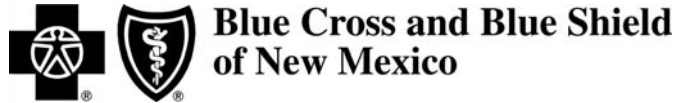


Endorsement: 2008 Benefit Changes for Fully Insured Group Plans



This *2008 Benefit Changes for Fully Insured 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 back of your identification card.

BY:

A handwritten signature in cursive script that reads "Elizabeth A. Watrin".

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

Pre-Existing Condition Limitation: Creditable Coverage Extension

Effective July 1, 2008, if your plan has a pre-existing condition limitation, revise the text in your booklet (and in the *2005 Benefit Endorsement*, if you received it) that discusses how the waiting period can be reduced with creditable coverage to read:

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 95 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 95 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 95-day rule.)

Note About Booklet Endorsement: A change in New Mexico law requires that fully insured group plans reduce your pre-existing condition waiting period by the amount of time you were covered under previous creditable health insurance (as defined in your booklet) so long as no more than **95 days** have elapsed since your prior coverage terminated. However, this extension of the former time limit of **63 days** (which is still the time limit in federal law) applies **ONLY** to fully insured group health plans in New Mexico and affects you **ONLY** when first enrolling **INTO** a new health care plan. Therefore, if your current group health plan coverage is terminated, but you later obtain individual coverage or coverage through an employer that is not subject to the 95-day time limit in New Mexico law (such as

certain large, self-insured employers), the 63-day period under federal law may still apply and **you may not have an extended (95-day) period of time during which you can have a lapse in coverage** and still receive credit toward any pre-existing condition waiting period. For this reason, you may want to consider making sure that you have no more than a 63-day lapse in coverage as is customary under federal law unless you determine that the extended 95-day period applies to the plan under which you are seeking coverage. Otherwise, if more than 63 days elapse from the time your prior coverage was terminated, your new plan may not reduce your pre-existing condition waiting period.

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.

BlueNet (EPO) & PPO Plans Only: Appeals Process

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 (the arbitration provision for non-ERISA plans and the external appeal option for ERISA plans is unchanged):

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 decision of committee 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.

ERISA Appeals Procedures — For plans subject to the Employee Retirement Income Security Act of 1974 (ERISA), BCBSNM's time frames for responding to your request for review may be different than those described above. As stated above, you have **180 days** from receiving a notice of adverse benefit determination to submit an appeal. Under the "Expedited Review" process for pre-service urgent care claims, BCBSNM will respond as soon as possible, but also no later than 72 hours after receiving your initial inquiry. However, under the "Standard Review" process, BCBSNM will respond to adverse determinations within the following time frames:

- **15 calendar days** after receiving your initial request for internal review of a **pre-service** claim; and
- **30 calendar days** after receiving your initial request for internal review of a **post-service** claim.

If you go on to request a second internal panel review, BCBSNM must respond to pre-service requests within another 15 calendar days and to post-service requests within another 30 calendar days of receiving the request for the internal panel review.

These time frames may be extended in accordance with ERISA. If you are not satisfied after completing the ERISA Appeal Procedure, you may have the right to bring a civil action under ERISA section 502(a).

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.

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 6 A.M.– 8 P.M. and 8 A.M.– 5 P.M. on Saturdays and most holidays 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 5:00 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: 1-800-432-0750

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.