



New Mexico Medical Insurance Pool

"When no one else will help, we're there."



Health Care Policy

NMMIP Administrator
P.O. Box 27630
Albuquerque, NM 87125-7630
1-800-432-0750
(505) 816-5671 fax
www.nmmip.com

**THE NEW MEXICO MEDICAL INSURANCE POOL IS ADMINISTERED BY:
Blue Cross and Blue Shield of New Mexico (the "Pool Administrator")**

Customer Service — When you have questions or concerns, call or visit the Pool Administrator's (Blue Cross and Blue Shield of New Mexico) Customer Service department. You may either call toll-free or visit the Administrator's Albuquerque offices at:

Street address: 4373 Alexander Blvd. NE
Toll-free telephone number: 1-800-432-0750

Send **written inquiries/prior approval requests** and submit **medical/surgical claims*** to:

NM Medical Insurance Pool Administrator
P.O. Box 27630
Albuquerque, NM 87125-7630

Prior Approvals — For admission review or other prior approvals (including for prescription drugs, mental health and chemical dependency services), call the Administrator's Health Services department, Monday through Friday, between 8 a.m. and 5 p.m., Mountain Time. **Note:** If you need prior approval assistance between 5 P.M. and 8 A.M. or on weekends, call the Administrator's Customer Service department (1-800-432-0750).

(505) 291-3585 or 1-800-325-8334

Administrator Web Site — For provider network information, claim forms, and other information, or to e-mail your question to the Administrator, visit the BCBSNM Web site at:

www.bcbsnm.com

BlueCard Out-of-Area Program — When you are outside New Mexico and need health care services, you can call the Blue Cross and Blue Shield Association's BlueCard Program for assistance in locating a participating provider near you. Call:

1-800-810-BLUE (2583)

Out-of-State Claims Submission — Claims for health care services received outside New Mexico from providers that do not contract **directly** with the Administrator should be sent to the Blue Cross Blue Shield Plan in the state where services were received. See *Section 7* for details on submitting claims.

Prescription Drug Claims — Do not submit prescription drug claims to the Administrator. The name and address of the prescription drug plan administrator is in a separate brochure.

New Mexico Medical Insurance Pool — If you need to contact the New Mexico Medical Insurance Pool, you may write, telephone, e-mail, or check the Pool Web site:

P.O. Box 1594
Roswell, New Mexico 88202-1594
Telephone: (505) 622-4711
Email: pjennings@nmmip.com
Web site: www.nmmip.com



Welcome to the New Mexico Medical Insurance Pool (“Pool”)

This Policy is issued to you by the New Mexico Medical Insurance Pool (Pool), which was created by the New Mexico State Legislature in 1987. The Pool is a nonprofit program that offers health care Policies to eligible residents of New Mexico who are denied coverage in the private or public markets as well as individuals eligible under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Pool is governed by a board of directors consisting of consumer, industry, medical, and health planning representatives. It is funded through premiums from the members, assessments to health insurance companies, a federal assistance grant, and a premium tax credit from the state. The Pool contracts with Blue Cross and Blue Shield of New Mexico (BCBSNM) for administrative services.

It is very important that you read this Policy! It explains what benefits the Pool will provide. Following the procedures of this Policy can save you money. If you ever have a question, it is best to call **Customer Service**, and they can assist you in understanding this Policy. If you are not satisfied with this Policy, you may send it back to the Pool Administrator, BCBSNM, within ten days after you receive it, and your premium will be refunded.

We appreciate the opportunity to offer you this Policy, and hope this health plan serves you well.

Sincerely,

Patricia K. Jennings, Executive Director
New Mexico Medical Insurance Pool

CORRESPONDENCE MAY BE DIRECTED TO:

New Mexico Medical Insurance Pool
Post Office Box 1594
Roswell, New Mexico 88202-1594
Telephone number: (505) 622-4711
Fax number: (505) 622-4788
E-mail: pjennings@nmmip.com
www.nmmip.com

Be sure to read this booklet carefully and refer to the
“Summary of Benefits and Plan Options” beginning on page iv.

Table of Contents

Summary of Benefits and Plan Options	iv		
1 Your Health Care Policy	1		
Other Benefit-Related Materials	1		
Prescription Drug Plan Brochure	1		
Provider Network Directory	1		
ID Card (Carry At All Times)	1		
Admission Review/Prior Approval Required	2		
2 How Your Plan Works	3		
Provider Choices	3		
Deductibles, Coinsurance, Out-of-Pocket	4		
Plan Deductible	5		
Coinsurance and Out-of-Pocket Limit	5		
Admission Review & Other Prior Approvals	6		
Admission Review Approval	7		
Other Prior Approvals	8		
Advance Benefit Information	9		
Utilization Review/Quality Management	10		
Health Care Fraud Information	10		
3 Covered Services	11		
Acupuncture Services	11		
Ambulance Services	11		
Blood Services	12		
Chemical Dependency	12		
Dental-Related/TMJ Services/Oral Surgery	13		
Dental and Facial Accidents	13		
Facility Charges	14		
Oral Surgery	14		
TMJ/CMJ Services	14		
Diabetic Services	15		
Equipment, Orthotics, Appliances, Supplies, and Prosthetics	16		
Durable Medical Equipment/Appliances	16		
Hearing Aids	16		
Medical Supplies	17		
Orthotics and Prosthetic Devices	17		
Family Planning/Infertility Services	18		
Genetic Inborn Errors of Metabolism	19		
Home Health Care/Home I.V. Services	19		
Hospice Care	20		
Hospital/Other Facility Services	21		
Lab, X-Ray, Other Diagnostic Services	22		
Mastectomy Services	22		
Mental Health Services	23		
Newborn Care	24		
Physician Visits/Medical Care	24		
Office, Urgent Care, and Emergency Room	24		
Inpatient Medical Visits	24		
Pregnancy Complications	25		
Prescription Drugs and Other Items	25		
Preventive Services	28		
Skilled Nursing Facility Services	29		
Smoking Cessation	29		
		Surgery and Related Services	30
		Surgeon's Services	30
		Anesthesia Services	31
		Assistant Surgeon Services	31
		Therapy and Rehabilitation	32
		Chemotherapy and Radiation Therapy	32
		Cardiac and Pulmonary Rehabilitation	32
		Dialysis	32
		Outpatient Physical, Occupational, Speech Therapy; Manipulation of Joints	32
		Physical Rehabilitation, Inpatient	33
		Transplant Services	34
		4 Maternity Services: OPTIONAL COVERAGE	37
		5 General Limitations and Exclusions	38
		Admissions/Treatments Discontinued	38
		Before Effective Date of Coverage	38
		Biofeedback	38
		Blood Services	38
		Complications of Noncovered Services	38
		Convalescent Care or Rest Cures	38
		Cosmetic Services	38
		Custodial Care	39
		Dental-Related Services	39
		Domiciliary Care	39
		Duplicate (Double) Coverage	39
		Duplicate Testing	39
		Experimental or Investigational Services	39
		Food or Lodging Expenses	40
		Genetic Testing or Counseling	40
		Hair Loss Treatments	40
		Hearing Exams, Procedures, or Aids	41
		Hypnotherapy	41
		Infertility Services/Artificial Conception	41
		Late Claims Filing	41
		Learning Deficiencies/Behavioral Problems	41
		Maintenance Therapy	41
		Maternity Services, Routine	41
		Medically Unnecessary Services	41
		No Legal Payment Obligation	42
		Noncovered Providers of Service	42
		Nonmedical Expenses	42
		Nonprescription Drugs	43
		Nutritional Supplements	43
		Obesity Treatment	43
		Post-Termination Services	43
		Pre-Existing Conditions	43
		Prior Approval Not Obtained When Required	43
		Private Duty Nursing Services	43
		Sex-Change Operations and Services	44
		Therapy and Counseling Services	44
		Thermography	44
		Transplant Services	44
		Travel and Other Transportation	44
		Veteran's Administration Facility	44
		Vision Services	44
		War-Related Conditions	44
		Weight Management	44
		Work-Related Conditions	45

6 Coordination of Benefits and Subrogation	46	8 Enrollment and Termination Information	54
Coordination of Benefits (COB)	46	Term of Coverage	54
Facility of Payment	46	Who Is Eligible	54
Right of Recovery	46	Family Provision	56
Third-Party Liability — Subrogation	46	Medicare/Medicaid-Eligible Members	57
7 Claims Payments and Appeals	48	Newborn and Adopted Children	57
Filing Claims	48	When Coverage Begins	58
Participating Providers	48	Pre-Existing Conditions Limitation	58
Nonparticipating Providers	48	Premium	60
Where to Send Claim Forms	49	Policy Termination	60
Claims Payment Provisions	50	Re-Entering the Pool After Termination	60
Participating Providers	50	9 General Provisions	61
Nonparticipating Providers	50	Contestability Period	61
Assignment of Benefits	50	Availability of Provider Services	61
Covered Charge	50	Changes to the Health Care Policy	61
BlueCard Program	50	Disclaimer of Liability	61
Prescription Drug Plan Copayments	51	Disclosure and Release of Information	61
Accident-Related Hospital Services	51	Execution of Papers	61
Overpayments	51	Independent Contractors	61
Request for Reconsideration	51	10 Definitions	62
External Appeals and Actions	52		
NM Medical Insurance Pool Appeals	52		
Review by NM Superintendent of Insurance	52		
Legal Action	52		
Certain Defenses	53		
Catastrophic Events	53		
Research Fees	53		
Sending Notices	53		



Summary of Benefits and Plan Options

This summary provides you with the deductible, copayment, coinsurance, out-of-pocket amounts, and very brief descriptions of your NM Medical Insurance Pool Policy benefits.

NM Medical Insurance Pool Benefits	The deductible you chose defines the percentage of covered charges* that the Pool will pay after deductible is met:			
Deductible Options (Per Member): Unless otherwise indicated, the calendar year deductible must be met before benefit payments are made. For families of three or more, the annual deductible for all family members combined is twice the Individual amount chosen.	80 percent plans			100 percent plans
	\$500	\$1000	\$2000	\$5000, \$7500 or \$10,000
Out-of-Pocket Limit (Per Member): Includes coinsurance and deductible amounts only. After the out-of-pocket limit is met, the Pool pays 100% of your covered charges for the rest of the calendar year. For families of three or more, the annual out-of-pocket limit is twice the Individual amount chosen.	\$2500	\$3500	\$5000	N/A - The Pool pays 100% of covered charges after the deductible is met.
Lifetime Maximum	There is no overall lifetime maximum payment limit. However, there are specific maximums for certain benefits			
Covered Services	After deductible, the Pool pays*:			
	80 percent plans			100 percent plans
Acupuncture (max. benefit \$1500/calendar year)	80%			100%
Ambulance	80% ¹			100% ¹
Chemical Dependency Services: Alcoholism and Drug Abuse (Lifetime maximum of two 12-month benefit periods) Inpatient Services (max. 30 days/visits per calendar year) Outpatient/Office Services (max. 30 visits/calendar year)	80% ^{1,2}			100% ^{1,2}
Dental/Facial Accidents, Oral Surgery, TMJ Services	80% ^{1,2}			100% ^{1,2}
Diabetic Services Self-Management Education (max. benefit \$800/calendar year and a lifetime maximum benefit payment of \$2500) Diabetic Supplies and Equipment	80% ³			100% ³
Diagnostic Services: Lab and X-Ray (Including Routine Pap Tests and Mammograms)	80% ¹			100% ¹
Outpatient Preadmission Testing (within 10 days of admission)	100% ³			100% ³
Equipment, Supplies, Prosthetics, Orthotics, Appliances	80% ¹			100% ¹
Hearing Aids and Related Services	80% ¹			100% ¹
Home Health Care/Home I.V. Services (max. 100 visits/calendar year)	80% ¹			100% ¹
Hospice Care (limited to two six-month benefit periods)	80% ^{1,3}			100% ^{1,3}
Hospital/Facility Services (including medical detoxification and mental health conditions) Note: Also see "Therapy and Rehabilitation," "Skilled Nursing Facility," "Chemical Dependency," and "Pregnancy-Related Services."				
Room and Board (including special care units), Other Hospital Services, and Physician Care such as Physician Visits, Surgeon, Obstetrician, and Anesthesiologist	80% ²			100% ²
Emergency Room, Observation, and Outpatient Services	80%			100%
Newborn Care for Covered Newborn Infants (Application must be made within 31 days of birth)	80% ²			100% ²
Smoking/Tobacco Cessation Counseling (up to 90 minutes total provider contact time OR two multi-session group counseling programs per calendar year from approved providers)	80%			100%

See footnotes on next page

Covered Services	After deductible, the Pool pays:	
	80 percent plans	100 percent plan
Physician Medical Visits (Inpatient, Outpatient, Emergency Room, Urgent Care Facility, and Office)		
Physician Care or Provider Visit, Exam, Consultation	80%	100%
Allergy Injections/Testing; Therapeutic Injections	80%	100%
Well Baby Care, Routine Child Care, Immunizations, and Routine Vision or Hearing Screening (through age 17): Maximum benefit of \$500 per child/calendar year.	100% ³	100% ³
Routine Adult Gynecological/Pelvic Exams, Pap Tests, Mammograms, Prostate Exams; Routine Testing (over age 17): Maximum benefit of \$500 per member/calendar year.	100% ³	100% ³
Mental Health Services, Inpatient and Outpatient	80% ^{1,2}	100% ^{1,2}
Pregnancy-Related Services (Complications only)	80% ^{1,2}	100% ^{1,2}
Therapy and Rehabilitation: Cardiac and Pulmonary Rehabilitation Chemotherapy, Dialysis, and Radiation Therapy Occupational, Physical, and Speech Therapy, Outpatient Joint Manipulation/Alignment (max. benefit \$1500/calendar year) Physical Rehabilitation, Inpatient (max. 30 days/calendar year)	80% ^{1,2}	100% ^{1,2}
Skilled Nursing Facility Care (max. 100 days/calendar year)	80% ²	100% ²
Surgery, Inpatient and Outpatient (including reconstructive surgery, mastectomy coverage, and morbid obesity surgery)	80% ^{1,2}	100% ^{1,2}
Transplant Services (Must be received at a participating transplant facility. Lifetime max. benefit per member of \$5,000,000. Additional maximums apply; see Section 3.)	80% ^{1,2}	100% ^{1,2}

Prescription Drugs, Insulin, Diabetic Supplies, Special Medical Foods

Out-of-pocket limit and deductible provisions do not apply. Special medical foods and certain drugs require prior approval or benefits will be denied. Prescription drugs for smoking/tobacco use cessation are limited to **two 90-day** courses of drug therapy when prior-approved by BCBSNM.⁴ In order to receive benefits for specialty pharmacy drugs, you may be required to purchase such drugs from a specialty pharmacy provider that contracts with the Claims Administrator.

