# BluePremier Point-of-Service
## Medical/Behavioral Health Plan Changes for 2001

BlueCross BlueShield of New Mexico
An Independent Licensee of the Blue Cross and Blue Shield Association.

This "BluePremier POS: Medical/Behavioral Health Plan Changes for 2001" amendment is to be made part of your benefit booklet. This amendment is effective January 1, 2001.

# *Summary of Point-of-Service Plan Benefits*

1. On page vi, the "Short-Term Rehabilitation (Office and Outpatient Services)" benefit is replaced with the following benefits:

| BluePremier POS Plan Benefits | What You Pay (See footnotes below and in your benefit booklet) | |
|---|---|---|
| | PCP-Coordinated Services (Tier 1) | Self-Coordinated Services[1] (Tier 2) |
| Pain Management *<br>(Limited benefit includes chronic pain treatment and excludes services received at a "pain clinic.") | Usual copays based on type/place of service | Not covered |
| Short-Term Rehabilitation (Outpatient and Office Services):<br>-Occupational, Physical, and Speech Therapy *<br>(20 visits/calendar year for all services combined) | $15 copay/visit [3] | 40%[3] |
| Acupuncture Services (20 visits/calendar year) | $15 copay/visit [3] | 40%[3] |
| Cardiac and Pulmonary Rehabilitation* | $15 copay/visit | 40% |
| Chiropractic Services (20 visits/calendar year) | $15 copay/visit [3] | 40%[3] |

* NOTE: These services must be prior-approved by BCBSNM.

1-For most self-coordinated services, the deductible must be met before benefit payments are made. (For families with members who meet the eligibility requirements of BluePremier Worldwide benefits, any deductible amounts applied under Worldwide benefits will apply to the deductible required under Tier 2 benefits, and vice versa.)
3-This benefit includes a maximum benefit payment or service level. (For families with members who meet the eligibility requirements of BluePremier Worldwide benefits, unless otherwise shown, any services received under Worldwide benefits will apply to the benefit maximums of Tier 2 benefits, and vice versa.)

# *Section 3: How BluePremier POS Works*

2. On page 38, the following changes are made to the section called "Other Prior Approvals:"
- "Chiropractic and acupuncture services" are removed from the list of rehabilitative service requiring prior approval.
- "Pain management treatment" is added to the list of services requiring prior approval.

# *Section 4: Covered Services*

3. On page 41, the following "Acupuncture Services," "Cardiac and Pulmonary Rehabilitation Services," and "Chiropractic Services" benefits are added:

### Acupuncture Services

*Acupuncture:* The use of needles inserted into the human 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.

Acupuncture services are covered when provided by a doctor of oriental medicine who acts within the scope of licensure and according to the standards of acupuncture medicine. Services must be for the treatment of accidental injury or illness, not to exceed the number of visits specified on the *Summary of Benefits and Copayments* per member per calendar year. The maximum benefit includes both PCP-coordinated (Tier 1) and self-coordinated (Tier 2) services combined. Prior approval from BCBSNM is not required.

A referral is not required to receive Tier 1 benefits for covered services received from an acupuncturist in the point-of-service network. A referral *is* required to receive Tier 1 benefits for covered services received from an acupuncturist *outside* the point-of-service network. If you receive covered services from an acupuncturist outside the point-of-service network without a referral, Tier 2 benefits will apply.

### Cardiac and Pulmonary Rehabilitation Services

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

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

Cardiac rehabilitation programs received within six months of a cardiac incident and pulmonary rehabilitation are covered when medically necessary. To be covered, you must have **prior approval** from BCBSNM for cardiac and pulmonary rehabilitation treatments. A referral is required to receive Tier 1 benefits. A referral is not required to receive Tier 2 benefits.

Benefits are **not** available for:

- any diagnostic, therapeutic, rehabilitative, or health maintenance service provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered provider
- any therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights)
- long-term therapies (Therapies are considered long-term if significant improvement is not possible within a two-month period.)

### Chiropractic Services

*Chiropractic office services:* Any service or supply administered by a chiropractor.

Chiropractic office services are covered when provided by a chiropractor who acts within the scope of licensure and according to the standards of chiropractic medicine. Services must be for the treatment of accidental injury or illness, not to exceed the number of visits specified on the *Summary of Benefits and Copayments* per member per calendar year. The maximum benefit includes both PCP-coordinated (Tier 1) and self-coordinated (Tier 2) services combined. Prior approval from BCBSNM is not required.

A referral is not required to receive Tier 1 benefits for covered services received from a chiropractor in the point-of-service network. A referral *is* required to receive Tier 1 benefits for covered services received from a chiropractor *outside* the point-of-service network. If you receive covered services from a chiropractor outside the point-of-service network without a referral, Tier 2 benefits will apply.

Benefits are **not** available for:

- any diagnostic, therapeutic, rehabilitative, or health maintenance service provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered provider
- any therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights)
- massage therapy or rolfing

4. On page 57, the following "Pain Management" benefit is added:

### Pain Management

*Chronic pain:* Pain lasting six months or longer.

Subject to the deductible and coinsurance listed on the *Summary of Benefits and Copayments*, pain management services, including treatments for chronic pain, are covered when the services are **PCP-coordinated** and have **prior approval** from BCBSNM.

Benefits are **not** available for:

- any diagnostic, therapeutic, rehabilitative, or health maintenance service provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered provider
- any therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights)
- massage therapy or rolfing
- services received at a pain clinic
- self-coordinated pain management services

5. On page 67, the "Short-Term Rehabilitation, Outpatient and Office Services" benefit is replaced with the following benefit:

### Short-Term Rehabilitation, Outpatient and Office Services

*Home-based services:* Physical rehabilitation services received in the home, but not connected to a formal home health or hospice care treatment plan. (When related to home health or hospice care, benefits are determined based on the "Home Health Care/Home I.V. Services" or "Hospice Care" provisions of this medical plan, as applicable.)

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

*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.

*Short-term rehabilitation* — A broad term used to describe occupational, physical, and speech therapy techniques that are medically necessary to restore and improve lost bodily functions following illness or injury. Physical rehabilitation does not include chemical dependency rehabilitation.

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

---

To be covered, all outpatient, office, and home-based short-term rehabilitation treatments must receive **prior approval** from BCBSNM. Short-term rehabilitation required due to reinjury or aggravation of an injury is also covered, but must receive **prior approval** from BCBSNM, even if therapy was authorized for the original injury. Benefits are available for all of the following outpatient, office, and home-based services for the treatment of accidental injury or illness, not to exceed the number of visits specified on the *Summary of Benefits and Copayments* per member per calendar year for all services combined:

- occupational therapy performed by a licensed occupational therapist
- physical therapy performed by a physician or licensed physical therapist
- speech therapy, including audio diagnostic testing, performed by a properly accredited speech therapist

The maximum benefit includes both PCP-coordinated (Tier 1) and self-coordinated (Tier 2) services combined.

To be eligible for benefits, therapies must meet the following conditions:

- There is a documented condition or delay in recovery that can be expected to improve with therapy within two months of the initial treatment.
- Improvement would not normally be expected to occur without intervention.

Benefits are **not** available for:

- visits in excess of the number specified on the *Summary of Benefits and Copayments*, unless prior-approved by BCBSNM
- maintenance therapy or care provided after the patient has reached his/her rehabilitative potential as determined by BCBSNM (See the "Long-Term and Maintenance Therapy" exclusion in *Section 5.)*
- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay

- any diagnostic, therapeutic, rehabilitative, or health maintenance service provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered provider
- any 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; 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; or stuttering
- long-term therapies (Therapies are long-term if significant improvement is not possible within a two-month period. See "Hospital/Other Facility Services" for long-term inpatient rehabilitation benefits.)

# *Section 10: Employee Behavioral Health Benefits Plan*

6. On pages 114-137, the "Mental Health Services" benefits in *Section 10* have been changed as follows:

- There is no longer a 130-day "Maximum Inpatient Benefit, Per Member Per Lifetime" for inpatient Mental Health Services. A 130-day "Maximum Inpatient Benefit, Per Member Per Lifetime" continues to apply to all inpatient Chemical Dependency benefits.
- The "Coverage Level" for inpatient Mental Health Services is changed from 80 percent to 100 percent of authorized charges. There is no longer a 65-day per Calendar Year benefit maximum per Member. There is no longer a Calendar Year Deductible.
- The Copayment for Outpatient Treatment is changed to $15 per visit. The 50-visit per Calendar Year maximum per Member is no longer in effect.

The "Schedule of Behavioral Health Benefits" on pages 115 and 116 is replaced with the following:

The Calendar Year Deductible, Benefit Maximums, Benefit Level, and Lifetime Maximums are combined for a Member who transfers between the BluePremier Point-of-Service, Worldwide, and HMO New Mexico benefits.

| | |
|---|---|
| **Mental Health Services** | |
| Maximum Inpatient Benefit, per Member per Lifetime | None |
| **Inpatient, Residential, and Day Treatment** | Based on Medical Necessity |
| Coverage Level | 100% |
| Calendar Year Deductible Amount | None |
| **Outpatient Treatment** | Based on Medical Necessity |
| Copayment | $15 per visit |
| **Chemical Dependency Rehabilitation** | |
| Maximum Inpatient Benefit, per Member per Lifetime | 130 days* (Combined with Detoxification) |
| Calendar Year Maximum Benefit | $10,000 |
| **Inpatient, Residential, Day and Outpatient Treatment** (Combined with Detoxification) | 1 treatment episode per Calendar Year** |
| Days to be determined based on the following levels of care:<br>Inpatient<br>Residential Treatment<br>Day Treatment | <br>1 day<br>7/10 of 1 day<br>6/10 of 1 day |
| Calendar Year Deductible Amount (Waived for detoxification and outpatient treatment) | $250 |
| Coverage Level | 80% |
| Non-Compliance Reduction (the percentage by which the Member's coverage level is reduced when the Member leaves the Chemical Dependency Inpatient, Residential Treatment, or Day Treatment program against the medical advice of a PacifiCare Behavioral Health, Inc. Participating Provider). | 30% |
| **Detoxification** | |
| Maximum Inpatient Benefit, per Member per Lifetime (Combined with Chemical Dependency) | 130 days* (Combined with Chemical Dependency) |
| Calendar Year Maximum Benefit | $10,000 |
| Maximum Benefit, per Member, per Calendar Year (Combined with Chemical Dependency) | 1 treatment episode per Calendar Year** |
| Calendar Year Deductible Amount | None |
| Coverage Level | 80% |

**All Mental Health, Chemical Dependency, and Detoxification treatment must be Pre-Authorized by PBHI. The number of visits, days, or episodes authorized must be Medically Necessary.**

*For purposes of determining the number of treatment days for the maximum Inpatient benefit, Residential Treatment days are counted as 70 percent of one day and Day Treatment days are counted as 60 percent of one day. This permits the Member to obtain additional coverage when alternate levels of care are utilized. Number of days are determined by clinical appropriateness under the Plan's guidelines for Medical Necessity.

**Length of treatment episode(s) is (are) determined by clinical appropriateness under the Plan's guidelines for Medical Necessity.

Benefit Booklet

Go to Summary

Go to Table of Contents

# BluePremier
## Point-of-Service (POS)

*University of California*
*Los Alamos National Laboratory*

*Administered by:*

BlueCross BlueShield of New Mexico

M499 (01/99)

Return to Table of Contents

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

The legal agreement between The Regents of the University of California and New Mexico Blue Cross and Blue Shield, Inc., (hereafter referred to as BCBSNM) includes the following documents:

- this benefit booklet (other than *Section 10)* and any amendments or endorsements;
- the Enrollment Form (hard copy or electronic) for the subscriber and his/her dependents; and
- the members' identification cards.

