Endorsement:
2009 Benefit Changes for Fully Insured Managed Health Care Plans (Individual Markets)

Blue Cross and Blue Shield of New Mexico

This *2009 Benefit Changes for Fully Insured Managed Health Care Plans* endorsement is made a part of your Blue Cross and Blue Shield of New Mexico (BCBSNM) health care plan benefit booklet. These changes are being made as a result of changes in state laws and regulations. If you have a question about these changes, please call your Customer Service Advocate at the phone number printed on the back of your identification card.

BY:

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

Managed Health Care Plans (MHCP Rule)

Effective September 1, 2009, add the following information to your PPO, EPO, or HMO plan booklet (this information does not apply to Medicare Supplements, Carveout plans, dental or vision care plans, indemnity plans, or to short-term travel-only or limited duration policies):

A "managed health care plan" is a health plan that requires a member to use, or encourages a member to use, a "network" provider (your provider network is determined by the type of health plan you have, whether HMO, EPO, or PPO). Your health plan may require you to use network providers in order to receive benefits (e.g., HMO Blue, BlueNet EPO) or may provide a higher level of benefit for in-network services (e.g., BluePPO). Therefore, your choice of provider under a managed health care plan determines the amount and kind of **benefits** you receive under your health care plan. **Your BCBSNM health plan does not prevent you from choosing to receive services from a provider outside the network.** The choice of provider is still up to you – but the health plan is not obligated to provide benefits for every service you seek to receive. You may receive no benefits or reduced benefits for services received outside the network. Check your health plan benefit booklet to find out what your benefits are in-network and out-of-network.

Preventive Services (MHCP Rule)

Effective September 1, 2009, replace the list of covered services under the "Preventive Services" provision in *Section 3* of your benefit booklet with the following list:

- routine physical, breast, and pelvic examinations
- routine adult and pediatric immunizations (including human papillomavirus vaccinations (HPV) for members aged 9 through 26)
- an annual routine gynecological or pelvic examination and low-dose mammogram screenings, papilloma virus screening, and cytologic screening (a Pap test or liquid-based cervical cytopathology)
- 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 or colonoscopy; periodic colorectal screening; and periodic glaucoma eye tests

- well-child care, including well-baby and well-child screening for diagnosing the presence of autism spectrum disorder (This routine service is not limited by the $36,000 annual or $200,000 lifetime maximum benefit for autism spectrum disorders; see "Autism Spectrum Disorders" for additional covered services.)
- 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 to include an annual consultation to discuss lifestyle behaviors that promote health and well-being

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.

Emergency Services (MHCP Rule)

Effective September 1, 2009, replace the definition of "Emergency" (or "Emergency care") with the following definition:

Emergency care — Medical or surgical procedures, treatments, or services delivered after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to his/her health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part; or disfigurement. (In addition, initial treatment must be sought **within 48 hours** of the accident or onset of symptoms **and** services must be received in an emergency room, trauma center, or ambulance to qualify as an emergency.)

Prescription Drugs and Other Items (MHCP Rule)

Effective September 1, 2009, add the following paragraph to the *Covered Services* section of your benefit booklet or, if you are enrolled in a group plan, to either your separately issued *Drug Plan Rider* or to the "Prescription Drugs and Other Items" provision in the *Covered Services* section of your benefit booklet, whichever is applicable. (If you are an individual – or "nongroup" member – you should add this information to your benefit booklet in the *Covered Services* section and entitle it "Prescription Drugs and Other Items" regardless of whether or not you have a separately issued *Drug Plan Rider*):

Prescription drugs under your drug plan will not be excluded only because the drug has not been approved by the FDA for the treatment of your particular condition. Such a drug may be covered under the drug plan if it is recognized as safe and effective for the treatment of your condition in at least one standard medical reference compendium, including the "AMA Drug Evaluation," the "American Hospital Formulary Service Drug Information," and "Drug Information for the Healthcare Provider," OR is being provided during a covered cancer clinical trial as required under NM state law. The drug will not be covered, however, if it is excluded for another reason (such as being for weight loss, cosmetic, etc.).

