedure, device, or drug; or the written informed consent used by the treating facility or by another facility studying substantially the same medical treatment, procedure, device, or drug. *Experimental* or *investigational* does not mean cancer chemotherapy or other types of therapies that are the subjects of ongoing phase IV clinical trials.

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 were performed; and
- the physician or other professional provider has had the appropriate training and experience to provide the treatment or procedure.

Food or Lodging Expenses — **This plan does not cover** food or lodging expenses, except for those that are eligible for a per diem allowance under the

See additional exclusions related to specific types of covered services in *Section 3.*

"Transplant Services" provision in *Section 3* and not excluded by any other provision in this *Section 4*.

Genetic Counseling or Testing — **This plan does not cover** services related to genetic counseling and testing (e.g., amniocentesis, ultrasound, or any other tests to determine, for example, the sex or physical characteristics of an unborn child).

Hair Loss Treatments **— This plan does not cover** wigs, artificial hairpieces, hair transplants or implants, or medication used to promote hair growth or control hair loss, even if there is a medical reason for hair loss.

Hearing Exams, Procedures, and Aids — **This plan does not cover** audiometric (hearing) tests unless 1) required for the diagnosis and/or treatment of an accidental injury or an illness, or 2) covered as a preventive *screening* service for children through age 17. (A screening does *not* include a hearing test to determine the amount and kind of correction needed.) **This plan does not cover** hearing aids and ear molds, fitting of hearing aids or ear molds, or any related service or supply. (For surgically implanted devices, see "Surgery and Related Services" in *Section 3*.)

Home Health, Home I.V., and Hospice Services — In addition to services excluded by the other general limitations and exclusions listed throughout this *Section 4,* see "Home Health Care/Home I.V. Services" or "Hospice Care" in *Section 3* for additional exclusions.

Hypnotherapy — **This plan does not cover** hypnosis or services related to hypnosis, whether for medical or anesthetic purposes.

Infertility Services/Artificial Conception — **This plan does not cover** services related to, but not limited to, procedures such as: artificial conception or insemination, fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such as in-vivo or in-vitro ("test tube") fertilization, Gamete Intrafallopian Transfer (GIFT) or Zygote Intrafallopian Transfer (ZIFT), embryo transfer, drugs for induced ovulation, or other artificial methods of conception. **This plan does not cover** the cost of donor sperm, costs associated with the collection, preparation, or storage of sperm for artificial insemination, or donor fees.

This plan does not cover infertility testing, treatments, or related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization. **This plan does not cover** reversal of a prior sterilization procedure. (Certain treatments of medical conditions that sometimes result in restored fertility may be covered; see "Family Planning and Infertility-Related Services" in *Section 3*.)

Late Claims Filing — **This plan does not cover** services of a nonparticipating provider if the claim for such services is received by BCBSNM more than **12 months** after the date of service. (Preferred providers and providers that have a "participating" provider agreement with BCBSNM will file claims for you and must submit them within a specified period of time, usually within 90 days.) See "Filing Claims" in *Section 6* for details.

See additional exclusions related to specific types of covered services in *Section 3.*

Learning Deficiencies/Behavioral Problems — **This plan does not cover** special education, counseling, therapy, diagnostic testing, treatment, or any other service for learning deficiencies or chronic behavioral problems, whether or not associated with a manifest mental disorder, retardation, or other disturbance. (See "Early Developmental Delay and Disability" in *Section 6* for reimbursement of certain services provided to eligible children by the Department of Health.)

Limited Services/Covered Charges — **This plan does not cover** amounts in excess of covered charges or services that exceed any maximum benefit limits listed in this benefit booklet, or any amendments, riders, addenda, or endorsements.

Local Anesthesia — **This plan does not cover** local anesthesia. (Coverage for surgical, diagnostic, and other procedures includes an allowance for local anesthesia because it is considered a routine part of the procedure.)

Long-Term or Maintenance Therapy — **This plan does not cover** long-term therapy, even if medically necessary and even if any applicable benefit maximum has not yet been reached. (Therapies are considered long-term if measurable improvement is not possible within two months of beginning active therapy.) **Note**: This exclusion does not apply to benefits for medication or medication management.

This plan does not cover maintenance therapy or care or any treatment that does not significantly improve your function or productivity, or care provided after you have reached your rehabilitative potential (unless therapy is covered during an approved hospice benefit period). In a dispute about whether your rehabilitative potential has been reached, you are responsible for furnishing documentation from your physician supporting his/her opinion. **Note:** Even if your rehabilitative potential has not yet been reached, **this plan does not cover** services that exceed maximum benefit limits.

Maternity Care — **This plan does not cover** maternity care, which includes any condition that is pregnancy-related, prenatal care, delivery or pregnancy termination, and postnatal care.

Medical Policy Determinations — Any technologies, procedures, or services for which medical policies have been developed by BCBSNM are either limited or excluded as defined in the medical policy (see "Medical policy" in the *Glossary).*

Medically Unnecessary Services — **This plan does not cover** services that are not medically necessary as defined in *Section 3* unless such services are specifically listed as covered (e.g., see "Preventive Services" in *Section 3*). 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. (BCBSNM, at its sole discretion, determines medical necessity.)

Mental Health Services — **This plan does not cover** any mental health services or services related to the treatment of mental illness.

See additional exclusions related to specific types of covered services in *Section 3.*

No Legal Payment Obligation — **This plan 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 plan
- services for which you have received a professional or courtesy discount
- volunteer services
- services provided by you for yourself or a covered family member, by a person ordinarily residing in your household, or by a family member
- physician charges exceeding the amount specified by CMS when primary benefits are payable under Medicare

Note: This exclusion does not apply to services received at Department of Defense facilities or covered by Indian Health Service/Contract Health Services, Medicaid, or certain services that are reimbursed to the Department of Health according to the "Early Developmental Delay and Disability" provision in *Section 6*.

Noncovered Providers of Service — **This plan does not cover** services prescribed or administered by a:

- member of your immediate family or a person normally residing in your home
- physician, other person, supplier, or facility (including staff members) that are not specifically listed as covered in this benefit booklet, such as a:
  - health spa or health fitness center (whether or not services are provided by a licensed or registered provider)
  - school infirmary
  - halfway house
  - massage therapist
  - private sanitarium
  - extended care facility or similar institution
  - residential treatment center (A residential treatment center is a facility where the primary services are the provision of room and board and constant supervision or a structured daily routine for a person who is impaired but whose condition does not require acute care hospitalization.)
  - dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group
  - pain clinic or any provider primarily in the practice of pain management or treatment

Nonmedical Expenses — **This plan does not cover** nonmedical expenses (even if medically recommended and regardless of therapeutic value), including costs for services or items such as, but not limited to:

- adoption or surrogate expenses
- educational programs such as behavior modification and arthritis classes (Some diabetic services and other educational programs may be covered; see "Preventive Services" and "Physician Visits/Medical Care" in *Section 3* for details.)
- vocational or training services and supplies
- mailing and/or shipping and handling
- modifications to home, vehicle, or workplace to accommodate medical conditions; voice synthesizers; other communication devices

See additional exclusions related to specific types of covered services in *Section 3.*

- missed appointments; "get-acquainted" visits without physical assessment or medical care; telephone consultations; provision of medical information to perform admission review or other prior approvals; filling out of claim forms; copies of medical records; interest expenses
- membership at spas, health clubs, or other such facilities
- personal convenience items such as air conditioners, humidifiers, or exercise equipment, or personal services such as haircuts, shampoos, guest meals, and television rentals
- personal comfort services, including homemaker and housekeeping services, except in association with respite care covered during a hospice admission
- immunizations or medications required for international travel
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; phone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- physicals or screening exams and immunizations given primarily for insurance, licensing, employment, camp, weight reduction programs, medical research programs, sports, or for any nonpreventive purpose
- hepatitis B immunizations when required due to possible exposure during the member's work
- court- or police-ordered services unless the services would otherwise be covered or services rendered as a condition of parole or probation
- the cost of any damages to a treatment facility that are caused by the member
- psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education

No Non-PPO Provider Benefits

Nonpreferred Provider Services — **This plan does not cover** the following services when received from a nonpreferred provider: acupuncture, spinal manipulation, outpatient cardiac and pulmonary rehabilitation, inpatient or outpatient physical therapy, preventive services, speech therapy, occupational therapy, skilled nursing facility services, and transplants.

Nonprescription Drugs **— This plan does not cover** nonprescription or over-the-counter drugs, medications, ointments, or creams, including herbal or homeopathic preparations, or prescription drugs that have over-the-counter equivalents, except for those products specifically listed as covered in "Prescription Drugs and Other Items" in *Section 3.* (Equivalents have the same strength and cause similar action on bodily tissues.)

Nutritional Supplements — **This plan does not cover** vitamins, dietary/nutritional supplements, special foods, formulas, mother's milk, or diets, unless prescribed by a physician. Such supplements must require a prescription to be covered under the "Home Health Care/Home I.V. Services" provision in *Section 3.* This plan covers other nutritional products only under specific conditions set forth under "Prescription Drugs and Other Items" in *Section 3.*

Obesity Treatment — **This plan does not cover** surgical, dietary, or medical treatment of obesity under any circumstance.

See additional exclusions related to specific types of covered services in *Section 3.*

Post-Termination Services — **This plan does not cover** any service received or item or drug purchased after your coverage is terminated, even if: 1) prior approval for such service, item, or drug was received from BCBSNM, or 2) the service, item, or drug was needed because of an event that occurred while you were covered. If you are an inpatient when coverage ends, benefits for the admission will be available only for those covered services received before your termination date.

Pre-Existing Conditions — For members who are subject to this provision, **this plan does not cover** any pre-existing conditions for up to **six months** following their effective date of coverage. See "Pre-Existing Conditions Limitation" in *Section 7*.

Prior Approval Not Obtained When Required — **This plan does not cover** certain services if you do not obtain prior approval from BCBSNM before those services are received. See "Admission Review and Other Prior Approvals" in *Section 2*.

Private Duty Nursing Services — **This plan does not cover** private duty nursing services.

Private Room Expenses — **This plan does not cover** private room expenses, unless your medical condition requires isolation for protection from exposure to bacteria or diseases (e.g., severe burns and conditions that require isolation according to public health laws). Private room charges must be **prior-approved** by BCBSNM to be covered.

Sex-Change Operations and Services — **This plan does not cover** services related to sex-change operations, reversals of such procedures, or complications arising from transsexual surgery.

Sexual Dysfunction Treatment — **This plan does not cover** services related to the treatment of sexual dysfunction.