In addition, The Regents of the University of California have the Administrative Services Agreement between BCBSNM and the employer, which is part of the legal agreement.

The above documents constitute the entire legal agreement between BCBSNM and The Regents of the University of California. No change or modification to the agreement will be valid unless it is in writing and signed by an officer of BCBSNM. No agent or employee of BCBSNM has authority to change this benefit booklet or waive any of its provisions.

**BCBSNM provides administrative claims payment services.**

# *Your BluePremier Point-of-Service (POS) Medical Plan*

This booklet describes the coverage available to persons enrolled in the POS (in-area) benefits. Worldwide benefits are described in a separate booklet. This section describes which benefits (POS or Worldwide) are available to eligible employees/annuitants and their eligible dependents.

New Mexico Blue Cross and Blue Shield, Inc. (BCBSNM) provides certain administrative services for medical/hospital/surgical benefits.

PacifiCare Behavioral Health, Inc. (PBHI) provides certain administrative services for mental health/chemical dependency benefits.

*Section 2: Enrollment and Termination Information* applies to both BCBSNM and PBHI portions of the BluePremier POS benefits.

The *Summary of Benefits and Copayments* beginning on page v, *Section 1,* and *Sections 3* through *9* apply to the BCBSNM-administered medical/hospital/surgical benefits only.

*Section 10* applies to the PBHI-administered mental health/chemical dependency benefits only.

*Section 11* describes Plan Administration.

The following pages present the most important features of the POS benefits. Please read them carefully so you become familiar with the benefits available to you and your family.

This booklet describes the Plan benefits in everyday terms whenever possible. Not all details are included in every case. The extent of coverage for each person enrolled is governed at all times by the terms of the Plan Documents and the University of California Group Insurance Regulations. Copies of these documents will be furnished upon request (see *Section 11: Plan Administration*).

## BluePremier POS (in-area) benefits eligibility

You are eligible for POS (in-area) benefits if you are an eligible employee or annuitant permanently living inside the POS Tier 1 service area.

If you are eligible for POS benefits, your dependents are eligible only for POS benefits unless 3 or 4 on the next page applies.

If you are living or traveling outside the POS Tier 1 Service Area and you are assigned POS (in-area) benefits, you are also eligible for the PBHI benefits described in this booklet. However, in-area members who live or travel outside the United States receive emergency PBHI benefits only.

## BluePremier Worldwide (out-of-area) benefits eligibility

You are eligible for Worldwide (out-of-area) benefits if you are:

1. An employee or annuitant permanently living outside the POS Tier 1 service area. All dependents of such employees and annuitants are eligible only for Worldwide benefits.
2. A faculty member on sabbatical (not in residence) or participating in the Education Abroad Program, or staff member on professional leave outside the POS Tier 1 service area. Dependents are eligible for POS (in-area) benefits or may accompany you and be eligible for Worldwide (out-of-area) benefits.
3. A child who is a full-time student living away from home outside the POS Tier 1 service area during the academic year.*
4. A natural or adopted child living with an ex-spouse more than 50 percent of the year outside the POS Tier 1 service area.*

* Note: The rest of the family of the children described in 3 and 4 above will retain POS benefits.

If you are assigned Worldwide (out-of-area) benefits, you are also eligible for the PBHI benefits described in the BluePremier Worldwide booklet.

The calendar year deductible, benefit maximums, benefit limits, and lifetime maximums are combined for members who transfer between POS and Worldwide status.

**Contact your Benefits Office for more information.**

## Medicare Private Contracting Provision

Recently enacted Federal legislation allows physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services (that would otherwise be covered by Medicare) from these physicians or practitioners will need to enter into written “private contracts” with these physicians or practitioners requiring the beneficiary to be responsible for all payments to such providers. Services provided under “private contracts” are not covered by Medicare, and the Medicare limiting charge will not apply.

If you are classified as a retiree by the University of California (or otherwise have Medicare as primary coverage) and enrolled in Medicare Part B, and choose to enter into such a “private contract” arrangement with one or more physicians or practitioners, under the law you have in effect “opted out” of Medicare for the services provided by these physicians or other practitioners. No benefits will be paid by this University of California Plan for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered.

However, if you do sign a private contract with a physician or practitioner, you may see other physicians or practitioners without those private contract restrictions as long as they have not opted out of Medicare.

# Table of Contents

Return to Cover Page

# *Summary of Benefits and Copayments*

This summary provides you with a very brief description of benefits, the copayments, deductible, out-of-pocket amounts, and coinsurance percentages of BluePremier POS.

| BluePremier POS Plan Benefits | What You Pay | |
|---|---|---|
| | PCP-Coordinated Services (Tier 1) | Self-Coordinated Services [1] (Tier 2) |
| Deductible (Individual/Family) | None | $500/$1500[1] |
| Out-of-Pocket Limit (Individual/Family) | $2000/$6000 | $6000/$18,000[2] |
| Lifetime Maximum | None | $2,000,000[11] |
| Ambulance Services[5] | 10% | 40% |
| Diagnostic Services: Lab and X-Ray (Including Annual Screening Pap Tests and Mammograms) | 10% | 40%[6] |
| Emergency and Urgent Care (including accidental injury; also see "Office and Home Visits") | | |
| Emergency Room | 10% after $50 facility copay[7] | 40% after $50 facility copay[7] |
| Urgent Care Facility/Office | $15 copay/visit | 40% |
| Home Health Care/Home I.V. Services | 10% | 40% (100 visits/year)[3,6,10] |
| Hospice Care (max. $7400/benefit period) | 10%[3] | 40%[3,6,10] |
| Inpatient Services (**Note:** No additional copayment required for routine nursery care for covered newborns.) | | |
| Acute Medical/Surgical and Maternity-Related Services, Hospital Room and Board | 10% after $250 copay/admission | 40% after $250 copay/admission[4] |
| Physician Visits and Maternity Services | No charge to member | 40% |
| Non-Maternity Surgical Services, Including Anesthesiologist, Assistant Surgeon, and Surgeon's Services | 10% | 40% |
| Physical Rehabilitation: Skilled nursing facility admissions and other inpatient physical rehabilitation services (100-day maximum per condition for Tier 1 and 2 services combined.) | 10% (100-day maximum)[3] | 40% (70-day maximum)[3,4,10] |
| Office and Home Services (including casts, splints, and dressings) | | |
| Nonroutine Physician Care/Visit; Office Surgery; Routine Gynecological Exam | $15 copay/visit (no copay up to age 2) | 40% |
| Maternity Services, Including Pre-Natal and Post-Natal Care | $15 copay for initial visit only (no charge for subsequent office visits) | 40% |
| NORPLANT Insertion/Removal | $50 copay | 40% |
| Allergy Injections | No copay | 40%[6] |
| Routine Child Care, Well-Baby Care, Immunizations (through age 18) | $15 copay/visit (no copay up to age 6) | 40%[10] |

**Except for specific OB/gyn services, you must have a referral from your PCP to receive the PCP-coordinated level of coverage for services that are not directly provided by your PCP.**

See footnotes on next page.

| BluePremier POS Plan Benefits | What You Pay | |
|---|---|---|
| | PCP-Coordinated Services (Tier 1) | Self-Coordinated Services [1] (Tier 2) |
| Routine Adult Physicals (nongynecological) and Related Lab Tests and X-Rays; Immunizations (age 19 and over) | $15 copay/visit | Not covered |
| Routine Vision/Hearing Screening (thru age 18) | $15 copay/visit | Not covered |
| Prescription Drugs (Out-of-pocket maximum provision does not apply.) [9,10] | | |
| Retail Pharmacy Program (30-day supply)<br>-Formulary drug<br>-Nonformulary drug | $15 generic/$25 brand-name<br>$40 copay for either generic or brand-name | |
| Mail Service Program | One copay (as specified above) for up to a 30-day supply; two copays for a 31-day to 90-day supply | |
| Private Duty Nursing | 10% | 40% ($8000 max/year) [3,6] |
| Short-Term Rehabilitation (Office and Outpatient Services):Cardiac and Pulmonary Rehabilitation, Occupational, Physical, and Speech Therapy, Chiropractic, Acupuncture (maximum of 60 days per condition for all services COMBINED) | $15 copay/visit [3] | 40% [3,6] |
| Supplies, Prosthetics, and Durable Medical Equipment | 10% | 40% [6,8] |
| Orthotics | 10% | Not covered |
| Surgery: Outpatient (no admission) | 10% | 40% [6] |
| Therapy: Chemotherapy, Dialysis, and Radiation Therapy | 10% | 40% [6] |
| TMJ Services | $15 copay/visit | 40% [6] |
| Transplant Services: Heart, Heart-Lung, Liver, Lung, Pancreas-Kidney | 10% (coinsurance applies to a separate $5,000/transplant out-of-pocket maximum) [3,4,6,10] | |

1-For most self-coordinated services, the deductible must be met before benefit payments are made. (For families with members who meet the eligibility requirements of BluePremier Worldwide benefits, any deductible amounts applied under Worldwide benefits will apply to the deductible required under Tier 2 benefits, and vice versa.)
2-After a member (or family) reaches the out-of-pocket maximum, BCBSNM pays 100 percent of that member's (or family's) applicable covered charges for the rest of the calendar year. (For families with members who meet the eligibility requirements of BluePremier Worldwide benefits, unless otherwise shown, any out-of-pocket amounts met under the Worldwide benefits will apply to the out-of-pocket under Tier 2 benefits, and vice versa.)
3-This benefit includes a maximum benefit payment or service level. (For families with members who meet the eligibility requirements of BluePremier Worldwide benefits, unless otherwise shown, any services received under Worldwide benefits will apply to the benefit maximums of Tier 2 benefits, and vice versa.)
4-Admission review is required for admissions; benefits will be reduced by $300 if admission review is not obtained before the member is admitted (or within 48 hours of admission in an emergency).
5-Transportation must be medically necessary to protect the life of the patient. Prior approval is required for air ambulance services.
6-No benefit is available for certain services if prior approval is not obtained from BCBSNM. See *Section 3* for a complete list of services requiring prior approval.
7-The $50 emergency care copay is waived if an admission results; then hospital admission copay applies.
8-Prior approval is required for specified equipment and orthotics and when total billed charge is $500 or more.
9-Prescription drugs must be purchased at a pharmacy that participates in the Retail Pharmacy or Mail Service Programs. If a generic equivalent is available and you or your provider request the brand-name, you must pay the applicable generic copayment ($15 for formulary or $40 for nonformulary) plus the cost difference between the brand-name and generic drug. (BCBSNM has contracted with a separate program for administration of the outpatient prescription drug benefits. This program is not an affiliate of BCBSNM.) Some prescription drugs require prior approval before coverage will be available.
10-These services are not subject to the annual deductible.
11-For families with members who meet the eligibility requirements of BluePremier Worldwide benefits, any benefit payments made under the Worldwide benefits will apply to the member's lifetime maximum under Tier 2 benefits, and vice versa.

**Deductibles and coinsurance percentages are applied to BCBSNM's covered charges.**

# 1 BluePremier POS at a Glance

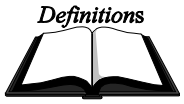
This benefit booklet describes the coverage available to members of this BluePremier POS plan and benefit limitations and exclusions.

## Summary of Benefits and Copayments

The *Summary of Benefits and Copayments* on pages v and vi shows specific copayment and other cost-sharing amounts applicable to your medical plan. Throughout this booklet, you are asked to refer to the *Summary of Benefits and Copayments* for specific benefit and copayment, deductible, and coinsurance information. You will receive a new *Summary of Benefits and Copayments* if changes are made to this medical plan.

## Using the Informational Graphics

This benefit booklet is designed to make it easy for you to determine your coverage. Graphic symbols are used throughout this benefit booklet to call your attention to important information and requirements. Here are the symbols and what they mean:




### Definitions

Throughout this benefit booklet, this symbol calls attention to definitions of important terms. For example, if you need to know what surgical services are covered, turn to *Section 4: Covered Services*. In *Section 4*, the "Surgical Services and Other Procedures" subsection defines what a surgical service is.