BCBSNM uses an open formulary to administer the drug benefit. This means all drugs are covered unless specifically excluded. (See the "Exclusions" heading under "Prescription Drugs and Other Items" in your benefit booklet or, if applicable, at the end of your *Drug Plan Rider* **and** see the *General Limitations and Exclusions* section in your benefit booklet. For example, if your plan excludes weight management or obesity treatment, drugs for the treatment of obesity are also excluded.) If you are covered by a 3-Tier or 4-

Tier drug plan, drugs are available at "tiered" copayment levels. Generic drugs are covered at Tier One, the lowest copayment. Brand medications on the BCBSNM Drug List are covered at Tier Two. Brand medications that are not on the Drug List are covered at Tier Three. Your drug plan may have a 4th tier copayment for specialty pharmacy. To determine your copayment, check your drug against the BCBSNM Drug List. The Drug List will indicate the **copayment level** you must pay for a specific drug under your Plan. The entire Drug List is on the BCBSNM Web site at www.bcbsnm.com. If you do not have Internet access, you may request a copy of the Drug List from a Customer Service Advocate.

Coverage Termination

Effective September 1, 2009, add the following information to your benefit booklet:

If you believe your coverage was cancelled due to health status or health requirements, race, gender, age, or sexual orientation, you may appeal such termination to the New Mexico Superintendent of Insurance. Also, BCBSNM will not cancel your coverage for nonpayment of copayments if such a cancellation would constitute abandonment of a member who is hospitalized and receiving treatment for a life-threatening condition. In addition, BCBSNM will not cancel your coverage if you refuse to follow a prescribed course of treatment. Before terminating your coverage for reasons other than nonpayment of premium, BCBSNM must provide you written notice at least 30 calendar days in advance. The notice must be in writing and dated, state the reason for the cancellation and the date on which it becomes effective, provide you the list of circumstances under which your coverage cannot be cancelled, and provide you information about appealing your termination to the New Mexico Superintendent of Insurance. You will not receive a notice of cancellation if there is no renewal provision in your contract.

Transition of Care

Effective September 1, 2009, add this "Transition of Care" provision to your benefit booklet:

If your health care provider leaves the BCBSNM provider network (for reasons other than medical competence or professional behavior) or if you are a new member and your provider is not in the provider network when you enroll, BCBSNM may authorize you to continue an ongoing course of treatment with the provider for a transitional period of time of not less than 30 days. (If necessary and ordered by the treating provider, BCBSNM may also authorize transitional care from other out-of-network providers.) The period will be sufficient to permit coordinated transition planning consistent with your condition and needs. Special provisions may apply if the required transitional period exceeds 30 days. If you have entered the third trimester of pregnancy at the effective date of enrollment, the transitional period shall include post-partum care directly related to the delivery. Call the BCBSNM Customer Service department for details.

Members who extend coverage under an extension of benefits due to disability after the Group Contract is terminated are not eligible to receive prior approval for services of an out-of-network provider. Services of an out-of-network provider are **not** covered at the in-network level (if any) in such instances of extended coverage.

Consumer Advisory Board

Effective September 1, 2009, add the following definition to your benefit booklet:
BCBSNM has established a Consumer Advisory Board to provide input from the member's point-of-view about BCBSNM's general operations and internal policies and to identify areas that need improvement.

PPO Plan: Provider Payment Examples

Effective September 1, 2009, add the following example to your benefit booklet under "Claims Payment Provisions" in the *Claims Payments and Appeals* section:

The two examples below demonstrate the difference between your liability for services from an in-network provider versus an out-of-network provider. Both examples are for a Plan that pays 80 percent of covered charges with the remaining 20 percent of covered charges paid by the member.

See your *Summary of Benefits* for your Plan's coinsurance amount, which may be higher for out-of-network providers.