Retail and Specialty Pharmacy Programs (up to a 34-day supply or 100 units, whichever is greater; oral contraceptives covered)	30% of covered charge (with a minimum copayment of \$5 and a maximum copayment amount of \$250 per prescription or refill)
Mail-Order Plan (up to a 90-day supply)	30% of covered charge (with a minimum copayment of \$15 and a maximum copayment amount of \$750 per prescription or refill)

Maternity Services: OPTIONAL COVERAGE (additional premium required for each member choosing this coverage)

Routine delivery, pre- and post-natal care, anesthesia, assistant, diagnostic tests, elective abortion (Covered only for pregnancies conceived after the effective date of this optional coverage, unless you are a HIPAA-eligible individual or had prior routine maternity coverage per <i>Section 4</i> .)	80% ^{1,2}	100% ^{1,2}
---	--------------------	---------------------

- 1-For some services, no benefits are available if prior approval is not obtained from the Administrator. See Section 2 for a list of services requiring prior approval.
- 2-Admission review is required for inpatient admissions; benefits for facility services are reduced by 20 percent if admission review is not obtained before the member is admitted (or within 48 hours of admission in an emergency or for pregnancy-related admissions).
- 3-Not subject to deductible.
- 4-Prescription drugs, insulin, diabetic supplies, and special medical foods must be purchased at a pharmacy that participates in the Retail and/or Specialty Pharmacy or Mail Service Programs. If a generic equivalent is available and you or your provider request the brand-name (and your doctor does not specify "no substitution" on the prescription), you must pay the copayment in addition to the difference in cost between the brand-name and generic drug. (The Administrator, BCBSNM, has contracted with a separate program for administration of the outpatient prescription drug benefits.)

*** NOTE:** Billed charges and covered charges are not the same. The "covered charge" is the amount that the Administrator determines is fair and reasonable for a particular covered service. It is often less than the billed charge. The Administrator will pay the provider 80% of covered charges (or, under the 100 percent plans, 100% of covered charges) after you have paid your share (e.g., deductible, coinsurance, copayment, penalty amount). If you choose a participating provider, you will only have to pay up to the covered charge amount. If you choose a nonparticipating provider, you will have to pay the difference.



Notes

1

Your Health Care Policy

This Policy describes the benefits, plan options, and limitations of the NM Medical Insurance Pool program. It explains how to file claims (if needed) and how to request reconsideration of a claim or an adjustment of your benefit payment.

If you are not satisfied with this Policy, you may send it back to the Pool Administrator within ten days after you receive it, and your premium will be refunded.

Please take time to read this Policy. Then keep it handy for later reference. You may be accustomed to reading about your health care benefits only *after* you have claims for medical and hospital services. To receive maximum benefits with the NM Medical Insurance Pool program, you should read about your benefits *before* treatment. You have benefit choices and decisions. Your participation and cooperation are required for some features. In addition, it can be financially advantageous for you to request care from hospitals and physicians who have contracted with the Administrator. (See “Provider Choices,” in *Section 2*.) If you have questions after you read this Policy, contact the Pool Administrator, BCBSNM.

Not sure what a particular word or medical term means? See the “Definitions” section toward the back of this booklet for help.

Other Benefit-Related Materials

In addition to this booklet you should have the following benefit-related documents:

Prescription Drug Plan Brochure

You should also have a separately issued prescription drug plan brochure and a mail-order claim form from the prescription drug plan administrator. It provides important information about your prescription drug benefits.

Provider Network Directory

The provider network directory lists all providers in the Administrator’s participating provider network, including mental health/chemical dependency providers and participating pharmacies.

Note: Although provider directories are current as of the date shown at the bottom of each page, they can change without notice. To verify a provider’s status or if you have any questions about how to use the directory, contact a Customer Service representative or visit the BCBSNM Web site at www.bcbsnm.com.

ID Card (Carry At All Times)

Your NM Medical Insurance Pool identification (ID) card shows the individual deductible and out-of-pocket limit chosen by you. The ID card provides the information needed when you require health care services or prescription drugs, or when you are contacting a Customer Service representative. Carry it with you. Have your ID card handy when you call for an appointment and show it to the receptionist when you sign in for an appointment.

Your ID card is part of your coverage. Do not let anyone who is not named in your coverage use your card to receive benefits. If you want additional cards or need to replace a lost card, contact a Customer Service representative.

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



Admission Review or Prior Approval Required

This symbol is a reminder that, in order to receive full benefits for certain services, you (or your provider) must call for approval **before** you receive the services. Call Monday through Friday, 8 A.M. to 5 P.M., Mountain Time. **Note:** Call Customer Service if you need prior approvals assistance after 5 P.M.



Call Within
48 Hours
(505) 291-3585
(800) 325-8334

Emergency Admissions: Call Within 48 Hours — In order to receive full benefits for emergency or maternity-related hospital inpatient admissions, you (or your provider) must notify the Administrator **within 48 hours** of the admission. Call the Administrator's Health Services department, Monday through Friday, 8 A.M. to 5 P.M., Mountain Time. **Note:** Call Customer Service if you need prior approvals assistance after 5 P.M.



Written Request Required — If a **written request** for prior approval is required in order for a service to be covered, the provider should send the request, along with appropriate documentation, to the address below. Please ask your health care provider to submit your request early enough so that there is time to process the request before the date you are planning to receive services.

NM Medical Insurance Pool Administrator
Attn: Health Services Department
P.O. Box 27630
Albuquerque, NM 87125-7630

2

How Your Plan Works

Provider Choices

Your choice of health care provider can make a difference in the amount you pay for covered services and the benefits you receive.

You have a choice between selecting a **Participating Provider** (one that contracts with BCBSNM to provide services at a potentially reduced rates) or a **Nonparticipating Provider** (one that does not contract with BCBSNM).

The amount the Pool pays for a covered service is always based on the “covered charge” for that service. The covered charge is always less than or equal to the provider’s billed amount. You may have to pay the difference between the billed amount and the covered charge.

The advantages of choosing a **Participating Provider** is that:

- the provider will file your claim for you, and
- you will **not** have to pay the difference between the amount billed by the provider and the covered charge for that service.

Example 1: Participating Provider Claim Payment (80% Plan; deductible is met):	
Provider’s billed charge	\$2000.00
Covered charge (maximum amount that can be considered for benefit payment)	\$1800.00
The Pool’s payment to provider (80% of \$1800)	\$1440.00
Member’s coinsurance: (20% of \$1800) applied to out-of-pocket limit	- \$ 360.00
Amount in excess of covered charge (\$2000 - \$1800) NOT applied to out-of-pocket limit, but participating provider will not bill member for this amount.	- \$ 0.00
Total amount due from policyholder: Member coinsurance (\$360)	\$360.00

When you choose a **Nonparticipating Provider**, the provider:

- does not have to file your claim for you, and
- you may have to pay the difference between the amount billed by the provider and the covered charge for that service (it is up to the provider).

Example 2: Nonparticipating Claim Payment (80% Plan; deductible is met):	
Provider’s billed charge	\$2000.00
Covered charge (maximum amount that can be considered for benefit payment)	\$1800.00
The Pool’s payment to member/provider (80% of \$1800)	\$1440.00
Member’s coinsurance: (20% of \$1800) applied to out-of-pocket limit	- \$ 360.00
Amount in excess of covered charge (\$2000 - \$1800) NOT applied to out-of-pocket limit and member may be billed by provider for this amount.	- \$ 200.00
Total amount due from policyholder: Member coinsurance (\$360) PLUS amount in excess of covered charge (\$200)	\$560.00

Selecting a Provider — When you need medical care in New Mexico (or along the border of neighboring states), use your *Participating Provider Network Directory* to choose a participating provider.

To verify a provider's current status or if you have any questions about how to use the directory, contact a Customer Service representative or visit the BCBSNM Web site at www.bcbsnm.com.

Note: Although provider directories are current as of the dates shown at the bottom of each page, they can change without notice. If you do not have a current directory, ask a Customer Service representative to send you one or visit the BCBSNM Web site.

When you receive treatment or schedule a surgery or admission, ask each of your providers if he/she is a participating provider. (A physician's or other provider's contract may be separate from the facility's contract.)

Outside New Mexico — For a list of contracting providers outside New Mexico, call the BlueCard Doctor and Hospital Information Line at 1-800-810-BLUE (2583) or visit the BCBSNM Web site at www.bcbsnm.com. If you call, a BlueCard representative will give you the name and telephone number of a local provider who will be able to call Customer Service for eligibility information and will submit a claim to the Administrator's local, affiliated Blue Cross Blue Shield Plan office.

■ Deductibles, Coinsurance, Out-of-Pocket

The Individual deductible you chose is indicated on your ID card. The table below lists the deductible and the out-of-pocket limits that apply to your Policy — based on the Individual deductible amount selected by you and printed on your ID card.

While the Pool does not offer a "Family" Policy, if you have three or more qualified family members on Pool Policies with the same deductible you may receive reduced deductible and out-of-pocket limits as indicated on the table below.

Plan Variable (printed on ID card)	Individual Deductible Choice and Family Amount	Out-of-Pocket Limit (annual deductible plus coinsurance)
500	Individual = \$500 Family = \$1,000	Individual = \$2,500 Family = \$5,000
1,000	Individual = \$1,000 Family = \$2,000	Individual = \$3,500 Family = \$7,000
2,000	Individual = \$2,000 Family = \$4,000	Individual = \$5,000 Family = \$10,000
5,000	Individual = \$5,000 Family = \$10,000	NA - The Pool pays 100% after deductible is met
7,500	Individual = \$7,500 Family = \$15,000	NA - The Pool pays 100% after deductible is met
10,000	Individual = \$10,000 Family = \$20,000	NA - The Pool pays 100% after deductible is met

Note: Amounts applied to the annual deductible and to member coinsurance are not used to calculate benefit limitations that are based on a dollar amount (e.g., \$1,500 per calendar year). Such limits are based on amounts actually paid out by the Pool. However, when a limitation is based on a maximum number of days, visits, or benefit periods (e.g., 30 days per calendar year), the maximum benefit may be reached even if all covered charges were applied to the deductible.

Plan Deductible

See your ID card for your individual deductible amount.

Deductible — The deductible you chose is indicated on your ID card (see table, above). You must pay your deductible amount before the Pool will begin paying its share of your covered charges. Only covered charges are applied toward the deductible. Covered charges may be less than the billed amount. If you receive services from a nonparticipating provider, you will be responsible for paying the provider any amounts over the covered charge, in addition to your deductible.

Family Deductible — An entire family meets an annual deductible when the total deductible amount for all family members reaches two times the Individual deductible amount chosen (see table, above). **Note:** If a member's Individual deductible is met, no more charges incurred by that member may be used to satisfy the Family deductible.

Change in Deductible Plan — Pool members can change from a lower to a higher deductible plan at any time upon written notice to the Administrator. The effective date of the change is the next premium due date following the request date.

If you increase your deductible amount, the new deductible amount must be met for all services received as of the change effective date. This means that if you had met your lower deductible and then change to a higher deductible, for services received as of the change effective date, you do not receive benefit payments until the increase in deductible is met.

Pool members can change from a higher to a lower deductible plan on or before October 1 each year. The effective date will be January 1 the following year. Requests for such changes must be made in writing to the Administrator. If you decrease your deductible amount, you do not receive a refund for any deductible amounts applied for services before the change effective date.

Coinsurance and Out-of-Pocket Limit

Note for members with the \$5000, \$7500 or \$10,000 deductible options:
This section does not apply to your plan. No member coinsurance is required. Once you meet your deductible, the Pool pays 100 percent of covered charges (except that you pay a percentage of covered charges for items covered under the prescription drug plan, not subject to the deductible.) **Remember:** If you receive services from a nonparticipating provider, you will be responsible for paying the provider any amounts over the covered charge. See the examples on page 3.

See your ID card for your individual deductible amount (which determines your out-of-pocket limit) and the Summary of Benefits and Plan Options for your coinsurance percentages.

Coinsurance — If you selected the \$500, \$1000, or \$2000 deductible: For most covered services, you pay a percentage of covered charges as “coinsurance” after the annual deductible has been met. Covered charges may be less than the billed amount. If you receive services from a nonparticipating provider, you will be responsible for paying the provider any amounts over the covered charge (see the

examples on page 3), in addition to your deductible and your percentage of the covered charge (coinsurance).

Out-of-Pocket Limit — The total amount of **deductible** and **coinsurance** you must pay each calendar year is called the out-of-pocket limit (see table on page 4). After the limit is met, the Pool pays 100 percent of your **covered charges** for the rest of the calendar year. **Remember:** If you receive services from a nonparticipating provider, you will be responsible for paying the provider any amounts over the covered charge, even if your out-of-pocket limit is met. See the examples on page 3.

Admission review penalty amounts, amounts over the covered charge, noncovered expenses, and prescription drug plan copayments are **not** applied to the out-of-pocket limit and are not eligible for 100 percent payment under this provision.

Family Limit — An entire family meets the out-of-pocket limit when the total deductible and coinsurance amounts for all family members reaches the amount specified on the *Summary of Benefits and Plan Options*. (When a member meets the out-of-pocket limit, no more charges incurred by that member may be used to satisfy the family out-of-pocket limit.)

Out-of-Pocket Limit Changes — Changing your deductible plan also affects your out-of-pocket limit provisions. This means that if you had met your lower out-of-pocket limit and then you change to a higher out-of-pocket limit, for services received as of the change effective date, you do not receive the 100 percent payment until the increase in out-of-pocket is met.