### Limitations and Exclusions

Each subsection in *Section 4* describes your coverage and also lists the most important limitations and exclusions applied to that particular service. *Section 5: General Limitations and Exclusions* lists other limitations and exclusions that apply to **all** services. This graphic symbol will indicate when important limitations or exclusions are being listed in *Section 4*.

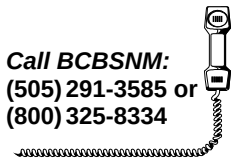

### Cross-References

Throughout this benefit booklet, cross-references direct you to read other sections of the booklet or the *Summary of Benefits and Copayments* when applicable. You will see this symbol next to all such references.


### PCP-Coordinated Benefit Only

Certain services are eligible for benefits **only** when PCP-coordinated. This symbol will be next to those services.

## Admission Review or Prior Approval From BCBSNM Required




To receive full benefits for some **self-coordinated** medical/surgical services, you or your provider must call the BCBSNM Health Services Department **before** you or a family member receives treatment. This symbol is a reminder to do so. Call Monday through Friday, 8 A.M. to 5 P.M., Mountain Time. (When a PCP coordinates care, the PCP arranges for any necessary approvals.) See "Medical/Surgical Admission Review and Other Prior Approvals" in *Section 3* for details.


***Contact BCBSNM Within 48 Hours*** — To receive full benefits for self-coordinated emergency or pregnancy-related hospital admissions, you (or your provider) must notify BCBSNM **within 48 hours** of admission (or on the next workday following a 48-hour period that falls on a weekend or holiday). This symbol is a reminder to do so. Call BCBSNM's Health Services Department, Monday through Friday, 8 A.M. to 5 P.M., Mountain Time.


***Written Request Required*** — If a **written request** for prior approval is required in order for a medical plan service to be covered, the provider should send the request, along with appropriate documentation, to:

**Blue Cross and Blue Shield of New Mexico**
**Attn: Health Services Department, LANL DSU**
**P.O. Box 27630**
**Albuquerque, NM, 87125-7630**

Please ask your health care provider to submit your request early enough to ensure that there is time to process the request before the date you are planning to receive services.


## Deadlines

You will see this symbol when you must take action within a specified amount of time. (For example, you have 31 days in which to make most enrollment changes, and 12 months in which to file claims.)

# A Quick Overview of BluePremier POS

BluePremier POS gives you choice and flexibility for your medical care plus the opportunity to save money. When you need health care, you have three choices:

- PCP-Coordinated Care (Tier 1)
- Self-Coordinated In-Network **or** Out-of-Network Care (Tier 2)

You receive the broadest range of medical care at the lowest cost to you when your care is PCP-coordinated. You also receive benefits when you self-coordinate your care to either an in-network or out-of-network provider.

## PCP-Coordinated Care (Tier 1)

Primary care providers (PCPs) and other point-of-service providers have special contracts with BCBSNM that allow lower out-of-pocket expenses and additional benefits. The PCP agrees to be responsible for coordinating and managing all of your health care. PCPs include family and general practice, internal medicine, obstetrics/gynecology, and pediatric physicians who are located throughout New Mexico and along the borders of neighboring states. PCPs and other point-of-service providers will obtain any required admission review and other prior approvals for you.

If you need care that is not available from a PCP, your PCP will refer you to the appropriate provider — usually a point-of-service provider (providers in your BCBSNM directory with the special identifying symbol next to their name). You will receive the PCP-coordinated level of benefits for all covered services you receive at the direction of your PCP (some services must be authorized by BCBSNM in order to be covered). There is no deductible to satisfy; you will usually pay only a small, predetermined copayment at the time you receive services.

## Self-Coordinated Care (Tier 2)

With BluePremier POS, you may also self-coordinate your care. You do not have to obtain your care through a PCP or at a PCP's direction, but you will have to satisfy an annual deductible and pay a percentage of covered charges. If you do **not** receive a referral from a PCP **before** you receive nonemergency care, your benefits will be at the self-coordinated level — either in-network or out-of-network.

When self-coordinating your care, you have the choice of selecting an in-network or out-of-network provider:

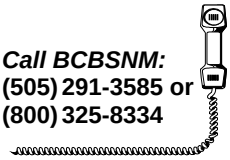
*In-network providers* agree to accept payment based upon covered charges. You are responsible for paying only the applicable deductible, copayment, and coinsurance amounts for covered services, any penalty amounts, and noncovered expenses.

*Out-of-network providers* do not have contractual agreements with BCBSNM or with their local Blue Cross and/or Blue Shield Plan. You are responsible for paying any amounts greater than covered charges — in addition to the deductible, copayment, and coinsurance amounts for covered services, any penalty amounts, and noncovered expenses.

When self-coordinating your care, you are always responsible for obtaining any necessary admission reviews and prior approvals. Also, some benefits are not available if you self-coordinate your care; see the *Summary of Benefits and Copayments*.

## Admission Review and Prior Approvals

If your care is PCP-coordinated, your PCP (or the point-of-service specialist to whom your PCP referred you) is responsible for any admission review requirements for inpatient admissions and for obtaining any other required prior approvals.




For inpatient admissions that are **not** PCP-coordinated, you are responsible for obtaining admission review. If admission review is not obtained, benefits for covered facility services will be **reduced by $300.** You are also responsible for obtaining any necessary prior approvals for other services (see the list under "Other Prior Approvals" in *Section 3*). Failure to obtain prior approval for these services may result in a denial of benefits.

# ■ Medical/Surgical Plan Customer Service

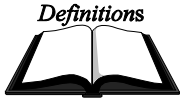
**When you have questions or concerns about your medical/surgical plan, Customer Service wants to know.** We welcome your comments and suggestions. Listening to you helps improve customer service. BCBSNM Customer Service representatives are available **24 hours a day, 7 days a week.** When appropriate, your concerns will be shared with your PCP. Your Customer Service representative knows about your plan benefits, covered services and procedures, and providers. (Please have your ID card handy when calling a Customer Service representative.)

Your satisfaction is our goal — so call when you have a question or complaint, or just to let us know what you appreciate about your plan or our service to you.

**Blue Cross and Blue Shield of New Mexico**
**Attn: LANL DSU**
**Street address:** **12800 Indian School Rd. NE**
**Mailing address:** **P.O. Box 27630**
**Albuquerque, New Mexico 87125-7630**
**Phone number:** **1-800-711-3795 or (505) 889-0188**

# 2 Enrollment and Termination Information

## Who Is Eligible

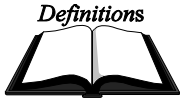



*Subscriber* — The individual whose employment or other status, except for family dependency, is the basis for enrollment eligibility, or in the case of a direct-pay contract, the person in whose name the contract is issued. The term "subscriber" may also encompass other persons in a nonemployee relationship with the group if specified in the Administrative Services Agreement (e.g., annuitants, survivor annuitants).

The University of California establishes its own medical plan eligibility criteria for employees and annuitants based on the University of California Group Insurance Regulations.

**Note:** Anyone enrolled in a non-University Medicare+Choice HMO plan is not eligible for this BluePremier POS Plan.

### Eligible Employees



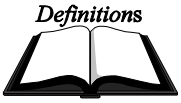

*Employee* — A person employed by Los Alamos National Laboratory who meets the eligibility criteria below.

***Eligibility Criteria*** — To be eligible for this medical plan, the employee must have established his/her permanent address within the BluePremier POS plan service area. Eligible dependents are not required to reside in the service area in order to maintain coverage under this BluePremier POS plan. If the employee later establishes residency outside the service area, the employee and his/her covered dependents must switch to BluePremier Worldwide benefits.

Employees are eligible if appointed to work at least 50 percent time for one year or more or 100 percent time for three months or more. To remain eligible, the employee must maintain an average regular paid time of at least 20 hours per week and maintain an eligible appointment of at least 50 percent time. **Note:** If your appointment is at least 50 percent time, your appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

Working employees and their spouses age 65 and over may be entitled to the same benefits as those employees under age 65. (See "Medicare-Eligible Members" later in this *Section 2*.)

## Eligible Annuitant/Survivor Annuitant



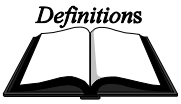

*Annuitant/survivor annuitant* — A retired or disabled University employee, or a deceased employee's (annuitant's) family member, receiving a monthly income from a defined benefit plan to which the University contributes.

***Eligibility Criteria*** — To be eligible for this medical plan, the annuitant or survivor annuitant must have established his/her permanent address within the BluePremier POS plan service area. Eligible dependents are not required to reside in the service area in order to maintain coverage under this BluePremier POS plan. If the annuitant or survivor annuitant later establishes residency outside the service area, the annuitant or survivor annuitant and his/her covered dependents must switch to Blue-Premier Worldwide benefits.

Annuitants may continue medical plan coverage when they retire or start collecting disability or survivor benefits (survivor annuitant) from the University of California Retirement Plan (or any other defined benefit plan to which the University contributes). These conditions apply provided:

- the annuitant was in a University medical plan immediately before retiring;
- the effective date of annuitant status is within 120 calendar days of the date employment ends (or the date of the employee's/annuitant's death in the case of a survivor annuitant);
- medical coverage is continuous from the date employment ends;
- the annuitant's monthly check is large enough to cover the annuitant's portion, if any, of the medical plan premium;
- the annuitant elects to continue coverage at the time of retirement; *and*
- the annuitant meets the University's service credit requirements for annuitant medical eligibility.

## Eligible Dependents




*Eligible dependents* — Family members of the subscriber, limited to the persons described below.

The University and/or BCBSNM reserve the right to periodically request documentation to verify eligibility of dependents. Such documentation could include a marriage certificate, birth certificate(s), adoption records, or other official documentation.

Eligible dependents are limited to the persons described below:

***Spouse*** — The employee's or annuitant's legal spouse (Exception: A *survivor* annuitant may not enroll his/her legal spouse.)

***Natural Child/Adopted Child*** — The subscriber's unmarried, natural or legally adopted child **under age 23.** The following children are also eligible:

a) **Stepchild:** The subscriber's unmarried stepchild **under age 23** who resides with the subscriber, depends upon the subscriber (or spouse) for at least 50 percent of his/her support, and is the subscriber's (or spouse's) dependent for income tax purposes.
b) **Grandchild:** The subscriber's unmarried grandchild **under age 23** who resides with the subscriber, depends upon the subscriber (or spouse) for at least 50 percent of his/her support, and is the subscriber's (or spouse's) dependent for income tax purposes.
c) **Legal Guardianship:** A dependent **under age 18** for whom the subscriber is the legal guardian and who resides with the subscriber, depends upon the subscriber for at least 50 percent of his/her support, and is the subscriber's dependent for income tax purposes.

The subscriber's signature on the Enrollment Form (or the electronic enrollment, if enrolling electronically) attests to the satisfaction of all eligibility conditions a), b), and c) above. The subscriber will be asked to submit a signed copy annually of his/her Federal income tax return (IRS form 1040 or IRS equivalent showing the covered dependent) to the University to verify income tax dependency.

***Disabled Child*** — The **subscriber's** unmarried child over age 23 who was enrolled as a dependent at the time of reaching age 23, and is **medically certified as disabled,** is the subscriber's dependent for income tax purposes, and depends upon the subscriber for at least 50 percent of his/her support. **Note:** Eligible stepchildren and covered grandchildren must also *reside* with the subscriber in order to be eligible for continued coverage. A child may remain a dependent beyond age 23 only if the disabling condition began before the child loses his/her eligibility due to age and the child has maintained continuous medical plan coverage since the disabling condition began. The disability must be certified by a physician and approved by BCBSNM, and BCBSNM must receive written notice of the disabling condition before the end of the month in which the child reaches age 23. **(This provision does not apply to children for whom the subscriber is the legal guardian. Such children may be covered only to age 18.)**

BCBSNM may periodically request proof of continued disability.