Supplies, Equipment, and Prosthetics — In addition to services excluded by the other general limitations and exclusions listed throughout this *Section 4,* see "Supplies, Equipment, and Prosthetics" in *Section 3* for additional exclusions.

Surgery and Related Services — In addition to services excluded by the other general limitations and exclusions listed throughout this *Section 4,* see "Surgery and Related Services" in *Section 3* for additional exclusions.

Therapy and Counseling Services — **This plan does not cover** therapies and counseling programs other than the therapies listed as covered in this booklet. In addition to treatments excluded by the other general limitations and exclusions listed throughout this *Section 4,* see "Rehabilitation and Other Therapy" in *Section 3* for additional exclusions. **This plan does not cover** services such as, but not limited to:

- recreational, sleep, crystal, primal scream, sex, and Z therapies
- self-help, smoking cessation, stress management, codependency, and weight-loss programs

See additional exclusions related to specific types of covered services in *Section 3.*

- services of a massage therapist or rolfing
- transactional analysis, encounter groups, and transcendental meditation (TM); moxibustion; sensitivity or assertiveness training
- vision therapy; orthoptics
- pastoral, spiritual, religious, marital, or bereavement counseling
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this plan
- therapy for chronic conditions such as, but not limited to, cerebral palsy or developmental delay (See "Early Developmental Delay and Disability" in *Section 6* for reimbursement of certain services provided to eligible children by the Department of Health.)
- any therapeutic exercise equipment for home use (e.g., treadmill, weights)
- psychotherapy and other mental health and/or chemical dependency services

Thermography — **This plan does not cover** thermography (a technique that photographically represents the surface temperatures of the body).

TMJ/CMJ Services — **This plan does not cover** nonstandard diagnostic, therapeutic, or surgical TMJ/CMJ **treatments. This plan does not cover** orthodontic appliances and treatment, crowns, bridges, or dentures for TMJ/CMJ treatments unless required as the result of an accidental injury to the TMJ/CMJ.

Transplant Services — Please see "Transplant Services" in *Section 3* for specific transplant services that are covered and related limitations and exclusions. In addition to services excluded by the other general limitations and exclusions listed throughout this *Section 4,* **this plan does not cover** any other transplants (or organ-combination transplants) or services related to any other transplants.

Travel or Transportation — **This plan does not cover** travel expenses, even if travel is necessary to receive covered services unless such services are eligible for reimbursement under "Transplant Services" or "Ambulance Services" in *Section 3*.

Veteran's Administration Facility — **This plan does not cover** services or supplies furnished by a Veterans Administration facility for a service-connected disability or while a member is in active military service.

Vision Services — **This plan does not cover** any services related to refractive keratoplasty (surgery to correct nearsightedness) or any complication related to keratoplasty, including radial keratotomy or any procedure designed to correct visual refractive defect (e.g., farsightedness or astigmatism). **This plan does not cover** eyeglasses, contact lenses, prescriptions associated with such procedures, and costs related to the prescribing or fitting of glasses or lenses, unless listed as covered under "Supplies, Equipment, and Prosthetics" in *Section 3.* **This plan does not cover** sunglasses, special tints, or other extra features for eyeglasses or contact lenses.

See additional exclusions related to specific types of covered services in *Section 3.*

War-Related Conditions — **This plan does not cover** any service required as the result of any act of war or related to an illness or accidental injury sustained during combat or active military service.

Weight Management — **This plan does not cover** weight-loss or other weight-management programs, dietary control, or surgical or medical obesity treatment.

Work-Related Conditions — **This plan does not cover** services resulting from work-related illness or injury, or charges resulting from occupational accidents or sickness covered under:

- occupational disease laws
- employer's liability
- municipal, state, or federal law (except Medicaid)
- Workers' Compensation Act

To recover benefits for a work-related illness or injury, you must pursue your rights under the Workers' Compensation Act or any of the above provisions that apply, including filing an appeal. (BCBSNM may pay claims during the appeal process on the condition that you sign a reimbursement agreement.)

This plan does not cover a work-related illness or injury, **even if:**

- You fail to file a claim within the filing period allowed by the applicable law.
- You obtain care not authorized by Workers' Compensation insurance.
- Your employer fails to carry the required Workers' Compensation insurance. (The employer may be liable for an employee's work-related illness or injury expenses.)
- You fail to comply with any other provisions of the law.

Note: This "Work-Related Conditions" exclusion does not apply to an executive employee or sole proprietor of a professional or business corporation who has affirmatively elected not to accept the provisions of the New Mexico Workers' Compensation Act. You must provide documentation showing that you have waived Workers' Compensation and are eligible for the waiver. (The Workers' Compensation Act may also not apply if an employer has a very small number of employees or employs certain types of laborers excluded from the Act.)

See additional exclusions related to specific types of covered services in *Section 3.*

5 Coordination of Benefits/Reimbursement

Coordination of Benefits (COB)

Other valid coverage — All other group and individual (or direct-pay) insurance policies or health care benefit plans (including Medicare, but excluding Indian Health Service and Medicaid coverages), that provide payments for medical services.

For a work-related injury or condition, see the "Work-Related Conditions" exclusion in Section 4.

This plan contains a coordination of benefits (COB) provision that prevents duplication of payments. When you are enrolled in any other valid coverage, the combined benefit payments from all coverages cannot exceed 100 percent of BCBSNM's covered charges.

If you are also covered by Medicare, special COB rules may apply. Contact a Customer Service representative for more information. If you are enrolled in federal continuation coverage, coverage ends at the beginning of the month when you become entitled to Medicare or when you become insured under any other valid coverage (unless a pre-existing conditions limitation applies).

When this plan is secondary, all provisions (such as obtaining prior approval) must be followed or benefits may be denied or reduced.

The following rules determine which coverage pays first:

No COB Provision — If the other valid coverage does not include a COB provision, that coverage pays first.

Subscriber/Dependent — If a member is covered as the subscriber under one coverage and as a dependent under another, the subscriber's coverage pays first. **Exception:** If Medicare is secondary to the plan of an *active* worker covering the Medicare beneficiary as a dependent, then that plan determines its benefits first, then Medicare, and last, the plan covering the Medicare beneficiary as the subscriber.

If you have other valid group coverage *and* Medicare, contact the other carrier's customer service department to find out if the other coverage is primary to Medicare. There are many federal regulations regarding Medicare Secondary Payer provisions, and other coverage may not be subject to those provisions.

Dependent Child — For a dependent child whose parents are not separated or divorced, the coverage of the parent whose birthday falls earlier in the calendar year pays first. If the other coverage does not follow this rule, the father's coverage pays first.

Dependent Child, Parents Separated or Divorced — For a dependent child of divorced or separated parents, benefits are coordinated in the following order:

- *Court-Decreed Obligations.* Regardless of which parent has custody, if a court decree specifies which parent is financially responsible for the child's health care expenses, the coverage of that parent pays first.

- *Custodial/Noncustodial.* The plan of the custodial parent pays first. The plan of the spouse of the custodial parent pays second. The plan of the noncustodial parent pays last.
- *Joint Custody.* If the parents share joint custody, and the court decree does not state which parent is responsible for the health care expenses of the child, the plans follow the rules that apply to children whose parents are not separated or divorced.

Active/Inactive Employee — If a member is covered as an active employee under one coverage and as an inactive employee under another, the coverage through active employment pays first. (Even if a member is covered as a dependent under both coverages, the coverage through active employment pays first.) If the other plan does not have this rule and the plans do not agree on the order of benefits, the next rule applies.

Longer/Shorter Length of Coverage — When none of the above applies, the plan in effect for the longest continuous period of time pays first. (The start of a new plan does not include a change in the amount or scope of benefits, a change in the entity that pays, provides, or administers the benefits, or a change from one type of plan to another.)

COB with Medicare — This health care plan will pay secondary benefits to Medicare coverage.

Responsibility for Timely Notice

BCBSNM is not responsible for coordination of benefits if timely information is not provided.

Facility of Payment

Whenever any other plan makes benefit payments that should have been made under this plan, BCBSNM has the right to pay the other plan any amount BCBSNM determines will satisfy the intent of this provision. Any amount so paid will be considered to be benefits paid under this plan, and with that payment BCBSNM will fully satisfy its liability under this provision.

Right of Recovery

Regardless of who was paid, whenever benefit payments made by BCBSNM exceed the amount necessary to satisfy the intent of this provision, BCBSNM has the right to recover the excess amount from any persons to or for whom those payments were made, or from any insurance company, service plan, or any other organizations or persons.

Reimbursement Provision

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for covered services described in this benefit booklet, you agree:

> BCBSNM has the 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 you or your legal representative as a result of that sickness or injury, in the amount of the total covered charges for covered services for which BCBSNM provided benefits to you or your dependents.

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 you, your covered dependents or your 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.

You are 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.

6 Claims Payments and Appeals

Filing Claims

You must submit claims **within 12 months** after the date services or supplies were received. **A claim submitted more than 12 months after the service was received will not be accepted under any circumstance.** If a claim is returned for further information, resubmit it **within 45 days.**

Important Note About Filing Claims — **This section addresses the procedures for filing claims and appeals.** The instructions in no way imply that filing a claim or an appeal will result in benefit payment and do not exempt you from adhering to all of the provisions described in this benefit booklet. All claims submitted will be processed by BCBSNM according to the patient's eligibility and benefits in effect at the time services are received. Whether inside or outside New Mexico and/or the United States, you must meet all admission review and prior approval requirements or benefits may be reduced or denied as explained in *Section 2.* Covered services are the same services listed as covered in *Section 3* and all services are subject to the limitations and exclusions listed throughout this booklet.

If You Have Other Coverage — When you have other coverage that is "primary" over this plan, you need to file your claim with the other coverage first. (See *Section 5: COB and Reimbursement*.) After your other coverage (including health care insurance, dental or vision plan, Medicare, automobile or other liability insurance, Workers' Compensation, etc.) pays its benefits, a copy of their payment explanation form must be attached to the claim sent to BCBSNM or to the local BCBS Plan, as instructed under "Where to Send Claim Forms," on the next page.

If the other coverage pays benefits to you (or your family member) directly, give your provider a copy of the payment explanation so that he/she can include it with the claim sent to BCBSNM or to the local BCBS Plan. (If a nonpreferred provider does not file claims for you, attach a copy of the payment explanation to the claim that you send to BCBSNM or to the local BCBS Plan, as applicable.)

Participating and Preferred Providers

Your "preferred" provider may have two agreements with the local BCBS Plan — a preferred contract and another "participating" provider contract. Some providers have only the participating provider contract and are not considered preferred. However, all participating and preferred providers file claims with their local BCBS Plan and payment is made directly to them. Be sure that these providers know you have health care coverage administered by BCBSNM. Do **not** file claims for these services yourself.