■ Admission Review & Other Prior Approvals

In order to receive benefits, services must be listed as covered and medically necessary, services must not be excluded, and the procedures described in this section must be followed regardless of where services are rendered or by whom.

These approval requirements will provide you with assurance that you are being treated in the most efficient and appropriate health care setting and can help manage the rising costs of health care. **Failure to obtain a required approval may result in a reduction or denial of benefits.** Please note:

Prior Approval Does Not Guarantee Payment or Validate Eligibility	Prior approval determines only the medical necessity of a specific service and/or an admission and an allowable length of stay. Prior approval does not guarantee payment or eligibility for coverage. Eligibility and benefits available are based on the date you receive the services. If you lose coverage under this Policy, benefits are not allowed for any service received after coverage ends, even if prior approval was obtained from BCBSNM.
When You Have Other Coverage	Even when this Policy is not your primary coverage, these approval procedures must be followed.
Retroactive Approvals Not Given	Retroactive approvals will not be given and you may be responsible for the charges if approval is not obtained before the service is received.

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



If a provider recommends an admission or a service that requires prior approval, the provider is not obligated to obtain the approval for you. The provider may call on your behalf, but it is **your responsibility** to ensure that the Administrator is called:

Call Monday through Friday, 8 A.M. to 5 P.M., Mountain Time
(505) 291-3585
(800) 325-8334

Note: Prior approvals are not processed after 5 P.M. If you need prior approval assistance between 5 P.M. and 8 A.M. or on weekends, call Customer Service.

Admission Review Approval

Admission review is required for most admissions **before** you are admitted, transferred, or re-admitted to the hospital, physical rehabilitation facility, or other treatment facility. If you do not obtain admission review approval for admissions within the time limits indicated in the chart below, benefits for covered facility services will be **denied or reduced by 20 percent** as explained on the next page.

Type of inpatient admission, readmission, or transfer	When to obtain admission review approval:
Nonemergency	Before the patient is admitted.
Emergency, nonmaternity	Within 48 hours of the inpatient admission. If the patient's condition makes it impossible to call within 48 hours, call as soon as possible. (No approval is required for emergency room services that do not result in an inpatient admission.)
Maternity-related (including eligible newborns for whom the mother will not be covered)	Before the mother's maternity due date, usually about one or two months before delivery. However, make sure you or your hospital calls within 48 hours of the admission for routine deliveries (96 hours for C-sections). If the mother's condition makes it impossible to call within 48 (or 96) hours, call as soon as possible.
Extended stay, newborn (an eligible newborn stays in the hospital longer than the mother)	Before the newborn's mother is discharged.

How the Approval Procedure Works — When you or your provider call, the Administrator's Health Services staff will ask for information about your medical condition, the proposed treatment plan, and the estimated length of stay. The Health Services staff will evaluate the information and notify the attending physician and the facility (usually at the time of the call) if benefits for the proposed hospitalization are approved. If the admission is not approved, you may appeal the decision as explained in *Section 7*.

Penalty for Not Obtaining Admission Approval — If you or your provider do not call, or if you call and do not receive approval for inpatient benefits, but you choose to be hospitalized anyway, no benefits may be paid or partial payment may be made as specified in the table on the next page:

If you do not obtain admission approval and based on a review of the claim:	Then:
The admission was not for a covered service .	Benefits for the facility and all related services will be denied .*
The admission was for an item listed under “ Other Prior Approvals ,” below (e.g., high-dose chemotherapy).	Benefits for the facility and all related services will be denied .*
The admission was for any other covered service but hospitalization was not medically necessary .	Benefits will be denied for room, board, and other charges that are not medically necessary.*
The admission was for a medically necessary covered service .	Benefits for the facility’s covered services will be reduced by 20 percent .*

* The 20 percent admission review penalty and charges for noncovered and denied services are **not** applied to any deductible or out-of-pocket limit.

Admission review requirements may affect the amounts that the Pool pays for inpatient services, but they do not deny your right to be admitted to any facility and to choose your services. If an admission is not approved by the Administrator, you may always choose to receive the services and pay the full amount billed by the facility and other health care providers for the admission.

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



Other Prior Approvals

In addition to admission review for all inpatient services, prior approval is required for certain other services or **benefits will be denied** for all related services. Most prior approvals may be requested over the telephone. If a *written* request is needed and you call, a Health Services representative will give you instructions for filing a written request for prior approval:

- equipment, supplies, hearing aids, and prosthetics costing **\$500** (or more) or requiring **long-term rental**
- treatment of **accidental injuries to teeth** (except initial treatment)
- **air ambulance** services (unless during a medical emergency)
- **cardiac** or **pulmonary rehabilitation**
- **cardiac CT scans**
- **chemical dependency services (alcoholism or drug abuse)**; inpatient, outpatient, and office services
- **chemotherapy** (high-dose)
- **dental-related** hospital services (The procedure may not be covered even if benefits for the hospital stay are approved as medically necessary; see *Section 3*.)
- certain **drugs** purchased through the “Prescription Drugs and Other Items” provision (such as for smoking cessation or erectile dysfunction); prescription **refills** before the supply should have been exhausted
- **electroshock therapy** and **narcosynthesis**, outpatient
- **home dialysis**
- **home health care** and **home I.V.** services
- **home sleep studies**
- **hospice care**
- **infertility-related services** (Only limited procedures are covered.)
- certain **injections**
- **insulin pumps**
- treatment of **orthognathism**
- **orthopedic appliances**
- **orthotics**
- **PET scans**

- **private room charges**
- **prosthetics, surgically implanted**
- outpatient **psychiatric intake evaluations** and **medication checks** that are not related to chemical dependency
- **psychological testing** and **psychotherapy** that is not related to chemical dependency; outpatient (For inpatient services, you must obtain admission approval or benefits for covered services will be reduced by 20 percent.)
- **rehabilitative services** (inpatient and outpatient physical, occupational, and speech therapy)
- **routine foot care** and orthopedic shoes required due to diagnosed severe non-diabetic neuropathy of the foot
- **special medical foods** required to compensate for inborn errors of metabolism
- **specialty pharmacy drugs** (see “Prescription Drugs and Other Items.”)
- certain **surgical procedures**, including:
 - **breast reduction**
 - **breast surgery following a mastectomy** (Note: This is the only cosmetic procedure covered under this Policy.)
 - **cochlear implants**
 - surgical treatment of **morbid obesity**
 - **orthotripsy**
 - **reconstructive surgical procedures**
 - **transplants**, including pretransplant evaluations

The services listed above and on the previous page may not be approved for payment (for example, due to being experimental/investigational or not medically necessary). It is strongly recommended that you request prior approval for high-cost services in order to reduce the likelihood of benefits being denied *after* charges are incurred. The complete list of services requiring prior approval is subject to review and change by the NM Medical Insurance Pool Board of Directors. Participating providers have a list of all procedures and services, including individual surgical procedures and injectable drugs, that require prior approval. If you need a copy of this list, call a Customer Service representative.

Remember: Even if you receive prior approval for an inpatient procedure, admission review approval is also required for all inpatient admissions, transfers, re-admissions, and extended stay newborn hospitalizations. See “Admission Review Approval,” earlier in this section.

■ Advance Benefit Information

If you want to know what benefits will be paid before receiving services or filing a claim, the Administrator may require a written request. The Administrator may also require a written statement from the provider identifying the circumstances of the case and the specific services that will be provided. An advance confirmation of benefits **does not guarantee** benefits if the actual circumstances of the case differ from those originally described. When submitted, claims are reviewed according to the terms of this Policy or any other coverage that applies on the date of service.

■ Utilization Review/Quality Management

Medical records, claims, and requests for covered services may be reviewed to establish that the services are/were medically necessary, delivered in the appropriate setting, and consistent with the condition reported and with generally accepted standards of medical and surgical practice in the area where performed and according to the findings and opinions of the Administrator's professional consultants. Utilization management decisions are based only on appropriateness of care and service. The Administrator does not reward providers or other individuals conducting utilization review for denying coverage or services and does not offer incentives to utilization review decision-makers to encourage under-utilization.

■ Health Care Fraud Information

Health care and insurance fraud results in cost increases for health care plans. You can help. Always:

- Be wary of offers to waive copayments, deductibles, or coinsurance. These costs are passed on to you eventually.
- Be wary of mobile health testing labs. Ask what your health care insurance will be charged for the tests.
- Review the bills from your providers and the *Explanation of Benefits* (EOB) form you receive from the Administrator after a claim has been paid or denied. Verify that all services billed to the Administrator were received. If there are any discrepancies, call a Customer Service representative.
- Be very cautious about giving information about your health care insurance over the phone.

If you suspect fraud, contact the BCBSNM Fraud Hotline at 1-888-841-7998.

3

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.

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



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.

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



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:

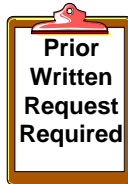
- services provided or billed by a school, halfway house, or residential treatment center or their staff members
- long-term care
- court-ordered or police-ordered services unless the services would otherwise be covered; services rendered as a condition of parole or probation
- the cost of any damages 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

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



■ 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.)

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



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

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



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.)

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



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.)

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



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.

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



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

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



- 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.)

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



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.

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



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)

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



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.

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



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

Call BCBSNM
for Approval:
(505) 291-3585 or
(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.

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



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*.

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



■ 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.

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



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”

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.

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



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





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").

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



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.

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



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**

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



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.

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



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.”



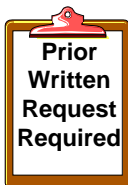
Prior Approval Required — Prior approval, requested in writing, is required **before** a pretransplant evaluation is scheduled. If approved, a case manager will be assigned to you (the transplant recipient candidate) by the Administrator and must later be contacted with the results of the evaluation.

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)

4

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

5

General Limitations and Exclusions

These general limitations and exclusions apply to **all** services listed in this Policy (or benefit booklet).

This Policy does not cover any service or supply not specifically listed as a covered service in this booklet. If a service is not covered, then all services performed in conjunction with it are not covered.

Also see Section 3: Covered Services for specific benefit limits and exclusions.

This Policy will not cover any of the following services, supplies, situations, or related expenses:

Admissions/Treatments Discontinued by Patient — This Policy may **not cover** charges associated with any episode of alcoholism or drug abuse for which the patient did not complete the prescribed continuum of care.

Before Effective Date of Coverage — This Policy **does not cover** any service received, item purchased, prescription filled, or health care expense incurred before your effective date of coverage. If you are an inpatient when coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date.

Biofeedback — This Policy **does not cover** services related to biofeedback.

Blood Services — This Policy **does not cover** blood storage fees unless 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 for or by the patient through donor credit.

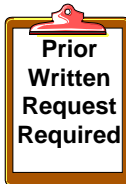
Complications of Noncovered Services — This Policy **does not cover** any complications of a noncovered service, treatment, or procedure (e.g., due to a noncovered sex change operation, cosmetic surgery, transplant, or experimental procedure).

Convalescent Care or Rest Cures — This Policy **does not cover** convalescent care or rest cures.

Cosmetic Services — Cosmetic surgery is beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic. **This Policy does not cover** cosmetic surgery, services, or procedures for psychiatric or psychological reasons, or to change family characteristics or conditions caused by aging. **This Policy does not cover** services related to or required as a result of a cosmetic service, procedure, or surgery, or subsequent

procedures to correct unsatisfactory cosmetic results attained during an initial surgery.

Examples of cosmetic procedures are: dermabrasion; revision of surgically induced scars; breast augmentation; rhinoplasty; surgical alteration of the eye; correction of prognathism or micrognathism; excision or reformation of sagging skin on any part of the body including, but not limited to, eyelids, face, neck, abdomen, arms, legs, or buttock; services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body including, but not limited to, breast, face, lips, jaw, chin, nose, ears, or genitals; or any procedures that the Administrator determines are not required to materially improve the physiological function of an organ or body part.



Exception: Cosmetic breast/nipple surgery required due to a mastectomy related to breast cancer may be covered. However, **prior approval, requested in writing**, is required. Also, prior-approved reconstructive surgery, which may have a coincidental cosmetic effect, may be covered when required as the result of accidental injury, illness, or congenital defect. See *Section 3* for details.

Custodial Care — **This Policy does not cover** custodial care, or care in a place that is primarily your residence when you do not require skilled nursing.

Dental-Related Services — **This Policy does not cover dental-related services**, except for those services specifically listed as covered in *Section 3*.

Domiciliary Care — **This Policy does not cover** domiciliary care or care provided in a residential institution, treatment center, halfway house, or school.

Duplicate (Double) Coverage — **This Policy does not cover** amounts already paid by other valid coverage or that would have been paid by Medicare as the primary carrier if you were entitled to Medicare, had applied for Medicare, and had claimed Medicare benefits. See *Section 6* for more information. Also, if your prior coverage has an extension of benefits provision, **this Policy will not cover** charges incurred after your effective date under this Policy that are covered under the prior plan's extension of benefits provision.

Duplicate Testing — **This Policy does not cover** duplicative diagnostic testing or overreads of laboratory, pathology, or radiology tests.

Experimental, Investigational, or Unproven Services — **This Policy does not cover** any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical practice* (as defined on the next page) or those considered experimental, investigational, or unproven. Also, services must be medically necessary and not excluded by any other contract exclusion. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted when services were administered, the service is experimental and will not be covered. To be considered experimental, investigational, or unproven, one or more of the following conditions must be met:

- The device, drug, or medicine cannot be marketed lawfully without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the device, drug, or medicine is furnished.
- Reliable evidence shows that the treatment, device, drug, or medicine is the subject of ongoing phase I, II, or III clinical trials or under study to determine

its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug, or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in authoritative peer-reviewed medical and scientific literature; the written protocol or protocols used by the treating facility, or the protocol(s) of another facility studying substantially the same medical treatment, procedure, device, or drug; or the written informed consent used by the treating facility or by another facility studying substantially the same medical treatment, procedure, device, or drug. *Experimental* or *investigational* does not mean cancer chemotherapy or other types of therapies that are the subjects of ongoing phase IV clinical trials.