**Note:** Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan. If enrollment is transferred from one plan to another, a new application for continued coverage is not required.

A newly hired employee with an over-age, incapacitated dependent child, may apply for coverage for that child under the same general terms as a current employee. The child must have had continuous group medical coverage since age 23, and application for coverage must be made during the employee's "Period of Initial Eligibility."

***Other Eligible Dependents*** — The subscriber may enroll an adult dependent relative or same-sex domestic partner and their eligible children as set forth in the University of California Group Insurance Regulations. For information on who qualifies and on the requirements to enroll an adult dependent relative or same-sex partner, the subscriber should contact his/her local Benefits Office.

## Nonduplication of Coverage

Eligible persons may be covered under only one of the following categories: as an employee, an annuitant, a survivor annuitant, or a dependent, but not under any combination of these. If both husband and wife are eligible, each may enroll separately or one may cover the other as a dependent. If they enroll separately, neither may enroll the other as a dependent. Eligible children may be enrolled under either parent's coverage, but not under both.

## Medicare-Eligible Members

Shortly before you turn age 65, or if you qualify for Medicare benefits, you are responsible for contacting the local Social Security office to establish Medicare eligibility. You should then contact your Benefits Office to discuss coverage options and changes in cost of coverage, if any.

In general, **employees** and their dependents who are covered under Medicare receive primary coverage under this plan. However, employees and their dependents who **choose** Medicare as primary coverage in such cases are **not** eligible for coverage under this plan, but must convert to a nongroup, direct-pay Medicare supplemental plan. Annuitants, and those who are eligible for Medicare as primary coverage due to having end-stage renal disease (ESRD), or those who turn 65 after enrolling in Medicare due to disability, may retain coverage under this plan (Medicare will be the primary coverage).

Special rules apply if you are receiving benefits from Medicare due to a disability or end-stage renal disease. Contact your Benefits Office for more information.

**Note:** Recently enacted Federal legislation allows physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services (that would otherwise be covered by Medicare) from these physicians or practitioners will need to enter into written "private contracts" with these physicians or practitioners requiring the beneficiary to be responsible for all payments to such providers. Services provided under "private contracts" are not covered by Medicare, and the Medicare limiting charge will not apply.

If you are classified as a retiree by the University of California (or otherwise have Medicare as primary coverage) and enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement with one

or more physicians or practitioners, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. No benefits will be paid by this University of California Plan for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered.

However, if you do sign a private contract with a physician or practitioner, you may see other physicians or practitioners without those private contract restrictions as long as they have not opted out of Medicare.


### Notification of Eligibility Changes

A subscriber must notify his/her Benefits Office **within 31 days** following any changes that may affect his/her or a dependent's eligibility or employee paycheck deduction for cost of coverage by indicating such changes on an Enrollment Form. It is also the subscriber's responsibility to notify his/her Benefits Office of any change to a member's name or address. This University form is available from your Benefits Office.

When a member becomes eligible for Medicare as **primary coverage,** the subscriber must complete a University of California Medicare Declaration form. This notifies the University that the member is covered by either one or both Parts of Medicare. Medicare Declaration forms are available through the local Benefits Office and completed forms should be returned to the address on the form. Upon receipt by the University of confirmation of Medicare enrollment, any change in employee contribution amount will go into effect when the member enrolls in Medicare or on the first of the month following the Benefits Office's receipt of the Medicare Declaration form, whichever is later.

**Note:** Members covered under state or federal continuation coverage must notify BCBSNM of any eligibility changes.

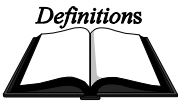
## ■ Applying for Coverage

Employees enrolling themselves and/or their dependents can obtain necessary Enrollment Forms from their local Benefits Office. All forms should be returned to their local office.


An employee may enroll him/herself and any eligible dependents during a 31-day period called a "Period of Initial Eligibility" (PIE).

The PIE for a newly eligible employee and his/her eligible dependents starts the day the employee becomes eligible for benefits. (See "Adding a Dependent to Coverage" for applying for coverage for newly acquired spouses and/or children.)

## Special Enrollment




*Involuntary loss of coverage* — Loss of other coverage due to legal separation, divorce, death, termination of employment, reduction in hours, or termination of employer contributions. If the member was covered under a state or federal continuation policy, involuntary loss of coverage includes exhaustion of the maximum continuation time period.

**Note:** There is no "special enrollment" for members enrolled in this plan under a state or federal continuation coverage provision. If you do not enroll timely under continuation coverage, you may not enroll at a later date.

There are three instances in which an otherwise late applicant can enroll in this group plan without being subject to the late applicant provision. In these instances, the PIE begins on:

***Loss of Other Coverage*** — The date any person who is eligible to enroll in this medical plan has an involuntary loss of other group medical coverage.


An otherwise eligible subscriber (or his/her dependent) who declined coverage when initially eligible because of having other comprehensive group medical coverage and who later *involuntarily* loses the other coverage, may apply for coverage for himself/herself and eligible dependents without being considered late if application is made **within 31 days** of losing the other coverage. (BCBSNM reserves the right to verify the individual's eligibility for coverage by requesting proof of loss of coverage or proof of date of the event.)

A person who declines coverage due to having other health care coverage available must provide a written statement when he/she first becomes eligible for coverage under this medical plan that indicates his/her reason for declining coverage. The applicant will not be eligible for a special enrollment under this provision if no written statement was provided to the University and/or BCBSNM indicating that coverage was being declined due to the availability of other health care coverage.

If application for coverage is **not** made within 31 days of losing other group medical coverage, the subscriber and his/her dependents may apply for BluePremier coverage during the group's next annual open enrollment or upon completion of 90 consecutive calendar days as explained on the next page under the "Late Applicant Provision."

***Change in Family Status*** — The date any employee who is eligible to enroll in this plan acquires a new eligible dependent.

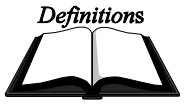
An otherwise eligible employee who declined coverage when initially eligible but who later acquires a new eligible dependent due to marriage,


birth, or adoption, may apply for coverage for himself/herself and eligible dependents without being considered late — *if* application is made **within 31 days** of the day the eligible employee acquired the new dependent. If application is **not** made within 31 days, the employee and his/her dependents may apply for coverage during the group's next annual open enrollment or upon completion of 90 consecutive calendar days as explained below under the "Late Applicant Provision."

***Court Ordered Dependent Coverage*** — The date any employee is ordered by a court to provide coverage for an otherwise eligible dependent child.

When an employee or employer is required by a court or administrative order to provide coverage for a dependent child, the dependent may be enrolled in an employee's Family coverage and will not be considered a late applicant. (If the employee has Single-Party coverage, an additional employee contribution amount for the cost of coverage must be paid in order for the dependent to be added.) The University must receive a copy of the court order.

## Late Applicant Provision




*Late applicant* — Anyone eligible but not enrolled during the group's initial enrollment or **within his/her PIE.** For example, unless eligible for a late enrollment due to one of the "Special Enrollment" provisions, a newborn child added to coverage more than 31 days after birth (when Family coverage is not already in effect) or a child placed in the subscriber's home for the purpose of adoption added more than 31 days after legal adoption is a late applicant. A new employee or a new spouse added to coverage more than 31 days after becoming eligible is also a late applicant unless eligible for a special enrollment (see "Special Enrollment").

If an employee or his/her eligible dependent fails to enroll during a PIE or open enrollment period, the eligible person may enroll at any other time upon completion of a 90 consecutive calendar day waiting period. The 90-day waiting period starts on the date the enrollment form is received by the local Benefits Office and ends 90 consecutive calendar days later.

**Late applicants may also enroll during the group's next annual open enrollment.**

## Open Enrollment

An open enrollment period is held annually. During the open enrollment period, any eligible employee and his/her eligible dependents may enroll as members under this group BluePremier POS plan. Subscribers (and their dependents) who meet the eligibility criteria of other University-sponsored medical plans can also switch enrollment to another University-sponsored medical plan during the open enrollment period. **(Note:** Open enrollment is **not** available under direct-pay coverage. If a member does

not enroll timely in direct-pay coverage, he/she may **not** enroll at a later date. However, members covered under direct-pay continuation coverage may transfer plans during an annual open enrollment period, and are also eligible for switch enrollment privileges.)

### Re-Enrollment

If a previously covered subscriber and/or dependent is re-enrolled at any time, he/she will be considered a *late applicant* (except as provided under "Special Enrollment"). See "Late Applicant Provision" and "Special Enrollment" for details.

Any member whose previous coverage under a BCBSNM plan was terminated for good cause is not eligible to re-enroll in this plan, unless approved in writing by BCBSNM.

## ■ Adding a Dependent to Coverage


Subscribers may apply for coverage of newly acquired dependents (such as a new spouse, a newborn child, or a child placed in the subscriber's home for the purpose of adoption). Enrollment Forms can be obtained from the local Benefits Office. Completed forms should be returned to the address on the form. **Within 31 days** of acquiring the new dependent, the subscriber must:

- complete and submit all necessary Enrollment Forms and legal documentation of proof of dependency (if required), and
- pay any additional employee contribution amount for the cost of coverage (if necessary), which may mean changing, for example, from Single-Party to Two-Party or Family coverage.

Also see "Special Enrollment" for adding certain dependents to coverage who were **not** added when initially eligible.

**Note:** Members covered under state or federal continuation coverage must notify BCBSNM of any eligibility changes.

### Adding a New Spouse


If a subscriber does not change from Single-Party to Two-Party or Family coverage or add a new spouse to existing Family coverage **within 31 days** of marriage, the new spouse will be considered a late applicant. (**Note:** A survivor annuitant may **not** add a new spouse to coverage.)

### Adding Dependent Children


If a subscriber does not change from Single-Party to Two-Party or Family coverage or add a newly acquired child to existing Family coverage **within 31 days** of birth, adoption, marriage, or legal guardianship, the child will be considered a late applicant.


***Newborn Children*** — If Family coverage is in effect, a newborn, natural child is covered from birth. (The subscriber should, however, complete and submit an Enrollment Form to add the newborn as a dependent as soon as possible after birth.) A subscriber enrolled under Single-Party coverage must change to Family coverage (or Two-Party) **within 31 days** of the birth in order for any benefits to be available for newborn care. If the Enrollment Form and additional employee contribution amount for the cost of coverage are not received within 31 days, the newborn may not be added to coverage until the group's next open enrollment or upon completion of a 90 consecutive calendar day waiting period. (See "Late Applicant Provision.")

***Adopted Children*** — A child placed in the subscriber's home for the purposes of adoption may be added to coverage as soon as the child is placed in the home. However, application for coverage can be made as late as 31 days following the date the adoption becomes final without being considered late.

***Stepchildren, Grandchildren, and Legal Guardianship*** — Application for coverage must be made for a stepchild, grandchild, or child for whom the subscriber becomes the legal guardian within 31 days of the date the child meets the University eligibility criteria established for dependents. If application is not made within 31 days, the child will be considered a late applicant.

## When Coverage Begins

**This plan does not cover** any service received before the member's effective date of coverage, including any portion of an admission that began before the member's effective date of coverage. Also, if a member's prior coverage has an extension of benefits provision, this plan will not cover charges incurred after a member's effective date that are covered under the prior plan's extension of benefits provision.

Your coverage effective date may vary based on a variety of circumstances:

**Newly eligible employees and their dependents:** Coverage for newly eligible employees and their dependents is effective on the date of eligibility provided they are enrolled (by receipt of a completed Enrollment Form by the local Benefits Office) within the PIE.

