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Covered Services

This section describes the services and supplies covered by this Policy, subject to the limitations and exclusions in *Sections 2* and *4*. All payments are based on covered charges as determined by the Administrator. **Reminder:** It is to your financial advantage to receive care from participating providers.

Medical Necessity — The Administrator determines what is medically necessary based on what is:

- medically appropriate, considering your age and health, for the symptoms and diagnosis or treatment of your medical condition, illness, or injury;
- in accordance with standards of sound medical practice;
- not primarily for your, your family's, or your provider's convenience; and
- the most appropriate supply or level of service that can safely be provided to you. When applied to hospitalization, this also means that you require inpatient acute care due to the nature of the services rendered or of your condition, and you cannot receive safe or adequate care as an outpatient.

Note: The decision as to whether a service is medically necessary is based on generally accepted medical or surgical standards. **Because a provider prescribes, orders, recommends, or approves a service does not make it medically necessary or make it a covered service, even if it is not specifically listed as an exclusion.** If you disagree with a decision made by the Administrator, see *Section 7* for information on appeals.

Acupuncture Services

Acupuncture is covered when administered by a licensed provider acting within the scope of licensure and when necessary for the treatment of a medical condition. Benefits are limited each calendar year to a maximum benefit payment of **\$1500**. Reimbursement is limited to the covered charge for the acupuncture treatment itself and associated office visit.

Acupuncture benefits include acupuncture used as an anesthetic during a covered surgical procedure or in the treatment of severe pain and administered by a physician or a licensed acupuncturist.

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

- herbs, homeopathic preparations, or nutritional supplements
- massage therapy or rolfing

Ambulance Services

This Policy covers ambulance services in an emergency (e.g., cardiac arrest, stroke). When you cannot be safely transported by any other means in a nonemergency situation, this Policy also covers medically necessary ambulance transportation to a hospital with appropriate facilities, or from one hospital to another.

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Air Ambulance — Air ambulance is covered only when terrain, distance, or your physical condition requires the use of air ambulance services, or for high-risk maternity and newborn transport to tertiary care facilities.

Prior approval is required for nonemergency air ambulance services.

The Administrator determines, on a case-by-case basis, when air ambulance is covered. If the Administrator determines that ground ambulance services could have been used, benefits are limited to the cost of ground ambulance services.

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

- commercial transport, private aviation, or air taxi services
- services not specifically listed as covered, such as private automobile, public transportation, or wheelchair ambulance
- services ordered only because other transportation was not available or for your convenience

Blood Services

This Policy covers the processing, transporting, handling, and administration of blood. **Note:** This Policy covers blood storage fees only when the blood is to be used for an already scheduled surgical procedure **and** only if the donor has specifically indicated that you, the policyholder, are to receive the donated blood. (This includes situations in which you are donating blood to be used in your own scheduled procedure.) Blood storage costs for any other purpose will not be covered. This Policy does **not** cover blood replaced by or for the patient through donor credit.

Chemical Dependency

This Policy covers the following inpatient and outpatient care (including intensive outpatient programs and partial hospitalization), for the evaluation, diagnosis, and/or treatment of chemical dependency, which includes both alcoholism and drug abuse:

- therapeutic individual and group psychotherapy rendered by psychiatrists, psychologists, licensed family therapists, and other mental health/chemical dependency providers (as defined in *Section 10: Definitions*)
- inpatient visits and other professional provider services received on a day during which hospital benefits were provided
- medical management of prescription medication
- intake evaluations and psychological testing
- family counseling, or counseling with family members to assist in the patient's diagnosis and treatment
- other therapeutic services, as appropriate and **prior-approved** by the Administrator

Prior approval is required for inpatient and outpatient chemical dependency services.

Medical Detoxification — This Policy also covers medically necessary services related to medical detoxification from the effects of alcoholism or drug abuse. Detoxification is the treatment in an acute care facility for withdrawal from the physiological effects of alcoholism or drug abuse, which usually takes about three days in an acute care facility. Benefits for detoxification services are the same as for any other acute medical/surgical condition.

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Benefit Limitations — Benefits for chemical dependency rehabilitation are limited to **30 inpatient days/physician visits** and **30 outpatient visits** per calendar year, with a lifetime maximum of **two 12-month benefit periods** (see below). (Outpatient benefits are not available for services received while you are an inpatient. Inpatient benefits are not available for services received on an outpatient basis.)

Chemical Dependency Benefit Period Limitation — Benefits for drug and alcohol abuse rehabilitation are limited to those treatments you receive during a maximum of **two 12-month benefit periods** for as long as you remain covered under the plan. Even if you have not exhausted your annual benefit, you will not be extended coverage for chemical dependency rehabilitation beyond the two benefit periods to which you are entitled (except as provided for alcoholism rehabilitation, below). The benefit periods need not be consecutive in order to be covered (as long as you maintain eligibility).

Minimum Coverage for Alcoholism Rehabilitation — If you exhaust your maximum benefits when receiving chemical dependency services that are *not* related to alcoholism, you are still entitled to up to 30 inpatient days and 30 outpatient visits for medically necessary alcoholism rehabilitation during a calendar-year benefit period, not to exceed two benefit periods in a lifetime. However, if you exhaust a maximum chemical dependency benefit (either annual or lifetime) while receiving alcoholism treatment, this Policy will **not** cover services related to drug abuse rehabilitation.

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

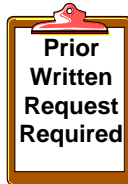
- services provided or billed by a school, halfway house, or residential treatment center or their staff members
- long-term care
- court-ordered or police-ordered services unless the services would otherwise be covered; services rendered as a condition of parole or probation
- the cost of any damages to a treatment facility
- charges associated with any episode of alcoholism or drug abuse for which you did not complete the prescribed continuum of care
- custodial care (See the “Custodial Care” exclusion in *Section 5*.)
- confinement for environmental change

■ **Dental-Related/TMJ Services and Oral Surgery**

The following services are the only dental services and oral surgery procedures covered under this Policy. When alternative procedures or devices are available, benefits are based upon the most cost-effective, medically appropriate procedure or device available.

Dental and Facial Accidents — Benefits for covered services for the treatment of accidental injuries to the jaw, mouth, face, or sound natural teeth are generally subject to the same limitations, exclusions, and member cost-sharing provisions that would apply to similar services when not dental-related (e.g., x-rays, medical supplies, surgical procedures).

To be covered, *initial* treatment for the injury must be sought within **72 hours** of the accident. Subsequent services must be received **within 24 months** of the date of accident in order to be covered.



Prior approval is required for any services required after the initial treatment.

Facility Charges — Inpatient or outpatient hospital expenses are covered **only** if the patient is under age six or has a nondental, hazardous physical or mental condition (e.g., heart disease or hemophilia) that makes hospitalization medically necessary. All hospital services for dental procedures must be **prior-approved** by the Administrator. **Note:** Unless listed as a covered procedure in this section, the dentist's services for the procedure will not be covered.