Standard medical practice means the services or supplies that are in general use in the medical community in the United States and:

- have been demonstrated in standard medical textbooks published in the United States and/or peer-reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the hospital or other facility provider in which they were performed; and
- the physician or other professional provider has had the appropriate training and experience to provide the treatment or procedure.

Food or Lodging Expenses — This Policy does not cover food or lodging expenses, except for those that are eligible under the “Transplant Services” provision in *Section 3* or prior-approved as a covered special medical food for a member with a genetic inborn error of metabolism (see “Prescription Drugs and Other Items” in *Section 3*).

Genetic Testing or Counseling — This Policy does not cover genetic counseling or testing, unless the testing has received **prior approval** from 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.) **This Policy does not cover** tests such as amniocentesis or ultrasound to determine the sex of an unborn child.

Hair Loss Treatments — This Policy does not cover wigs, artificial hairpieces, hair transplants or implants, or medication used to promote hair growth or control hair loss, even if there is a medical reason for hair loss.

Hearing Exams, Procedures, or Aids — This Policy does not cover audiometric (hearing) tests unless 1) required for the diagnosis and/or treatment of an accidental injury or an illness, 2) for prescribing an appropriate hearing aid for a known hearing loss, or 3) covered as a preventive *screening* service for children through age 17 as described under “Preventive Services” in *Section 3*. (A screening does *not* include a hearing test to determine the amount and kind of correction needed.) For hearing aid benefits and exclusions, including cochlear

implantation of a hearing device, see “Equipment, Orthotics, Appliances, Supplies, and Prosthetics.”

Hypnotherapy — **This Policy does not cover** hypnosis or services related to hypnosis, whether for medical or anesthetic purposes.

Infertility Services/Artificial Conception — **This Policy does not cover** artificial conception, infertility testing, treatments, or related services. **This Policy does not cover** reversal of a prior sterilization procedure. (Certain treatments of medical conditions that sometimes result in restored fertility may be covered; see “Family Planning/Infertility Services” in *Section 3*.)



Late Claims Filing — **This Policy does not cover** services of a nonparticipating provider if the claim for such services is received by the Administrator more than **18 months** after the date of service. (Participating providers will file claims for you.) See “Filing Claims” in *Section 6* for details.

Learning Deficiencies/Behavioral Problems — **This Policy does not cover** special education, counseling, therapy, nonmedical care, or any other service for learning deficiencies or disabilities or for chronic behavioral problems, whether or not associated with childhood autism, retardation, hyperkinetic syndromes (abnormally increase muscle movement), or attention deficit disorders.

Maintenance Therapy — **This Policy does not cover** maintenance therapy or care or any treatment that does not significantly improve your function or productivity, or care provided after you have reached your rehabilitative potential (unless therapy is covered during an approved hospice benefit period). In a dispute about whether your rehabilitative potential has been reached, you are responsible for furnishing documentation from your physician supporting his/her opinion.



Maternity Services, Routine — Unless you purchased the **optional** routine *Maternity Services: OPTIONAL COVERAGE* described in *Section 4*, **this Policy does not cover** routine maternity services or elective abortions. If you did **not** purchase the optional coverage for routine maternity care, you are covered only for complications of pregnancy. If you purchased the optional coverage, **this Policy does not cover** routine maternity care or elective abortions for pregnancies conceived before such optional coverage became effective – unless you had prior creditable coverage or are HIPAA-eligible as described in *Section 4*. (HIPAA-eligibles are not subject to any pre-existing condition exclusion, regardless of when the medical condition occurred.) **Note:** Refer to the “Checklist” included with your application to determine if you are HIPAA-eligible.

Medically Unnecessary Services — **This Policy does not cover** services that are not medically necessary unless such services are specifically listed as covered (e.g., see “Preventive Services” in *Section 3*).

The Administrator determines whether a service or supply is medically necessary and whether it is covered. Because a provider prescribes, orders, recommends, or approves a service or supply does *not* make it medically necessary or make it a covered service, even if it is not specifically listed as an exclusion. (The Administrator determines medical necessity. To request a reconsideration of a decision, see *Section 7*.)

No Legal Payment Obligation — This Policy does not cover services for which you have no legal obligation to pay or that are free, including:

- charges made only because benefits are available under this Policy
- services for which you have received a professional or courtesy discount
- volunteer services
- services provided by you for yourself or a covered family member, by a person ordinarily residing in your household, or by a family member
- physician charges exceeding the amount specified by CMS when primary benefits are payable under Medicare

Noncovered Providers of Service — This Policy does not cover services prescribed or administered by a:

- member of your immediate family or a person normally residing in your home
- physician, other person, supplier, or facility (including staff members) that are not specifically listed as covered in this Policy, such as a:
 - health spa or health fitness center (whether or not services are provided by a licensed or registered provider)
 - school infirmary
 - halfway house or residential treatment center
 - massage therapist
 - private sanitarium
 - extended care facility or similar institution
 - dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group
 - pain clinic or any provider primarily in the practice of pain management or treatment

Nonmedical Expenses — This Policy does not cover nonmedical expenses (even if medically recommended and regardless of therapeutic value), including costs for services or items such as, but not limited to:

- adoption or surrogate expenses
- educational programs such as behavior modification and arthritis classes (Some diabetic services and other educational programs may be covered; see “Preventive Services” and “Diabetic Services” in *Section 3* for details.)
- vocational or training services and supplies
- mailing, shipping, handling, or delivery
- missed appointments; “get-acquainted” visits without physical assessment or medical care; telephone consultations; provision of medical information to perform admission review or other prior approvals; filling out of claim forms; copies of medical records; interest expenses
- modifications to home, vehicle, or workplace to accommodate medical conditions; voice synthesizers; other communication devices
- membership at spas, health clubs, or other such facilities
- personal convenience items such as air conditioners, humidifiers, or exercise equipment, or personal services such as haircuts, shampoos, guest meals, and television rentals
- personal comfort services, including homemaker and housekeeping services, except in association with respite care covered during a hospice admission
- immunizations or medications required for international travel
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; phone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)

- physicals or screening exams and immunizations given primarily for insurance, licensing, employment, camp, weight reduction programs, medical research programs, sports, or for any nonpreventive purpose
- hepatitis B immunizations when required due to possible exposure during the member's work
- court- or police-ordered services unless the services would otherwise be covered or services rendered as a condition of parole or probation
- the cost of any damages to a treatment facility that are caused by the member

Nonprescription Drugs — **This Policy does not cover** outpatient nonprescription or over-the-counter drugs, ointments, medications, or creams (unless specifically listed as covered in *Section 3*) 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.)

Nutritional Supplements — **This Policy does not cover** vitamins, dietary/nutritional supplements, special foods, formulas, mother's milk, or diets, unless 1) a prescription is required for the product; or 2) it meets the definition of 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 (as defined) in order to maintain their adequate nutritional status.

Obesity Treatment — **This Policy does not cover** dietary or medical (non-surgical) treatment of obesity under any circumstance. The surgical treatment of morbid obesity is covered only if prior-approved by the Administrator.

Post-Termination Services — **This Policy does not cover** any service, item, or drug received after your Pool coverage is terminated, even if: 1) admission review or prior approval for such service, item, or drug was received from the Administrator, or 2) the service, item, or drug was needed because of an accident, illness, or other event that occurred while you were covered.

Pre-Existing Conditions — For a member who is subject to this provision, **this Policy does not cover** any pre-existing conditions for up to **six months** following his/her initial effective date of coverage. (HIPAA-eligible members are not subject to any pre-existing conditions exclusion, regardless of when the illness or injury occurred.) See "Pre-Existing Conditions Limitation" in *Section 8*. Complications of pregnancy are **not** considered pre-existing conditions under this Policy. However, if you selected the **optional** coverage for routine maternity services, **this Policy does not cover** routine maternity care or elective abortions for pregnancies conceived before the optional coverage became effective unless you had prior creditable coverage or are HIPAA-eligible as described in *Section 4*.

Prior Approval Not Obtained When Required — **This Policy does not cover** certain services if you do not obtain prior approval from the Administrator before those services are received. See "Admission Review and Other Prior Approvals" in *Section 2*.

Private Duty Nursing Services — **This Policy does not cover** private duty nursing services.

Sex-Change Operations and Services — This Policy does not cover services related to sex-change operations, reversals of such procedures, or complications arising from transsexual surgery.

Therapy and Counseling Services — This Policy does not cover therapies and counseling programs except as listed in *Section 3*. See *Section 3* for additional exclusions. This Policy does not cover services such as, but not limited to:

- recreational, sleep, crystal, primal scream, sex, and Z therapies
- self-help, stress management, codependency, and weight-loss programs
- massage therapy or rolfing
- 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
- psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education

Thermography — This Policy does not cover thermography.

Transplant Services — In addition to services excluded by the other general limitations and exclusions listed throughout this *Section 5*, please see “Transplant Services” in *Section 3* for specific transplant services that are covered and related limitations and exclusions. This Policy does not cover any other transplants (or organ-combination transplants) or services related to any other transplants.

Travel and Other Transportation — This Policy does not cover therapeutic travel recommended for mental or physical health reasons or any travel expenses, even if travel is necessary to receive covered services unless such services are eligible for coverage under “Transplant Services” or “Ambulance Services” in *Section 3*.

Veteran’s Administration Facility — This Policy does not cover services or supplies furnished by a Veterans Administration facility for a service-connected disability or while a member is in active military service.

Vision Services — This Policy does not cover any services related to refractive keratoplasty (surgery to correct nearsightedness) or any complication related to keratoplasty, including radial keratotomy or any procedure designed to correct visual refractive defect (e.g., farsightedness or astigmatism). This Policy does not cover eyeglasses, contact lenses, prescriptions associated with such procedures, and costs related to the prescribing or fitting of glasses or lenses, unless listed as covered under “Equipment, Orthotics, Appliances, Supplies, and Prosthetics” in *Section 3*. This Policy does not cover sunglasses, special tints, or other extra features for eyeglasses or contact lenses.

War-Related Conditions — This Policy does not cover any service required as the result of any act of war or related to an illness or accidental injury sustained during combat or active military service.

Weight Management — This Policy does not cover weight-loss or other weight-management programs, dietary control, or medical obesity treatment, except for the surgical treatment of morbid obesity that has been **prior-approved** by the Administrator.

Work-Related Conditions — This Policy does not cover services resulting from work-related illness or injury, or charges resulting from occupational accidents or sickness covered under:

- occupational disease laws
- employer's liability
- municipal, state, or federal law (except Medicaid)
- Workers' Compensation Act

To recover benefits for a work-related illness or injury, you must pursue your rights under the Workers' Compensation Act or any of the above provisions that apply, including filing an appeal. (The Pool may pay claims during the appeal process on the condition that you sign a reimbursement agreement.)

This Policy does not cover a work-related illness or injury, **even if:**

- You fail to file a claim within the filing period allowed by the applicable law.
- You obtain care not authorized by Workers' Compensation insurance.
- Your employer fails to carry the required Workers' Compensation insurance. (The employer may be liable for an employee's work-related illness or injury expenses.)
- You fail to comply with any other provisions of the law.

Note: This "Work-Related Conditions" exclusion does not apply to an executive employee or sole proprietor of a professional or business corporation who has affirmatively elected not to accept the provisions of the New Mexico Workers' Compensation Act. You must provide documentation showing that you have waived Workers' Compensation and are eligible for the waiver. (The Workers' Compensation Act may also not apply if an employer has a very small number of employees or employs certain types of laborers excluded from the Act.)

6

Coordination of Benefits and Subrogation

■ Coordination of Benefits (COB)

For a work-related injury or condition, see the "Work-Related Conditions" exclusion in Section 5.

Your Pool Policy is the last payer of benefits when any other benefit payers or plans are available. Benefits otherwise payable under this Policy will be reduced by all amounts paid or payable through any other health insurance or health benefit plan. This also includes Medicare, Medicaid, self-insured plans, all hospital and medical expenses benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance, whether provided on the basis of fault or no-fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law program. This Pool Policy is also secondary to group coverage unless the claim is excluded under group coverage due to pre-existing conditions limitations.

Facility of Payment

Whenever any other plan makes benefit payments that should have been made under this Policy, the Pool has the right to pay the other plan any amount the Administrator determines will satisfy the intent of this provision. Any amount so paid will be considered to be benefits paid under this Policy, and with that payment the Pool will fully satisfy its liability under this provision.

Right of Recovery

Regardless of who was paid, whenever benefit payments made by the Pool exceed the amount necessary to satisfy the intent of this provision, the Administrator has the right to recover the excess amount from any persons to or for whom those payments were made, or from any insurance company, service plan, or any other organizations or persons.

■ Third-Party Liability — Subrogation

Third-party liability exists when someone else is or may be legally responsible for your condition or injury. If you suffer any illness or injury for which a third party may be responsible and if the Pool has paid benefits for that illness or injury, the Pool will have the right to recover fully any benefits paid, or benefits that may become payable, for that illness or injury — regardless of the source.

When a third party is liable for the costs of any covered service, the Pool has subrogation rights. This means that the Pool has the right, either as co-plaintiff or by direct suit, to enforce your claim against a third party for the benefits paid to you or on your behalf. If the Pool provides benefits, the Pool has a direct first-party priority lien against any money you may recover from a third party or any other source as a result of the condition or injury. The Pool's lien must be satisfied regardless of the amount you recover.

If a third party is or may be liable for the cost of or charges for any covered services, the following actions must be taken:

- You must promptly notify the Administrator of the claim against the third party.
- If you receive money for the claim by suit, settlement, or otherwise, you or your attorney must reimburse the Pool, through its Administrator, for the amount of benefits provided under this Policy or an amount agreed upon with the Administrator. You may not exclude recovery for Pool health care benefits from any type of damages or settlement recovered.
- You must cooperate in every way necessary to help the Pool enforce its subrogation rights.

You may not take any action that might prejudice the Pool's subrogation rights. When you fail to cooperate in satisfying the Pool's subrogation interest, and the Pool must file a lawsuit against you or the third party in order to enforce its rights under this provision, you or any of your dependents receiving benefits under this Policy will be responsible for attorneys' fees and costs incurred by the Pool.