Example 1. In-Network Provider Claim Payment (Plan pays 80 percent; deductible is met):

Provider's billed charge	$10,000
Covered charges (maximum amount that can be considered for benefit payment)	$8,000
BCBSNM payment to provider (80% of $8,000)	$6,400
Member coinsurance (20% of $8,000) applied to the out-of-pocket limit	$1,600
Amount over the covered charges - the in-network provider writes off the difference between billed amount and covered charge	$0
Total amount due from member (coinsurance only):	$1,600

Example 2. Out-of-Network Provider Claim Payment (Plan pays 80 percent; deductible is met):

Provider's billed charge	$10,000
Covered charges (maximum amount that can be considered for benefit payment)	$8,000
BCBSNM payment to provider (80% of $8,000)	$6,400
Member coinsurance (20% of $8,000) applied to the out-of-pocket limit	$1,600
Amount over the covered charges - the member is responsible for all costs incurred over the covered charges and these amounts do not apply to your out-of-pocket limits	$2,000
Total amount due from member (coinsurance plus amount over covered charges, if any):	$3,600

Provider Network

Effective September 1, 2009, add the following information to your benefit booklet:

Network providers are not required to comply with any specified numbers, targeted averages, or maximum durations of patient visits. You will not be held liable to a network provider for any sums owed to the provider by BCBSNM.

Member Rights and Responsibilities

As a member enrolled in a managed health care plan administered by BCBSNM, you have these rights:

- The right to available and accessible services when medically necessary
- The right to be treated with courtesy and consideration, and with respect for your dignity and your need for privacy.
- The right to be provided with information concerning BCBSNM's policies and procedures regarding products, services, providers, appeals procedures and other information about the company and the benefits provided.
- The right to all the rights afforded by law, rule, or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language you understand.
- The right to receive from your physician(s) or provider, in terms that you understand, an explanation of your complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, irrespective of BCBSNM's position on treatment options. If you are not capable of understanding the information, the explanation shall be provided to your next of kin, guardian, agent or surrogate, if able, and documented in your medical record.
- The right to prompt notification of termination or changes in benefits, services or provider network.
- The right to file a complaint or appeal with BCBSNM or with the New Mexico Superintendent of Insurance and to receive an answer to those complaints in accordance with existing law.
- The right to privacy of medical and financial records maintained by BCBSNM and health care providers contracted with BCBSNM, in accordance with existing law.
- The right to request information about any financial arrangements or provisions between BCBSNM and its network providers that may restrict referral or treatment options or limit the services offered to members.
- The right to adequate access to qualified health professionals for the treatment of covered conditions who are near your work or home within New Mexico.
- The right to affordable health care, including the right to seek care from an out-of-network provider, and an explanation of your financial responsibility when services are provided by an out-of-network provider, or provided without required prior approval.
- The right to detailed information about coverage, maximum benefits, and exclusions of specific conditions, ailments or disorders, including restricted prescription benefits, and all requirements that you must follow for prior approval and utilization review.
- The right to receive an approved example of the financial responsibility incurred by you when going out-of-network (see "PPO Plan: Provider Payment Examples," on the previous page, for example).
- The right to a complete explanation of why care is denied, an opportunity to appeal the decision to BCBSNM's internal review, the right to a secondary appeal, and the right to request the assistance of the Superintendent of Insurance.

As a member enrolled in a managed health care plan administered by BCBSNM, you have these responsibilities:

- The responsibility to supply information (to the extent possible) that BCBSNM and its network practitioners and health care providers need in order to provide care.
- The responsibility to follow plans and instructions for care that you have agreed on with your treating provider or practitioners.
- The 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.

Prior Approval/Prior Authorization

Effective immediately, *remove* the following services from the list of services in your benefit booklet that require prior approval or authorization in order to be covered. (However, these services may still be denied if they are not medically necessary, considered experimental, or otherwise not covered under your Plan; only the *prior approval* requirement is being removed. As always, you should call before receiving any high-cost service to make sure that the service is eligible under your Plan.)