Prior approval is required for inpatient and outpatient services.

Oral Surgery — Covered services include surgeon's charges for the following oral surgical procedures only:

- removal of fully or partially bony impacted teeth
- external or intraoral cutting and draining of cellulitis (not including treatment of dental-related abscesses)
- incision of accessory sinuses, salivary glands, or ducts
- medically necessary orthognathic surgery
- lingual frenectomy
- removal or biopsy of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of mouth when pathological examination is required
- removal of exostoses (bony growths) on the jaws and hard palate, provided the procedure is not done in preparation of the mouth for dentures

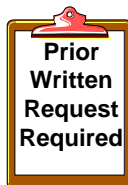
Prior approval is required for orthognathic surgery.

TMJ/CMJ Services — This Policy covers standard diagnostic, therapeutic, surgical, and nonsurgical treatments of temporomandibular joint (TMJ) or craniomandibular joint (CMJ) disorders or accidental injuries. Treatment may include orthodontic appliances and treatment, crowns, bridges, or dentures **only if** required because of an accidental injury to sound natural teeth involving the TMJ or CMJ.

Exclusions — **This Policy does not cover** oral or dental procedures not specifically listed as covered such as, but not limited to:

- nonstandard services (diagnostic, therapeutic, or surgical)
- removal of tori
- vestibuloplasty (surgical modification following periodontal treatment)
- dental services that may be related to, or required as the result of, a medical condition or procedure (e.g., chemotherapy or radiation therapy)
- procedures involving orthodontic care, the teeth, dental implants, periodontal disease or condition, or preparing the mouth for dentures
- procedures to correct anomalies relating to teeth or structures supporting the teeth or for cosmetic procedures when the surgery does not correct a bodily malfunction
- duplicate or "spare" appliances
- personalized restorations, cosmetic replacement of serviceable restorations, or materials (such as precious metals) that are more expensive than necessary to restore damaged teeth
- artificial devices and/or bone grafts for denture wear

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■ Diabetic Services

See "Lab, X-Ray, and Other Diagnostic Services" for diabetes-related laboratory tests.

See "Prescription Drugs and Other Items" for benefits for insulin and prescriptive oral agents to control blood glucose levels, needles, syringes, and test strips

Diabetes Self-Management — This Policy covers diabetes self-management training and education prescribed by a health care provider. A *diabetes patient education program* is a planned program of instruction that is:

- provided by a health professional diabetes educator who is certified by the National Certification Board for Diabetes Educators (CDE); and
- designed to teach patients with diabetes and their families to:
 - understand the relationship between diabetes control and complications
 - perform diabetic management skills to achieve adequate diabetes control
 - avoid frequent hospital confinements and complications

Covered services are limited to:

- medically necessary visits upon the diagnosis of diabetes
- visits following a physician diagnosis that represents a significant change in your symptoms or condition that warrants changes in your self-management
- visits when re-education or refresher training is prescribed by a health care provider
- medical nutrition therapy related to diabetes management

Diabetes self-management benefits are limited to a maximum benefit payment of **\$800** per calendar year with a **\$2,500** lifetime maximum benefit payment. These maximum limitations do not apply to diabetic equipment, supplies, or laboratory charges.

Diabetic Supplies and Equipment — This provision of the Policy covers the following supplies and equipment for diabetic members and individuals with elevated blood glucose levels due to pregnancy (for supplies, this Policy covers up to a **month's supply** purchased during any given month):

- insulin pump supplies
- injection aids, including those adaptable to meet the needs of the legally blind
- insulin pumps
- blood glucose monitors, including those for the legally blind
- medically necessary podiatric appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices, and shoe modifications
- insulin needles, syringes, and diabetic supplies (e.g., glucagon emergency kits, autolet, lancets, lancet devices, blood glucose and visual reading urine and ketone test strips) (There is a separate copayment for each item purchased.)

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Prior approval is required for items costing \$500 or more, insulin pumps, and orthotics.

■ Equipment, Orthotics, Appliances, Supplies, and Prosthetics

For diabetic equipment and supplies, see "Diabetic Services."

Durable Medical Equipment and Appliances — This Policy covers the following items:

- orthopedic appliances
- replacement of items only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- oxygen and oxygen equipment, wheelchairs, hospital beds, crutches, and other necessary durable medical equipment
- lens implants for aphakic patients (those with no lens in the eye) and soft lenses or sclera shells (white supporting tissue of eyeball)
- either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) when necessary to replace lenses absent at birth or lost through cataract or other intraocular surgery or ocular injury, to treat conditions related to genetic inborn errors of metabolism, or prescribed by a physician as the only treatment available for keratoconus (Duplicate glasses/lenses are not covered. Replacement is covered only if a physician or optometrist recommends a change in prescription due to a change in your medical condition.)
- cardiac pacemakers
- stethoscopes and blood pressure monitors
- the rental of (or at the option of the Administrator, the purchase of) durable medical equipment, including repairs to purchased equipment, when prescribed by a covered health care provider and required for therapeutic use

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Prior approval is required for orthopedic appliances, long-term rental of an item, and when total charges for an item equal \$500 or more. (*Total charges* means either the total purchase price of the item or total rental charges for the estimated period of use.)

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Hearing Aids — This Policy covers the following items if prescribed by a physician and received from a physician, qualified audiologist, or hearing aid dealer:

- the hearing aid unit and its acquisition costs
- ear mold, necessary cords, tubing, and connectors
- standard package of batteries
- earphone or oscillator

This Policy does **not** cover:

- "spare" hearing aids
- hearing aids that do not meet FDA or FTC requirements
- eyeglass-type hearing aids, to the extent the charge for such hearing aid exceeds the covered hearing aid expense for one basic behind-the-ear type model

Prior approval is required for items costing \$500 or more.

Cochlear implantation of a hearing device (such as an electromagnetic bone conductor) for the profoundly hearing impaired, including the cost of the device and training to use the device, may be covered.

Prior approval, submitted in writing, is required.



Medical Supplies — For the following medical supplies, this Policy covers up to a **month's supply** purchased during any given month:

- colostomy bags, catheters
- gastrostomy tubes
- hollister supplies
- tracheostomy kits, masks
- lamb's wool or sheepskin pads
- ace bandages, elastic supports when billed by a physician or other provider during a covered office visit
- slings

Orthotics and Prosthetic Devices — This Policy covers:

- functional orthotics only for patients having a locomotive problem or gait difficulty resulting from mechanical problems of the foot, ankle, or leg (A functional orthotic is used to control the function of the joints.)
- surgically implanted prosthetics or devices, including penile implants required as a result of illness or injury
- externally attached prostheses to replace a limb or other body part lost after accidental injury or surgical removal; their fitting, adjustment, repairs, and replacement
- replacement of prosthetics only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- breast prosthetics when required as the result of a mastectomy

When alternative prosthetic devices are available, the allowance for a prosthesis will be based upon the most cost-effective, medically appropriate item.

