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Maternity Services: OPTIONAL COVERAGE

If you selected this additional, optional coverage (and paid the additional, required premium), this Policy covers normal, routine maternity care, including elective abortions, if one of the following conditions is met:

- The **pregnancy must have been conceived after the effective date of this optional maternity services coverage**. To calculate the date of conception, the Administrator relies on the obstetrician's estimated date of delivery for your pregnancy at full-term. If the estimated date is less than nine months after your routine maternity services coverage becomes effective, no benefits will be available for routine maternity services related to that pregnancy. **Note:** A HIPAA-eligible individual who has paid for this optional coverage does not have to have prior creditable coverage specific to maternity services to be covered for pregnancy, regardless of the date of conception.
- You had **previous coverage that provided benefits for routine maternity services** and no more than 31 days have elapsed between the termination date of that prior coverage and your effective date under this optional maternity services coverage or you are a HIPAA-eligible member.

If you experience complications of pregnancy or require a C-section, see "Pregnancy Complications" in Section 3. In such cases, conception does not have to occur after your effective date of coverage nor do you need to have had prior maternity services coverage in order for benefits to be available for the complication.

Call BCBSNM
for Approval:
(505) 291-3585 or
(800) 325-8334



Admission review approval is required. You must call **within 48 hours** of admission or as soon as possible. (If you are pregnant, you should call before your maternity due date.) See "Admission Review and Prior Approvals" in *Section 2*.

Covered Services — Covered maternity services include:

- hospital or other facility charges for semiprivate room, board, and other services, including the use of labor, delivery, and recovery rooms (This Policy covers all medically necessary hospitalization, including at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a C-section.)
- delivery services, including prenatal and postnatal medical care of an obstetrician, certified nurse-midwife, or licensed midwife in a hospital, in a licensed birthing center staffed by a certified nurse midwife or physician, or at home (Expenses for prenatal and postnatal care are included in the total covered charge for the actual delivery or completion of pregnancy.)
- pregnancy-related diagnostic tests, including genetic testing or counseling if **prior-approved** by the Administrator (Services must be sought due to a family history of a sex-linked genetic disorder or to diagnose a possible congenital defect caused by a present, external factor that increases risk, such as advanced maternal age or alcohol abuse. For example, tests such as amniocentesis or ultrasound to determine the sex of a child are not covered.)
- necessary anesthesia services by a provider qualified to perform such services, including acupuncture used as an anesthetic during a covered procedure and administered by a physician, a licensed doctor of oriental medicine, or other practitioner as required by law
- services of a physician who actively assists the operating surgeon in performing a covered procedure when the procedure requires an assistant
- elective termination of pregnancy prior to the third trimester