- diabetes self-management educational programs
- health education and counseling programs
- private room charges
- MRIs, MRAs, or CT scans (other than cardiac CT scans, which *do* require prior approval)

Provider Claims Payment Provisions

Effective immediately, if your booklet indicates a method for determining covered charges when services are received from an out-of-network provider, delete that information. BCBSNM determines covered charges for out-of-network providers the same way that it determines covered charges for in-network providers.

Summary of Benefits

Effective September 1, 2009, the following summary of exclusions is included with your *Summary of Benefits.* Please attach the following list of exclusions to your *Summary of Benefits* (the following exclusions are a summary only and are more accurately and completely described in your benefit booklet):

§ Admissions/Treatments Discontinued by Patient **§** Services Before Effective Date of Coverage or After Termination **§** Biofeedback **§** Complications of Noncovered Services **§** Convalescent Care or Rest Cures **§** Cosmetic Services **§** Custodial Care **§** Domiciliary Care **§** Duplicate Coverage **§** Duplicate Testing **§** Experimental, Investigational, or Unproven Services **§** Food, Lodging, Travel Expenses (unless approved as part of a covered transplant) **§** Genetic Testing or Counseling **§** Hair Loss Treatments **§** Hearing Exams, Procedures, or Aids (unless listed as covered) **§** Hypnotherapy **§** Infertility Services/Artificial Conception **§** Late Claim Filings **§** Learning Deficiencies/Behavioral Problems **§** Limited Services/Covered Charges **§** Local Anesthesia **§** Long-Term or Maintenance Therapy **§** Medical Policy Determinations **§** Medically Unnecessary Services **§** No Legal Payment Obligation **§** Noncovered Providers of Service (e.g., member of your family; health spa; school infirmary; halfway house; massage therapist; private sanitarium; rolfer) **§** Nonmedical Expenses **§** Noncontracted Provider Services (under HMO and EPO Plans) **§** Noncovered Therapy (recreational, sleep, crystal, primal scream, sex, and Z therapies; self-help, stress management, codependency, and weight-loss programs; transactional analysis, encounter groups, and transcendental meditation (TM); moxibustion; sensitivity or assertiveness training; vision therapy; orthoptics; pastoral, spiritual, religious, marital, or bereavement counseling; therapy for chronic conditions such as, but not limited to, cerebral palsy or developmental delay, unless specifically listed as covered under "Autism Services") **§** Nonprescription Drugs or Nutritional Supplements Unless Required Under Law **§** Obesity Treatment or Other Weight Management **§** Pre-Existing Conditions (for up to 18 months for late applicants) **§** Prior Approval Not Obtained When Required (specified services) **§** Private Duty Nursing **§** Private Room Expenses **§** Sex-Change Operations or Services **§** Sexual Dysfunction Treatment **§** Thermography **§** Veteran's Administration Facility **§** Vision Services **§** War-Related Conditions **§** Work-Related Conditions

Endorsement:
2009 Benefit Changes for
Autism/Cancer Clinical Trials

Blue Cross and Blue Shield of New Mexico

This *2009 Benefit Changes for Autism / Cancer Clinical Trials* endorsement is made a part of your Blue Cross and Blue Shield of New Mexico (BCBSNM) health care plan benefit booklet. These changes are being made as a result of changes in state laws and regulations. If you have a question about these changes, please call your Customer Service Advocate at the phone number printed on the back of your identification card.

BY:

Elizabeth A. Watrin

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President
Blue Cross and Blue Shield of New Mexico

Cancer Clinical Trials (SB42) and Autism Spectrum Disorders (SB39)

Effective 06/19/09, the following changes are being made to your benefits.