7

Claims Payments and Appeals



Filing Claims

You must submit claims **within 18 months** after the date services or supplies were received. **A claim submitted more than 18 months after the service was received will not be accepted under any circumstance.** If a claim is returned for further information, resubmit it **within 45 days**.

Participating Providers

All participating providers that are contracted directly with the Administrator have specific timely filing limits in their contracts with the Administrator. The contract language lets providers know that they may not bill the member if they do not meet that filing limit for a service and the claim for that service is denied. Also, participating providers file claims with the Administrator (or with their local BCBS Plan) and payment is made directly to them. Be sure that these providers know you have health care coverage administered by BCBSNM. **Do not** file claims for these services yourself.

Nonparticipating Providers

A nonparticipating provider is one that has no participating provider contract, either directly or indirectly, with the Administrator. If your nonparticipating provider does not file a claim for you, attach itemized bills and, if applicable, your other coverage's payment explanation, to a *Member Claim Form*. (Forms can be printed from the BCBSNM Web site or requested from a Customer Service representative.) Complete the claim form using the instructions on the form. (See special claims filing instructions for out-of-country claims under "Where to Send Claim Forms," on the next page.)

Itemized Bills — Claims for covered services must be itemized on the provider's billing forms or letterhead stationery and must show:

- member's identification number
- member's name and address
- member's date of birth
- name, address, and tax ID or social security number of the health care provider
- date of service or purchase, diagnosis, type of service or treatment, procedure, and amount charged for each service (each service must be listed separately)
- accident or surgery date (when applicable)

Correctly itemized bills are necessary for your claim to be processed.

The only acceptable bills are those from health care providers. **Do not** file bills you prepared yourself, canceled checks, balance due statements, or cash register receipts. Make a copy of all itemized bills for your records before you send them. The bills are not returned to you. All information on the claim and itemized bills must be readable. If information is missing or is not readable, the Administrator will return it to you or the provider.

Do not file for the same service twice unless asked to do so by a Customer Service representative. If your itemized bills include services previously filed, identify clearly the new charges that you are submitting.

All itemized bills for services received outside the United States must be translated into English before being filed with the Administrator. (See “Where to Send Claim Forms,” below, for special instructions regarding out-of-country claims.)

If You Have Other Coverage — When you have other coverage that is “primary” over this Policy, you need to file your claim with the other coverage first. (See *Section 6: COB and Subrogation*.)

After your other coverage (including health care insurance, dental or vision plan, Medicare, automobile or other liability insurance, Workers’ Compensation, etc.) pays its benefits, a copy of their payment explanation form must be attached to the claim sent to the Administrator (or to the local Blue Cross Blue Shield Plan, as instructed under “Where to Send Claims Forms,” below).

If the other coverage pays benefits to you (or your family member) directly, give your provider a copy of the payment explanation so that he/she can include it with the claim sent to the Administrator. (If a nonparticipating provider does not file claims for you, attach a copy of the payment explanation to the claim that you send to the Administrator.)

Where to Send Claim Forms

If your provider does not file a claim for you, you (not the provider) are responsible for filing the claim. **Remember:** Participating providers will file claims for you; these procedures are used only when you must file your own claim. See “Participating Providers,” on the previous page, for more information.

Medical/Surgical Claims — When covered services are received from nonparticipating providers in New Mexico, mail the forms and itemized bills to:

NM Medical Insurance Pool Administrator
P.O. Box 27630
Albuquerque, New Mexico 87125-7630

Prescription Drug Claims — Claims for items covered under the prescription drug plan must be sent to the prescription drug plan administrator — **not** to BCBSNM. If not included in your enrollment materials, you can obtain the name and address of the administrator and the necessary claim forms from a Customer Service representative or on the BCBSNM Web site (www.bcbsnm.com).

Outside New Mexico — Claims for covered services received outside New Mexico from a provider that does not contract directly with the Administrator should be sent to the BCBS Plan in the state where services were received. If a provider will not file a claim for you, ask for an itemized bill, complete a member claim form, and mail both forms to the BCBS plan of that state.

Canada and Puerto Rico — Claims for covered services received in Canada or Puerto Rico should be handled the same way as is described in “Outside New Mexico,” on the previous page.

Outside the United States — For covered inpatient hospital services received outside the United States (including Puerto Rico) and Canada, show your NM Medical Insurance Pool ID card. If the hospital has an agreement with the Association, the hospital files the claim for you to the appropriate Blue Cross Plan. Payment is made to the hospital by that Plan, and then the Administrator reimburses the other Plan.

For inpatient care at a BlueCard Worldwide® hospital that was arranged through the BlueCard Worldwide Service Center, 1.800.810.BLUE (2583), you only pay the provider the usual out-of-pocket expenses (noncovered services, deductible, copayment and coinsurance). The provider files the claim for you.

For all outpatient and professional medical care, you pay the provider and submit a claim as described under “Nonparticipating Providers,” earlier in this section. You may also have to pay the hospital (and submit a claim) for inpatient care obtained from a non-BlueCard Worldwide® hospital or when inpatient care was not arranged through the BlueCard Worldwide Service Center. Make copies of your itemized bills and translate them into English. Submit the original itemized bills, along with the translation, to the Administrator for benefit determination.

■ Claims Payment Provisions

After a claim has been processed, the member will receive an *Explanation of Benefits* (EOB). The EOB indicates what charges were covered and what charges, if any, were not.

Participating Providers — Payments for covered services usually are sent directly to participating providers. The EOB you receive explains the payment.

Nonparticipating Providers — If services are received from a nonparticipating provider in New Mexico, payments are usually made to the member. The check will be attached to an EOB that explains the Administrator’s payment. In these cases, you are responsible for arranging payment to the provider and for paying any amounts greater than covered charges plus deductibles, coinsurance, any penalty amounts, and noncovered expenses.

Assignment of Benefits — The Administrator specifically reserves the right to pay the member directly and to refuse to honor an assignment of benefits in any circumstances. No person may execute any power of attorney to interfere with the Administrator’s right to pay the member instead of anyone else.

Covered Charge — Provider payments are based upon participating provider agreements and covered charges as determined by the Administrator. For services received outside of New Mexico, covered charges may be based on the local Plan practice. You are responsible for paying copayments, deductibles, coinsurance, any penalty amounts, and noncovered expenses. For covered services received in foreign countries, the Administrator will use the exchange rate in effect on the date of service in order to determine billed charges.

BlueCard Program — BCBSNM hereby informs you that other Blue Cross and Blue Shield Plans outside of New Mexico (“Host Blue”) may have contracts with certain providers in their service areas. Often, this “negotiated price” is a **simple discount** that reflects the actual price the Host Blue pays. Sometimes, it is an **estimated price** that takes into account special arrangements the Host Blue has with an individual provider or a group of providers. Such arrangements may include settlements, withholds, non-claims transactions, and/or other types of variable payments. The “negotiated price” may also be an **average price** based on a discount that results in expected average savings (after taking into account the same special arrangements used to obtain an estimated price). Average prices tend to vary more from actual prices than estimated prices.

Negotiated prices may be adjusted from time to time to correct for over- or under-estimation of past prices. However, the amount used by BCBSNM to calculate your share of the billed amount is considered a final price.

Laws in a small number of states may require the Host Blue to 1) use another method for, or 2) add a surcharge to, your liability calculation. If any state laws mandate other liability calculation methods, including a surcharge, BCBSNM would calculate your liability for any covered services according to the applicable state law in effect when you received care.

Drug Plan Copayments — When the copayment for an item is greater than the covered charge for the supply being purchased from a participating pharmacy, you pay the **lesser** of: 1) your copayment, or 2) the pharmacy’s retail price. For claims submitted to the drug plan administrator for reimbursement, you are paid the **lesser** of: 1) the sum of the drug ingredient cost, the dispensing fee that would be payable to a participating pharmacy, and any sales tax minus the applicable copayment, or 2) the pharmacy’s retail price minus the applicable copayment.

Accident-Related Hospital Services — If services are administered as a result of an accident, a hospital or treatment facility may place a lien upon a compromise, settlement, or judgement obtained by you when the facility has not been paid its total billed charges from all other sources.

Overpayments — If the Administrator makes an erroneous benefit payment for any reason (e.g., provider billing error, claims processing error), the Pool may recover overpayments from you. If you do not refund the overpayment, the Administrator reserves the right to withhold future benefits to apply to the amount that you owe the Pool, and/or to secure the services of an agency or attorney to collect and recover any payments that were greater than the benefits under this Policy.

■ Request for Reconsideration

If you disagree with the denial or payment of your claim, you may ask for a review. Call a Customer Service representative for assistance. If you continue to disagree, you may ask for a formal review. Send your request for reconsideration to a Customer Service representative and, if possible, please include:

- a copy of the *Explanation of Benefits* (EOB) and/or denial letter; *and*
- copies of related medical records from your provider; *and*
- any additional information from your provider in support of your request.



The formal reconsideration request must be filed to the Administrator within **180 days** of the date the first denial or payment notice is mailed. If you do not file the reconsideration request within the 180-day period, you waive your right to reconsideration.

The Administrator will acknowledge receipt of the request for reconsideration. The Administrator will review your request and give you a decision within 60 calendar days, unless you are asked for more information. If there is no change in the original decision, you are provided reasons in writing.

External Appeals and Actions

If you are still not satisfied after having completed the Administrator's reconsideration procedure, you may submit an appeal to the Pool:

NM Medical Insurance Pool Appeals

Pool applicants who have been denied coverage and Pool members have the right to appeal decisions made by the Administrator concerning Pool enrollment, eligibility, benefits, etc. Appeals to the NM Medical Insurance Pool Board of Directors are to be made in **writing** at the following address:

New Mexico Medical Insurance Pool
ATTN: Executive Director
P.O. Box 1594
Roswell, NM 88202-1594
Telephone number: (505) 622-4711

Review by the NM Superintendent of Insurance



If you are dissatisfied with the decision of the NM Medical Insurance Pool Board of Directors on your appeal, you have the right to request further review by the New Mexico Superintendent of Insurance by filing a written request **within 20 working days** of receipt of the written NM Medical Insurance Pool Board of Directors' appeal decision. You may file your request by:

- Mail to the Superintendent of Insurance, Attention: Complaint Department - External Review Request, New Mexico Public Regulation Commission, P.O. Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269; or
- Fax to the Superintendent of Insurance, Attention: Complaint Department - External Review Request, at (505) 827-4734.

You will need to provide a copy of the Administrator's reconsideration decision; the NM Medical Insurance Pool Board of Directors appeal decision; a fully executed release form authorizing the Superintendent to obtain any necessary medical records from BCBSNM or other health care service provider; and any other supporting documentation.

Legal Action

You may not take legal action to recover benefits under this Policy after 3 years from the date that the claim in question must be filed with the Administrator.

■ **Certain Defenses**

There is nothing contained in this Policy upon which the member can claim any right, action, or cause of action, either at law or in equity, against the Pool, the NM Medical Insurance Pool Board of Directors, or its Administrator for any act or omission of any person, firm, or corporation who is involved directly or indirectly in furnishing any item or providing any services to a member.

■ **Catastrophic Events**

In case of fire, flood, war, civil disturbance, court order, strike, or other cause beyond the Administrator's control, the Administrator may be unable to process claims or provide prior approval for services on a timely basis

■ **Research Fees**

The NM Medical Insurance Pool reserves the right to charge you an administrative fee when extensive research is necessary to reconstruct information that has already been provided to you in explanations of benefits, letters, or other forms.

■ **Sending Notices**

All notices to you are considered to be sent to and received by you when deposited in the United States mail with first-class postage prepaid and addressed to the member at the latest address on the Administrator's membership records.

8

Enrollment and Termination Information

■ Term of Coverage

Your coverage starts on the Policy's effective date at 12:01 a.m. Standard Time where you live. It ends at 12:01 a.m., the same Standard time, or the first renewal date. Each time you renew your Policy by paying the premium within the 31-day grace period, the new term begins when the old term ends.

■ Who Is Eligible

To be eligible for the NM Medical Insurance Pool program, you must be and continue to be a **resident of the state of New Mexico** (a resident is any person who resides within the state of New Mexico in a place of permanent habitation). Unless otherwise indicated below, you must apply for Pool coverage **within the time frames indicated, if any**, after satisfying the condition that caused you to become eligible. An application is dated on the later of the requested effective date or the day of the postmark date affixed by the United States Post Office. (If the envelope containing the application is not postmarked by the United States Post Office or the postmark is not legible, the application date will be the later of the requested effective date or the date received by the Pool.)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that New Mexico residents are eligible for Pool coverage if:

- They have had an aggregate of 18 or more months of creditable coverage, the last of which must be group coverage; and
- They have received notice of termination of comprehensive medical/surgical group coverage (including COBRA continuation and meeting a general lifetime maximum benefit under prior coverage) that terminates within 63 days prior to the initial application date for Pool coverage; and
- Proof of such existing coverage must be included with the application for Pool coverage.

NOTE: If the most recent creditable coverage available to you under this provision was terminated as a result of nonpayment of premium or due to fraud, you are not eligible for Pool coverage.

In addition, if you are a New Mexico resident, you are eligible for Pool coverage if you have received one or more of the following:

1. A notice of rejection for comprehensive major medical coverage in the last 12 months.
2. A note or letter from a physician stating that you have been specifically diagnosed with one of the qualifying medical or health conditions (you may review the list of qualifying conditions on the NM Medical Insurance Pool Web site or request a copy of the list from the Administrator)
3. A notice of health insurance being available **ONLY** with a rider, waiver, or restrictive provision for a specific condition for a period of time of not less than 12 months.
4. Proof that your current premium rate for in-force coverage (or a quote received within last 31 days for applied-for health insurance coverage) exceeds 125 percent of the Pool's standard risk rate for similar deductible options for your age and sex.