Preferred providers (and participating providers) also have specific timely filing limits in their contracts with BCBSNM, usually 90 days. The contract language lets providers know that they may not bill the any member if they do not meet that filing limit for a service and the claim for that service is denied.

Nonparticipating Providers

A nonparticipating provider is one that has neither a preferred or a participating provider agreement. If your nonparticipating provider does not file a claim for you, submit a separate claim form for each family member as the services are received. Attach itemized bills and, if applicable, your other coverage's payment explanation, to a *Member Claim Form.* (Forms can be printed from the BCBSNM Web site or requested from a Customer Service representative.) Complete the claim form using the instructions on the form. (See special claims filing instructions for out-of-country claims under "Where to Send Claim Forms," below.)

Itemized Bills — Claims for covered services must be itemized on the provider's billing forms or letterhead stationery and must show:

- member's identification number
- member's and subscriber's name and address
- member's date of birth and relationship to the subscriber
- name, address, and tax ID or social security number of the provider
- 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)

Correctly 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. 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 or the provider.

Do not file for the same service twice unless asked to do so by a Customer Service representative. If your itemized bills include services previously filed, identify clearly the new charges that you are submitting.

All itemized bills for services received outside the United States must be translated into English before being filed with BCBSNM. (See "Where to Send Claim Forms," below, for special instructions regarding out-of-country claims.)

Reminder: If you go to a participating or preferred provider, the provider files your claims.

Where to Send Claim Forms

If your provider does not file a claim for you, you (not the provider) are responsible for filing the claim. *Member Claim Forms* are available from a BCBSNM Customer Service representative or can be printed from the BCBSNM Web site at www.bcbsnm.com. **Remember:** Participating and preferred providers will file claims for you; these procedures are used only when you must file your own claim. See "Participating and Preferred Providers," on the previous page, for more information.

Medical/Surgical Claims — When covered services are received from nonparticipating providers in New Mexico, mail the forms and itemized bills to:

Blue Cross and Blue Shield of New Mexico
P.O. Box 3235
Naperville, Il 60566-7235

Drug Plan Claims — If you purchase a prescription drug or other item covered under the drug plan from a nonparticipating pharmacy or other provider in an emergency, or if you do not have your ID card with you when purchasing a prescription or other covered item, you must pay for the prescription or item in full and then submit a claim to BCBSNM's designated drug plan administrator. **Do not send these claims to BCBSNM.** The bills or receipts must be issued by the pharmacy and must include pharmacy name and address, drug name, prescription number, and amount charged. If not included in your enrollment materials, you can obtain the name and address of the administrator and the necessary claim forms from a Customer Service representative or on the BCBSNM Web site (www.bcbsnm.com).

Outside New Mexico — Claims for covered services received outside New Mexico from a provider that does not contract directly with BCBSNM should be sent to the BCBS Plan in the state where services were received. If a provider will not file a claim for you, ask for an itemized bill, complete it the same way that you would for services received from any other nonparticipating provider, and mail both forms to the BCBS plan of that state.

Canada and Puerto Rico — Claims for covered services received in Canada or Puerto Rico should be handled the same way as is described in "Outside New Mexico," above.

Outside the United States — For covered inpatient hospital services received outside the United States (including Puerto Rico) and Canada, show your BCBSNM ID card. BCBSNM participates in a claims payment program with the Blue Cross and Blue Shield Association.

If the hospital has an agreement with the Association, the hospital files the claim for you to the appropriate Blue Cross Plan. Payment is made to the hospital by that Plan, and then BCBSNM reimburses the other Plan.

When outside the United States, bills for the following services must be submitted to BCBSNM as described under "Nonparticipating Providers," on the previous page: 1) covered services received from hospitals that do *not* contract with the Association, 2) *all* covered outpatient hospital services, and 3) *all* covered physician services. Make copies of your itemized bills and translate them into English. Submit the original itemized bills, along with the translation, to BCBSNM for benefit determination.

Claims Payment Provisions

After a claim has been processed, the subscriber will receive an *Explanation of Benefits* (EOB). The EOB indicates what charges were covered and what charges, if any, were not. **Note:** If a Qualified Child Medical Support Order (QCMSO) is in effect, the QCMSO provisions will be followed. For example, when the member is a dependent child of divorced parents, and the subscriber under this plan is the noncustodial parent, the custodial parent may submit claims and may receive the payment and the EOB.

If a Claim is Denied — If benefits are denied or only partially paid, BCBSNM will notify you of the determination. The notice to you will include: 1) the reasons for denial; 2) a reference to the health care plan provisions on which the denial is based; and 3) an explanation of how you may appeal the decision if you do not agree with the denial (see "Reconsideration Requests," later in this section).

Participating and Preferred Providers — Payments for covered services usually are sent directly to in-network (preferred or participating) providers. The EOB you receive explains the payment.

Nonparticipating Providers — If services are received from a nonparticipating provider in New Mexico, payments are usually made to the subscriber (or to the applicable alternate payee when a QCMSO is in effect). The check will be attached to an EOB that explains BCBSNM's payment. In these cases, you are responsible for arranging payment to the provider and for paying any amounts greater than covered charges plus copayments, deductibles, coinsurance, any penalty amounts, and noncovered expenses.

Accident-Related Hospital Services — If services are administered as a result of an accident, a hospital or treatment facility may place a lien upon a compromise, settlement, or judgement obtained by you when the facility has not been paid its total billed charges from all other sources.

Assignment of Benefits — BCBSNM specifically reserves the right to pay the subscriber directly and to refuse to honor an assignment of benefits in any circumstances. No person may execute any power of attorney to interfere with BCBSNM's right to pay the subscriber instead of anyone else.

BlueCard — Other Blue Cross and Blue Shield Plans outside of New Mexico ("Host Blue") may have contracts with certain providers ("Host Blue Providers") in their service area. When you receive health care services through BlueCard outside of New Mexico and from a provider which does not have a contract with BCBSNM, the amount you pay for covered services is calculated on the lower of:

- the billed charges for your covered services, or
- the negotiated price that the Host Blue passes on to BCBSNM.

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

Here's an example of how this calculation could work. Suppose you receive covered medical services for an illness while you are on vacation outside of New Mexico. You show your identification card to the provider to let him or her know that you are covered by BCBSNM. The provider has negotiated with the Host Blue a price of $80, even though the provider's standard charge for this service is $100. In this example, the provider bills the Host Blue $100. The Host Blue, in

turn, forwards the claim to BCBSNM and indicates that the negotiated price for the covered service is $80. BCBSNM would then base the amount you must pay for the service — the amount applied to your deductible, if any, and your coinsurance percentage — on the $80 negotiated price, not the $100 billed charge. So, for example, if your coinsurance is 20 percent, you would pay $16 (20 percent of $80), not $20 (20 percent of $100). You are not responsible for amounts over the negotiated price for a covered service.

Please Note: The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Look at your *Summary of Benefits* for your payment responsibilities under this plan.

Negotiated prices may be adjusted from time to time to correct for over- or underestimation of past prices. However, the amount used by BCBSNM to calculate your share of the billed amount is considered a final price. Laws in a small number of states may require the Host Blue to: 1) use another method for, or 2) add a surcharge to, your liability calculation. If any state laws mandate other liability calculation methods, including a surcharge, BCBSNM would calculate your liability for any covered services according to the applicable state law in effect when you received care.

Covered Charge — Provider payments are based upon preferred provider and participating provider agreements and covered charges as determined by BCBSNM. For services received outside of New Mexico, covered charges may be based on the local Plan practice (e.g., for out-of-state providers that contract with their local Blue Cross Blue Shield Plan, the covered charge may be based upon the amount negotiated by the other Plan with its own contracted providers). You are responsible for paying copayments, deductibles, coinsurance, any penalty amounts, and noncovered expenses. For covered services received in foreign countries, BCBSNM will use the exchange rate in effect on the date of service in order to determine billed charges.

Drug Plan Copayments — For claims submitted to the drug plan administrator for reimbursement, you are paid the **lesser** of: 1) the sum of the drug ingredient cost, the dispensing fee that would be payable to a participating pharmacy, and any sales tax minus the applicable copayment, or 2) the pharmacy's retail price minus the applicable copayment.

Early Developmental Delay and Disability — For covered dependent children under age 4 who are also eligible for services under the Department of Health's (DOH) "Family, Infant, and Toddler" (FIT) program, your BCBSNM health care plan will reimburse the DOH for certain medically necessary early intervention services that are provided as part of an individualized family service plan under the FIT program by personnel who are licensed and certified for the DOH's FIT program as defined in Title 7 Chapter 30 Part 8 Health Family & Children Health Care Services Requirements for Family Infant Toddler Early Intervention Services. The maximum reimbursement under the BCBSNM health care plan is limited to **$3,500** per year. However, amounts paid to DOH for such services are not included in any annual or lifetime benefit maximums under the health care plan. Claims for services payable to the DOH under this provision will be honored only if submitted to BCBSNM by the DOH.

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

Medicare — If you are 65 years of age or older, BCBSNM will suspend your claims until it receives a) an Explanation of Medicare Benefits (EOMB) for each claim (if you are entitled to Medicare), or b) Social Security Administration documentation showing that you are not entitled to Medicare.

Overpayments — If BCBSNM makes an erroneous benefit payment for any reason (e.g., provider billing error, claims processing error), BCBSNM may recover overpayments from you. If you do not refund the overpayment, BCBSNM reserves the right to withhold future benefits to apply to the amount that you owe BCBSNM, and to take legal action to correct payments made in error.

Reconsideration Requests

If you disagree with the denial or payment of your claim or prior approval request, you may ask for a review. Call a BCBSNM Customer Service representative for assistance. If you continue to disagree, you may ask BCBSNM for a formal review. You should send your request for review to the BCBSNM Customer Service department and, if possible, please include:

- a copy of the *Explanation of Benefits* (EOB) and/or denial letter; *and*
- copies of related medical records from your provider; *and*
- any additional information from your provider in support of your request.

The formal reconsideration request must be filed to BCBSNM within **180 days** of the date the first denial or payment notice is mailed. If you do not file the request within 180 days, you waive your right to reconsideration. BCBSNM will acknowledge receipt of the request for reconsideration. BCBSNM will review your request and give you a decision within 60 calendar days, unless you are asked for more information. If there is no change in the original decision, you are provided reasons in writing.

Arbitration

If a dispute about coverage, benefits, or handling of claims continues after the member has followed and exhausted the “Reconsideration Requests” process, the issue or claim may be submitted to arbitration upon agreement by the member. The rules for arbitration shall be the “Commercial Arbitration Rules” developed by the American Arbitration Association. You may obtain a copy of these rules from a Customer Service representative. The rules are also available from the American Arbitration Association’s Web site (www.adr.org).