Prior approval is required for orthotics, surgically implanted prosthetics, long-term rental of an item, and when total charges for an item equal \$500 or more. (*Total charges* means either the total purchase price of the item or total rental charges for the estimated period of use.)

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Exclusions — This Policy does **not** cover, regardless of therapeutic value, items such as, but not limited to:

- air conditioners, biofeedback equipment, humidifiers, purifiers, self-help devices, or whirlpools
- items that are primarily nonmedical in nature such as Jacuzzi units, hot tubs, exercise equipment, heating pads, hot water bottles, or diapers
- nonstandard or deluxe equipment when standard equipment is available and adequate
- external prosthetics that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing
- repairs to items that you do not own
- comfort items such as bedboards, beds or mattresses of any kind, bathtub lifts, overbed tables, or telephone arms
- repair costs that exceed the rental price of another unit for the estimated period of need, or repair or rental costs that exceed the purchase price of a new unit
- dental appliances (See "Dental-Related/TMJ Services and Oral Surgery" for exceptions.)
- accommodative orthotics (deal with structural abnormalities of the foot, accommodate such abnormalities, and provide comfort, but do not alter function)
- orthopedic shoes, unless joined to braces (Diabetic members and members with diagnosed severe neuropathy may be eligible to receive benefits for these

items. Call the Administrator's Health Services department for details. Also see "Diabetic Services.")

- equipment or supplies not ordered by a health care provider, including items used for comfort, convenience, or personal hygiene
- duplicate items; repairs to duplicate items; or the replacement of items because of loss, theft, or destruction
- voice synthesizers or other communication devices
- eyeglasses or contact lenses or the costs related to prescribing or fitting of glasses or contact lenses, unless listed as covered; sunglasses, special tints, and other extra features for eyeglasses or contact lenses
- syringes or needles for self-administering drugs (Coverage for insulin needles and syringes and other diabetic supplies not listed as covered in this section is described under "Diabetic Services.")
- items that can be purchased over-the-counter (unless listed as covered under "Medical Supplies"), including but not limited to dressings for bed sores or burns, gauze, and bandages

■ Family Planning/Infertility Services

For oral contraceptive coverage, see "Prescription Drugs and Other Items."

Family Planning — Covered family planning services include FDA-approved devices and other procedures such as:

- injection of Depo-Provera for birth control purposes
- diaphragm, including fitting
- NORPLANT device, including surgical implantation and removal
- IUDs or cervical caps, including fitting, insertion, and removal
- surgical sterilization procedures such as vasectomies and tubal ligations

Exclusions — This Policy does **not** cover services not listed as covered, such as contraceptive devices that do not require a prescription, including over-the-counter contraceptive products such as condoms and spermicide.

Infertility-Related Services — This Policy covers the following infertility-related treatments (note that the following procedures only *secondarily* also treat infertility):

- surgical treatments such as opening an obstructed fallopian tube, epididymis, or vas when the obstruction is **not** the result of a surgical sterilization
- replacement of a naturally occurring hormone if there is documented evidence that the hormone is deficient

The above services are the **only** infertility-related treatments that will be considered for benefit payment.

Infertility *testing* is covered only to diagnose the cause of infertility. Once the cause has been established and the treatment determined to be noncovered, no further testing is covered. For example, the Pool will cover lab tests to monitor hormone levels following the hormone replacement treatment listed as covered above. However, daily ultrasounds to monitor ova maturation are **not** covered since the testing is being used to monitor a noncovered infertility treatment.

Prior approval is required for all infertility-related services.

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

- sterilization reversal for males or females
- infertility treatments and related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization
- Gamete Intrafallopian Transfer (GIFT) or Zygote Intrafallopian Transfer (ZIFT)
- cost of donor sperm
- artificial conception or insemination, including fertilization and/or growth of a fetus outside the mother's body in an artificial environment, such as in-vivo or in-vitro ("test tube") fertilization, and embryo transfer; drugs for induced ovulation; or other artificial methods of conception

■ Genetic Inborn Errors of Metabolism

This Policy covers medically necessary expenses related to the diagnosis, monitoring, and control of genetic inborn errors of metabolism (as defined in *Section 10: Definitions*). Covered services include medical assessment, including clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the genetic inborn error of metabolism, nutritional management, and **prior-approved** special medical foods (as defined) that are used to treat and to compensate for the metabolic abnormality of members with genetic inborn errors of metabolism in order to maintain their adequate nutritional status. In order to be covered, services cannot be excluded under any other provision of this booklet and are paid according to the provisions of the Policy that apply to that particular type of service (e.g., special medical foods are covered under "Prescription Drugs and Other Items," medical assessments under "Physician Visits/Medical Care," and corrective lenses under "Equipment, Orthotics, Appliances, Supplies, and Prosthetics").

To be covered, the member must be receiving medical treatment provided by licensed health care professionals, including physicians, dietitians, and nutritionists, who have specific training in managing patients diagnosed with genetic inborn errors of metabolism.

■ Home Health Care/Home I.V. Services

For oxygen, ostomy supplies, and medical equipment, see "Equipment, Supplies, and Prosthetics."

Conditions and Limitations of Coverage — If you are homebound (unable to receive medical care on an outpatient basis), home health care and home I.V. services are covered. Benefits are limited to **100 visits** per calendar year. A *visit* is one period of home health service of up to four hours. Services must be provided under the direction of a physician and nursing management must be through a home health care agency approved by the Administrator.

Prior approval is required for home health care or home I.V. therapy.

Covered Services — The following services are covered, subject to the conditions and limitations above, when provided by an approved home health care agency during a covered visit in your home:

- skilled nursing care provided on an intermittent basis by a registered nurse or licensed practical nurse
- physical, occupational, respiratory, or speech therapy provided by licensed or certified therapists

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- intravenous medications and other prescription drugs ordinarily not available through a retail pharmacy if **prior approval** is received from the Administrator (If drugs are *not* provided by the home health care agency, see “Prescription Drugs and Other Items.”)
- parenteral and enteral nutritional products that can only be legally dispensed by the written prescription of a physician and are labeled as such on the packages (If *not* provided by the home health care agency, see “Prescription Drugs and Other Items.”)
- medical supplies
- skilled services by a qualified aide to do such things as change dressings and check blood pressure, pulse, and temperature

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

- care provided primarily for your or your family’s convenience
- homemaking services or care that consists mostly of bathing, feeding, exercising, preparing meals for, moving, giving medications to, or acting as a sitter for the patient (See the “Custodial Care” exclusion in *Section 5*.)
- services provided by a nurse who ordinarily resides in your home or is a member of your immediate family
- nonprescription enteral nutritional products

Hospice Care

Conditions and Limitations — This Policy covers hospice services for a terminally ill member received during a hospice benefit period when provided by a hospice program approved by the Administrator. Benefits are usually limited to two six-month benefit periods. (If you need an extension of the hospice benefit period, the hospice agency must provide a new treatment plan and the attending physician must recertify your condition to the Administrator. However, no more than two hospice benefit periods will be approved.)

