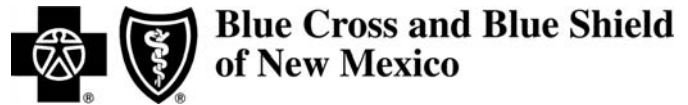


Endorsement:

2008 Benefit Changes for Fully Insured Individual Plans



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:

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

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

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

Complaints, Appeals, and Grievances

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 or writing BCBSNM Customer Service. If you are not satisfied with the initial response, you can make an oral complaint or file a written appeal or grievance to BCBSNM.

If you make an oral appeal or 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 appeals, grievances, questions, or complaints. Call:

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

You may designate a representative to act for you in the review and appeal or grievance procedures. 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, request an appeal, 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 complaint (or "inquiry"), appeal, and grievance procedures. You may request a more detailed written explanation of these procedures by calling BCBSNM Customer Service.

Appeal and Grievances

If you are not satisfied with the response to the initial decision, 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 covered person 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 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 telephonically, 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 utilized by BCBSNM for any oral or written complaint submitted by you or on your behalf regarding 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. If necessary, arrangements will be made for

you to participate in the hearing 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 Appeals and Grievances — For more information, contact:

BCBSNM
Attention: Appeals Unit
P.O. Box 11968
Albuquerque, NM 87192

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 the Superintendent
- E-mail to the Superintendent of Insurance, Attention: Managed Health Care Bureau-External Review Request, at mhcb.grievance@state.nm.us; or
- Online at www.nmprc.state.nm.us/mhcb.htm to the Superintendent of Insurance, Attention: Managed Health Care Bureau-External Review.

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 service provider; and any other supporting documentation. You may contact the Managed Health Care Bureau to assist you in this process.

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 nor 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 when you renew your coverage 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: 1-800-325-8334

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: (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.

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:

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

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 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.)