Legal Action

You may not take legal action to recover benefits under this plan or make an arbitration demand against this plan until 60 days after BCBSNM has received the claim in question. Also, you may not take any legal action or make an arbitration demand after three years from the date that the claim in question must be filed with BCBSNM.

Catastrophic Events

In case of fire, flood, war, civil disturbance, court order, strike, or other cause beyond BCBSNM's control, BCBSNM may be unable to process claims or provide prior approval for services on a timely basis. If due to circumstances not within the control of BCBSNM or a network provider (such as partial or complete destruction of facilities, war, riot, disability of a network provider, or similar case), BCBSNM and the provider will have no liability or obligation if medical services are delayed or not provided. BCBSNM and its network providers will, however, make a good-faith effort to provide services.

Research Fees

BCBSNM reserves the right to charge you an administrative fee when extensive research is necessary to reconstruct information that has already been provided to you in explanations of benefits, letters, or other forms. If BCBSNM requires an independent medical examination (IME) before authorizing a service or processing a claim, BCBSNM will cover the cost of the IME. In the unlikely event that BCBSNM requires an autopsy before paying a claim, BCBSNM will pay the cost of the autopsy.

Sending Notices

All notices to you are considered to be sent to and received by you when deposited in the United States mail with first-class postage prepaid and addressed to the subscriber at the latest address on BCBSNM membership records.

7 Enrollment and Termination Information

Who Is Eligible

Member — Each enrollee (the subscriber and any eligible dependent) who is enrolled for coverage and entitled to receive benefits under this plan. Throughout this booklet, "you" and "your" refer to each member.

Subscriber — The person in whose name the contract is issued.

Eligible dependents — The subscriber's legal spouse and/or unmarried children through the end of the month in which the child becomes age 25. Once a child reaches age 25, the child is automatically removed from coverage as a dependent and rates adjusted accordingly. (An unmarried child age 25 or older who was enrolled as a dependent at the time of reaching age 25, and who is medically certified as handicapped and chiefly dependent upon the subscriber for support and maintenance, may continue to be covered beyond the age of 25 if the condition began before or during the month in which the child loses coverage due to his/her age. BCBSNM must receive written notice of the disabling condition before the end of the month in which the child reaches age 25 and the disabling condition must be certified by a physician and BCBSNM.)

Child — An unmarried dependent, which includes only the following persons:

- natural or legally adopted child of the subscriber, whether or not the subscriber is the custodial or noncustodial parent, and whether or not the child is claimed on income tax or residing in the subscriber's home (including a child for whom the subscriber is a party in a suit in which the adoption of the child by the subscriber is being sought)
- child under age 18 placed in the subscriber's home for purposes of adoption
- stepchild of the subscriber whose primary residence is the subscriber's household
- child for whom the subscriber must provide coverage because of a court order or administrative order pursuant to state law

Eligible persons can apply for coverage for self and/or eligible dependents by submitting to BCBSNM an *Application for Individual Medical Insurance and Annual Renewable Term Life Insurance* (i.e., the *"Application")* form (which includes a "Health History" section that must be completed for all applicants, unless the requirement is waived as described under "Adding Dependents"). The application(s) for coverage may or may not be accepted.

BCBSNM may require acceptable proof (such as a copy of legal adoption or legal guardianship papers or court orders) that an individual qualifies as an eligible dependent under this coverage.

Who is Not Eligible — Unless listed as an eligible dependent above, no other family member, domestic partner, common-law spouse, relative, or person is eligible for coverage as a dependent. Also, persons who are eligible for Medicare

benefits and persons age 65 and older (even if not eligible for Medicare) are **not** eligible to enroll in this plan.

Coverage Under "BlueEdge Individual for Kids" — BlueEdge Individual coverage specifically designed and rated for dependent children under age 18 is available. Children are enrolled individually in "BlueEdge Individual for Kids"; the parent or legal guardian is not covered and is not eligible for benefits under this Policy. If a child is under the age of 15, his/her parent, legal guardian, or other responsible party must submit the *Application* on the child's behalf. Also, for any child covered under "BlueEdge Individual for Kids," any obligations of the subscriber set forth in this Policy, any endorsements, addenda, or riders will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the child's behalf. *Applications* for a "Child-Only" policy will **not** be accepted for an adult child aged 18 or older. Adult children who are applying as the sole member(s) covered under a policy of insurance must apply for his/her own Individual Policy and must sign or authorize the *Application*.

If a child is enrolled in "BlueEdge Individual for Kids," no additional dependents may be added to the child's coverage. Each child must be enrolled in his/her own "BlueEdge Individual for Kids" policy. **Note:** If a child covered under "BlueEdge Individual for Kids" acquires a new dependent child of his/her own, the new dependent child may be enrolled in his/her own "BlueEdge Individual for Kids" coverage without submitting a health statement **if** application for coverage is made within 31 days of acquiring the new dependent. See "Adding a Dependent Child to Coverage," later in this section.

Once a "BlueEdge Individual for Kids" subscriber reaches age 19, the child's coverage may continue, but his/her premium will be recalculated based on regular BlueEdge Individual plan coverage rates.

When Coverage Begins

BCBSNM will determine the effective date of your and your dependents' BlueEdge Individual coverage. Coverage begins on the **later** of midnight on the effective date requested by you when you first apply or the day your *Application* is approved, whichever is later.

The following conditions must be met before BlueEdge Individual coverage can begin:

- The subscriber must be a permanent resident of New Mexico and must live in New Mexico at least six months each year; and
- Your completed *Application* and processing fee are received by BCBSNM **within 30 days** of the primary applicant's signature date.

The ID card is part of your coverage. Do not let anyone who is not named in your coverage use your card to receive benefits. If you want additional cards or need to replace a lost card, contact a Customer Service representative.

This plan does not cover any service received before the member's effective date of coverage. Also, if a member's prior coverage has an extension of benefits provision, BCBSNM will not cover charges incurred after a member's effective date under this plan that are covered under the prior plan's extension of benefits provision.

Notification of Eligibility Changes

A subscriber must notify BCBSNM **within 31 days** following any changes that may affect his/her or a dependent's eligibility by indicating such changes on an *Application*. It is also the subscriber's responsibility to notify BCBSNM of any change to a member's name or address. This form can be obtained by calling the BCBSNM Customer Service Department.

Pre-Existing Conditions Limitation

Effective date of coverage — 12:01 A.M. of the date on which a member's coverage under this plan begins.

Pre-existing condition — A physical or mental condition for which medical advice, medication, diagnosis, care, or treatment was recommended for or received by an applicant, or for which a reasonable person would have sought treatment, within the **six-month** period before his/her effective date of coverage. **Pregnancy, complications of pregnancy, pregnancy-related diagnoses, and mental health or chemical dependency services are not covered.**

No benefits are available for any pre-existing condition for **six months** after the member's effective date of coverage. All members on the Policy are subject to the "Pre-Existing Conditions Limitation," **except:**

- newborn child added to coverage within 31 days of being born to a current subscriber
- adopted child of a current subscriber (or child placed in the current subscriber's home for the purpose of adoption) added to coverage prior to or within 31 days of adoption

Reduction in Waiting Period — Your pre-existing conditions limitation waiting period may be reduced if you had previous health care coverage if similar conditions have been satisfied under any prior health insurance coverage, *and* if application for new coverage is made within 63 days following the termination of prior coverage, *and* applicable premium is paid. Proof of such prior coverage (e.g., Certificate of Creditable Coverage) is required at enrollment. BCBSNM cannot use genetic information or require genetic testing in order to determine if a condition is pre-existing or to limit or deny coverage.

Adding a Spouse to Coverage

Application for coverage of a spouse may be submitted at any time, but must always be submitted with the "Health Statement" portion completed for the spouse. Coverage may be denied. If the application for coverage is approved, you will have to pay any additional premium or, if necessary, send an updated *Bank Draft Authorization Request Form* to BCBSNM. The "Pre-Existing Conditions Limitation" will apply. **Note:** A spouse may not be added to "BlueEdge Individual for Kids" coverage.

Adding a Dependent Child to Coverage

To add a dependent child, the subscriber must:

- notify BCBSNM of the membership change;
- complete and submit a new *Application,* along with legal documentation of proof of dependency if required, and
- pay any additional premium or, if necessary, send an updated *Bank Draft Authorization Request Form* to BCBSNM.

If application is made **within 31 days** of the birth, adoption, court or administrative order, or legal guardianship as outlined below and premium received, the "Health History" section on the *Application* need not be completed to add a child to your Policy. However, if a subscriber does **not** submit an *Application* for a newly acquired dependent child and pay the required additional premium **within 31 days** of the event, the "Health Statement" portion of the *Application* requesting the change in coverage will need to be completed for the child. **The request for coverage may be denied in such cases.**

A subscriber may apply to add coverage for a newly acquired dependent child to his/her **existing** Policy **only** in the following circumstances:

Newborn Children — Application for coverage must be made for a newborn child within 31 days of birth. **Note:** If the parent of the newborn is a dependent child of the subscriber (i.e., the newborn is the grandchild of the subscriber), benefits are **not** available for the newborn.

Adopted Children — A child under age 18 placed in the subscriber's home for the purposes of adoption may be added to coverage as soon as the child is placed in the home. However, application for coverage can be made as late as 31 days following legal adoption without being considered late.

Legal Guardianship — Application for coverage must be made for a child for whom the subscriber or the subscriber's spouse becomes the legal guardian within 31 days of the court order or administrative granting guardianship.

Court Order or Administrative Order — Application for coverage must be made for a child for whom the subscriber has received a court order or administrative order requiring that he/she have financial responsibility for providing health insurance within **31 days** of receiving the court or administrative order. (If not specified in the court order or administrative order, the dependent's earliest effective date of coverage will be the date the order has been filed as public record with the State.)

Note: Unless listed as an exception under "Pre-Existing Conditions Limitation," each additional dependent added to coverage **is** subject to the pre-existing conditions limitation.

Coverage Termination

This plan does not cover services, even if prior approval for such services was received from BCBSNM, that are received after a member's coverage under this health care plan is terminated — even if the services were made necessary by an accident, illness, or other event that occurred while coverage was in effect.