Prior approval is required for hospice care.

Covered Services — The following services are covered, subject to the conditions and limitations above, under the hospice care benefit:

- inpatient hospice care and hospice home visits by a physician
- skilled nursing care by a registered nurse or licensed practical nurse
- physical, occupational therapy, speech therapy provided by licensed providers
- medical supplies (If supplies are *not* provided by the hospice agency, see “Equipment, Supplies, and Prosthetics.”)
- drugs and medications for the terminally ill patient (If drugs are *not* provided by the hospice agency, see “Prescription Drugs and Other Items.”)
- medical social services provided by a qualified individual with a degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training, and experience (Such services must be recommended by a physician to help the member or his/her family deal with a specified medical condition.)
- services of a home health aide under the supervision of a registered nurse and in conjunction with skilled nursing care
- nutritional guidance and support, such as intravenous feeding and hyperalimentation
- respite care for a period not to exceed 5 continuous days for every 60 days of hospice care and no more than two respite care periods during the hospice benefit period (*Respite care* provides a brief break from total care-giving by the family.)

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

- food, housing, or delivered meals
- medical transportation
- volunteer services
- homemaker and housekeeping services; comfort items
- private duty nursing
- pastoral, spiritual, or bereavement counseling
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this Policy
- care or services received after the member's coverage terminates

The following services are **not** hospice care benefits but may be covered elsewhere under this Policy: acute inpatient hospital care for curative services, durable medical equipment, physician visits unrelated to hospice care, and ambulance services.

■ Hospital/Other Facility Services

If applicable, see:

- "Chemical Dependency"*
- "Dental-Related/TMJ Services and Oral Surgery"*
- "Hospice Care"*
- "Pregnancy-Related Services"*
- "Mental Health Services"*
- "Newborn Care"*
- "Skilled Nursing Facility Services"*

For inpatient physician medical visits, see "Physician Visits/Medical Care."

For inpatient and outpatient physical, speech, and occupational therapy, including joint manipulation, chemotherapy, radiation therapy, dialysis, and for cardiac and pulmonary rehabilitation, see "Therapy and Rehabilitation."

See other subheadings in this section that apply to the type of services required during an admission, such as "Surgery and Related Services" or "Transplant Services."

See Section 8 for details about enrolling your newborn.

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Inpatient Services — For acute care received during a covered hospital admission, this Policy covers semiprivate room or special care unit (e.g., ICU, CCU) expenses and other medically necessary services provided by the facility. For hospitals that do not have semiprivate rooms, the covered room rate will be 90 percent of the hospital's lowest private room rate. (If you have a private room for any reason other than isolation, covered room expenses are limited to the average semiprivate room rate, whether or not a semiprivate room is available. The Administrator must give **prior approval** for medically necessary private room charges to be covered.)

Prior approval is required for all nonemergency inpatient admissions.

If you are admitted because of an **emergency** or for a pregnancy-related condition, the Administrator must be called **within 48 hours** of the admission or as soon as reasonably possible or benefits for covered facility services will be **reduced by 20 percent**.

Outpatient/Emergency Room Services — This Policy covers medically necessary outpatient, observation, and other treatment room services.

Emergency Room — If services are received in an emergency room or other trauma center, the condition must meet the definition of an “emergency” in order to be covered. If the emergency room is used for conditions that are not emergency conditions, benefits may be denied.

■ Lab, X-Ray, Other Diagnostic Services

For services received during a covered inpatient admission, see “Hospital/Other Facility Services.”

If applicable, also see these topics:

“Dental-Related/TMJ Services and Oral Surgery”

“Preventive Services”

“Transplant Services”

For invasive diagnostic procedures such as biopsies and endoscopies or any procedure that requires the use of an operating or recovery room, see “Surgery and Related Services.”

This Policy covers diagnostic services, including preadmission testing, that are related to an illness or injury. Covered services include:

- x-ray and radiology services, ultrasound, and imaging studies
- laboratory and pathology tests
- EKG, EEG, and other electronic diagnostic medical procedures
- audiometric (hearing) and vision tests required for the diagnosis and/or treatment of an accidental injury or an illness or for prescribing an appropriate hearing aid for a known hearing loss
- direct skin (percutaneous and intradermal) and patch allergy tests; radio-allergosorbent testing (RAST)
- an annual routine, low-dose mammogram screening and Pap test in accordance with national medical standards (if you have exhausted your annual maximum benefit for preventive services)

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Note: To be covered, infertility-related testing (see “Family Planning/Infertility Services”), PET (positron emission tomography) scans, cardiac CT scans, and home sleep studies require **prior approval** from the Administrator. (These services may not be approved.)

Preadmission Testing — This Policy covers 100 percent of the covered charge for hospital outpatient preadmission testing that is received **within 10 days** before the start of a related inpatient stay. This benefit is not subject to deductible, coinsurance, or out-of-pocket limit provisions.

■ Mastectomy Services

This Policy covers medically necessary hospitalization related to a covered mastectomy (including at least 48 hours of inpatient care following a mastectomy and 24 hours following a lymph node dissection).

This Policy also covers cosmetic breast surgery for a mastectomy related to breast cancer. Benefits are limited to:

- cosmetic surgery of the breast/nipple on which the mastectomy was performed, including tattooing procedures; and
- the initial surgery of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications following the mastectomy, including treatment of lymphedema.

Prior approval is required for cosmetic breast surgery.

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This Policy does **not** cover subsequent procedures to correct unsatisfactory cosmetic results attained during the initial breast/nipple surgery or tattooing, or breast surgery that has not received prior approval from the Administrator.

■ Mental Health Services

For services related to alcoholism or drug abuse, see "Chemical Dependency."

Medical Necessity — In order to be covered, treatment must be medically necessary and not experimental or investigational. Therapy must be:

- required for the treatment of a distinct disorder as defined by the latest version of the *Diagnostic and Statistical Manual* published by the American Psychiatric Association; and
- reasonably expected to result in significant and sustained improvement in your condition and daily functioning; and
- consistent with your symptoms, functional impairments, and diagnoses, and in keeping with generally accepted national and local standards of care; and
- provided to you at the least restrictive level of care.