**Newly eligible dependents:** Coverage for newly eligible dependents is effective on the date the dependent becomes eligible provided they are enrolled (by receipt of a completed Enrollment Form by the local Benefits Office) within the PIE. **Exception:** Coverage for a newly eligible adopted child enrolling during the additional PIE is effective on the date the adoption becomes final.

**Open enrollment:** The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

**Loss of other coverage:** Coverage for members who enroll under the "Special Enrollment" provision is effective the day after loss of other group coverage provided they are enrolled (by receipt of a completed Enrollment Form by the local Benefits Office) within 31 days of losing the other coverage.

**Change in family status:** Coverage for members who enroll under the "Special Enrollment" provision is effective on the date of change in the employee's family status provided they are enrolled (by receipt of a completed Enrollment Form by the local Benefits Office) within 31 days of acquiring the new dependent(s).

**The subscriber is responsible for notifying the local Benefits Office if he or she and/or any dependents are affected by the above requirements.**

For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment form is received by the local Benefits Office.

***Changing Coverage Type*** — To change from Single-Party to Two-Party coverage or from Two-Party to Family coverage, a new Enrollment Form must be completed and returned to the local Benefits Office within the PIE following the event, e.g., marriage or birth. (Members covered under state or federal continuation coverage must notify BCBSNM of any eligibility or coverage changes.)

## ■ ID Card

Your BluePremier POS ID card identifies you and your point-of-service coverage. On your card is your identification number, your group number, your name, and your PCP's name. You will receive a new ID card if you or a covered family member changes PCPs.

Carry your ID card(s) with you and show the appropriate ID card to the receptionist when you sign in for an appointment. When contacting a Customer Service representative, always refer to your identification and group numbers.

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

## ■ Coverage Termination

Any member losing eligibility under this plan may be able to continue as a group member for a limited period of time. (Members who terminate coverage for themselves or dependents who are terminated by the subscriber before losing their eligibility status are not eligible for any state or federal continuation or conversion coverage described under "How Coverage May Continue.")


**This plan does not cover** services, even if prior approval for such services was received from BCBSNM, that are received after your coverage under this medical plan is terminated or after coverage provided under 1) the "Extension of Benefits" provision or 2) any state or federal continuation is exhausted — even if the services were made necessary by an accident, illness, or other event that occurred while coverage was in effect, **unless** inpatient services are related to a covered admission that began before coverage termination. In such cases, coverage for the admission and related inpatient services continues until the earlier of the following events occurs:

- benefits for the admission are exhausted, or
- there is an interruption of the inpatient stay or leave of absence from the facility, regardless of the date of discharge.

See "How Coverage May Continue: Extension of Benefits" for information regarding a temporary extension of benefits for disability-related services.

## When Coverage Ends

Unless stated otherwise, if a member does not elect or does not qualify for continuation coverage, coverage for any member (including dependents) ends at the end of the month following the earliest of the following dates:

- For a direct-pay member, coverage will be terminated at the end of the last-paid billing period. Also, if coverage is terminated, any claims received and paid for during the 30-day grace period will be billed both to the employee and to the group or, in the case of a member covered under continuation coverage, to the person in whose name the coverage was issued.
- When the group gives BCBSNM, or BCBSNM gives the group, 60 days' advance written notice of termination with cause (or four months' advance written notice of termination if without cause), or upon 30 days' advance written notice received from a subscriber covered by continuation coverage.
- Following the employee's termination of employment or, for any member, his/her other loss of eligibility according to the terms of this plan, on the day of the last pay period for which employee contribution payment is paid based on earnings as an eligible employee.
- The date group coverage is discontinued for the entire group or for the employee's enrollment classification.
- Upon the subscriber's death (contact your Benefits Office for information about survivor annuitant benefits).
- When the member enters the armed forces for more than six months.
- When the member acts in a disruptive manner that prevents the orderly business operation of any participating provider or is dishonestly attempting to gain a financial or material advantage.
- When the member **chooses** Medicare Part A or B as his/her primary coverage (see "Medicare-Eligible Members" earlier in this section for details). Regardless of age, rights to continue coverage may be different if the member is considered disabled or has end-stage renal disease. For specific rules governing Medicare coverage, check with Medicare.

- On the day when there is a failure of the subscriber to pay the employee contributions or other applicable charges for coverage; a material failure to abide by the rules, policies, or procedures of this plan; or fraud or material misrepresentation affecting coverage. If a member knowingly gave false material information in connection with the eligibility or enrollment of the subscriber or any of his/her dependents, BCBSNM may terminate the subscriber and his/her dependents. Such termination will be effective upon the mailing of written notice by the Plan to the employee/annuitant and the University. Termination of coverage of a dependent for fraud shall not cancel the enrollment of other family members. Termination of an employee's, annuitant's, or other subscriber's coverage shall automatically cancel the enrollment of all covered dependents. The subscriber is liable for any benefit payments made as a result of such improper actions.
- If BCBSNM ceases operations. BCBSNM will be obligated for services for the rest of the period for which the necessary fees were already paid.

***Additional Dependent Termination Reasons*** — In addition, coverage will end for any dependent on the earliest of the above dates or the earliest of the following dates:

- The end of the last-paid billing period for dependent coverage.
- The end of the month that the dependent child no longer qualifies as a dependent under the plan (e.g., a child being adopted is removed from placement in the subscriber's home, or a child marries or reaches the dependent or legal ward age limit).
- The end of the month of a final divorce decree or legal separation for a dependent spouse.
- The end of the month following a written request from the subscriber to end coverage for a dependent. (Note: Members covered under state or federal continuation coverage must request coverage termination from BCBSNM.)

**Note: Any member covered under a direct-pay continuation policy should refer to "How Coverage May Continue" for additional termination information in these special instances.**

***Voluntary Termination*** — To remove a dependent from coverage, the subscriber must complete and submit an Enrollment Form to his/her Benefits Office.


If a dependent is being removed from coverage because of losing his/her eligibility under the plan (for reasons other than reaching the dependent child or legal ward age limit), the University must receive the Enrollment Form **within 31 days** following the effective date of the change. In these cases, the dependent will be removed from coverage as of the change in his/her eligibility status. BCBSNM and the providers of care may recover benefits erroneously paid to the subscriber on behalf of the removed member during the period of time during which the member was ineligible.

If a subscriber or dependent is being voluntarily removed from coverage by the subscriber before he/she becomes ineligible for coverage, the termination will be effective according to Payroll practices. These terminated members are not eligible for any state or federal continuation, conversion, or extension of benefits coverage provided under the plan, but may be eligible to re-enroll under this plan as late applicants (except as provided under "Special Enrollment").

**Note:** Members covered under state or federal continuation coverage must notify BCBSNM of any voluntary terminations.

***Leave of Absence*** — Contact your Benefits Office for information.

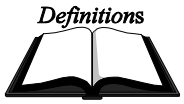
# How Coverage May Continue

If a member loses coverage under this plan, medical plan coverage can be continued on a direct-pay basis. However, unless approved in writing by BCBSNM, the following persons may **not** enroll in any of the continuation or conversion coverage options listed below:

- one who **voluntarily** terminated group coverage while still eligible (**Involuntary** termination includes loss of coverage under the following situations only: legal separation, divorce, loss of dependent child eligibility status, death of the subscriber, termination of employment, reduction in hours, or termination of employer contributions. Any other reason is considered voluntary.)
- a dependent who was removed from coverage by the subscriber while the dependent was still eligible
- any member whose coverage under a BCBSNM plan was terminated for good cause (see the *Glossary)*

**Note:** There is no special enrollment period for members applying for or covered under state or federal continuation or conversion coverage. Members must enroll in these direct-pay coverages in a timely manner or the application for coverage will not be accepted.

## Extension of Benefits




*Totally disabled* — A member is prevented, solely because of illness or accidental injury, from engaging in substantial gainful employment or is incapable of doing most of the normal tasks and activities for that person's age and family status.

If, on the date the employer's group coverage terminates, a member is totally disabled, then the member's medical plan coverage may be continued for only the disabling condition for up to 12 consecutive months after the group terminates coverage.

An extension of benefits is available if:

- the member was totally disabled on the date of the group's termination; *and*
- the member incurs an expense directly resulting from that particular disability that would have been a covered service before termination.

If coverage is continued under this provision, benefits for only the disabling condition are paid subject to all applicable limitations, exclusions, and maximums that applied at the time the group's coverage terminated.


A member claiming an extension of benefits must notify BCBSNM within **31 days** of the group's coverage termination date and provide evidence of total disability.

## State and Federal Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, enrolled persons who would lose coverage under the BluePremier POS medical plan due to certain "Qualifying Events" are entitled to elect, without having to submit evidence of good health, continued coverage at their own expense. Continued coverage will be the same as for active eligible employees and their eligible dependents covered under the University group plan. If coverage is modified for active eligible employees and their eligible dependents, it will also be modified in the same manner for persons with continued coverage (Qualified Beneficiaries) and an appropriate adjustment in premiums may be made.

***Right to Continue Benefits*** — A right under this part is subject to the rest of these provisions:

An employee has the right to continue benefits under the plan for him/herself and any enrolled dependents if coverage would have ended for either of the following Qualifying Events:

- because the employee's employment ended for a reason other than gross misconduct; or
- because the employee's work hours were reduced (including approved leave without pay or layoff).

Each of the employee's eligible dependents has the right to continue benefits under the plan under the following circumstances:

- The employee's spouse may continue coverage for him/herself and any enrolled dependent children if the spouse's coverage would have ended because of any of the following Qualifying Events:
  - the employee's employment ended for a reason other than gross misconduct; or
  - the employee's work hours were reduced (including approved leave without pay or layoff); or
  - the employee died; or
  - the employee became entitled to Medicare benefits, thus leaving dependents without coverage; or
  - the employee's spouse ceased to be an eligible dependent as a result of divorce, legal separation, or annulment.

  If coverage for a spouse ended because of divorce, legal separation, or annulment, see the "Notice" on the next page.

- A child may continue coverage for him/herself if the child's coverage would have ended because of any of the following Qualifying Events:
  - the employee's employment ended for a reason other than gross misconduct; or
  - the employee's work hours were reduced (including approved leave without pay or layoff); or
  - the employee died; or
  - the employee became entitled to Medicare benefits, thus leaving dependents without coverage; or
  - because of the employee's divorce, legal separation, or annulment; or
  - when the employee's child ceased to be an eligible dependent under the rules of the plan.

If coverage for an eligible dependent ends because of the employee's divorce, legal separation, or annulment, or because the child ceased to be an eligible dependent under the rules of the plan, please see the "Notice," below.

For a Qualifying Event due to employment termination for reasons other than gross misconduct, or reduction in work hours, if the employee becomes entitled to Medicare due to age within 18 months before the Qualifying Event, the eligible dependent spouse or child may continue COBRA continuation coverage for up to 36 months — counted from the date the employee became entitled to Medicare.

If a second Qualifying Event occurs to a Qualified Beneficiary who already has continuation coverage because employment has ended or work hours were reduced, that Qualified Beneficiary's coverage may be continued up to a maximum of 36 months from the date of the first Qualifying Event.


**Notice:** If coverage for a dependent ends due to the employee's divorce, legal separation, or annulment, or if a child ceased to be an eligible dependent under the rules of the plan, the subscriber or dependent must give **written notice** of the event to the employer at the local Benefits Office **within 60 days** of the event or eligibility to elect continuation coverage will be lost.

***Notification of Continuation Rights*** — Once aware of a Qualifying Event, the employer will give a written election notice of the right to continue the coverage to the employee (or to the Qualified Beneficiary in the event of the employee's death). The notice will state the amount of the premium required for the continued coverage. If a person wants to continue the coverage, the "Election Notice" must be completed and returned to the address on the next page, along with the first month's premium, **within 60 days** of the later of:

- the date of the Qualifying Event; or
- the date the Qualified Beneficiary received notice informing the person of the right to continue.

