

Amendment:

2007 Benefit Changes for the NM Medical Insurance Pool (Pool) Plans



Blue Cross and Blue Shield
of New Mexico

This **amendment** to your New Mexico Medical Insurance Pool (Pool) Health Care Policy shall be made part of your Pool Health Care Policy and shall replace the current language in your Pool Health Care Policy. Changes are being made to **prescription drug benefits and maternity coverage**. These changes will be effective January 1, 2007.

Sincerely,

A handwritten signature in cursive script that reads "Patricia Jennings".

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

Prescription Drug Plan Changes: Effective January 1, 2007

GENERIC DRUG SUBSTITUTION IS MANDATORY. Replace the information about "Brand-Name vs. Generic Drug Costs" on page 26 of your Policy with the following text:

Brand-Name vs. Generic Drug Costs — When there is an FDA-approved generic equivalent available for a brand-name drug that has been prescribed by your physician, you will receive the generic drug and pay the generic drug copayment amount (see below). If there is no generic equivalent drug available, you will pay the brand-name percentage copayment amount, which is subject to a maximum copayment as listed below. If there is a generic equivalent drug available and you or your provider requests the brand-name drug, you will pay the generic drug copayment plus the difference in the total covered drug costs between the brand-name and the generic drug. In this case, there is no maximum copayment limit. (NOTE: Drug plan benefits are **not** subject to a deductible. Also, drug plan copayments, including any cost difference you pay for brand-name drugs, are **not** applied to the medical/surgical plan's out-of-pocket limit or waived once the medical/surgical plan out-of-pocket limit is met.)

If your physician feels that the brand-name is medically necessary, you may appeal the benefit payment as described under "Reconsideration Request" on page 51 of the Policy.

Replace footnote #4 on your "Summary of Benefits" with the following footnote:

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, you must pay the generic drug copayment in addition to the difference in total covered drug costs between the brand-name and generic drug. (The Administrator, BCBSNM, has contracted with a separate program for administration of the outpatient prescription drug benefits.)

The minimum copayment is being increased to \$10. Replace the prescription drug plan line items in your "Summary of Benefits" and the information about "Member Copayments" and "Supply Limitations" on pages 26-27 of the Policy with the following:

Member Copayments and Supply Limitations — For covered prescription drugs (including specialty pharmacy drugs), insulin, diabetic supplies, and nutritional products, you pay a fixed-dollar or a percentage copayment (see next page), not to exceed the actual retail price, for each prescription filled or item purchased (not to exceed supply limitations listed in the table below). Copayments are **not** subject to a deductible, are **not** included in any out-of-pocket limit, and are **not** eligible for reimbursement once an out-of-pocket limit is reached. You may also have to pay the difference in cost between a brand-name drug and its generic equivalent (see previous page).

Prescription Drugs, Insulin, Diabetic Supplies, Special Medical Foods

Out-of-pocket limit and deductible provisions do not apply. Oral contraceptives are covered. 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.

Drug Plan Program and Supply Limitations*	Generic Drug	Brand-Name Drug (NO generic equivalent)	Brand-Name Drug (with generic equivalent)
Retail and Specialty Pharmacy Programs: During each one-month period, up to a 34-day supply or 100 units (e.g., pills), whichever is greater.	\$10	30% or \$10, whichever is greater, up to a maximum copayment of \$250	\$10 plus difference in cost between the generic drug and the brand-name purchased
Mail-Order Plan During each three-month period, up to a 90-day supply.	\$30	30% or \$30, whichever is greater, up to a maximum copayment of \$750	\$30 plus difference in cost between the generic drug and the brand-name purchased

* NOTE: For commercially packaged items (such as an inhaler, a tube of ointment, or a blister pack of tablets or capsules), you will pay the applicable copayment or percentage amount for a 30-day supply – usually one packaged item – under the retail pharmacy and specialty pharmacy programs. You will pay three times that amount for up to a 90-day supply of the same item purchased through the mail-order program).

Add the following paragraph to the “Retail Pharmacy/Specialty Pharmacy Program” information on page 26 of your Pool Health Care Policy:

If you are leaving the country or need an extended supply of medication, call Customer Service at least two weeks before you intend to leave. (Extended supplies or vacation overrides are not available through the Mail Order Service and may be approved through the Retail Pharmacy Program only. In some cases, you may be asked to provide proof of continued enrollment eligibility under the Retail Pharmacy Program.)

Replace the “Mail-Order Service” information on page 26 of your Pool Health Care Policy with the text below:

Mail Order Service — Except for supply limitations and enteral nutritional products, all items that are covered under the Mail-Order Service are the same items that are covered under the Retail Pharmacy Program and are subject to the same limitations and exclusions. Specialty pharmacy drugs are not available through the mail-order program, and may have to be purchased from a participating specialty pharmacy provider in order to be covered. 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 BCBSNM Customer Service representative.)

Note: Prescription drugs and other items may **not** be mailed outside the United States. Extended supplies or vacation overrides required when you are outside the country may be approved through the Retail Pharmacy Program only.

Maternity Covered on All Policies: Effective January 1, 2007

ROUTINE AND COMPLICATED MATERNITY/PREGNANCY-RELATED SERVICES ARE NOW COVERED UNDER ALL POLICIES. Remove any information from your Pool Health Care Policy and the "Summary of Benefits" that indicates the benefits detailed in *Section 4: Maternity Services* of the Policy are "optional." Also, move the services listed as covered in Section 4 to Section 3 of your benefit booklet and replace the first paragraph with the following paragraphs (the list of covered services remains the same).

This Policy covers normal, routine maternity care, including elective abortions, if one of the following conditions is met:

- The **pre-existing conditions limitation must have been satisfied** (see *Section 8*). **Note:** A HIPAA-eligible individual does not have to have prior creditable coverage specific to maternity services to be covered for pregnancy, regardless of the date of conception or the amount of time covered under this Policy.
- 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 maternity services coverage or you are a HIPAA-eligible member.

The following routine maternity services are subject to the pre-existing conditions limitation that applies to other medical services; see *Section 8*.

Remove the "Maternity Services, Routine" exclusion in Section 5.

Replace the first paragraph of the "Pre-Existing Conditions" provision in Section 8 (on page 58) with the following paragraph:

A pre-existing condition is a physical or mental condition (including pregnancy) 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.) However, complication of pregnancy is **not** considered a pre-existing condition.

Breast Reconstruction and Mastectomy Notification (WHCRA)

This is notice that your health care plan provides benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and treatment for complications resulting from a mastectomy (including lymphedema), when such benefits are required by the federal Women's Health and Cancer Rights Act of 1998. Check your benefit materials or call Customer Service for more information.