When Coverage Ends

BCBSNM will not terminate coverage for any member based solely on the member's health status or health care needs. Coverage for any member (including dependents) ends at the end of the paid-to-date following the earliest of the following dates:

- when BCBSNM does not receive the **premium payment** on time or when there is a **bank draft failure** (Coverage will be suspended if premium is not paid when it is due. If premium is not received within 30 days after the premium due date, the affected member(s) will be terminated at the end of the last-paid billing period. Also, if coverage is terminated, any claims received and paid for during the 30-day grace period will be billed to the subscriber or to the parent, legal guardian, or other responsible party who applied for coverage on a "BlueEdge Individual for Kids" subscriber's behalf.)
- upon the member's **death** (If the subscriber dies, coverage for all remaining surviving eligible members under age 65 will continue under this Policy with the eldest dependent as subscriber. Coverage for such surviving dependents will terminate on the next date of termination identified as being the earliest date of termination under this provision. If there are no surviving eligible dependents, and if premium has been paid beyond the subscriber's death, a pro rata portion will be returned to the subscriber's estate. **Note:** See "How Coverage May Continue" for information about continuing BlueEdge Individual coverage.)
- when the member enters the **armed forces** except for temporary duty of 30 days or less
- on the date a member's **lifetime benefit maximum** is reached (if any)
- upon **written notice** from the subscriber of a **future** cancellation date
- on the day when there is a **material failure to abide by the rules, policies, or procedures** of this plan; or fraud or material misrepresentation affecting coverage (If a member — or the parent, legal guardian, or other responsible party who applied for coverage on behalf of a "BlueEdge Individual for Kids" subscriber — knowingly gave false material information in connection with the eligibility or enrollment of the subscriber or any of his/her dependents, BCBSNM may terminate the subscriber and his/her dependents retroactively to the date of initial enrollment. The subscriber is liable for any benefit payments made as a result of such improper actions.)
- when the member acts in a **disruptive manner** that prevents the orderly business operation of any participating provider or is dishonestly attempting to gain a financial or material advantage
- when the subscriber establishes **residency outside New Mexico** (Call a BCBSNM Customer Service representative for details on transferring coverage to the Blue Cross Blue Shield Plan in the state where the member is living.)

If BCBSNM ceases operations. BCBSNM will be obligated for services for the rest of the period for which premiums were already paid.

Except for nonpayment of premium, BCBSNM will not terminate a member's coverage without giving the member 30 days' written notice. Also, if a member's coverage is canceled (for reasons other than fraud or deception) and the subscriber had paid premium in advance on behalf of the affected member, BCBSNM will return to the subscriber, within 30 days, the appropriate pro rata portion of the premium, less any amounts due to BCBSNM.

BCBSNM may not refund membership premiums paid in advance on behalf of the removed member if:

- the *Application* is not received **within 31 days** of the change in eligibility status; or
- any claims or capitation amounts have been paid on behalf of the removed member during the period for which premiums have been paid.

Additional Dependent Termination Reasons — In addition, coverage will end for any dependent on the earliest of the above dates or the earliest of the following dates:

- on the day the dependent child marries
- at the end of the last-paid billing period for dependent coverage
- when the dependent child no longer qualifies as a dependent under the plan (e.g., a child being adopted is removed from placement in the subscriber's home or reaches age 25)
- on the date of a final divorce decree or legal separation for a dependent spouse
- when the subscriber notifies BCBSNM in writing to end coverage for a dependent

Removing a Dependent From Coverage

Note: The information in this "Removing a Dependent From Coverage" section is not applicable to the "BlueEdge Individual for Kids" coverage.

To remove a dependent from coverage, the subscriber (original primary applicant in the case of a "BlueEdge for Kids" policy) must submit a written request to BCBSNM. If a subscriber voluntarily removes a dependent from coverage before he/she becomes ineligible for coverage, the termination will be effective the first day of the monthly billing cycle following receipt of the request for the dependent's removal. These terminated dependents are eligible to **re-enroll** under the plan only if a new *Application* is completed and signed by the subscriber, and submitted to and approved by BCBSNM.

If a dependent is being removed from coverage because of losing his/her eligibility under the plan (for reasons other than reaching the dependent child age limit), BCBSNM must receive the written request **within 31 days** following the effective date of the change. In these cases, the dependent will be removed from coverage as of the change in his/her eligibility status. BCBSNM and the providers of care may recover benefits erroneously paid to the subscriber on behalf of the removed member during the period of time during which the member was ineligible.

Reinstatement

Any applicant whose previous BCBSNM contract was terminated for good cause is not eligible to re-enroll in this plan or be re-instated, unless approved in writing by BCBSNM.

When coverage lapses because the subscriber has not paid the premium, the terminated member(s) can apply for reinstatement of coverage by sending in the appropriate premium due.

If the subscriber has included the necessary payment and no more than 60 days have elapsed since termination due to nonpayment of premium, coverage will be reinstated back to the date coverage lapsed.

If more than 60 days have elapsed since coverage was terminated, the subscriber will have to complete a new *Application,* including the "Health History" portion, for each member applying for coverage. BCBSNM may accept or deny the *Application*. The subscriber will be notified within 30 days of receipt of application of acceptance or declination of reinstatement. If notice is not sent within 30 days, reinstatement will be deemed approved.

How Coverage May Continue

A dependent who involuntarily loses coverage under this plan (i.e., due to divorce, annulment, death of subscriber, legal separation, marriage, or becoming age 25 – or age 19 for children under a "BlueEdge Individual for Kids" policy) may submit an *Application* to BCBSNM to convert to his/her own BlueEdge Individual coverage. If submitted **within 31 days** of losing coverage under this plan, a health history will not be required if the *Application* is for the same deductible level.

Note: Unless a member is transferring "BlueEdge Individual for Kids" coverage to a regular BlueEdge Individual contract, any deductible or out-of-pocket expenses met by the member under the terminating BlueEdge Individual coverage will **not** be applied to the deductible or out-of-pocket expense of the new BlueEdge Individual contract.

To be eligible for continued coverage, the member must pay BlueEdge Individual coverage premiums from the date of his/her termination under the previous plan.

Continued coverage under this plan is **not** available when the terminating member is age 65 or older, eligible for Medicare benefits, or residing outside of or moving out of New Mexico. (Call a BCBSNM Customer Service representative for details on transferring coverage to the Blue Cross Blue Shield Plan in the state where the member is living.)

Medicare-eligible members may apply for BCBSNM's Medicare Supplemental coverage by calling 1-800-307-8144.

Direct-Pay Premium Payments

The required premiums are determined and established by BCBSNM based on the deductible amount and BlueEdge Individual plan option selected on the *Application*, the sex of the subscriber, his/her age, his/her place of residence, and the number of family members covered under the Policy according to the schedules filed with New Mexico Public Regulatory Commission. Premiums will be calculated based on the age of each adult (or of the child under a "BlueEdge Individual for Kids" Policy) and each dependent child to be included under this Policy.

BCBSNM will not increase your premium amount unless you add an eligible child or spouse to coverage according to the provisions set forth earlier in this section. BCBSNM may change premium amounts according to any of the following:

- changes in federal and state law, or
- changes to coverage classifications (for example, to a new age category or geographic location, or from a single dependent coverage to a two dependent coverage type), or
- after giving the subscriber 60 days' written notice.

If premium is paid beyond the effective date of the premium change, BCBSNM may require the subscriber to pay an additional premium or accept a refund (whichever is necessary).

Premium payments should be sent to:

Blue Cross and Blue Shield of New Mexico
P.O. Box 3240
Naperville, IL 60566-7240

When Premiums Are Not Paid on Time — If premiums are not paid **within 30 days** of the premium due date (for example, due to a bank draft failure), coverage under this plan will automatically terminate. Such a cancellation will be effective retroactively to the last date of the period for which the affected members' premium was paid. BCBSNM will not pay for any service provided to a member after the date of cancellation.

Refund Policy — The subscriber has the right to read this benefit booklet and if not satisfied for any reason, may return it to BCBSNM within 30 days from the date it was sent to the subscriber. BCBSNM will refund to the subscriber all premiums he/she paid for that 30-day period. However, BCBSNM has the right to recover any benefit payments made for claims during that 30-day period. Otherwise, premiums for BlueEdge Individual coverage are **not** refundable unless you have paid premiums in advance and wish to cancel coverage (with 30 days prior notice) and except in the case of the death of a member. The one-time application fee, if any, is also non-refundable.

Premium Payment Obligations — It is the subscriber's responsibility to pay premiums to BCBSNM. Under no circumstances will premium payments on behalf of the subscriber or any member be accepted from a physician, a hospital, or any other provider of the member's health care services. The receipt of a premium payment from such a provider may result in cancellation of the member's coverage.

Contracting Entity

The subscriber acknowledges his/her understanding that this policy constitutes a contract solely between the subscriber and BCBSNM, that BCBSNM is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, the Blue Cross and Blue Shield Association permitting BCBSNM to use the Blue Cross and Blue Shield Service Mark in the state of New Mexico, and that BCBSNM is not contracting as the agent of the Blue Cross and Blue Shield Association. The subscriber further acknowledges and agrees that he/she has not entered into this policy based upon representations by any other person other than BCBSNM and that no person, entity, or organization other than BCBSNM shall be held accountable or liable to the subscriber for any of BCBSNM's obligations created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of BCBSNM other than those obligations created under the provisions of this agreement.

Discontinuation of Policy

BCBSNM reserves the right to discontinue BlueEdge Individual coverage. Such discontinuation would apply to all members covered under BlueEdge Individual for HSA. The subscriber will be notified at least 30 days in advance of such discontinuation.

Membership Records

BCBSNM will keep membership records to administer the benefits of this plan. All records concerning your membership in this health care plan are available for your inspection during normal business hours given reasonable advance notice.

8 General Provisions

Application Statement

No statement (except a fraudulent statement) made by a member in any application for coverage that is more than two years old can void this coverage or be used against the member in any legal action or proceeding relating to this coverage unless the *Application* or a true copy of it is incorporated in or attached to the contract.

Any omission or misstatement of a material fact on your application will result in the cancellation or reformation of your Policy retroactive to the coverage date. In the event of such cancellation, BCBSNM will refund any premiums paid during the period for which cancellation is effected. However, BCBSNM will deduct from the premium refund any amounts made in claim payments during this period and you will be liable for any claim payment amounts greater than the total amount of premiums paid during the period for which cancellation is effected.

At any time when BCBSNM is entitled to decline to accept an application for coverage or to rescind coverage already in force, BCBSNM may at its sole option make an offer to reform the Policy being offered or already in force. In the event of reformation of a policy already in force, the Policy will be reissued in the form it would have been issued had the misstated or omitted information been known at the time of the application.

Availability of Provider Services

BCBSNM does not guarantee that a certain type of room or service will be available at any hospital or other facility within the BCBSNM network, nor that the services of a particular hospital, physician, or other provider will be available.