**Blue Cross and Blue Shield of New Mexico**
**Attn: UC/LANL COBRA Enrollment**
**P. O. Box 27630**
**Albuquerque, New Mexico 87125-7630**

Benefits of the continuation plan are identical to this group medical plan (cost is explained under "Cost of Continuation Coverage" on page 22).

***When Continuation Coverage Ends*** — The continued coverage period runs concurrently with any other University continuation provisions (e.g., during leave without pay) except continuation under the Family and Medical Leave Act (FMLA). Coverage will be continued from the date it would have ended until the first of these events occurs:

- For an employee and any of his/her Qualified Beneficiaries, **18 months** from the earlier of the date:
  - employment ended for a reason other than gross misconduct; or
  - work hours were reduced.

  **Note**: Coverage may continue for all Qualified Beneficiaries for up to 11 additional months while the Qualified Beneficiary is determined to be disabled under Title II or XVI of the United States Social Security Act if:
  - the disability was determined to exist at the time of, or during the first 60 days of, the 18 months of COBRA coverage; and
  - the person gives BCBSNM **written notice** of the disability **within 60 days** after the determination of disability is made and **within 18 months** after the date employment ended or work hours were reduced.

  BCBSNM must be notified if there is a final determination under the United States Social Security Act that the person is no longer disabled. The notice must be provided **within 30 days** after the final determination. The coverage will end on the first of the month that starts more than 30 days after the determination.

- For Qualified Beneficiaries (other than the employee), **36 months** from the earliest of the date:
  - of the employee's death; or
  - of the employee's entitlement to Medicare benefits; or
  - of the employee's divorce, annulment, or legal separation; or
  - the employee's child ceases to be an eligible dependent under the rules of the plan.

  The 36-month period will be counted from the date of the earliest Qualifying Event.

- For any Qualified Beneficiary:
  - if the person fails to make any premium payment required for the continued coverage, the end of the period for which the person has made required payments; or
  - the day the person becomes covered (after the day the person made the election for continuation coverage) under any other group health plan, on an insured or uninsured basis (this item by itself will not prevent coverage from being continued until the end of any period for which pre-existing conditions are excluded or benefits for them are limited under the other health plan); or
  - the day the person becomes entitled to Medicare benefits; or
  - the day the employer no longer provides group health coverage to any of its employees.

When continuation coverage ends, the member may be entitled to convert to a nongroup, direct-pay conversion policy offered by BCBSNM. See "Conversion to Nongroup Coverage."

***California Continuation Coverage*** — Employees entitled to COBRA continuation coverage due to employment termination are entitled to extend medical coverage for themselves and their spouses after their initial 18-month COBRA period ends — provided the employee was at least age 60 on the date employment ended, had worked for the University for at least five continuous years immediately prior to termination, and was eligible for and elected COBRA continuation medical plan coverage in connection with the termination of employment. The former spouse of the above former employee is entitled to this continuation coverage, provided the former spouse continued coverage under COBRA as a Qualified Beneficiary. This continuation does **not** apply to children of a former employee. The continuation will end on the earliest of the following dates:

- the date the individual turns 65;
- the date the University no longer maintains the group plan, including any replacement plan;
- the date the individual is covered by a group medical plan not maintained by the University;
- the date the individual becomes entitled to Medicare;
- for the spouse or former spouse only, the date five years from the date COBRA ends for the spouse or former spouse.


If the employee's coverage terminates, the spouse may continue coverage until one of the terminating events applies to the spouse. BCBSNM will notify eligible COBRA Qualified Beneficiaries before the end of the maximum 18-month COBRA continuation period. If an eligible individual wishes to continue the coverage, he/she must apply **in writing** to BCBSNM no later than **30 days** before the end of the COBRA continuation period.

***Cost of Continuation Coverage*** — The cost of the coverage will include any portion previously paid by the employer and shall not be more than 102 percent of the applicable group rate during the period of basic COBRA coverage; or not more than 150 percent any time during the 11-month disability extension period (i.e., during the 19th through the 29th months); or not more than 213 percent during the extension period allowed by California continuation coverage.

For information on open enrollment actions for which a Qualified Beneficiary may be eligible and/or any applicable plan modifications and premium adjustments, contact University of California Human Resources and Benefits at 1-800-888-8267, extension 70651 during the group's annual open enrollment period.

***Direct-Pay Premium Payments*** — Premium payments for state and federal continuation coverage are payable in advance by direct-pay subscribers to BCBSNM at its offices in Albuquerque, New Mexico. The first payment should be submitted with the application for direct-pay continuation coverage. Subsequent premium payments are due and payable before the first of each month during which coverage is in effect.

The amount paid for coverage is subject to change on the group's annual renewal date.

## Conversion to Nongroup Coverage


Involuntarily terminating members may change to direct-pay conversion coverage (at then available coverage rates and benefits) if group coverage or continuation coverage is lost due to one of the following circumstances:

- termination of employment (the employee and any eligible dependents *who were covered* at the time that group coverage was lost are eligible to apply for conversion coverage)
- a member no longer meets the eligibility requirements of the plan
- the period of continuation coverage with the group expires (providing that group coverage is still in effect)
- a dependent terminates coverage for one of the following reasons:
  - divorce or legal separation from the subscriber
  - disqualification of a dependent under the plan's definition of a dependent child
  - death of the subscriber
  - an employee who is subject to Medicare Secondary Payer provisions selects Medicare as primary coverage — leaving dependents without coverage

The member must have been covered under a University-sponsored medical plan for a minimum of three months before he/she will be eligible for conversion coverage.


**BCBSNM must receive the member's application for conversion coverage within 31 days after group coverage is terminated. (A health statement is not required.) The member must pay conversion coverage premiums from the date of such termination.**

BCBSNM conversion coverage is **not** available in the following situations:

- when the member is covered by Medicare Part A and/or Part B
- when coverage administered by BCBSNM was discontinued for any reason for the entire group or the employee's enrollment classification
- when the terminating member resides outside of or moves out of New Mexico (If still eligible for a University-sponsored medical plan, the member may switch enrollment to BluePremier Worldwide benefits. If the member is residing outside of New Mexico and is no longer eligible for a University-sponsored medical plan, he/she may call BCBSNM for details on transferring coverage to the Blue Cross and/or Blue Shield Plan in the state where the member is living. Conversion coverage is not available to members moving outside of the United States.)

The benefits and premiums for conversion coverage will be those available to terminated medical plan members on the member's coverage termination date. Contact a BCBSNM Customer Service representative for information and forms.

You will receive a new benefit booklet if you change to conversion coverage. (Some benefits of this plan, such as the mental health and chemical dependency benefits administered by PBHI, are not available under BCBSNM conversion coverage. Call a BCBSNM Customer Service representative for details.)

## Membership Records

BCBSNM will keep membership records, and the employer will periodically forward information to BCBSNM to administer the benefits of this plan.

## Application Statement

Any statement, including a fraudulent statement, made by you in any application for coverage can void this coverage or can be used against you in any legal action or proceeding relating to this coverage.

# 3 How BluePremier POS Works

## Welcome to BluePremier POS

BCBSNM is pleased to administer the medical/surgical portion of the health care plan provided by the University of California — coverage that allows you choice and flexibility for your family's and your health care. Our goal is to provide you with the quality health care coverage and service that you expect. By encouraging physicians, hospitals, other providers, and members to work together, BCBSNM works to manage health care costs while providing you and any covered family members with a comprehensive, affordable, and quality medical plan.

Please take some time to get to know your BluePremier POS coverage, including benefit limitations and exclusions, by reviewing this important document and any enclosures. Learning how the plan works can help you make the best use of your health care benefits.

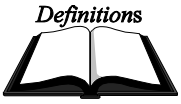
Thank you for selecting BluePremier POS for your medical plan. We look forward to working with you to provide personalized, affordable, and high quality health care now and in the future.

Sincerely,

Norman P. Becker
President
New Mexico Blue Cross and Blue Shield, Inc.

Be sure to read this booklet carefully and refer to the *Summary of Benefits and Copayments* on pages v and vi.

## Benefit Choices

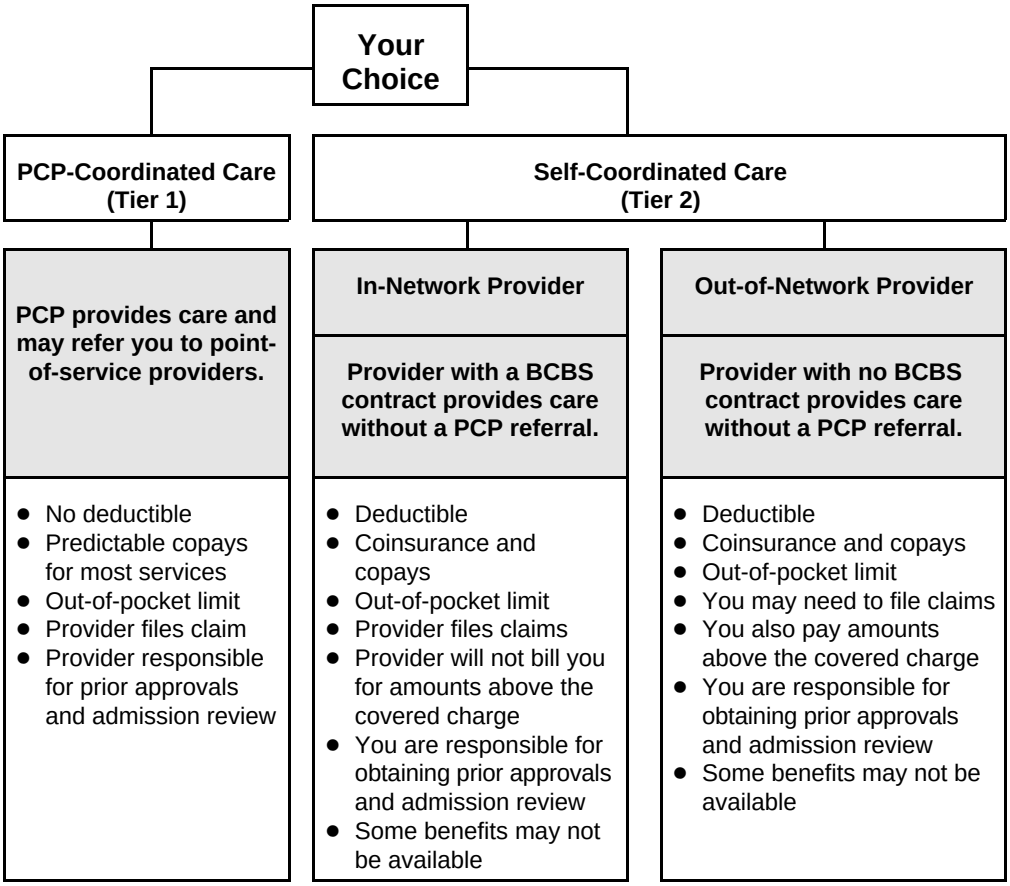



*Covered charge* — The amount that BCBSNM determines is a fair and reasonable allowance for a particular covered service. After your share of a covered charge has been calculated, this plan pays the remaining amount of the covered charge, up to maximum benefit limitations, if any. **The covered charge may be less than the billed charge for a covered service.** Your choice of provider, as explained below, will determine if you will also have to pay the difference between the covered charge and the billed charge.

*Providers* — Physicians, hospitals, and other health care professionals or facilities, licensed when required, that provide medical services and care, and perform within the scope of licensure.

BluePremier POS gives you choices and flexibility for your medical care plus the opportunity to save money. When you need health care, you have three choices: PCP-Coordinated Care (Tier 1), or Self-Coordinated In-Network or Out-of-Network Care (Tier 2). Each time you need health care, your choice of provider — a point-of-service PCP, another in-network provider, or an out-of-network provider — will determine the benefits paid for covered services received from that provider.