5. A notice of current enrollment with the New Mexico Health Insurance Alliance (and you wish to switch enrollment to the Pool).
6. A notice stating that your most recent prior comprehensive major medical coverage has, or will terminate because the insurer stopped issuing coverage in New Mexico, or your coverage in another state's high risk pool ended due to non-residency, or you moved to New Mexico and your current coverage is not valid. In order to prevent a lapse in coverage, you must apply for Pool coverage within 31 days after termination of prior coverage and pay premiums for the entire coverage period; the pre-existing condition limitation may still apply.
7. A notice stating that you are on Medicare due to a disability and under the age of 65. (Note: Persons eligible due to this criterion will receive the NM Medical Insurance Pool Medicare Carve-Out Policy.)

Each member of a family covered under the Pool must meet the eligibility provisions of this Policy, except newborns up to 31 days old. There are no family rates; each family member who is enrolled will be charged the rate applicable to his/her age and sex.

Who is Not Eligible — You are not eligible to enroll if any of the following conditions apply to you:

- You have or are eligible for **Medicare** (unless you are under age 65) or **Medicaid**, unless such coverage is limited to coverage for amounts in excess of limited policies such as dread disease, cancer policies, or hospital indemnity policies. In such instances Medicare or Medicaid coverage will be the primary payer and the Pool will be the secondary payer. (If you are under age 65 and become eligible for both Parts of Medicare after enrollment in the Pool, you are eligible to enroll in the Pool's Carveout Plan or you may retain coverage under this Policy until you reach age 65. If you reach age 65 and become eligible for Medicare after January 1, 2006, you may **not** continue coverage under any Pool Policy. If you are age 65 or older and enrolled for coverage under this Policy before January 1, 2006, you may continue coverage under this Policy, whether or not you are eligible for Medicare.)
- You are eligible for coverage under a group health plan or have other comprehensive major medical health insurance coverage, including benefits consisting of medical care, items, or services provided directly, through insurance or reimbursement, or otherwise under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract. (You may continue coverage under the Pool while satisfying a pre-existing condition waiting period under the other group health plan or health insurance policy. You may also continue other coverage if you qualify for Pool coverage due to premium rate or a condition rider. The Pool Policy is secondary to all other coverage.)
- You were offered the option of continuing coverage under a federal COBRA provision or similar state program, but the coverage meets the conditions for eligibility described under numbers 3, 4, or 5 starting on the previous page.
- You have voluntarily terminated a Pool Policy within the past 12 months. However, if you terminated Pool coverage because you became eligible for and covered by a health plan and such coverage was then involuntarily terminated in less than 12 months, you may re-apply for a Pool Policy. Persons who are HIPAA-eligible individuals at the time of re-application are also eligible to re-apply for Pool coverage within a 12-month period.
- You are an inmate of a public institution or eligible for public programs for which medical care is provided.

Family Provision

While the Pool does not offer a “Family” Policy, if you have three or more qualified family members on Pool Policies with the same deductible you may receive reduced deductible and out-of-pocket limits as indicated on the chart below.

Plan Variable (printed on ID card)	Individual Deductible Choice and Family Amount	Out-of-Pocket Limit (annual deductible plus coinsurance)
500	Individual = \$500 Family = \$1,000	Individual = \$2,500 Family = \$5,000
1000	Individual = \$1,000 Family = \$2,000	Individual = \$3,500 Family = \$7,000
2000	Individual = \$2,000 Family = \$4,000	Individual = \$5,000 Family = \$10,000
5000	Individual = \$5,000 Family = \$10,000	NA - The Pool pays 100% after deductible is met
7500	Individual = \$7,500 Family = \$15,000	NA - The Pool pays 100% after deductible is met
10,000	Individual = \$10,000 Family = \$20,000	NA - The Pool pays 100% after deductible is met

Family Members — In order to qualify as a member of a family, the members must be related to you in one of the following ways:

- your legal **spouse**
- your unmarried **child** through the end of the billing period in which the child becomes age **25** (At that time, the child is automatically removed from the Family provision.)
- your unmarried child over age 25 who was enrolled as a dependent at the time of reaching the age limit, and who is medically certified as **disabled** and chiefly dependent upon you for support and maintenance (Such condition must be certified by a physician and the Administrator. Also, a child may continue to be eligible for coverage under a “Family” Policy beyond the dependent age limit only if the condition began before or during the month in which the child would lose coverage due to his/her age status. Proof of incapacity and dependency must be furnished to the Administrator within 120 days of the dependent’s 25th birthday. The Administrator may request subsequent proof of incapacity and dependency but no more often than on an annual basis after a two-year period following attainment of the limiting age. (A child who is no longer your eligible dependent and therefore not able to continue coverage under your “Family” policy, but who meets the criteria for continued coverage under the Pool, may apply for his/her own Pool Policy.)

Children — A child is considered to be a specific age on the first day of the month following his/her birthday, and includes your unmarried:

- natural or legally adopted child
- child under age 18 placed in your home for purposes of adoption
- stepchild who depends upon you for support and maintenance and resides with you in a parent-child relationship

Note: If three or more children family members, as defined above, are members of the Pool program, they can qualify as a family even if you or your spouse are not covered. However, if a child qualifying as part of a family has his or her own child, the newborn child may not qualify as part of the same family. The newborn, if

eligible, must switch to his/her own Policy and the additional premium for the newborn must be paid.

Family members covered under the Pool program must each meet the eligibility provisions of this Policy. The Administrator may require acceptable proof (such as copies of income tax forms, legal adoption or legal guardianship papers, or court orders) that an individual qualifies as a family member. Unless listed as an eligible family member, no other relative or person is eligible for coverage as a family.

If a child is under the age of 15, his/her parent, legal guardian, or other responsible party must submit the application for coverage on the child's behalf. Also, for any child covered under a Pool Policy, any obligations of the policyholder set forth in this benefit booklet, any endorsements, addenda, or riders will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the child's behalf.

You may not apply for a Pool Policy on behalf of a non-disabled adult child without obtaining authorization from the child to enter into a health insurance contract; therefore, an application for any such coverage of an adult child, whether as a dependent or as the subscriber, must be signed by the child. If the adult child is disabled and unable to sign the application, his/her legal guardian may apply for coverage on his/her behalf and, by doing so, accepts any obligations of the subscriber set forth in the Policy, including any endorsements, addenda, or riders. You may be required to provide a copy of a power of attorney for an adult child.

Medicare/Medicaid-Eligible Members

Shortly before you turn age 65 or qualify for Medicare benefits for other reasons, you are responsible for contacting the local Social Security office to establish Medicare eligibility.

Members with both Parts of Medicare may also choose to apply for an individual Medicare Supplemental Policy, which may require a health statement and/or a pre-existing conditions waiting period. (The options available to members under age 65 and eligible for Medicare may differ from those available to members age 65 and older.)

A person is eligible to enroll if he/she has Medicaid coverage that provides benefits only for limited conditions.

Newborn and Adopted Children

If you are a member of the pool, your newborn child, a child physically placed in your home for the purpose of adoption, or your newly adopted child is automatically eligible for 31 consecutive calendar days of coverage **for an additional premium**. (This provision applies only to children of adult policyholders. If a Pool member is the dependent child of another policyholder and has his/her own child, the child of the dependent may qualify for automatic coverage but the dependent must switch to his/her own Policy and pay the additional premium for the newborn.)

You must complete an application for coverage and submit it to the Administrator **within 31 days** of the birth, placement in the home, or legal adoption. In such cases, the child does not have to establish eligibility for Pool coverage, this Policy's pre-existing conditions limitation does not apply, and the newborn is covered

at birth (or, in the case of a child who has been placed in your home or adopted, for 31 days following placement or adoption).

Eligibility must be established for the child to remain on the Policy beyond 31 days.

Note: A child under age 18 who is physically placed in your home for the purposes of adoption may acquire Pool coverage as soon as the child is physically placed in the home or upon completion of the legal adoption (or any time in between). They must still establish continued eligibility to be covered beyond the 31-day period.

■ When Coverage Begins

Your Pool coverage begins on the first of the month following the date your application is accepted and the premium is paid. This date is your effective date. The Pool pays for covered services that you receive after the effective date of coverage. In some instances, coverage may begin on the first of the month during which your prior coverage terminated; in such cases, retroactive premium may be required.

This Policy does not cover any service received or any admission that begins before your effective date of coverage. Also, if your prior coverage has an extension of benefits provision, this Policy will not cover those charges incurred after your effective date that are covered under the prior plan.

Pre-Existing Conditions Limitation

A pre-existing condition is a physical or mental condition for which medical advice, medication, diagnosis, care, or treatment was recommended for or received by an applicant within the **six-month** period before his/her effective date of coverage. (No pre-existing condition limitation or exclusion may be imposed on a HIPAA-eligible individual regardless of when the medical condition occurred.) Complication of pregnancy is **not** considered a pre-existing condition. (However, if you selected the optional routine maternity services coverage, this Policy does not cover routine maternity care or elective abortion for pregnancies conceived before the optional coverage became effective, unless the pre-existing condition limitation was waived upon enrollment, as described under “Exceptions,” below. See *Section 4* for details.)

No benefits are available for any pre-existing condition for **six months** after the member’s effective date of coverage under this Policy, except as described below.

Exceptions — The following members are **not** subject to this pre-existing conditions limitation:

- Any member who enrolled as a HIPAA-eligible individual.
- Newborn child acquiring Pool coverage within 31 days of birth.
- Adopted child under age 18 (or child under age 18 physically placed in your home for the purpose of adoption) and acquiring Pool coverage prior to or within 31 days of adoption.
- Members who had satisfied the pre-existing conditions limitation, if any, under their prior creditable coverage and who applied timely (within 31 days) for Pool coverage.

- A newborn or adopted child who was enrolled in any group health plan or other creditable coverage within 31 days of birth or adoption who has not experienced any significant lapse of coverage (i.e., 63 or more days) prior to enrolling in this Pool program.

If you do not qualify for a full waiver of the pre-existing conditions limitation, the six-month waiting period will be reduced to the extent similar waiting periods were satisfied under previous creditable coverage. To obtain the waiting period reduction, your application for Pool coverage must be received by the Administrator within 31 days of termination of prior coverage (or the notification date of involuntary termination, if later, or receipt of information indicating you have met your lifetime maximum benefit under creditable coverage).

You can add up any creditable coverage you had prior to enrollment under this Policy, but if you went for 63 days or more without any creditable coverage (excluding any excepted time periods outlined below), the coverage you had before the break will not be counted. Proof of such prior creditable coverage (e.g., Certificate of Creditable Coverage) is required before credit will be given. For persons enrolling as HIPAA-eligible applicants, proof of prior coverage must be included **with** the application for Pool coverage.

Premiums must be paid for the entire coverage period.

Note: The waiver and/or reduction in the pre-existing conditions limitation may not apply to services covered under the optional routine maternity services coverage. See *Section 4* for details.

What is Not Considered a Break in Coverage — For purposes of determining any significant break in coverage (i.e., 63 or more days), lapses in coverage due to any of the following situations will not be considered as part of a break:

- a waiting period imposed by a group health plan before it allowed you to become eligible for enrollment
- the amount of time between the date you submitted a substantially complete application for individual plan coverage and either the date the coverage began (if you were accepted), or the date on which the application was denied or on which the offer of coverage lapsed (if you were not accepted)
- the period of time between loss of coverage and COBRA election for certain workers whose employment was adversely affected by international trade and who were entitled to a second COBRA election period as a result

■ Premium

Your Policy will be renewed each time the required premium payment is made. The premium is due and payable to the Administrator in advance of each period for which the coverage is to be in effect. A grace period of 31 days is granted following the premium due date. No benefits are available for care for services received during the grace period unless the premium is remitted to the Administrator's office before the grace period's expiration date.

Failure to receive premium due notices does not relieve the applicant from responsibility for paying the premium when due.

Rates are re-evaluated on January 1 and July 1 of each year and may be adjusted based on various factors, including your age (e.g., your premium may increase on the first of the month following your birthday). The Administrator will notify you at least 60 days before an increase in premium occurs due to a re-evaluation of rates. (You will not be notified of a rate increase that occurs due to age.)

■ Policy Termination

Unless stated otherwise, coverage ends at the end of the last-paid billing period during which one of the following events occurs:

- When the Administrator does not receive the premium payment on time. If the month's premium is not received within 31 days after the premium due date (known as the "grace period"), your coverage will be terminated at the end of the last period for which premium was paid.
- When you become covered by a group plan. Such termination may be made retroactively upon disclosure of the group coverage. If you are subject to a pre-existing conditions period under the group coverage, the Pool coverage will terminate on the date the period ends.
- When you are no longer eligible for coverage under the New Mexico Medical Insurance Pool program.
- When you are no longer a New Mexico resident.
- When you do not reply within 30 days after the date that the Administrator makes an inquiry concerning your place of residence.
- When you request this Policy to end.
- When New Mexico statutes require cancellation of this Policy.

If you knowingly gave false material information in connection with your or a family member's eligibility or enrollment, the Administrator may terminate the coverage of you and all family members retroactively to the date of initial enrollment. You are liable for any benefit payments made as a result of such improper actions.

Re-Entering the Pool After Termination

If you fail to pay the premium in accordance with the terms of this Policy, or if you voluntarily leave the Pool, you will not be eligible to re-apply until 365 days have passed from the date of termination of coverage. However, if you terminated Pool coverage because you became covered by a health plan that was then involuntarily terminated in less than 12 months OR if you qualified as a HIPAA-eligible individual or were enrolled in a federally eligible plan, you may re-apply for Pool coverage.

9

General Provisions

Contestability Period

If at any time it is determined that you are no longer eligible for coverage according to the eligibility requirements for the Pool, you will be terminated effective the end of the month you are determined ineligible.

Availability of Provider Services

The Administrator does not guarantee that a certain type of room or service will be available at any hospital or other facility within the Administrator's participating provider network, nor that the services of a particular hospital, physician, or other provider will be available.

Changes to the Health Care Policy

This Policy and any attachments are the entire Policy of Insurance. Only the Board of Directors of the New Mexico Medical Insurance Pool or the Legislature of the State of New Mexico can approve a change to the Policy. Any such change(s) must be shown in your Policy.