Changes to the Benefit Booklet

BCBSNM may amend this benefit booklet when authorized by an officer of BCBSNM. BCBSNM will give you at least 30 days' prior written notice of an amendment to this benefit booklet. No employee of BCBSNM may change this benefit booklet by giving incomplete or incorrect information, or by contradicting the terms of this benefit booklet. Any such situation will not prevent BCBSNM from administering this benefit booklet in strict accordance with its terms.

Delivery of Documents

BCBSNM will mail to the subscriber's address as listed on the *Application,* a benefit booklet setting forth the services to which members are entitled, a *Summary of Benefits,* and a BCBSNM plan identification (ID) card.

Disclaimer of Liability

BCBSNM has no control over any diagnosis, treatment, care, or other service provided to you by any facility or professional provider, whether preferred or not. BCBSNM is not liable for any loss or injury caused by any health care provider by reason of negligence or otherwise.

Disclosure and Release of Information

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

Entire Contract

This benefit booklet (and any amendments, riders, and endorsements), your enrollment *Application,* and your identification card shall constitute the entire contract. All statements, in the absence of fraud, made by any applicant shall be deemed representations and not warranties. No such statements shall void coverage or reduce benefits unless contained in a written application for coverage.

Execution of Papers

On behalf of yourself and your dependents you must, upon request, execute and deliver to BCBSNM any documents and papers necessary to carry out the provisions of this plan.

Independent Contractors

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

Member Rights and Responsibilities

a right to receive information about BCBSNM, its services, its network practitioners and providers and members' rights and responsibilities;

- a right to be treated with respect and recognition of your dignity and right to privacy;
- a right to a candid discussion with your treating provider of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage;
- a right to voice complaints or appeals about BCBSNM or the health care coverage it provides;
- a right to make recommendations regarding BCBSNM's member rights and responsibilities policies;
- a responsibility to supply information (to the extent possible) that BCBSNM and its network practitioners and providers need in order to provide care;
- a responsibility to follow plans and instructions for care that you have agreed on with your treating provider or practitioners; and
- a responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals with your treating provider or practitioner to the degree possible.

9 Glossary

It is important for you to understand the meaning of the following terms. The definition of many terms determines your benefit eligibility.

Accidental injury — A bodily injury caused solely by external, traumatic, and unforeseen means. Accidental injury does not include disease or infection, hernia, or cerebral vascular accident. Dental injury caused by chewing, biting, or malocclusion is not considered an accidental injury.

Acupuncture — The use of needles inserted into the human body for the prevention, cure, or correction of any disease, illness, injury, pain, or other condition by controlling and regulating the flow and balance of energy and functioning of the person to restore health.

Admission — The period of time between the dates a patient enters a facility as an inpatient and is discharged as an inpatient. (If you are an inpatient at the time your coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date.)

Alcoholism — A condition defined by patterns of usage that continue despite occupational, social, marital, or physical problems related to compulsive use of alcohol. There may also be significant risk of severe withdrawal symptoms if the use of alcohol is discontinued. **Note:** This plan does **not** cover services related to alcoholism rehabilitation.

Ambulance — A specially designed and equipped vehicle used **only** for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an ambulance.

Ambulatory surgical facility — An appropriately licensed provider, with an organized staff of physicians, that meets all of the following criteria:

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis; *and*
- provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility; *and*
- does not provide inpatient accommodations; *and*
- is not a facility used primarily as an office or clinic for the private practice of a physician or other provider.

Appliance — A device used to provide a functional or therapeutic effect.

Benefit booklet — This document or evidence of coverage, which explains the benefits, limitations, exclusions, terms, and conditions of your health coverage.

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; also referred to as BCBSNM.

BlueEdge Individual for Kids — BlueEdge Individual coverage specifically designed and rated for children under age 19. Children are enrolled individually in "BlueEdge Individual for Kids"; the parent or legal guardian is not covered and is not eligible for benefits under this plan. If a child is under the age of 15, his/her parent, legal guardian, or other responsible party must submit the *Application* for coverage on the child's behalf. Also, for any child covered under "BlueEdge Individual for Kids," any obligations of the subscriber set forth in this benefit booklet, any endorsements, addenda, or riders will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the child's behalf. Applications for a "Child-Only" policy will not be accepted for an adult child aged 18 or older. Adult children who are applying as the sole member(s) covered under a policy of insurance must apply for his/her own Individual policy and must sign or authorize the *Application*. See "Important Information About Children Aged 18 and Older" in *Section 7* of this benefit booklet.

Calendar year — January 1 through December 31 of the same year. The initial calendar year benefit period is from a member's effective date of coverage through December 31 of the same year, which may be less than 12 months.

Cancer clinical trial — A course of treatment provided to a patient for the prevention of reoccurrence, early detection, or treatment or palliation of cancer for which standard cancer treatment has not been effective or does not exist. It does not include trials designed to test toxicity or disease pathophysiology, but must have a therapeutic intent and be provided as part of a study being conducted in a phase II, III, or IV cancer clinical trial. The scientific study must have been approved by an institutional review board the proposed clinical trial or study has been reviewed and approved by an institutional review board that has an active federal-wide assurance of protection for human subjects, and include all of the following: the personnel specific goals, a rationale and background for the study, criteria for patient selection, specific direction for administering the therapy or intervention and for monitoring patients, a definition of quantitative measures for determining treatment response, methods for documenting and treating adverse reactions, and a reasonable expectation, based on clinical or preclinical data, that the treatment will be at least as efficacious as standard cancer treatment. The trial must have been approved by a United States federal agency; a federal national institutes of health cooperative group or center; the federal department of defense; the federal food and drug administration in the form of an investigational new drug application; the federal department of veterans affairs; or by a qualified research entity that meets the criteria established by the federal National Institutes of Health for grant eligibility. Pursuant to the patient informed consent document, no third party is liable for damages associated with the treatment provided during a phase of a cancer clinical trial.

Cardiac rehabilitation — An individualized, supervised physical reconditioning exercise session lasting from 4 – 12 weeks. Also includes education on nutrition and heart disease.

Certified nurse-midwife — A person who is licensed by the Board of Nursing as a registered nurse and who is licensed by the New Mexico Department of Health (or appropriate state regulatory body) as a certified nurse-midwife.

Certified nurse practitioner — A registered nurse whose qualifications are endorsed by the board of nursing for expanded practice as a certified nurse

practitioner and whose name and pertinent information is entered on the list of certified nurse practitioners maintained by the board of nursing.

Chemical dependency — Conditions defined by patterns of usage that continue despite occupational, marital, or physical problems that are related to compulsive use of alcohol, drugs, or other substance. Chemical dependency (also referred to as "substance abuse," which includes alcoholism and drug abuse) may also be defined by significant risk of severe withdrawal symptoms if the use of alcohol, drugs, or other substance is discontinued. **Note:** This plan does **not** cover services related to chemical dependency rehabilitation.

Chemotherapy — Drug therapy administered as treatment for malignant conditions and diseases of certain body systems.

Chiropractor — A person who is a doctor of chiropractic (D.C.) licensed by the appropriate governmental agency to practice chiropractic medicine.

Church plan — That term as defined pursuant to Section 3(33) of the federal Employee Retirement Income Security Act of 1974.

Coinsurance — The percentage of a covered charge that is your responsibility to pay. For covered services that are subject to coinsurance, you pay the percentage (indicated on the *Summary of Benefits*) of BCBSNM's covered charge after the deductible (if any) has been met.

Complications of pregnancy — Conditions such as, but not limited to, ectopic pregnancy, toxemia, abruptio placentae, missed abortion or spontaneous termination of pregnancy (miscarriage) before the 26th week of gestation; and other complications as determined by BCBSNM, such as acute nephritis, nephrosis, and cardiac decompensation. **This plan does not cover** services related to complications of pregnancy, genetic testing or counseling, elective abortions, or vaginal or cesarean deliveries.

Copayment — The fixed-dollar amount of a covered charge that you pay for prescription drugs and other items payable under the drug plan (some copayments may be based on a percentage of covered charges).

Cosmetic — See the "Cosmetic Services" exclusion in *Section 4*.

Cost effective — A procedure, service, or supply that is an economically efficient use of resources with respect to cost, relative to the benefits and harms associated with the procedure, service, or supply. When determining cost effectiveness, the situation and characteristics of the individual patient are considered.

Covered charge — The amount that BCBSNM determines is a fair and reasonable allowance for a particular covered service. After the member's share of a covered charge has been calculated, BCBSNM pays the remaining amount of the covered charge, up to maximum benefit limitations, if any. (For out-of-state providers that contract with their local Blue Cross Blue Shield Plan, the covered charge may be based upon the amount negotiated by the other Plan with its own contracted providers.) See "Claims Payment Provisions" in *Section 6*.

Covered services — Services or supplies that are listed in this benefit booklet, including any endorsements, addenda, or riders, for which benefits are provided.

Creditable coverage — Health care coverage through an employment-based group health plan; health insurance coverage; Part A or B of Title 18 of the Social Security Act (Medicare); Title 19 of the Social Security Act (Medicaid) except coverage consisting solely of benefits pursuant to section 1928 of that title; 10 USCA Chapter 55 (military benefits); a medical care program of the Indian Health Service or of an Indian nation, tribe, or pueblo; the NM Medical Insurance Pool (NMMIP) Act or similar state sponsored health insurance pool; a health plan offered pursuant to 5 USCA Chapter 89; a public health plan as defined in federal regulations, whether foreign or domestic; any coverage provided by a governmental entity, whether or not insured, a State Children's Health Insurance Program; or a health benefit plan offered pursuant to section 5(e) of the federal Peace Corps Act.

Deductible — The amount of money that you must pay in a calendar year before this plan pays benefits for all or part of your remaining covered charges incurred during the rest of the calendar year. Your individual deductible amount is indicated on your Plan ID card.

Dental-related services — Services performed for treatment of conditions related to the teeth or structures supporting the teeth.

Dentist, oral surgeon — A doctor of dental surgery (D.D.S.) or doctor of medical dentistry (D.M.D.) who is licensed to practice prevention, diagnosis, and treatment of diseases, accidental injuries, and malformation of the teeth, jaws, and mouth.

Dependent — A person entitled to apply for coverage as specified in *Section 7: Enrollment and Termination Information*.

Diagnostic services — Procedures such as laboratory and pathology tests, x-ray services, EKGs, and EEGs that do not require the use of an operating or recovery room, and that are ordered by a provider to determine a condition or disease.

Dialysis — The treatment of a kidney ailment during which impurities are mechanically removed from the body with dialysis equipment.

Doctor of oriental medicine — A person who is a doctor of oriental medicine (D.O.M.) licensed by the appropriate governmental agency to practice acupuncture and oriental medicine.