**Your choice can make a difference in the amount you pay:**




BluePremier POS includes these special features:

- You can choose at the time that care is needed whether to see your PCP or another provider.
- If you reside outside New Mexico, you can receive benefits for PCP services by traveling into areas of New Mexico and bordering states that have PCPs who contract with BCBSNM.
- If you self-coordinate your care, you will be able to choose from an extensive network of providers that contract with BCBSNM and other Blue Cross and/or Blue Shield Plans throughout the United States. In-network providers will accept the plan's payment plus your share of covered charges as payment in full.
- Freedom of choice remains for you if you choose to receive care from providers outside the network. However, for these services, you may be responsible for any amount above covered charges.

***PCP-Coordinated Care: Point-of-Service vs. Non-Point-of-Service*** — A health care provider may have one or more contracts with BCBSNM, including a "point-of-service" contract. Family and general practice, internal medicine, obstetrics/gynecology, and pediatric physicians can choose to be point-of-service plan PCPs. Since a PCP will generally refer you only to point-of-service providers, you should understand the differences between point-of-service and non-point-of-service providers. (See "PCP-Coordinated Care (Tier 1)," below, for more information.)

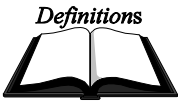
***Self-Coordinated Care: In-Network vs. Out-of-Network*** — All PCPs and point-of-service providers are considered in-network providers. However, non-point-of-service providers may still be in-network if they have another type of contract with BCBSNM or their local BCBS Plan. (Those that do not have a contract are out-of-network.) When you want to coordinate your own care, it's important to understand the differences between in-network and out-of-network providers because your choice can make a difference in the amount you pay. (See "Self-Coordinated Care (Tier 2)," later in this section, for more information about in-network and out-of-network providers.)

# ■ PCP-Coordinated Care (Tier 1)

When you receive services from a PCP or are appropriately referred to a specialist, you will receive PCP-coordinated benefits. This means you pay only a fixed-dollar copayment for most covered services (no deductible or additional coinsurance is required), and you receive the highest level of benefits.

To receive the PCP-coordinated level of benefits, you generally have to obtain services from a **PCP** or obtain a PCP's referral to visit another **point-of-service provider.** Therefore, you may want to know if a specialist is a point-of-service provider. (PCPs cannot refer you to a non-point-of-service provider without first obtaining prior approval for such a referral from BCBSNM.)

## Point-of-Service vs. Non-Point-of-Service Providers




*Point-of-service providers* have special contracts with BCBSNM to provide health care for point-of-service plan members. Providers in the "Facilities and Specialists" section of the *BCBSNM Point-of-Service Network Directory* that have the **special symbol next to their name** are point-of-service providers.

*Primary care providers (PCPs)* have point-of-service contracts with BCBSNM and have also agreed to be responsible for providing and coordinating all health care for point-of-service members. PCPs are conveniently located throughout New Mexico and along the borders of neighboring states.

*Non-point-of-service providers* have not contracted with BCBSNM as "point-of-service" specialists or PCPs. (They may have another type of contract with BCBSNM or with their local BCBS Plan, or they may have

no contract with a BCBS Plan. Those providers with other BCBSNM contracts are listed in the *BCBSNM Point-of-Service Network Directory* but **do not have the special symbol next to their names.**)

***PCPs and Point-of-Service Providers*** — All PCPs and other point-of-service providers:

- will keep your out-of-pocket costs lower since they agree to accept covered charges — which are usually less than billed charges — as payment in full for covered services and will not bill you for any difference between the covered charge and the billed charge; and
- will file claims to BCBSNM on your behalf; and
- are responsible for obtaining admission review and other prior approvals for you when they are recommending services.

Also, PCPs do not have to obtain prior approval from BCBSNM before referring you to a point-of-service provider (although specific services may require prior approval).

***Selecting a PCP or Other Point-of-Service Provider*** — At the time of enrollment, each member must select a PCP. Members of a single family are not required to choose the same PCP; each may select his/her own PCP. If you select a PCP that you have never visited, it is a good idea to establish a relationship with the PCP as soon as possible, or you may find that you have to self-coordinate emergency or urgent care. **Also, a PCP should be chosen for an eligible newborn before the child's birth, but no later than 31 days following birth, to ensure continuous coverage from birth.**

Use the *BCBSNM Point-of-Service Network Directory* when choosing your PCP. Some providers are listed as "Taking established patients only." This means that if you are not already a patient of that provider, you cannot choose him/her as your PCP. A provider may, however, open or close his/her practice to new patients after a directory has already gone to print. Therefore, you may want to confirm with the PCP that he/she is still accepting new patients as of the date you enroll.

PCPs are listed in the second section of your provider directory. Providers in other sections of the directory that have the special symbol next to their names are point-of-service providers. Those without the symbol are in-network, but are non-point-of-service providers (your PCP cannot refer you to these providers without first obtaining authorization from BCBSNM).

If you do not have a current directory, ask a BCBSNM Customer Service representative to send you one. **Note:** Although provider directories are current as of the date shown at the bottom of each page, they are subject to change without prior notice.

To verify a provider's current status with BCBSNM, or if you have any questions about how to use the directory, contact a BCBSNM Customer Service representative.

***Changing PCPs*** — You may select a new PCP any time by calling BCBSNM Customer Service and notifying them of the change.

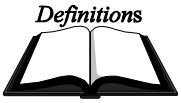
PCP changes may take from two to six weeks to process. If you request a change before the 15th day of the month, the change will be effective by the first day of the following month. Requests received after the 15th day of the month may not be effective for six weeks. (To have medical records transferred from one physician to another, contact your former PCP. You are responsible for any charges related to transferring medical records.)

Any referrals provided by your previous PCP must be reviewed and new referrals issued by the new PCP before such care will be considered for benefits.

***Non-Point-of-Service Providers*** — Referrals to non-point-of-service providers **always** require prior approval from BCBSNM. If approval is not obtained, the PCP-coordinated level of benefits may not be available. Non-point-of-service providers are **not** responsible for obtaining admission review or other necessary prior approvals (see "Medical/Surgical Admission Review and Other Prior Approvals," later in this section).

Whether or not the non-point-of-service provider accepts covered charges or files claims to BCBSNM depends on whether he/she has another type of contract with a BCBS Plan. See "Self-Coordinated Care (Tier 2)," later in this section, for more information about in-network and out-of-network providers.

## Referrals




*Referral* —Authorization from your PCP (or, when approved by BCBSNM, from a point-of-service specialist), received in advance of services that allows you to seek care or services from another health care provider and receive the PCP-coordinated level of benefits for covered services obtained from that provider.

To receive the PCP-coordinated level of benefits, you must obtain a referral from your PCP **before** seeking nonemergency care from a non-PCP provider. (Specialists who are recommending the services of another provider must receive prior approval from BCBSNM before issuing a referral.)

When referring you to another provider for your care, your PCP may give you a copy of the referral form (to take to your appointment), fax a copy of the referral to the health care provider, or call the provider with a phone referral. The PCP will also provide the referral information to BCBSNM.

**Be sure your PCP has issued a referral before you make an appointment with the recommended provider.** To ensure that the referral will be covered, you should:

- call a Customer Service representative to obtain the referral number **before** making an appointment with the specialist; and
- take your referral number with you when you visit the specialist. (If you do not have your referral number with you at the time of your appointment, the specialist may ask you to sign a disclaimer indicating that you will be responsible for all charges if services are denied.)

**A referral indicates the number of visits approved and the time period in which you must receive the care (usually not exceeding 60 days). Be sure you obtain this information from your PCP. If only one visit is authorized, a second visit will not be covered at the PCP-coordinated level of benefits. All covered services in excess of those authorized, and any covered services received before or after the specified time period, will be paid at the self-coordinated level of benefits. If you need care beyond the specified limits, contact your PCP for instructions.**

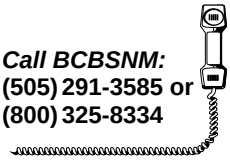
**A referral does not guarantee payment of provider bills.** Benefit payments are based on your eligibility and benefits in effect at the time you receive services. **Services not listed as covered and services that are not medically necessary will be denied.** If covered, services will not be eligible for the PCP-coordinated level of benefits if the referral should have been approved in advance by BCBSNM and no such approval was given (see "Medical/Surgical Admission Review and Other Prior Approvals").

**Exception:** A referral is not required to receive the PCP-coordinated level of benefits for a visit to any point-of-service women's health care provider for an annual well-woman gynecological exam, maternity care, or treatment of a gynecological condition.

**Call Your PCP Within 48 Hours**

***Emergency Services*** — You do **not** need to get a referral from your PCP **before** seeking emergency services. However, you must call your PCP **within 48 hours** (or as soon as possible) to report the emergency situation. Your PCP will then issue a referral for the services if he/she agrees that an emergency existed. If your PCP is not advised of the emergency services within a reasonable amount of time, or does not issue a referral because he/she does not agree that an emergency existed, covered services will be paid at the self-coordinated level of benefits. See "Emergency and Urgent Care" in *Section 4* for details.

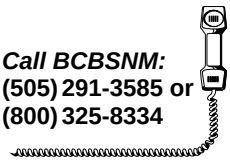
***Retroactive referrals*** — Referrals received **after** you have already visited a specialist or facility for nonemergency care **will not be accepted.** To receive the PCP-coordinated level of benefits for nonemergency services, you must obtain all referrals **before** receiving services. If you choose to visit a provider for nonemergency care — even a point-of-service provider — without going through the referral process or after a referral has been denied, you will receive self-coordinated benefits for covered services. (See the "Exception," above, regarding women's health care.)




***Referrals to Non-Point-of-Service Providers*** — A PCP usually will refer you only to point-of-service providers. Except for medical emergencies, BCBSNM must **prior-approve** referrals to non-point-of-service providers (providers either without the special symbol or not listed in the directory).

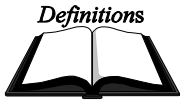
**BCBSNM may deny a request to approve a referral to a non-point-of-service provider.** If a point-of-service provider is available in another city, you may have to travel to receive the PCP-coordinated level of benefits for nonemergency services from a point-of-service provider. PCP-coordinated benefits are **not** available for referrals to providers outside the United States, unless there is a medical emergency.

## Second Opinion Consultations




If your PCP refuses to issue a referral that you think is medically necessary or is for a second medical or surgical opinion, call the BCBSNM Health Services department and request that your case be reviewed. If BCBSNM agrees that the referral is not necessary, you may file a complaint (see *Section 7* for details). If BCBSNM agrees that the referral is warranted, you will be issued a referral by BCBSNM.

## Copayments and Coinsurance for PCP-Coordinated Services

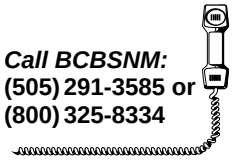



*Coinsurance* — The **percentage** of a covered charge that is your responsibility to pay.

*Copayment*— The **fixed-dollar** amount of a covered charge that you pay for some services such as PCP-coordinated office visits, emergency room visits, and hospital admissions.

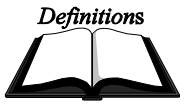
For PCP-coordinated covered office services, you generally pay only a copayment at the time services are received. For emergency room services and hospital admissions, you pay an additional percentage of covered charges (coinsurance) after the copayment has been satisfied. For other services, you pay only coinsurance; there is no copayment. See the *Summary of Benefits and Copayments* on pages v and vi for a complete list of required copayments and coinsurance percentages. (**Note:** PCP-coordinated benefits are **not** available for certain transplant services. You pay a specified percentage of covered charges for these services whether the service is PCP-coordinated or self-coordinated. See "Transplant Services" in *Section 4* for details.)

