Endorsement:

2005 Benefit and Eligibility Changes for Fully Insured BCBSNM Group Plans

Blue Cross and Blue Shield of New Mexico

This *2005 Benefit and Eligibility Changes for Fully Insured BCBSNM Group 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. These changes are being made as a result of state and federal legislation requiring that additional coverage be provided by health insurance plans to their members.

BY:

Elizabeth A. Watrin

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President
Blue Cross and Blue Shield of New Mexico

Papillomavirus Screening Mandate (HB477)

Effective July 1, 2005, add the following text to "Preventive Services" in *Section 3: Covered Services* of your benefit booklet:

This plan covers papillomavirus screening.

Note About Booklet Amendment: The statute requires that the benefit be provided at least once every 3 years for women age 30 and older; however, BCBSNM's coverage will not have any frequency limits. For covered preventive services, you and your physician are encouraged to determine how often and at what time you should receive preventive tests and you will receive coverage according to the benefits and limitations of your particular health care plan.

Early Developmental Delay and Disability Mandate (SB589)

Effective July 1, 2005, add the following provision to Section 3: Covered Services in your benefit booklet:

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 calendar year. Amounts paid to the 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. Once the annual DOH reimbursement maximum is reached, no more monies are available for services provided by the DOH for the remainder of that year.

Pre-Existing Conditions Limitation (HIPAA)

Effective July 1, 2005 for new groups or, for currently enrolled groups, on your group's annual renewal date* , add the following text to "Pre-Existing Conditions" in *Section 7* of your benefit booklet:

A newborn dependent child and a newly adopted child may be added to coverage more than 31 days after birth or adoption without being subject to the pre-existing conditions limitation if the child was enrolled in a group health plan within 30 days of being born or adopted and who obtained coverage under your current BCBSNM health care plan within 63 days of losing the prior coverage (or if prior coverage is still in effect and there has been no significant break in the child's coverage since his/her date of birth or adoption).

For purposes of determining any significant break in coverage in the "Reduction in Waiting Period" provision, lapses in coverage due to either of the following cases will not be considered as part of a break:1) a waiting period imposed by a group health plan before it allowed you to become eligible for enrollment, and 2) the amount of time between the date you submitted a substantially complete application for individual plan coverage and either the date the coverage began (if you were accepted), or the date on which the application was denied or on which the offer of coverage lapsed (if you were not accepted). You can add up any creditable coverage you had prior to enrollment in this plan, but if you went for 63 days or more without any coverage, the coverage you had before the break will not be counted. Proof of creditable coverage is required before credit will be given. (Note: Certain workers whose employment was adversely affected by international trade and who were entitled to a second COBRA election period as a result will not have the period of time between loss of coverage and COBRA election count as a break in coverage for purposes of the 63-day rule.)

Special Enrollment (HIPAA)

Effective July 1, 2005 for new groups or, for currently enrolled groups, on your group's annual renewal date*, replace the definition of "involuntary loss of coverage" with the following definition in your benefit booklet:

Loss of other coverage due to legal separation, divorce, death, reaching a dependent child age limit, moving out of an HMO service area, termination of employment, reduction in hours, or termination of employer contributions (even if the affected member continues such coverage by paying the amount previously paid by the employer). A loss of coverage may also occur if your employer ceased offering coverage to the particular class of workers or similarly situated individuals to which you belonged or terminated your benefit package option, and no substitute plan was offered. If the member is covered under a state or federal continuation policy due to prior employment, involuntary loss of coverage includes exhaustion of the maximum continuation time period. Involuntary loss of coverage does not include a loss of coverage due to the failure of the individual or member to pay premiums on a timely basis or termination of coverage for cause. You are also considered to have experienced a loss in coverage if you reach a lifetime benefit maximum under your prior health care plan.

Effective July 1, 2005 for new groups or, for currently enrolled groups, on your group's annual renewal date*, replace the definition of "creditable coverage" with the following definition in your benefit booklet:

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. COBRA election counts as a break in coverage for purposes of the 63-day rule.)

Special Switch Enrollment (HIPAA)

Effective July 1, 2005 for new groups or, for currently enrolled groups, on your group's annual renewal date*, add the following information to your benefit booklet:

Application for special enrollment must be made within 31 days of losing other coverage or experiencing a change in family status in order to qualify you and/or your dependent for a special enrollment or special switch enrollment right (switch enrollment may be available to members who are offered more than one benefit plan option). A qualifying change in family status may occur when an employee acquires a new dependent through marriage, birth, adoption, or placement for adoption. Please contact your benefits administrator for details about special enrollment privileges that apply to you and your eligible family members.

* **Note:** The effective date of HIPAA-related changes is as stated, unless your employer notifies you otherwise.

Part-Time Employee Eligibility (HB289)

Effective July 1, 2005 for new groups or on your group's annual renewal date for currently enrolled groups, add the following information to your benefit booklet:

Employers may request coverage for regular part-time employees expected to work an average of at least 20 hours per week over a 6-month period. Each employer may choose whether or not to offer health insurance to these part-time employees. Please contact your employer to find out if this optional coverage may affect you. (This optional coverage for part-time employees is not available to temporary or seasonal workers.)

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.

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