Covered Services — This Policy covers medically necessary short-term inpatient and outpatient care, evaluation, diagnosis, crisis intervention, and/or treatment of acute mental illness or other mental condition not related to alcoholism or other chemical dependency. This Policy covers inpatient physician services received on a day during which hospital benefits were provided. Covered services include:

- therapeutic individual and group psychotherapy rendered by psychiatrists, psychologists, licensed family therapists, and other providers (as defined in *Section 10: Definitions*)
- medical management of prescription medication
- intake evaluations and psychological testing
- inpatient family counseling, or counseling with family members to assist in the patient's diagnosis and treatment
- other therapeutic services, as appropriate

Prior approval is required for all inpatient and outpatient mental health services. (Outpatient benefits are not available for services received while you are an inpatient. Inpatient benefits are not available for services received on an outpatient basis.)

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

- services provided or billed by a school, halfway house, or residential treatment center or their staff members
- psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education
- court-ordered or police-ordered services unless the services would otherwise be covered; services rendered as a condition of parole or probation
- biofeedback or hypnotherapy
- religious counseling; marital counseling
- the cost of any damages to a treatment facility
- custodial care (See the "Custodial Care" exclusion in *Section 5*.)
- services related to rehabilitation of alcoholism or other chemical dependency (See "Chemical Dependency.")
- confinement for the purpose of environmental change
- treatment for learning disabilities or behavioral problems

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(800) 325-8334



■ Newborn Care

See Section 8 for details on obtaining coverage for your newborn.

If you obtain coverage for your newborn child within 31 days of birth, his/her newborn care is covered. If you do not obtain coverage for the newborn within 31 days of birth and pay the additional premium required, no benefits are available for newborn care.

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Admission review approval is required if your eligible newborn stays in the hospital longer than the mother for nonroutine medical or surgical services. You must call for approval **before** the mother is discharged from the hospital.

■ Physician Visits/Medical Care

If applicable, see these topics:

"Acupuncture Services"

"Dental-Related/TMJ Services and Oral Surgery"

"Family Planning/Infertility Services"

"Mental Health Services"

"Newborn Care"

"Pregnancy-Related Services"

"Therapy and Rehabilitation" for cardiac and pulmonary rehabilitation, chemotherapy, radiation therapy, and dialysis; outpatient physical, occupational, and speech therapy; joint manipulation; inpatient physical rehabilitation

"Preventive Services"

"Surgery and Related Services" or "Transplant Services"

This section describes benefits for medical visits to a health care provider for evaluating your condition and planning a course of treatment. See the topics referenced above for more information regarding a particular type of service.

Office, Urgent Care, and Emergency Room Visits

Covered services include office, urgent care facility, and emergency room visits, consultations (including second or third surgical opinions), and examinations — when not related to hospice care or payable as part of a surgical procedure. This Policy also covers other services and supplies received during the visit, such as allergy injections, therapeutic injections, casting, and sutures.

Emergency Room — If services are received in an emergency room or other trauma center, the condition must meet the definition of an “emergency” in order to be covered. If the emergency room is used for conditions that are not emergency conditions, benefits may be denied.

Inpatient Medical Visits

With the exception of dental-related services (see “Dental-Related/TMJ Services and Oral Surgery”), this Policy covers the following services when received on a covered inpatient hospital day:

- visits for a condition requiring **only** medical care, unless related to hospice care (See “Hospice Care.”)
- consultations (including second opinions) and, if surgery is performed, inpatient visits by a provider who is not the surgeon and who provides medical care **not** related to the surgery (For the surgeon’s services, see “Surgery and Related Services” or “Transplant Services.”)
- medical care requiring two or more physicians at the same time because of multiple illnesses

■ Pregnancy Complications

See “Physician Visits/Medical Care” and “Hospital/Other Facility Services” for benefits for routine newborn care.

See Section 4: Maternity Services: *OPTIONAL COVERAGE* if you paid the additional premium required for coverage of routine maternity care and elective abortions.

Covered Services — This Policy covers the complications of pregnancy the same as any other illness whether or not you purchase the additional coverage for routine maternity services. Complications of pregnancy include C-sections, ectopic pregnancies, toxemia, abruptio placentae, miscarriage, therapeutic termination of pregnancy prior to full term, and other complications as determined by the Administrator.

This Policy covers all medically necessary hospitalization related to complications of pregnancy, including at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a C-section delivery.

Prior approval is required for genetic testing or counseling.

Exclusions — Elective abortions and routine vaginal deliveries are not considered a complication of pregnancy and are not covered unless the member has purchased the **optional** maternity coverage described in *Section 4*.

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■ Prescription Drugs and Other Items

This Policy covers the following drugs, supplies, and other products through the prescription drug plan **only when dispensed by a participating pharmacy** under the Retail Pharmacy Program or Specialty Pharmacy Drug Program (unless required as the result of an emergency, as defined) **or ordered through the Mail Order Service:**

- prescription drugs and medicines (including compounded medications of which at least one ingredient is a prescription drug, prescriptive oral agents for controlling blood sugar levels, and prescription contraceptive medications), unless listed as an exclusion
- specialty pharmacy drugs such as, but not limited to, self-administered injectable drugs such as growth hormone, Copaxone, and Avonex (Most injectable drugs require **prior approval** from the Administrator. Some self-administered drugs, whether injectable or not, are identified as specialty pharmacy drugs and may have to be acquired through a participating specialty pharmacy provider in order to be covered.)

- insulin needles, syringes, and diabetic supplies (e.g., glucagon emergency kits, autolet, lancets, lancing devices, blood glucose and visual reading urine and ketone test strips) (There is a separate copayment for each item purchased.)
- special medical foods (as defined in *Section 10: Definitions*) that have been **prior-approved** by the Administrator and that are used to treat and to compensate for the metabolic abnormality of members with genetic inborn errors of metabolism in order to maintain their adequate nutritional status

Prior Approval Required for Certain Drugs — A list of drugs requiring prior approval is available from a Customer Service representative or on the BCBSNM Web site at www.bcbsnm.com. Your physician can request the necessary prior approval.

Retail Pharmacy/Specialty Pharmacy Program — All items covered under this provision of your Policy must be purchased from a participating retail pharmacy. **Some drugs may have to be purchased from a participating specialty pharmacy provider in order to be covered.** (Refer to your provider directory for a list of participating pharmacies and specialty pharmacy providers. If you do not have a directory, call Customer Service for a list or visit the BCBSNM Web site.)

You must present your NM Medical Insurance Pool ID card to the pharmacist at the time of purchase to receive this benefit. **Note:** You do not receive a separate prescription drug ID card; use your Pool ID card to receive all services covered under this Policy. You can use your ID card to purchase covered items only for yourself. When coverage for you ends, the ID card may not be used to purchase drugs or other items.

If you do not have your ID card with you or if you purchase your prescription or other covered item from a nonparticipating provider in an **emergency**, you must pay for the purchase in full and then submit a claim directly to the prescription drug plan administrator. (You should have received the address of the administrator among the materials you received upon enrollment. If you did not, call a Customer Service representative for the address and a claim form or visit the BCBSNM Web site at www.bcbsnm.com.)

Mail Order Service — To use the Mail Order Service, follow the instructions outlined in the materials provided to you in your enrollment packet. (If you do not have this information, call a Customer Service representative.)