General Limitations and Exclusions

On 6/19/09, make the following changes to the *General Limitations and Exclusions* section of your benefit booklet:

Replace the "Medical Policy Determinations" exclusion:

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).* **Exception:** The fact that this Plan covers certain services that are excluded under BCBSNM medical policy (such as acupuncture) and certain services defined as experimental or as maintenance therapy but which must be covered under New Mexico state law (such as cancer clinical trials and applied behavioral analysis) does not mean that any other services will be or should be covered when contraindicated by BCBSNM medical policy. Only covered acupuncture and those services mandated by state law will be excepted from this BCBSNM standard medical policy exclusion.

Replace the first sentence under the "Experimental, Investigational, or Unproven Services" exclusion in your benefit booklet with the following sentence:

This Plan does not cover any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical practice* (as defined) or those considered experimental, investigational, or unproven, unless for acupuncture rendered by a licensed doctor of oriental medicine or unless specifically listed as covered under "Autism Spectrum Disorders" or under "Cancer Clinical Trials" in *Section 3* and mandated by law.

Replace the first sentence under the "Medically Unnecessary Services" exclusion in your benefit booklet

with the following sentence:

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" or "Autism Spectrum Disorders" in *Section 3*).

Add the following sentence to the "Learning Deficiencies/Behavioral Problem" exclusion in your benefit booklet:

See "Autism Spectrum Disorders" in *Section 3* for details about mandated coverage for children with these diagnoses.)

Replace the "Note" in the "Long-Term and Maintenance Therapy" exclusion with the following Note:

Note: This exclusion does not apply to benefits for medication or medication management or to certain services required to be covered under New Mexico state law for children with autism spectrum disorders.

Glossary

On 6/19/09, make the following changes to the *Glossary* section of your benefit booklet (and to all similar definitions that occur outside the *Glossary):*

Mental disorder — A clinically significant behavioral or psychological syndrome or condition that causes distress and disability and for which improvement can be expected with relatively short-term treatment. Mental disorder does not include developmental disabilities, autism spectrum disorders, drug or alcohol abuse, or learning disabilities.

Replace the second sentence in the definition of "Cancer clinical trial" with the following sentence:

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 cancer clinical trial in New Mexico.

Covered Services

On 6/19/09, make the following changes to the *Covered Services* section of your benefit booklet:

Add the following item to the list of covered "Preventive Services" in your benefit booklet:

- well-baby and well-child screening for diagnosing the presence of autism spectrum disorder (This routine service is not limited by the $36,000 annual or $200,000 lifetime maximum benefit for autism spectrum disorders; see "Autism Spectrum Disorders" for additional covered services.)

In each case where therapy for chronic conditions, maintenance therapy, or long-term therapy is excluded (except under the "Psychotherapy" provision, which does not cover autism), change the exclusions to read:

- therapy for chronic conditions such as, but not limited to, cerebral palsy or developmental delay, except as required by law and described under "Autism Spectrum Disorders" in the *Covered Services* section of your booklet (See *Section 6* of your benefit booklet for reimbursement of certain services provided to eligible children by the Department of Health.)
- maintenance therapy or care provided after you have reached your rehabilitative potential except as required under New Mexico state law (See "Autism Spectrum Disorders" in the *Covered*

Services section and the "Long-Term or Maintenance Therapy" exclusion in the *General Limitations and Exclusions* section.)

- long-term therapies (Therapies are long-term if measurable improvement is not possible within two months of beginning active therapy except as required under New Mexico state law. This Plan does **not** cover long-term therapy even if you have not yet used or exhausted maximum benefits. See the "Long-Term or Maintenance Therapy" exclusion in the *General Limitations and Exclusions* section.)

Add the following "Autism Spectrum Disorders" provision to *Covered Services* in your benefit booklet. Please update your *Summary of Benefits* to reflect this addition.

Autism Spectrum Disorders

Applied behavioral analysis (ABA) — Services that include behavior modification training programs that are based on the theory that behavior is learned through interaction between an individual and the environment. The goal of behavior management is to reinforce and increase desirable, functional behaviors while reducing undesirable, "maladaptive" behaviors. Services would not apply to children over the age of seven.