Disclaimer of Liability

The Administrator has no control over any diagnosis, treatment, care, or other service provided to you by any facility or professional provider, whether participating or not. The NM Medical Insurance Pool and its contractors and subcontractors are not liable for any loss or injury caused by any health care provider by reason of negligence or otherwise.

Disclosure and Release of Information

The Administrator and the NM Medical Insurance Pool will only disclose information as permitted or required under state and federal law.

Execution of Papers

You must, upon request, execute and deliver to the Administrator any documents and papers necessary to carry out the provisions of this Policy.

Independent Contractors

The relationship between the Administrator and its participating providers is that of independent contractors; physicians and other providers are not agents or employees of the Administrator, and the Administrator and its employees are not employees or agents of any network provider. The Administrator will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any participating provider.

10

Definitions

It is important for you to understand the meaning of the following terms. The definition of many terms determines your benefit eligibility.

Accidental injury — A bodily injury caused solely by external, traumatic, and unforeseen means. Accidental injury does not include disease or infection, hernia, or cerebral vascular accident. Dental injury caused by chewing, biting, or malocclusion is not considered an accidental injury.

Acupuncture — The use of needles inserted into the body for the prevention, cure, or correction of any disease, illness, injury, pain, or other condition by controlling and regulating the flow and balance of energy and functioning of the person to restore health.

Administrator — The company that has been selected to administer eligibility, billing, claims administration, and customer services for the Pool program.

Admission — The period of time between the dates a patient enters a facility as an inpatient and is discharged as an inpatient.

Alcoholism — A condition defined by patterns of usage that continue despite occupational, social, marital, or physical problems related to compulsive use of alcohol. There may also be significant risk of severe withdrawal symptoms if the use of alcohol is discontinued.

Alcoholism treatment facility, alcoholism treatment program — An appropriately licensed provider of detoxification and rehabilitation treatment for alcoholism.

Ambulance — A specially designed and equipped vehicle used **only** for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an ambulance.

Ambulatory surgical facility — An appropriately licensed provider, with an organized staff of physicians, that meets all of the following criteria:

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis; *and*
- provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility; *and*
- does not provide inpatient accommodations; *and*
- is not a facility used primarily as an office or clinic for the private practice of a physician or other provider.

Appliance — A device used to provide a functional or therapeutic effect.

Benefit year — The specified time period—the calendar year (January 1 through December 31 of the same year)—during which expenses for covered services must be incurred in order to be eligible for payment by the Pool. An expense is incurred on the date the service or supply was provided. A member may have an initial benefit year of less than 12 months.

Blue Cross and Blue Shield of New Mexico (BCBSNM) — The Administrator for this NM Medical Insurance Pool Program. BCBSNM is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association; also referred to as BCBSNM or the Administrator.

Brand-name drug — A drug that is available from only one source, or when available from multiple sources, is protected with a patent.

Cancer clinical trial — A course of treatment provided to a patient for the prevention of reoccurrence, early detection, or treatment or palliation of cancer for which standard cancer treatment has not been effective or does not exist. 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 phase II, III, or IV cancer clinical trial. The scientific study must have been approved by an institutional review board that has an active federal-wide assurance of protection for human subjects, and include all of the following: specific goals, a rationale and background for the study, criteria for patient selection, specific direction for administering the therapy or intervention and for monitoring patients, a definition of quantitative measures for determining treatment response, methods for documenting and treating adverse reactions, and a reasonable expectation, based on clinical or pre-clinical data, that the treatment will be at least as efficacious as standard cancer treatment. The trial must have been approved by a United States federal agency or by a qualified research entity that meets the criteria established by the federal National Institutes of Health for grant eligibility.

Cardiac rehabilitation — An individualized, supervised physical reconditioning exercise session lasting from 4 – 12 weeks. Also includes education on nutrition and heart disease.

Certified nurse-midwife — A person who is licensed by the Board of Nursing as a registered nurse and who is licensed by the New Mexico Department of Health (or appropriate state regulatory body) as a certified nurse-midwife.

Certified nurse practitioner — A registered nurse whose qualifications are endorsed by the Board of Nursing for expanded practice as a certified nurse practitioner and whose name and pertinent information is entered on the list of certified nurse practitioners maintained by the Board of Nursing.

Cessation counseling — As applied to the “Smoking/Tobacco Use Cessation” benefit described in *Section 3*, cessation counseling means a program, including individual, group, or proactive telephone quit line, that:

- is designed to build positive behavior change practices and provides counseling at a minimum on: establishment of reasons for quitting, understanding nicotine addiction, techniques for quitting, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse preventive and follow-up;
- operates under a written program outline that meets minimum requirements established by the NM Public Regulation Commission;
- employs counselors who have formal training and experience in tobacco cessation programming and are active in relevant continuing education activities; and
- uses a formal evaluation process, including mechanisms for data collection and measuring participant rate and impact of the program.

Chemical dependency — Conditions defined by patterns of usage that continue despite occupational, marital, or physical problems that are related to aberrant use of alcohol, drugs, or other substance. Chemical dependency (also referred to as “substance abuse,” which includes alcoholism and drug abuse) may also be defined by significant risk of severe withdrawal symptoms if the use of alcohol, drugs, or other substance is discontinued.

Chemotherapy — Drug therapy administered as treatment for malignant conditions and diseases of certain body systems.

Chiropractor — A person who is a doctor of chiropractic (D.C.) licensed by the appropriate governmental agency to practice chiropractic medicine.

Church plan — That term as defined pursuant to Section 3(33) of the federal Employee Retirement Income Security Act of 1974.

Clinical psychologist — A person with a doctoral degree in clinical psychology licensed or certified in accordance with the New Mexico Professional Psychologist Act or similar statute in another state.

Coinsurance — The percentage of a covered charge that is your responsibility to pay for most covered services. For covered services that are subject to coinsurance, you pay the percentage (indicated on the *Summary of Benefits and Plan Options*) of the Administrator’s covered charge after the deductible (if any) has been met.

Complications of pregnancy — C-sections, ectopic pregnancies, toxemia, abruptio placentae, miscarriages, and other complications as determined by the Administrator. Elective abortions are not considered a complication of pregnancy under this Policy.

Copayment — The fixed-dollar amount (or in some cases, a percentage) of a covered charge that you pay for items covered under the prescription drug plan.

Cosmetic — See the “Cosmetic Services” exclusion in *Section 5*.

Cost-effective — A procedure, service, or supply that is an economically efficient use of resources, relative to the benefits and harms associated with the procedure, service, or supply. When determining cost effectiveness, the situation and characteristics of the individual patient are considered.

Covered charge — See “Claims Payment Provisions” in *Section 7*.

Covered services — Services or supplies that are listed in this Policy, including any endorsements, addenda, or riders, for which benefits are provided.

Creditable coverage — Health care coverage through an employment-based group health plan; health insurance coverage; Part A or B of Title 18 of the Social Security Act (Medicare); Title 19 of the Social Security Act (Medicaid) except coverage consisting solely of benefits pursuant to section 1928 of that title; 10 USCA Chapter 55 (military benefits); a medical care program of the Indian Health Service or of an Indian nation, tribe, or pueblo; the NM Medical Insurance Pool Act or similar state sponsored health insurance pool; a health plan offered pursuant to 5 USCA Chapter 89; a public health plan as defined in federal regulations, whether foreign or domestic; any coverage provided by a governmental entity, whether or not insured, a State Children’s Health Insurance Program; or a health benefit plan offered pursuant to section 5(e) of the federal Peace Corps Act.

Custodial care — Services to assist in activities of daily living (such as sitter’s or homemaker’s services), or services not requiring the continuous attention of

skilled medical or paramedical personnel, regardless of where they are furnished or by whom they were recommended. See the “Custodial Care” exclusion in *Section 5*.

Deductible — The amount that you must pay in a calendar year before this Policy pays benefits for all or part of your remaining covered charges incurred during the rest of the calendar year. Your individual deductible amount is indicated on your Pool program ID card.

Dental-related services — Services performed for treatment of conditions related to the teeth or structures supporting the teeth.

Dentist, oral surgeon — A doctor of dental surgery (D.D.S.) or doctor of medical dentistry (D.M.D.) who is licensed to practice prevention, diagnosis, and treatment of diseases, accidental injuries, and malformation of the teeth, jaws, and mouth.

Diagnostic services — Procedures such as laboratory and pathology tests, x-ray services, EKGs, and EEGs that do not require the use of an operating or recovery room, and that are ordered by a provider to determine a condition or disease.

Dialysis — The treatment of a kidney ailment during which impurities are mechanically removed from the body with dialysis equipment.

Doctor of oriental medicine — A person who is a doctor of oriental medicine (D.O.M.) licensed by the appropriate governmental agency to practice acupuncture and oriental medicine.

Drug abuse — A condition defined by patterns of usage that continue despite occupational, marital, or physical problems related to aberrant use of drugs or other substance. There may also be significant risk of severe withdrawal symptoms if the use of drugs is discontinued. Drug abuse does not include nicotine addiction or alcohol use.

Drug abuse treatment facility — An appropriately licensed provider primarily engaged in detoxification and rehabilitation treatment for chemical dependency.

Durable medical equipment — Any equipment that can withstand repeated use, is made to serve a medical purpose, and is generally considered useless to a person who is not ill or injured. This equipment is designed for repeated use, and includes items such as oxygen tents, wheelchairs, hospital beds, crutches, and other medical equipment.

Effective date of coverage — 12:01 A.M. of the date on which a member’s coverage begins.

Emergency — An accidental injury or a condition that occurs suddenly and unexpectedly and is life threatening or could result in permanent damage if not treated immediately. Initial treatment must be sought within 48 hours of the accident or onset of symptoms to qualify as an emergency. If you are hospitalized within 48 hours of an emergency occurrence, the entire hospitalization is considered part of the initial treatment.

Enteral nutritional product — A product designed to provide calories, protein, and essential micronutrients by the enteral route (i.e., by the gastrointestinal tract, which includes the stomach and small intestine only).

Governmental plan — That term as defined in Section 3(32) of the federal Employee Retirement Income Security Act of 1974 and includes a federal governmental plan (a governmental plan established or maintained for its employees by the United States government or an instrumentality of that government).

Group health plan — An employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care and includes items and services paid for as medical care (directly or through insurance, reimbursement, or otherwise) to employees or their dependents (as defined under the terms of the plan).

HIPAA-eligible individual — Any person who has had 18 or more months of creditable coverage (the last of which was group coverage), received notice of termination of such coverage (including COBRA continuation), submits an application for Pool coverage within 63 days of losing creditable coverage, and provides notice of such creditable coverage with the application for Pool coverage.

Home health care services — Covered services, as listed under “Home Health Care/Home I.V. Services” in *Section 3*, that are provided in the home according to a treatment plan by a certified home health care agency under active physician and nursing management. Registered nurses must coordinate the services on behalf of the home health care agency and the patient’s physician.

Hospice — A licensed program providing care and support to terminally ill patients and their families. An approved hospice must be licensed when required, Medicare-certified as, or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as, a hospice.

Hospice benefit period — The period of time during which hospice benefits are available. It begins on the date the attending physician certifies that the member is terminally ill and ends six months after the period began (or upon the member’s death, if sooner). The hospice benefit period must begin while the member is covered for these benefits, and coverage must be maintained throughout the hospice benefit period.

Hospice care — An alternative way of caring for terminally ill individuals in the home or institutional setting, which stresses controlling pain and relieving symptoms but does not cure. Supportive services are offered to the family before and after the death of the patient.

Hospital — A health institution offering facilities, beds, and continuous services 24 hours a day, 7 days a week. The hospital must meet all licensing and certification requirements of local and state regulatory agencies. Services provided include:

- diagnosis and treatment of illness, injury, deformity, abnormality, or pregnancy
- clinical laboratory, diagnostic x-ray, and definitive medical treatment provided by an organized medical staff within the institution
- treatment facilities for emergency and surgical services either within the institution or through a contractual arrangement with another licensed hospital (These contracted services must be documented by a well-defined plan and related to community needs.)

A hospital is not, other than incidentally, a skilled nursing facility, nursing home, custodial care home, health resort, spa, or sanatorium; is not a place for rest, the aging, or the treatment of mental illness, alcoholism, drug abuse, or pulmonary

tuberculosis; ordinarily does not provide hospice or rehabilitation care; and is not a residential treatment facility.

Inborn error of metabolism — A rare, inherited genetic disorder that is present at birth; if untreated, results in mental retardation or death; and causes the necessity for consumption of special medical foods.

Inpatient services — Care provided while you are confined as an inpatient in a hospital or treatment center for at least 24 hours. Inpatient care includes partial hospitalization (a nonresidential program that includes from 3–12 hours of continuous psychiatric care in a treatment facility).

Impacted teeth — Teeth that are fully or partially prevented from erupting in the dental arch by bone. Extraction of teeth that are only prevented from erupting by tissue, or fully impacted teeth that must be extracted in preparation of the mouth for dentures or orthodontic services are not covered.

Investigational drug or device — For purposes of the cancer clinical trial benefit described in *Section 3* under “Therapy and Rehabilitation,” an “investigational drug or device” means a drug or device that has not been approved by the federal Food and Drug Administration.

Licensed midwife — A person who practices lay midwifery and is registered as a licensed midwife by the New Mexico Department of Health (or appropriate state regulatory body).

Licensed practical nurse (L.P.N.) — A nurse who has graduated from a formal practical nursing education program and is licensed by appropriate state authority.

Maintenance therapy — Treatment that does not significantly enhance or increase the patient’s function or productivity, or care provided after the patient has reached his/her rehabilitative potential.

Maintenance medications — Prescription drugs taken regularly to treat a chronic health condition, such as high blood pressure or diabetes.

Maternity — Any condition that is related to pregnancy. Maternity care includes prenatal and postnatal care, and care for the complications of pregnancy, such as ectopic pregnancy, spontaneous abortion (miscarriage), elective abortion, or C-section. You may have benefits only for complications of pregnancy, depending on whether or not you purchased the optional routine maternity care coverage.

Medicaid — A state-funded program that provides medical care for indigent persons, as established under Title XIV of the Social Security Act of 1965, as amended.