Note: Prescription drugs and other items may **not** be mailed outside the United States. Call the Administrator's Health Services department at least **two weeks** before you intend to leave if you are leaving the country and need an extended supply of medication.

Brand-Name vs. Generic Drug Costs — If you or the provider requests a brand-name drug when there is an FDA-approved generic equivalent available (and your doctor does not specify "no substitution" on the prescription), **you must pay the difference in cost between the brand-name and its generic**, plus the usual copayment.

Member Copayments — For covered drugs (including specialty pharmacy drugs), special medical foods, and other items, you pay either **30 percent** of the

covered charge or a **\$5 copayment**, whichever amount is greater, for each prescription filled or item purchased. However, your copayment will not exceed **\$250** per prescription or refill. You may also have to pay the difference between the cost of a brand-name drug and its generic equivalent (see above). Copayments are **not** subject to the annual deductible, are not included in the out-of-pocket limit, and are not eligible for reimbursement once the out-of-pocket limit is reached.

Supply Limitations — For each copayment listed, you can obtain the following supply of a single covered prescription drug or other item:

Program	Supply Maximum	Copay Requirements
Retail Pharmacy	During each one-month period, a 34-day supply or 100 units (e.g., pills), whichever is less. For oral contraceptives, the supply is limited to one menstrual cycle (normally 28 days).	30 percent of covered charges (with a minimum copayment of \$5 and up to a maximum copayment amount of \$250 per prescription or refill).
Mail-Order	During each three-month period, a 90-day supply .	30 percent of covered charges (with a minimum copayment of \$15 and up to a maximum copayment amount of \$750 per prescription or refill).

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

- nonprescription and over-the-counter drugs (unless specifically listed as covered) including herbal or homeopathic preparations, or prescription drugs that have over-the-counter equivalents (Equivalents have the same strength and cause similar action on bodily tissues.)
- drugs (or special medical foods or other items covered only under the prescription drug plan) purchased from a nonparticipating pharmacy or other provider except in cases of emergency
- refills before the normal period of use has expired (Prescriptions cannot be refilled until at least 75 percent of the previously dispensed supply will have been exhausted according to the physician’s instructions. Call the Administrator for instructions on obtaining a greater supply if you are leaving home for more than a 30-day period of time.)
- replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced
- infertility medications
- therapeutic devices or appliances, including support garments and other non-medicinal substances
- medications or preparations used for cosmetic purposes (such as preparations to promote hair growth or medicated cosmetics), including tretinoin (sold under such brand names as Retin-A) for cosmetic purposes
- shipping, handling, or delivery charges
- prescription drugs required for international travel or work
- appetite suppressants or diet aids; weight reduction drugs; food or diet supplements and medication prescribed for body building or similar purposes

Brand-Name Exclusion — The Pool reserves the right to exclude any injectable drug currently being used by a member. Proposed new uses for injectable drugs previously approved by the FDA will be evaluated on a medication-by-medication basis. Call a Health Services representative if you have any questions about this Policy.

■ Preventive Services

See "Lab, X-Ray, and Other Diagnostic Services" for routine Pap tests and mammograms. Such services are not subject to the maximum annual benefit or cost-sharing provisions described in this subsection.

This Policy covers preventive services in accordance with national medical standards, the state of New Mexico, the American Academy of Pediatrics, and the U.S. Preventive Services Task Force, including services such as, but not limited to, the following:

- routine physical, breast, and pelvic examinations
- routine adult and pediatric immunizations
- an annual routine gynecological examination and low-dose mammogram screenings, papillomavirus screening, and Pap tests
- annual prostate examination and related testing
- 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; and periodic glaucoma eye tests
- well-child care
- 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.)

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 this Policy.

Benefit Limitations and Member Cost-Sharing — Benefits are payable under all deductible plan options at 100 percent of the covered charge up to a maximum calendar year benefit of **\$500 per member** (thereafter, no more benefits are available during that calendar year for routine or preventive services). These services are not subject to the calendar year deductible. **Note:** If you have exhausted your maximum calendar year benefit and have not yet received coverage for a routine Pap test and/or mammogram; see "Lab, X-Ray, and Other Diagnostic Services."

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

- employment physicals, insurance examinations, or examinations at the request of a third party (the requesting party may be responsible for payment); premarital examinations; sports or camp physicals; any other nonpreventive physical examination
- immunizations or medications required for international travel
- hepatitis B immunizations when required due to possible exposure during the member's work
- eye refractions; routine eye examinations
- hearing or visual screening for members aged 18 or older

■ Skilled Nursing Facility Services

This Policy covers the first **100 days** of confinement in a skilled nursing facility (SNF) each calendar year. Expenses incurred after the 100th day of skilled nursing confinement in a calendar year are not covered, and they cannot be used toward satisfying the deductible or out-of-pocket limits.

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Prior approval is required for skilled nursing facility services.

Conditions of Coverage — To be covered, the confinement must satisfy all of the following conditions:

- be recommended by a physician who certifies that 24-hour-a-day nursing care is required
- it starts within seven days from the last day of hospital confinement that lasts at least three continuous days (This does not apply to readmission to a skilled nursing facility if such readmission occurs within five days of the previous SNF discharge date.)
- be for the purpose of receiving the care for the condition that caused the hospital confinement
- be under the supervision of a physician

Confinement in an Acute Care Hospital — In some areas of New Mexico, a freestanding skilled nursing facility is not available. Therefore, some hospitals have set aside some of their semiprivate rooms to provide for skilled nursing care services. In these cases, the covered charge is one-half of the hospital's most common semiprivate room rate for up to 100 days of SNF care.

Confinement in an acute care hospital is a covered SNF service or supply if:

- the level of care needed has been reclassified from acute care to skilled nursing care;
- no skilled nursing care beds are available within a 30-mile radius of the hospital;
- the SNF is Medicare-certified and approved; and
- the SNF is licensed by the State of New Mexico.

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

- private room expenses, unless your medical condition requires isolation for protection from exposure to bacteria or diseases (e.g., severe burns or conditions that require isolation according to public health laws)
- admissions related to noncovered services or procedures
- extended care or residential treatment center admissions or admissions to similar institutions
- maintenance therapy or care provided after you have reached your rehabilitative potential (Even if you have not reached your rehabilitative potential, this Policy does **not** cover services that exceed maximum benefit limits.)
- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay

■ Smoking Cessation

This Policy covers smoking and tobacco use cessation treatment, limited to the following services received from participating providers (subject to member cost-sharing provisions applicable to the type of service received, such as prescription drugs, counseling, etc.):

- diagnostic services to identify tobacco use, use-related conditions, and dependence; and
- two 90-day courses of **prior-approved** treatment with FDA-approved prescription drugs to assist you with quitting tobacco use or smoking (see “Prescription Drugs and Other Items” for benefit details); and
- a choice of cessation counseling of up to 90 minutes total provider contact time or two multi-session group programs per calendar year (Covered counseling is restricted to programs that meet minimum requirements established by the NM Public Regulation Commission; see *Definitions* section for minimum cessation counseling requirements.)