Autism spectrum disorder — A condition that meets the diagnostic criteria for the pervasive developmental disorders published in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision, also known as *DSM-IV-TR*, published by the American Psychiatric Association, including autistic disorder; Asperger's disorder; pervasive development disorder not otherwise specified; Rhett's disorder; and childhood integrative disorder.

Habilitative treatment — Treatment programs that are necessary to: 1) develop, 2) maintain, and 3) restore to the maximum extent practicable the functioning of an individual. All three conditions must be met in order to be considered habilitative.

For a member **19 years old or younger** (or, if enrolled in high school, 22 years old or younger), this Plan covers the habilitative and rehabilitative treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy, and applied behavioral analysis (ABA) when provided by an in-network provider. Providers must be credentialed to provide such therapy. **Note:** ABA services are not indicated for children over the age of seven.

Treatment must be prescribed by the member's treating physician in accordance with a treatment plan. The treatment plan, must be **prior-approved** by BCBSNM; if services are received but were not approved as part of the treatment plan, benefits for covered services will be denied. Once maximum functionality has been reached and no additional improvement is expected, no therapies are covered unless required to maintain that member's current functionality (that is, in the absence of additional treatment, the patient would suffer a setback). **No benefits are available for any treatments not shown to be habilitative or rehabilitative.**

Benefits for all services for the treatment of autism spectrum disorder are limited for each eligible BCBSNM-insured person to **$36,000** per calendar year and to **$200,000** in total lifetime benefits. Once the annual maximum is reached, no more benefits for autism therapy are provided until the next year. Once a lifetime maximum is reached, no more benefits for autism therapy are provided for that BCBSNM member.

Changing from one plan to another under the same group, reinstating prior BCBSNM coverage, changing employers, changing policyholder or subscriber, or moving from individual coverage to group coverage or vice versa does **not** reinstate autism benefits once an annual or lifetime maximum

is reached for a particular insured member. All amounts payable under this provision are tracked at the member level regardless of the policy number under which charges accrued. For example, if a member is covered under two BCBSNM policies, the maximum annual benefit and the maximum lifetime benefit is not doubled for that member. Regardless of the number of policies under which the member is covered, benefits will not exceed the *per member* annual and lifetime maximum benefits mandated by law.

Services are subject to usual member cost-sharing features such as deductible, coinsurance, copayments, and out-of-pocket limits – based on place of treatment and type of service. All services are subject to the *General Limitations and Exclusions* of the member's Plan except where explicitly mentioned as being an exception. For example, certain autism spectrum disorder services mandated by law are excepted from the "Medical Policy Determinations" exclusion, but such services are not excepted from exclusions such as the "Nonpreferred Provider Services" or "Pre-Existing Conditions" exclusions.

Regardless of the type of therapy received, claims for services related to autism spectrum disorder should be mailed to **BCBSNM** – not to the behavioral health services administrator.

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

- any experimental, long-term, or maintenance treatments not required under state law
- any treatment or therapy from an out-of-network provider
- medically unnecessary or nonhabilitative services under any circumstance
- applied behavioral analysis (ABA) for children over the age of seven
- any services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children 3 to 22 years old who have autism spectrum disorder
- services that have not been prior-approved by BCBSNM or are provided by an out-of-network provider
- respite services or care
- Sensory Integration Therapy (SIT) or Auditory Integration Therapy (AIT)
- music therapy, vision therapy, or touch or massage therapy
- floor time
- facilitated communication
- elimination diets; nutritional supplements; intravenous immune globulin infusion; secretin infusion
- chelation therapy
- hippotherapy, animal therapy, or art therapy

Endorsement:
2009 Drug Plan Benefit Changes for Fully Insured Plans

Blue Cross and Blue Shield of New Mexico

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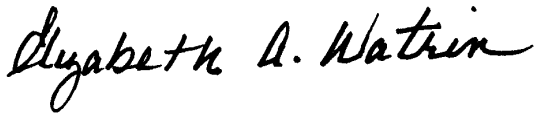
BY:



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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.)