Medical detoxification — Treatment in an acute care facility for withdrawal from the physiological effects of alcoholism or drug abuse (usually takes about three days in an acute care facility).

Medical supplies — Expendable items (except prescription drugs), ordered by a physician or other professional provider, that are required for the treatment of an illness or injury.

Medically necessary, 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.

Medicare — The program of health care for the aged, end-stage renal disease (ESRD) patients, and disabled persons established by Title XVIII of the Social Security Act of 1965, as amended.

Member — The person who is enrolled for coverage and entitled to receive benefits under this Policy in accordance with the law passed by the Legislature of the State of New Mexico. Throughout this booklet, the terms “you” and “your” refer to each member.

Mental illness — 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 illness does not include transitional responses to stress, adult situational reactions, social maladjustments, developmental disability, alcoholism, other chemical dependency, or learning disability.

Occupational therapist — A person registered to practice occupational therapy.

Occupational therapy — The use of rehabilitative techniques to improve a patient's functional ability to perform activities of daily living.

Optometrist — A licensed doctor of optometry (O.D.).

Orthopedic appliance — An individualized rigid or semirigid support that eliminates, restricts, or supports motion of a weak, injured, deformed, or diseased body part; for example, functional hand or leg brace, Milwaukee brace, or fracture brace.

Out-of-pocket limit — The maximum amount of coinsurance and deductible that you pay for most covered services in a calendar year. (Prescription drug plan copayments are not applied to the out-of-pocket limit.) After the out-of-pocket limit is reached, the Pool pays 100 percent of most of your covered charges for the rest of that calendar year, not to exceed any benefit limits.

Outpatient services — Medical/surgical services received in the outpatient department of a hospital, emergency room, ambulatory surgical facility, freestanding dialysis facility, or other covered outpatient treatment facility, such as intensive outpatient (IOP) services. Outpatient may also include office and urgent care facility services.

Participating pharmacy — See “Provider,” on the next page.

Participating provider — See “Provider,” on the next page.

Physical therapist — A licensed physical therapist. Where there is no licensure law, the physical therapist must be certified by the appropriate professional body.

Physical therapy — The use of physical agents to treat disability resulting from disease or injury. Physical agents include heat, cold, electrical currents, ultrasound, ultraviolet radiation, and therapeutic exercise.

Physician — A doctor of medicine (M.D.) or osteopathy (D.O.) who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

Podiatrist — A licensed doctor of podiatric medicine (D.P.M.).

Policy — This document or evidence of coverage, which explains the benefits, limitations, exclusions, terms, and conditions of your health coverage. Also referred to as a benefit booklet.

Practitioner of the healing arts — Any physician, professional provider, or other person holding a license or certificate provided for in Chapter 61, Article 4, 5, 6, or 14A NMSA 1978 authorizing the licensee to offer or undertake to diagnose, treat, operate on, or prescribe for any human pain, injury, disease, deformity or physical or mental condition.

Pre-existing condition — A pre-existing condition is a physical or mental condition for which medical advice, medication, diagnosis, care, or treatment was recommended for or received by an applicant within the **six-month** period before his/her effective date of coverage. Complication of pregnancy is **not** considered a pre-existing condition. Members enrolling in the Pool as “HIPAA-eligible individuals” are not subject to any pre-existing conditions limitations or exclusions.

Prescription drugs — Those that are taken at the direction and under the supervision of a provider, that require a prescription before being dispensed, and are labeled as such on their packages. All drugs and medicines must be approved by the FDA, and must not be experimental, investigational, or unproven. (See the “Experimental, Investigational, or Unproven Services” exclusion in *Section 5*.)

Preventive care services — Professional services rendered for the early detection of asymptomatic illnesses or abnormalities and to prevent illness or other conditions.

Prior approval — A requirement that you or your provider must obtain authorization from the Administrator before you are admitted as an inpatient (admission review approval) and before you receive certain types of services (other prior

approvals).

Prosthesis or prosthetic device — An externally attached or surgically implanted artificial substitute for an absent body part; for example, an artificial eye or limb.

Provider — A duly licensed hospital, physician, or other professional provider authorized to furnish health care services within the scope of licensure.

- **Health care facility:** An institution providing health care services, including a hospital or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing facility, a home health care agency, a diagnostic laboratory or imaging center, and a rehabilitation or other therapeutic health setting.
- **Professional provider:** A physician or health care practitioner, including a pharmacist, who is licensed, certified, or otherwise authorized by the state to provide health care services consistent with state law.
- **Participating provider:** Health care professionals and facilities that, for the service being provided, have directly contracted with the Administrator (or indirectly as a contractor or subcontractor), another BCBS Plan, or the Administrator's national transplant network as "participating" providers. These providers belong to the "Participating Provider Network."
- **Participating pharmacy:** A retail supplier that has contracted with the Administrator or its authorized representative to dispense covered prescription drugs and medicines, insulin, diabetic supplies, and special medical foods to Pool program members, and that has contractually accepted the terms and conditions as set forth by the Administrator and/or its authorized representative. Some participating pharmacies are contracted with the Administrator to provide specialty pharmacy drugs to Program members; these pharmacies are called "specialty pharmacy providers" and some drugs must be dispensed by these specially contracted pharmacy providers in order to be covered. They belong to the "Retail Pharmacy Network."
- **Nonparticipating provider:** An appropriately licensed health care provider that has not contracted directly or indirectly, for the service being provided, with the Administrator. **Note:** No benefits are available for transplants or related services if the transplant was received at a nonparticipating facility.
- **Other mental health/chemical dependency providers:** An alcoholism treatment program that complies with the Alcohol and Drug Abuse Program standards required by the state of New Mexico, a psychiatrist, clinical psychologists and the following masters-degreed psychotherapists (an independently **licensed** professional provider with either an M.A. or M.S. degree in psychology or counseling): licensed independent social workers (L.I.S.W.); licensed professional clinical mental health counselors (L.P.C.C.); masters-level registered nurse certified in psychiatric counseling (R.N.C.); licensed marriage and family therapist (L.M.F.T.). For chemical dependency services, a provider also includes a licensed alcohol and drug abuse counselor (L.A.D.A.C.).

In all cases, the provider agrees to provide health care services to members with an expectation of receiving payment (other than copayments, coinsurance, or deductibles) directly or indirectly from the Administrator (or other entity with whom the provider has contracted). A network provider agrees to bill the Administrator (or other contracting entity) directly and to accept this Policy's payment (provided in accordance with the provisions of the contract) plus the member's share (coinsurance, deductibles, copayments, etc.) as payment in full for covered services. However, if there is other coverage for your services (for example, auto

insurance, workers' compensation insurance, or other health plans), the participating provider under the contract with BCBSNM may be able to collect the billed charge amounts not covered by the BCBSNM payment. The Administrator (or other contracting entity) will pay the network provider directly.

Psychiatric hospital — A psychiatric facility licensed as an acute care facility or a psychiatric unit in a medical facility that is licensed as an acute care facility. Services are provided by or under the supervision of an organized staff of physicians. Continuous 24-hour nursing services are provided under the supervision of a registered nurse.

Pulmonary rehabilitation — An individualized, supervised physical conditioning program. Occupational therapists teach you how to pace yourself, conserve energy, and simplify tasks. Respiratory therapists train you in bronchial hygiene, proper use of inhalers, and proper breathing.

Radiation therapy — X-ray, radon, cobalt, betatron, telocobalt, and radioactive isotope treatment for malignant diseases and other medical conditions.

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.

Registered lay midwife — A person registered by the State of New Mexico to provide health care services in pregnancy and childbirth within the scope of New Mexico lay midwifery regulations.

Registered nurse (R.N.) — A nurse who has graduated from a formal program of nursing education (diploma school, associate degree, or baccalaureate program) and is licensed by appropriate state authority.

Rehabilitation hospital — An appropriately licensed facility that provides rehabilitation care services on an inpatient basis. Rehabilitation care services consist of the combined use of a multidisciplinary team of physical, occupational, speech, and respiratory therapists, medical social workers, and rehabilitation nurses to enable patients disabled by illness or accidental injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

Residential treatment center — See the “Noncovered Providers of Service” exclusion in *Section 5*.

Respiratory therapist — A person qualified for employment in the field of respiratory therapy.

Routine newborn care — Care of a child immediately following his/her birth that includes: routine hospital nursery services; routine medical care in the hospital after delivery, including alpha-fetoprotein IV screening; pediatrician standby care at a Cesarean section procedure; and services related to circumcision of a male newborn.

Routine patient care cost — For purposes of the cancer clinical trial benefit described under “Therapy and Rehabilitation” in *Section 3*, a “routine patient care

cost” means a medical service or treatment that is covered under a health plan that would be covered if you were receiving standard cancer treatment, or an FDA-approved drug provided to you during a cancer clinical trial, but only to the extent that the drug is not paid for by the manufacturer, distributor, or provider of the drug. **Note:** For a covered cancer clinical trial, it is not necessary for the FDA to approve the drug for use in treating your particular condition. A “routine patient care cost” does **not** include the cost of any investigational drug, device, or procedure, the cost of a non-health care service that you must receive as a result of your participation in the clinical trial, costs for managing the research, costs that would not be covered or that would not be rendered if non-investigational treatments were provided, or costs paid or not charged for by the trial providers.

Skilled nursing care — Care that can be provided only by someone with at least the qualifications of a licensed practical nurse (L.P.N.) or registered nurse (R.N.).

Skilled nursing facility — A facility or part of a facility that:

- is licensed in accordance with state or local law; and
- is a Medicare-participating facility; and
- is primarily engaged in providing skilled nursing care to inpatients under the supervision of a duly licensed physician; and
- provides continuous 24-hour nursing service by or under the supervision of a registered nurse; and
- does not include any facility that is primarily a rest home, a facility for the care of the aged, or for treatment of drug abuse, mental disease, or tuberculosis, or for intermediate, custodial, or educational care.

Sound natural teeth — Teeth that are whole, without impairment, without periodontal or other conditions, and not in need of treatment for any reason other than the accidental injury. Teeth with crowns or restorations (even if required due to a previous injury) are not sound natural teeth. Therefore, injury to a restored tooth will not be covered as an accident-related expense. (Your provider must submit x-rays taken before the dental or surgical procedure in order for the Administrator to determine whether the tooth was “sound.”)

Special care unit — A designated unit that has concentrated facilities, equipment, and supportive services to provide an intensive level of care for critically ill patients. Examples of special care units are intensive care unit (ICU), cardiac care unit (CCU), subintensive care unit, and isolation room.

Special medical foods — Nutritional substances, in any form, that are:

- formulated to be consumed or administered internally under the supervision of a physician; and
- specifically processed or formulated to be distinct in one or more nutrients present in natural form; and
- intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and
- essential to optimize growth, health, and metabolic homeostasis.

Specialty pharmacy drugs — Specialty pharmacy drugs must meet at least two of the following criteria: a) they are high cost, b) they are for use in limited patient populations or indications, c) they are typically self-injected, d) they have

limited availability, require special dispensing, or delivery and/or patient support is required and, therefore, they are difficult to obtain via traditional pharmacy channels, e) complex reimbursement procedures are required, and/or f) a considerable portion of the use and costs are frequently generated through office-based medical claims.

Speech therapist — A speech pathologist certified by the American Speech and Hearing Association.

Speech therapy — Services used for the diagnosis and treatment of speech and language disorders.

Summary of Benefits and Plan Options — The schedule, beginning on page iv, that defines your copayment and coinsurance requirements, deductible options, out-of-pocket limit, and prescription drug copayment amounts, and annual or lifetime benefit limits, and provides an overview of covered services.

Surgical services — Any of a variety of technical procedures for treatment or diagnosis of anatomical disease or injury including, but not limited to: cutting; microsurgery (use of scopes); laser procedures; grafting, suturing, castings; treatment of fractures and dislocations; electrical, chemical, or medical destruction of tissue; endoscopic examinations; anesthetic epidural procedures; other invasive procedures. Benefits for surgical services also include usual and related local anesthesia, necessary assistant surgeon expenses, and pre- and post-operative care, including recasting.

Temporomandibular joint (TMJ) syndrome — A condition that may include painful temporomandibular joints, tenderness in the muscles that move the jaw, clicking of joints, and limitation of jaw movement.

Terminally ill patient — A patient with a life expectancy of six months or less, as certified in writing by the attending physician.

Tertiary care facility — A hospital unit that provides complete perinatal care (occurring in the period shortly before and after birth), and intensive care of intrapartum (occurring during childbirth or delivery) and perinatal high-risk patients. This hospital unit also has responsibilities for coordination of transport, communication, and data analysis systems for the geographic area served.

Transplant-related services — Any hospitalizations and medical or surgical services related to a covered transplant or retransplant, and any subsequent hospitalizations and medical or surgical services related to a covered transplant or retransplant, and received within one year of the transplant or retransplant.

Urgent care — Medically necessary health care services received for an unforeseen condition that is not life-threatening. This condition does, however, require prompt medical attention to prevent a serious deterioration in your health (e.g., high fever, cuts requiring stitches).



Notes

Acceptance of coverage under this Policy constitutes acceptance of its terms, conditions, limitations, and exclusions. Members are bound by all of the terms of this Policy.

The legal agreement between you and the New Mexico Medical Insurance Pool (Pool) includes the following documents:

- this Policy and any amendments, riders, or endorsements;
- your enrollment/change form(s); and
- your NM Medical Insurance Pool identification card.

The above documents constitute the entire legal agreement between you and the Pool. No agent or employee of the Administrator has authority to change this Policy or waive any of its provisions. You will be notified of any changes to this Policy at least 30 days before the changes become effective.

Important Note: If a child is under age 15, his/her parent, legal guardian, or other responsible party must submit the application for coverage on the child's behalf. Also, for any child covered under the Pool program, any obligations of the policyholder set forth in this Policy, any endorsements, addenda, or riders will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the child's behalf.



Administered by:



**Blue Cross and Blue Shield
of New Mexico**

4373 Alexander Blvd., NE
PO Box 27630
Albuquerque, New Mexico 87125-7630
1-800-432-0750 • (505) 816-5671 FAX
www.nmmip.com
www.bcbsnm.com