Starting any course of prescription drug therapy or cessation counseling constitutes one entire course of drug therapy or cessation counseling – even if you discontinue or fail to complete the course. For example, if you purchase a one-month supply of a prescription drug for smoking cessation and do not continue the drug beyond one month, you will have used up one entire 90-day course of treatment with the 30-day supply.

To locate a provider that is approved to provide counseling sessions, you may call BCBSNM Customer Service, or you may ask your personal physician about obtaining a prescription for smoking cessation drugs.



This Policy does **not** cover the following services:

- cessation counseling or treatment received from non-approved providers
- acupuncture, biofeedback, or hypnotherapy for smoking/tobacco use cessation
- over-the-counter tobacco cessation products, including but not limited to items such as nicotine patches or nicotine gum

■ Surgery and Related Services

For oral surgery, see “Dental-Related/TMJ Services and Oral Surgery.”

If applicable, also see these topics:

“Family Planning/Infertility Services” for surgical sterilization, limited infertility treatments, etc.

“Hospital/Other Facility Services”

“Mastectomy Services”

“Pregnancy-Related Services” (for complicated deliveries, C-sections, ectopic pregnancies, etc.)

“Transplant Services”

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You are responsible for obtaining admission review and/or other prior approval when necessary (see *Section 2*).

Surgeon’s Services

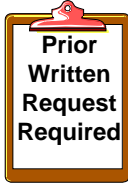
Covered services include surgeon’s charges for a covered surgical procedure.

Morbid Obesity Surgery — This Policy covers the surgical treatment of morbid obesity if approved by the Administrator before treatment begins. *Morbid obesity* means the state of being either 45 kilograms or 100 percent over ideal body weight.

Prior approval is required.

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Reconstructive Surgery — Reconstructive surgery improves or restores bodily function to the level experienced before the event that necessitated the surgery, or in the case of a congenital defect, to a level considered normal. Such surgeries may have a coincidental cosmetic effect. This Policy covers reconstructive surgery when required to correct a **functional** disorder caused by:

- an accidental injury
- a disease process or its treatment (For breast surgery following a mastectomy, see “Mastectomy Services,” earlier in this *Section 3*.)
- a functional congenital defect (any condition, present from birth, that is significantly different from the common form; for example, a cleft palate or certain heart defects)

Prior approval, requested in writing, is required.

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

- cosmetic or plastic surgery or procedures, such as breast augmentation, rhinoplasty, and surgical alteration of the eye that does not materially improve the physiological function of an organ or body part (unless covered under “Mastectomy Services,” earlier in this *Section 3*)
- procedures to correct cosmetically unsatisfactory surgical results or surgically induced scars
- refractive keratoplasty, including radial keratotomy, or any procedure to correct visual refractive defect
- unless required for members with diagnosed severe neuropathy of the foot (when **prior-approved** by the Administrator) or as part of medically necessary diabetic disease management, trimming of corns, calluses, toenails, or bunions (except surgical treatment such as capsular or bone surgery)
- sex change operations or complications arising from transsexual surgery
- subsequent surgical procedures needed because you did not comply with prescribed medical treatment or because of a complication from a previous noncovered procedure (such as a noncovered organ transplant, sex change operation, or previous cosmetic surgery)
- procedures to correct anomalies relating to teeth or structures supporting the teeth or for cosmetic procedures when the surgery does not correct a bodily malfunction
- standby services unless the procedure is identified by the Administrator as requiring the services of an assistant surgeon and the standby physician actually assists

Anesthesia Services

This Policy covers necessary anesthesia services, including acupuncture used as an anesthetic, when administered during a covered surgical procedure by a physician, certified registered nurse anesthetist (CRNA), a licensed doctor of oriental medicine (for acupuncture), or other practitioner as required by law. (See “Acupuncture Services” for information about acupuncture benefits.)

Assistant Surgeon Services

Covered services include services of a professional provider who actively assists the operating surgeon in the performance of a covered surgical procedure when the procedure requires an assistant.

This Policy does **not** cover:

- services of an assistant only because the hospital or other facility requires such services

- services performed by a resident, intern, or other salaried employee or person paid by the hospital
- services of more than one assistant surgeon unless the procedure is identified by the Administrator as requiring the services of more than one assistant surgeon

Therapy and Rehabilitation

When billed by a facility during a covered admission, therapy is covered in the same manner as the other covered hospital services (see "Hospital/Other Facility Services").

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Chemotherapy and Radiation Therapy

This Policy covers the treatment of malignant disease by standard chemotherapy and treatment of disease by radiation therapy is covered.

Prior approval is required for high-dose chemotherapy treatments.

Cancer Clinical Trials — If you are a participant in a phase II, III, or IV approved cancer clinical trial that is being conducted in New Mexico, you may receive coverage for certain routine patient care costs incurred in the trial. The trial must be conducted as part of a scientific study of a new therapy or intervention and be designed to study the reoccurrence, early detection, or treatment of cancer. The persons conducting the trial must provide BCBSNM with notice of when the member enters and leaves a qualified clinical trial.

The routine patient care costs that are covered must be the same services or treatments that would be covered if you were receiving standard cancer treatment. Member cost-sharing provisions will apply to these benefits. Benefits also include FDA-approved prescription drugs that are not paid for by the manufacturer, distributor, or provider of the drug. See "Prescription Drugs and Other Items."

If benefits for services provided in the trial are denied, see *Section 7* for requesting an appeal.

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Cardiac and Pulmonary Rehabilitation

This Policy covers outpatient cardiac rehabilitation programs initiated within six months of a cardiac incident and outpatient pulmonary rehabilitation services.

Prior approval is required.

Dialysis

This Policy covers the following services when received from a dialysis provider or in your home:

- renal dialysis (hemodialysis)
- continual ambulatory peritoneal dialysis (CAPD)
- apheresis and plasmapheresis
- the cost of equipment rentals and supplies for home dialysis

Prior approval is required for home dialysis.

Outpatient Physical, Occupational, and Speech Therapy; Manipulation of Joints

This Policy covers the following services for the treatment of accidental injury, illness, or conditions that existed at birth:

- occupational therapy
- physical therapy
- speech therapy, including audio diagnostic testing
- services or supplies necessary for the treatment of illness or accidental injury by alignment or manipulation of body joints and the spine not involved with fracture or surgery, limited to a maximum benefit of **\$1,500/calendar year**

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Prior approval is required for all physical, occupational, and speech therapy services. Services required due to reinjury or aggravation of an injury are also covered but must receive a separate **prior approval** from the Administrator, even if therapy was authorized for the original injury.