Drug abuse — A condition defined by patterns of usage that continue despite occupational, marital, or physical problems related to compulsive use of drugs or other substance. There may also be significant risk of severe withdrawal symptoms if the use of drugs is discontinued. Drug abuse does not include nicotine addiction or alcohol abuse. **Note:** This plan does **not** cover services related to drug abuse or other chemical dependency rehabilitation.

Durable medical equipment — Any equipment that can withstand repeated use, is made to serve a medical purpose, and is generally considered useless to a person who is not ill or injured.

Effective date of coverage — 12:01 A.M. of the date on which a member's coverage begins.

Emergency care — Covered services required after the sudden onset of a medical condition manifesting itself by acute symptoms that are severe enough that a reasonable person believes that immediate attention is required and that a lack of such immediate medical attention may place the person's health in jeopardy, or may result in impairment of bodily functions or dysfunction of any organ or part. Initial treatment must be sought within 48 hours of the accident or onset of symptoms to qualify as an emergency. Initial treatment must be sought within 48 hours of the accident or onset of symptoms to qualify as an emergency. If you are hospitalized within 48 hours of an emergency occurrence, the related inpatient hospitalization is considered part of the initial treatment.

Experimental, investigational, or unproven — See the "Experimental, Investigational, or Unproven Services" exclusion in *Section 4*.

Facility — A hospital (see "Hospital," on the next page) or other institution (see "Provider," later in this section).

Genetic inborn error of metabolism — A rare, inherited disorder that is present at birth; if untreated, results in mental retardation or death, and requires that the affected person consume special medical foods.

Good cause — Failure of the subscriber to pay the premiums or other applicable charges for coverage; a material failure to abide by the rules, policies, or procedures of this plan; or fraud or material misrepresentation affecting coverage.

Governmental plan — That term as defined in Section 3(32) of the federal Employee Retirement Income Security Act of 1974 and includes a federal governmental plan (a governmental plan established or maintained for its employees by the United States government or an instrumentality of that government).

Group — A bonafide employer covering employees of such employer for the benefit of persons other than the employer; or an association, including a labor union, that has a constitution and bylaws and is organized and maintained in good faith for purposes other than that of obtaining insurance.

Group health plan — An employee welfare benefit plan as defined in Section 3 (1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care and includes items and services paid for as medical care (directly or through insurance, reimbursement, or otherwise) to employees or their dependents (as defined under the terms of the plan).

Home health care agency — An appropriately licensed provider that both:

- brings skilled nursing and other services on an intermittent, visiting basis into your home in accordance with the licensing regulations for home health care agencies in New Mexico or in the state where the services are provided; *and*
- is responsible for supervising the delivery of these services under a plan prescribed and approved in writing by the attending physician.

Home health care services — Covered services, as listed under "Home Health Care/Home I.V. Services" in *Section 3,* that are provided in the home according to a treatment plan by a certified home health care agency under active physician and nursing management. Registered nurses must coordinate the services on behalf of the home health care agency and the patient's physician.

Hospice — A licensed program providing care and support to terminally ill patients and their families. An approved hospice must be licensed when required, Medicare-certified as, or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as, a hospice.

Hospice benefit period — The period of time during which hospice benefits are available. It begins on the date the attending physician certifies that the member is terminally ill and ends six months after the period began (or upon the member's death, if sooner). The hospice benefit period must begin while the member is covered for these benefits, and coverage must be maintained throughout the hospice benefit period.

Hospice care — An alternative way of caring for terminally ill individuals in the home or institutional setting, which stresses controlling pain and relieving symptoms but does not cure. Supportive services are offered to the family before the death of the patient.

Hospital — A health institution offering facilities, beds, and continuous services 24 hours a day, 7 days a week. The hospital must meet all licensing and certification requirements of local and state regulatory agencies. Services provided include:

- diagnosis and treatment of illness, injury, deformity, abnormality, or pregnancy
- clinical laboratory, diagnostic x-ray, and definitive medical treatment provided by an organized medical staff within the institution
- treatment facilities for emergency and surgical services either within the institution or through a contractual arrangement with another licensed hospital (These contracted services must be documented by a well-defined plan and related to community needs.)

A hospital is not, other than incidentally, a skilled nursing facility, nursing home, custodial care home, health resort, spa, or sanatorium; is not a place for rest, the aging, or the treatment of mental illness, alcoholism, drug abuse, or pulmonary tuberculosis; ordinarily does not provide hospice or rehabilitation care; and is not a residential treatment facility.

Identification card (ID card) — The card BCBSNM issues to the subscriber that identifies the cardholder as a BlueEdge Individual plan member.

Inpatient services — Care provided while you are confined as an inpatient in a hospital or treatment center for at least 24 hours. Inpatient hospital services include, but are not be limited to, semi-private room accommodations, general nursing care, meals and special diets or parenteral nutrition when medically necessary, physician and surgeon services, use of all hospital facilities when use of such facilities is determined to be medically necessary by your treating physician, pharmaceuticals and other medications, anesthesia and oxygen services, special duty nursing when medically necessary, radiation therapy, inhalation therapy, and administration of whole blood and blood components when medically necessary.

Investigational drug or device — For purposes of the cancer clinical trial benefit described in *Section 3* under "Rehabilitation and Other Therapy," an "investigational drug or device" means a drug or device that has not been approved by the federal Food and Drug Administration.

Legal agreement — This benefit booklet (including the separately issued *Summary of Benefits)*, any amendments, endorsements, or riders, and the member's ID card.

Licensed midwife — A person who practices lay midwifery and is registered as a licensed midwife by the New Mexico Department of Health (or appropriate state regulatory body).

Licensed practical nurse (L.P.N.) — A nurse who has graduated from a formal practical nursing education program and is licensed by appropriate state authority.

Maternity — Any condition that is related to pregnancy. Maternity care includes prenatal and postnatal care, and care for the complications of pregnancy, such as ectopic pregnancy, spontaneous abortion (miscarriage), elective abortion, or Cesarean section. **Note:** This plan does **not** cover pregnancy or maternity-related services.

Medicaid — A state-funded program that provides medical care for indigent persons, as established under Title XIV of the Social Security Act of 1965, as amended.

Medical detoxification — Treatment in an acute care facility for withdrawal from the physiological effects of alcoholism or drug abuse. (Detoxification usually takes about three days in an acute care facility.)

Medical policy — A coverage position developed by BCBSNM that summarizes the scientific knowledge currently available concerning new or existing technology, products, devices, procedures, treatment, services, supplies, or drugs and used by BCBSNM to adjudicate claims and provide benefits for covered services. Medical policies are posted on the BCBSNM Web site for review or copies of specific medical policies may be requested in writing from a Customer Service representative.

Medical supplies — Expendable items (except prescription drugs), ordered by a physician or other professional provider, that are required for the treatment of an illness or injury.

Medically necessary, medical necessity — See "Medically Necessary Services" in *Section 3*.

Medicare — The program of health care for the aged, end-stage renal disease (ESRD) patients, and disabled persons established by Title XVIII of the Social Security Act of 1965, as amended.

Medicare supplemental coverage — Nongroup health care coverage that provides supplemental benefits to Medicare coverage.

Member — The enrollee who is enrolled for coverage and entitled to receive benefits under this plan. Throughout this booklet, the terms "you" and "your" refer to each member. (For any child covered under "BlueEdge Individual for Kids," any obligations of the member/subscriber set forth in this benefit booklet, any endorsements, addenda, or riders will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the child's behalf.)

Nonparticipating provider — An appropriately licensed health care provider that has not contracted directly or indirectly, for the service being provided, with BCBSNM. See your *Summary of Benefits* for those services that are not covered if received from a nonpreferred provider (all nonparticipating providers are also nonpreferred). Also, this plan does not cover transplants or related services received at a nonparticipating facility.

Nonpreferred provider — Providers that have not contracted with BCBSNM, either directly or indirectly, to be part of the "preferred" or "PPO" provider network. (These providers may have "participating" provider agreements, but are **not** considered preferred. See "Participating provider," below, for more information.) **Note:** See your *Summary of Benefits* for those services that are not covered if received from a nonpreferred provider.

Occupational therapist — A person registered to practice occupational therapy. An occupational therapist treats neuromuscular and psychological dysfunction caused by disease, trauma, congenital anomaly, or prior therapeutic process through the use of specific tasks or goal-directed activities designed to improve functional performance of the patient.

Occupational therapy — The use of rehabilitative techniques to improve a patient's functional ability to perform activities of daily living.

Optometrist — A doctor of optometry (O.D.) licensed to examine and test eyes and treat visual defects by prescribing and adapting corrective lenses and other optical aids.

Orthopedic appliance — An individualized rigid or semirigid support that eliminates, restricts, or supports motion of a weak, injured, deformed, or diseased body part; for example, functional hand or leg brace, Milwaukee brace, or fracture brace.

Outpatient services — Medical/surgical services received in the outpatient department of a hospital, observation room, emergency room, ambulatory surgical facility, freestanding dialysis facility, or other covered outpatient treatment facility. Outpatient medical services include those hospital services that can reasonably be provided on an ambulatory basis, and those preventative, medically necessary, diagnostic, and treatment procedures prescribed by your attending physician. Such services may be provided at a hospital, any other appropriate licensed facility, or at any other appropriate facility if the professional delivering the services is licensed to practice, is certified, and is practicing under authority of the health care insurer, a medical group, an independent practice association or other authority authorized by applicable New Mexico law.

Participating pharmacy — See "Provider," on the next page.

Participating provider — Any provider that, for the service being provided, contracts with BCBSNM, a BCBSNM contractor or subcontractor, another Blue Cross Blue Shield (BCBS) Plan, or the national BCBS transplant network. Your "preferred" provider may have two agreements with the local BCBS Plan — a preferred contract and another "participating" provider contract. Providers that have only the participating provider contract are **not** considered preferred providers. See "Provider," on the next page.

Physical therapist — A licensed physical therapist. Where there is no licensure law, the physical therapist must be certified by the appropriate professional body. A physical therapist treats disease or accidental injury by physical and mechanical means (regulated exercise, water, light, or heat).

Physical therapy — The use of physical agents to treat disability resulting from disease or injury. Physical agents include heat, cold, electrical currents, ultrasound, ultraviolet radiation, and therapeutic exercise.

Physician — A practitioner of the healing arts, who is also a doctor of medicine (M.D.) or osteopathy (D.O.) and who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

Podiatrist — A licensed doctor of podiatric medicine (D.P.M.). A podiatrist treats conditions of the feet.

Practitioner of the healing arts — See "Provider," below.

