Endorsement:
2007 Benefit Changes for
Fully Insured BCBSNM Group Plans

Blue Cross and Blue Shield of New Mexico

This *2007 Benefit 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.

BY:

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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).

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.)

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.)

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.