Conditions of Coverage — To be eligible for benefits, therapies must meet the following conditions:

- Services must be medically necessary to restore and improve lost bodily functions following illness or injury.
- Improvement would not normally be expected to occur without intervention.
- With regard to speech therapy, services restore a demonstrated ability to speak or swallow (the loss must not be due to a mental, psychoneurotic, or personality disorder); or develop or improve speech after surgery to correct a defect that both existed at birth and impairs or would have impaired the ability to speak.

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Physical Rehabilitation, Inpatient

This Policy covers inpatient physical rehabilitation services that are medically necessary to restore and improve lost bodily or cognitive functions following accidental injury, illness, or surgery and that are provided in facilities that are authorized by the Administrator. Hospitalization for rehabilitation must begin **within one year** after the onset of the condition and while the member is covered under this Policy. Benefits are limited to a maximum of **30 days** per calendar year.

Prior approval, obtained at least one week before the admission, is required.

Exclusions

This Policy does **not** cover:

- maintenance therapy or care provided after you have reached your rehabilitative potential (Even if you have not reached your rehabilitative potential, this Policy does **not** cover services that exceed maximum benefit limits.)
- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay
- diagnostic, therapeutic, rehabilitative, or health maintenance services provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered provider
- therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights)
- massage therapy or rolfing
- speech therapy or diagnostic testing related to: learning disorders, deafness, or stuttering; or personality, developmental, voice, or rhythm disorders when these conditions are not the direct result of a diagnosed neurological, muscular, or structural abnormality involving the speech organs
- private room expenses, unless your medical condition requires isolation for protection from exposure to bacteria or diseases (e.g., severe burns or conditions that require isolation according to public health laws)

- admissions related to noncovered services or procedures (See “Dental-Related/TMJ Services and Oral Surgery” for an exception.)
- extended care or residential treatment center admissions or admissions to similar institutions

■ Transplant Services

Covered cardiac surgeries, such as valve replacements and pacemaker insertions, are covered under “Surgery and Related Services.”

Also see other subheadings in this section, such as “Hospital/Other Facility Services.”



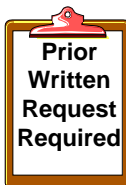
Prior Approval Required — Prior approval, requested in writing, is required **before** a pretransplant evaluation is scheduled. If approved, a case manager will be assigned to you (the transplant recipient candidate) by the Administrator and must later be contacted with the results of the evaluation.

If you are approved as a transplant recipient candidate, you must ensure that **prior approval** for the actual transplant is also received.

Note: Cornea transplants do not require prior approval. This is the only exception to the prior approval requirement for transplants.

Facility Must Be a Participating Transplant Provider — Benefits for covered services will be approved only when the transplant is performed at a facility that contracts with the Administrator, another Blue Cross Blue Shield (BCBS) Plan, or the Administrator’s national transplant network, for the transplant being provided. Your case manager will assist your provider with information on the exclusive network of contracted facilities and required approvals. Call the Administrator’s Health Services for information on these approved transplant programs.

Effect of Medicare Eligibility on Coverage — If you are now eligible for — or are *anticipating* receiving eligibility for — Medicare benefits, **you** are solely responsible for contacting Medicare to ensure that the transplant will be eligible for Medicare benefits.



Covered Transplants — This Policy covers the following organ/organ combination transplant procedures:

- bone marrow for a member with aplastic anemia, leukemia, severe combined immunodeficiency disease (SCID), or Wiskott-Aldrich syndrome, and other conditions determined by the Administrator to be medically necessary and not experimental or investigational
- cornea
- heart
- heart-lung
- kidney
- liver
- lung
- pancreas
- pancreas-kidney

These are the only transplants and organ-combination transplants that are covered.

The following benefits, limitations, and exclusions apply to this coverage for one year following the date of the actual transplant or retransplant. After one year, services are subject to usual health plan benefits and must be covered under other provisions of this Policy in order to be considered for benefit payment:

Organ Procurement or Donor Expenses — If a transplant is covered, the surgical removal, storage, and transportation of an organ acquired from a cadaver is also covered. If there is a living donor that requires surgery to make an organ available for a covered transplant, coverage is available for expenses incurred by the donor for surgery, organ storage expenses, and inpatient follow-up care only. Donor expenses are applied to the lifetime maximum transplant benefit described below. Benefits for the donor are payable only after expenses have been paid for the Pool member and only if the maximum benefit for transplants has not yet been reached.

This Policy does **not** cover donor expenses after the donor has been discharged from the transplant facility. Coverage for compatibility testing prior to organ procurement is limited to the testing of cadavers and, in the case of a live donor, to testing of the donor selected.

Recipient Travel and Per Diem Expenses — If the Administrator requires you (i.e., the transplant recipient) to temporarily relocate outside of your city of residence to receive a covered transplant, this Policy covers travel to the city where the transplant will be performed. Also, a standard per diem benefit (**\$150**) will be allocated for food and lodging expenses for one additional adult traveling with you (the transplant recipient). If the transplant recipient is a dependent child under the age of 18, benefits for travel and per diem expenses for **two** adults to accompany the child are available.

Travel expenses and standard per diem allowances are limited to a total combined lifetime maximum benefit payment of **\$10,000** per transplant. Your case manager may approve travel and per diem food and lodging allowances based upon the total number of days of temporary relocation, up to the maximum \$10,000 benefit. These amounts *are* applied to the lifetime maximum transplant benefit described below.

Travel expenses are **not** covered and per diem allowances are **not** paid if you *choose* to travel to receive a transplant for which travel is not considered medically necessary by the case manager. This Policy does **not** cover travel for a pre-transplant evaluation if the travel occurs more than five days before the actual transplant or date of admission, whichever is later. This Policy does **not** cover travel or provide per diem allowances for services required more than one year following the transplant or retransplant date.

Lifetime Maximum Transplant Benefit — Total benefits for human organ transplants are limited to a lifetime maximum payment **\$5,000,000** per member. Benefits applied toward this maximum include payments for hospitalization, medical services, travel, per diem allowances, and all other allowable expenses related to one or more transplants. The calculation of the maximum payment per member begins with the charges incurred five days before the date of the transplant or the date of admission for the transplant procedure, whichever

is later, and ends one year after the date of the transplant. The maximum benefit payment also includes any expenses payable on behalf of the donor.

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

- implantation of artificial organs or devices (mechanical heart); nonhuman organ transplants
- services related to a transplant performed in a facility not contracted directly or indirectly with the Administrator to provide the required transplant
- expenses incurred by a member of this Policy for the donation of an organ to another person
- donor expenses after the donor has been discharged from the transplant facility
- lodging, food, beverage, or meal expenses that are not covered by the per diem allowance, if available
- travel or per diem expenses:
 - incurred more than one year following or more than five days before the date of transplantation
 - if the recipient's case manager indicates that travel is not medically necessary
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; telephone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)