Pre-existing condition — A physical or mental condition for which medical advice, medication, diagnosis, care, or treatment was recommended for or received by an applicant, or for which a reasonable person would have sought treatment, within the **six-month** period before his/her effective date of coverage.

Pregnancy-related services — See "Maternity," earlier in this section. **Note:** This plan does **not** cover pregnancy or maternity-related services.

Preventive care services — Professional services rendered for the early detection of asymptomatic illnesses or abnormalities and to prevent illness or other conditions.

Prior approval — A requirement that you or your provider must obtain authorization from BCBSNM before you are admitted as an inpatient (admission review approval) and before you receive certain types of services (other prior approvals).

Prosthesis or prosthetic device — An externally attached or surgically implanted artificial substitute for an absent body part; for example, an artificial eye or limb.

Provider — A duly licensed hospital, physician, or other practitioner of the healing arts authorized to furnish health care services within the scope of licensure.

- **Health care facility:** An institution providing health care services, including a hospital or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing facility, a home health care agency, a diagnostic laboratory or imaging center, and a rehabilitation or other therapeutic health setting.
- **Physician:** A practitioner of the healing arts, who is also a doctor of medicine (M.D.) or osteopathy (D.O.) and who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.
- **Practitioner of the healing arts:** Any physician, professional provider, or other person holding a license or certificate provided for in Chapter 61, Article 4, 5, 6, or 14A NMSA 1978 authorizing the licensee to offer or undertake to diagnose, treat, operate on, or prescribe for any human pain, injury, disease, deformity or physical or mental condition. For example, a physician or other

health care practitioner, including (for example) a pharmacist, chiropractor, dentist or oral surgeon, optometrist, or registered nurse in expanded practice, or a podiatrist who is licensed, certified, or otherwise authorized by the state to provide health care services consistent with state law.

A provider may belong to one or more networks, but if you want to visit a network provider, you must choose the provider from the *appropriate* network:

- **Preferred provider:** Health care professionals and facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, another BCBS Plan, or the national BCBS transplant network as "preferred" or "PPO" providers. These providers belong to the "Preferred Provider Network."
- **Transplant providers:** These providers have contracted with BCBSNM through the Blue Cross and Blue Shield Association to provide transplant services covered under this health care plan. They belong to the "National BCBS Transplant Network."
- **Participating pharmacy:** A retail supplier that has contracted with the Claims Administrator or its authorized representative to dispense covered prescription drugs and medicines, insulin, diabetic supplies, special medical foods, and enteral nutritional products to Plan members, and that has contractually accepted the terms and conditions as set forth by the Claims Administrator and/or its authorized representative. They belong to the Retail Pharmacy Network. Some participating pharmacies are contracted with BCBSNM to provide specialty pharmacy drugs to plan members; these pharmacies are called "specialty pharmacy providers" and some drugs must be dispensed by these specially contracted pharmacy providers in order to be covered.

A network provider agrees to provide health care services to members with an expectation of receiving payment (other than copayments, coinsurance, or deductibles) directly or indirectly from BCBSNM (or other entity with whom the provider has contracted). A network provider agrees to bill BCBSNM (or other contracting entity) directly and to accept this plan's payment (provided in accordance with the provisions of the contract) plus the member's share (coinsurance, deductibles, copayments, etc.) as payment in full for covered services. BCBSNM (or other contracting entity) will pay the network provider directly. BCBSNM (or other contracting entity) may add, change, or terminate specific network providers at its discretion or recommend a specific provider for specialized care as medical necessity warrants.

Pulmonary rehabilitation — An individualized, supervised physical conditioning program. Occupational therapists teach you how to pace yourself, conserve energy, and simplify tasks. Respiratory therapists train you in bronchial hygiene, proper use of inhalers, and proper breathing.

Radiation therapy — X-ray, radon, cobalt, betatron, telocobalt, and radioactive isotope treatment for malignant diseases and other medical conditions.

Reconstructive surgery — Reconstructive surgery improves or restores bodily function to the level experienced before the event that necessitated the surgery, or in the case of a congenital defect, to a level considered normal. Such surgeries may have a coincidental cosmetic effect.

Registered nurse (R.N.) — A nurse who has graduated from a formal program of nursing education (diploma school, associate degree, or baccalaureate program) and is licensed by appropriate state authority.

Rehabilitation hospital — An appropriately licensed facility that provides rehabilitation care services on an inpatient basis. Rehabilitation care services consist of the combined use of a multidisciplinary team of physical, occupational, speech, and respiratory therapists, medical social workers, and rehabilitation nurses to enable patients disabled by illness or accidental injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of physicians. Continuous 24-hour nursing services are provided under the supervision of a registered nurse.

Residential treatment center — See the "Noncovered Providers of Service" exclusion in *Section 4*.

Respiratory therapist — A person qualified for employment in the field of respiratory therapy. A respiratory therapist assists patients with breathing problems.

Routine newborn care — Care of a child immediately following his/her birth that includes: routine hospital nursery services; routine medical care in the hospital after delivery; alpha-fetoprotein IV screening; pediatrician standby care at a C-section procedure; services related to circumcision of a male newborn.

Routine patient care cost — For purposes of the cancer clinical trial benefit described under "Rehabilitation and Other Therapy" in *Section 3,* a "routine patient care cost" means a medical service or treatment that is covered under a health plan that would be covered if you were receiving standard cancer treatment, or an FDA-approved drug provided to you during a cancer clinical trial, but only to the extent that the drug is not paid for by the manufacturer, distributor, or provider of the drug. **Note:** For a covered cancer clinical trial, it is not necessary for the FDA to approve the drug for use in treating your particular condition. A "routine patient care cost" does **not** include the cost of any investigational drug, device, or procedure, the cost of a non-health care service that you must receive as a result of your participation in the clinical trial, costs for managing the research, costs that would not be covered or that would not be rendered if non-investigational treatments were provided, or costs paid or not charged for by the trial providers.

Short-term rehabilitation — Occupational, physical, and speech therapy techniques that are medically necessary to restore and improve lost bodily functions following illness or injury. (This does not include alcoholism or drug abuse rehabilitation.)

Skilled nursing care — Care that can be provided only by someone with at least the qualifications of a licensed practical nurse (L.P.N.) or registered nurse (R.N.).

Skilled nursing facility — A facility or part of a facility that:

- is licensed in accordance with state or local law; *and*
- is a Medicare-participating facility; *and*
- is primarily engaged in providing skilled nursing care to inpatients under the supervision of a duly licensed physician; *and*
- provides continuous 24-hour nursing service by or under the supervision of a registered nurse; *and*

- does **not** include any facility that is primarily a rest home, a facility for the care of the aged, or for treatment of drug abuse, mental disease, or tuberculosis, or for intermediate, custodial, or educational care.

Special care unit — A designated unit that has concentrated facilities, equipment, and supportive services to provide an intensive level of care for critically ill patients. Examples of special care units are intensive care unit (ICU), cardiac care unit (CCU), subintensive care unit, and isolation room.

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

Specialty pharmacy drugs — Specialty pharmacy drugs must meet at least two of the following criteria: a) they are high cost, b) they are for use in limited patient populations or indications, c) they are typically self-injected, d) they have limited availability, require special dispensing, or delivery and/or patient support is required and, therefore, they are difficult to obtain via traditional pharmacy channels, e) complex reimbursement procedures are required, and/or f) a considerable portion of the use and costs are frequently generated through office-based medical claims.

Speech therapist — A speech pathologist certified by the American Speech and Hearing Association. A speech therapist assists patients in overcoming speech disorders.

Speech therapy — Services used for the diagnosis and treatment of speech and language disorders.

Subscriber — The person in whose name the contract is issued. (For any child covered under "BlueEdge Individual for Kids," any obligations of the subscriber set forth in this benefit booklet, any endorsements, addenda, or riders will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the child's behalf.)

Summary of Benefits — The separately issued schedule that defines your coinsurance requirements, deductible, out-of-pocket limit, and annual or lifetime benefit limits, and provides an overview of covered services.

Surgical services — Any of a variety of technical procedures for treatment or diagnosis of anatomical disease or injury including, but not limited to: cutting; microsurgery (use of scopes); laser procedures; grafting, suturing, castings; treatment of fractures and dislocations; electrical, chemical, or medical destruction of tissue; endoscopic examinations; anesthetic epidural procedures; other invasive procedures. Benefits for surgical services also include usual and related local anesthesia, necessary assistant surgeon expenses, and pre- and post-operative care, including recasting.

Temporomandibular joint (TMJ) syndrome — A condition that may include painful temporomandibular joints, tenderness in the muscles that move the jaw, clicking of joints, and limitation of jaw movement.

Tertiary care facility — A hospital unit that provides complete perinatal care (occurring in the period shortly before and after birth), and intensive care of intrapartum (occurring during childbirth or delivery) and perinatal high-risk patients. This hospital unit also has responsibilities for coordination of transport, communication, and data analysis systems for the geographic area served.

Transplant — A surgical process that involves the removal of an organ from one person and placement of the organ into another. Transplant can also mean removal of organs or tissue from a person for the purpose of treatment and re-implanting the removed organ or tissue into the same person.

Transplant-related services — Any hospitalizations and medical or surgical services related to a covered transplant or retransplant, and any subsequent hospitalizations and medical or surgical services related to a covered transplant or retransplant, and received within one year of the transplant or retransplant.

Urgent care — Medically necessary health care services received for an unforeseen condition that is not life-threatening. This condition does, however, require prompt medical attention to prevent a serious deterioration in your health (e.g., high fever, cuts requiring stitches).

Acceptance of coverage under this benefit booklet constitutes acceptance of its terms, conditions, limitations, and exclusions. Members are bound by all of the terms of this benefit booklet.

The legal agreement between you and Blue Cross and Blue Shield of New Mexico (BCBSNM) includes the following documents:

- this benefit booklet and any amendments, riders, or endorsements;
- the enrollment/change Application(s) for the subscriber and his/her dependents; and
- the members' identification cards.

The above documents constitute the entire legal agreement between BCBSNM and you. No change or modification to the agreement will be valid unless it is in writing and signed by an officer of BCBSNM. No agent or employee of BCBSNM has authority to change this benefit booklet or waive any of its provisions. You will be notified of any changes to this benefit booklet at least 30 days before the changes become effective.

Important Note Regarding "BlueEdge Individual for Kids" Coverage: If a child is under age 15, his/her parent, legal guardian, or other responsible party must submit the application for coverage on the child's behalf. Also, for any child covered under "BlueEdge Individual for Kids," any obligations of the subscriber set forth in this benefit booklet, any endorsements, addenda, or riders will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the child's behalf.

Blue Cross and Blue Shield of New Mexico

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