**You are responsible for making copayments and coinsurance payments directly to providers at the time of service and are always liable for a provider's full charges for any noncovered services.**




Services from non-point-of-service providers are covered at the PCP-coordinated level only under limited circumstances. However, when a physician receives **prior approval** from BCBSNM to refer you to a non-point-of-service provider or when the services of a non-point-of-service provider are medically necessary during an emergency situation (and your PCP approves the service as an emergency), your copayment responsibilities for covered services received from the non-point-of-service provider are the same as if services were received from a point-of-service provider.

## PCP-Coordinated Out-of-Pocket Limit




*PCP-coordinated out-of-pocket limit* — The total amount of copayments and coinsurance that a member (or family) pays for PCP-coordinated care in a calendar year. After the out-of-pocket limit is reached, this plan pays 100 percent of the member's (or family's) PCP-coordinated covered charges for the rest of that calendar year, up to the maximum benefit limitations.

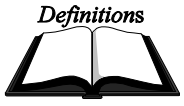
Each member's PCP-coordinated out-of-pocket limit is equal to the amount specified on the *Summary of Benefits and Copayments*. Once a member's PCP-coordinated out-of-pocket expenses reach this amount, this plan pays 100 percent of the covered PCP-coordinated charges incurred by that member for the rest of the calendar year.

Copayments and coinsurance for mental health services and chemical dependency treatments covered by PBHI, prescription drug copayments, and noncovered expenses are **not** included in calculating the out-of-pocket limit, and these services are not eligible for 100 percent payment under this provision.

**Note:** PCP-coordinated benefits are **not** available for services covered under the "Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney" transplant provision. Coinsurance paid for such services is applied to a separate $5,000 per transplant out-of-pocket limit. See "Transplant Services" in *Section 4* for details.

***Family Out-of-Pocket Limit*** — An entire family meets the out-of-pocket limit when the total coinsurance and copayment amount for all family members reaches the amount specified on the *Summary of Benefits and Copayments*. (If any one member's charges applied to the out-of-pocket limit equal the individual out-of-pocket limit amount, the out-of-pocket limit for that member is met and no additional amounts paid by that member may be used to satisfy the family out-of-pocket limit.)

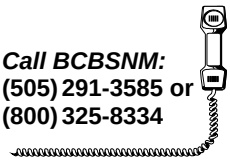
# ■ Self-Coordinated Care (Tier 2)




*Self-coordinated care* — Covered health care services received without first visiting your PCP or without obtaining an appropriate referral from your PCP **before** the services are provided. Also, if you do not notify your PCP within 48 hours of receiving emergency care (or as soon as reasonably

possible) or if your PCP does not agree that you were in an emergency situation, covered services will be paid at the self-coordinated benefit level.

***Cost-Sharing Features*** — Self-coordinated care is subject to an annual deductible amount, member coinsurance, and an annual out-of-pocket limit. Emergency room services and inpatient hospital admissions are subject to an additional copayment amount. (Information about deductibles, copayments, coinsurance, and out-of-pocket limits is on the following pages.) Also, some benefits are **not** available if you self-coordinate your care; see the *Summary of Benefits and Copayments*.




***Prior Approvals and Admission Review*** — Although providers may call for approvals on your behalf, **you are responsible** for ensuring that any necessary admission review and/or prior approvals are obtained from BCBSNM **before** self-coordinated services are received. **Benefits may be reduced or denied if the necessary approvals are not obtained in advance.** (See "Medical/Surgical Admission Review and Other Prior Approvals," later in this section, for details.)

## Provider Choices

When you self-coordinate your medical care, you have the choice of selecting an in-network or out-of-network provider. You should consider the difference between your share of total charges when services are received from in-network providers and your share of total charges when services are received from out-of-network providers.

***In-Network Providers*** — All in-network providers:

- will keep your out-of-pocket costs lower since they agree to accept covered charges — which are usually less than billed charges — as payment in full for covered services and will "write off" any difference between the covered charge and the billed charge; *and*
- will file claims to BCBSNM on your behalf.

You pay only the copayment, deductible, and/or coinsurance for covered services (shown on the *Summary of Benefits and Copayments)*, any penalty amounts, and noncovered expenses.

**Selecting a Network Provider:** All providers in the *BCBSNM Point-of-Service Network Directory* are in-network providers. If you do not have a current directory, ask a BCBSNM Customer Service representative to send you one. **Note:** Although provider directories are current as of the dates shown at the bottom of each page, they are subject to change without prior notice.

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

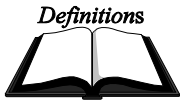
For a list of contracting providers outside New Mexico, contact the local BCBS Plan or call the BlueCard Doctor and Hospital Information Line at 1-800-810-BLUE. (**Remember:** These providers are "in-network" under the self-coordinated level of benefits, but are **not** BCBSNM point-of-service providers.)

***Out-of-Network Providers*** — For services from out-of-network providers:

- if the covered charge for a service is less than the provider's billed charge, the provider may bill you for the difference; *and*
- you may have to file your own claims for covered services.

You are also responsible for paying out-of-network providers copayments, deductible, and coinsurance, penalty amounts, and noncovered expenses.

## Self-Coordinated Deductibles




*Deductible* — The amount of covered charges incurred by a member in a calendar year that the member must pay before this plan begins to pay its share of the member's self-coordinated covered charges incurred during the same calendar year. (PCP-coordinated services are not subject to a deductible.)

For families with members who meet the eligibility requirements of BluePremier Worldwide benefits, any deductible amounts paid by a member under Worldwide benefits will apply to the deductible under POS plan Tier 2 benefits, and vice versa.

***Individual Deductible*** — Once a member's deductible payments reach the individual deductible amount specified on the *Summary of Benefits and Copayments*, this plan will begin paying its share of the member's covered self-coordinated charges for the calendar year.

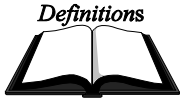
If a deductible has been met and an **admission** continues into a new year, no additional deductible or hospital copayment is applied for that admission's covered services. However, all other services received during the new year are subject to the deductible for the new year and the hospital copayments.


**Important:** Most self-coordinated care benefits are payable only after BCBSNM's records show that the deductible has been met. If you file your own claims for out-of-network services, you should submit them promptly so that your deductible record is accurate. You must file your claims within **12 months** of the date of service. See "Filing Claims" in *Section 7* for more information.

***Family Deductible*** — An entire family meets the deductible when the total deductible amount for all family members reaches the family deductible amount specified on the *Summary of Benefits and Copayments*. (If any one member's covered charges applied to the deductible equal the individual deductible amount, no additional charges incurred by that member may be used to satisfy the family deductible.)

***What is Not Subject to the Deductible*** — Emergency room, inpatient hospital, and prescription drug copayments are not applied to the annual deductible amount. Also, some services, such as skilled nursing facility admissions, home health care/home I.V. services, hospice care, certain preventive services, mental health and chemical dependency services covered by PBHI, and services covered under the "Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney" transplant provision in *Section 4* are **not** subject to the deductible. See the *Summary of Benefits and Copayments* and the *Schedule of Behavioral Health Benefits* for details.

## Self-Coordinated Copayments and Coinsurance




*Coinsurance* — The **percentage** of covered charges that you must pay for self-coordinated covered services after the deductible (if applicable) has been met and emergency room or hospital copayment (if applicable) has been paid.

*Copayment*— The **fixed-dollar** amount of a covered charge, in addition to deductible and coinsurance, that you must pay for some self-coordinated services such as emergency room visits and hospital admissions.


*See the* Summary of Benefits and Copayments *for your copayment and coinsurance amounts.*

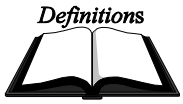
For self-coordinated services, you must pay a percentage of covered charges as member coinsurance. For some self-coordinated covered services, you pay a fixed-dollar copayment, in addition to the regular deductible and coinsurance amounts, at the time services are received.

After your share of covered charges has been calculated, this plan pays the remainder of the covered charge, up to maximum benefit limitations, if any. **The covered charge may be less than the provider's billed charge for a covered service.** (In-network providers may not bill you more than the covered charge; out-of-network providers may bill you for amounts in excess of covered charges.)

**Note:** Hospital admission copayments are **not** required for certain transplant services nor for inpatient physical rehabilitation admissions.

**You are responsible for making copayment, deductible, and coinsurance payments directly to providers at the time of service.**

## Self-Coordinated Out-of-Pocket Limit




*Self-coordinated out-of-pocket limit* — The maximum amount of deductible and coinsurance that a member pays for self-coordinated care in a calendar year. After the self-coordinated out-of-pocket limit is reached, this plan pays 100 percent of most of that member's self-coordinated covered charges for the rest of that calendar year, up to maximum benefit limitations.

**Note:** For families with members who meet the eligibility requirements of BluePremier Worldwide benefits, any deductible and coinsurance amounts applied to the out-of-pocket under the Worldwide benefits will apply to the out-of-pocket under POS plan Tier 2 benefits, and vice versa.

***Individual Out-of-Pocket Limit*** — Once a member's out-of-pocket expenses reach the individual out-of-pocket limit specified on the *Summary of Benefits and Copayments*, this plan pays 100 percent of most of that member's self-coordinated covered charges for the rest of the calendar year.

***Family Out-of-Pocket Limit*** — An entire family meets the out-of-pocket limit when the total coinsurance and deductible amount for all family members reaches the amount specified on the *Summary of Benefits and Copayments*. (If a member reaches his/her out-of-pocket limit, no additional coinsurance or deductible paid by that member may be used to satisfy the family out-of-pocket limit.)

***What is Not Included in the Out-of-Pocket Limit*** — The following amounts are **not** included in calculating the out-of-pocket limit and are not eligible for 100 percent payment under this provision: expenses in excess of covered charges; penalty amounts; noncovered expenses; expenses related to PCP-coordinated care; emergency room, hospital admission, and prescription drug copayments; any amounts paid for mental health services and chemical dependency treatments covered by PBHI; and coinsurance for services covered under the "Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney" transplant provision. (Coinsurance for services covered under the "Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney" transplant provision is applied to a separate $5,000 per transplant out-of-pocket limit.)

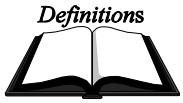
### Maximum Lifetime Benefit for Self-Coordinated Services

Each member has a maximum lifetime benefit of **$2,000,000.** This includes all amounts paid under the BluePremier POS and Worldwide benefits for self-coordinated covered services. (For families with members who meet the eligibility requirements of BluePremier Worldwide benefits, any benefit payments made under Worldwide benefits will apply to the member's self-coordinated care lifetime maximum under POS plan benefits, and vice versa.)

## ■ Calendar Year Benefit Period

Some benefits are limited to a specific dollar amount or number of days or visits allowed during a calendar year: January 1 through December 31 of the same year. The initial calendar year benefit period is from a member's effective date of coverage through December 31 of the same year, which may be less than 12 months.

# Medical/Surgical Admission Review and Other Prior Approvals




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

Admission review and other prior approval requirements can help manage the rising costs of health care. They will also provide you with assurance that, when self-coordinating your care, you are being treated in the most efficient and appropriate health care setting.

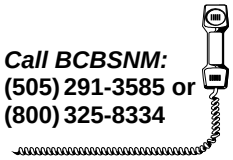
Even when this plan is not your primary coverage, these admission review and prior approval requirements must be followed. Failure to do so may result in a penalty or in a denial of benefits. Obtaining approval for an inpatient admission (see "Admission Review Approval") does not eliminate the need to obtain any required prior approval for a procedure related to the admission (see "Other Prior Approvals") nor vice versa.

Prior approvals determine only the medical necessity of a medical/surgical admission or of a specific procedure, and an allowable length of stay. Prior approvals (for example, to receive nonspecified services from a particular provider) do not guarantee payment or that you will receive the highest level of benefits, and do not validate eligibility. Benefit payments are based on the your eligibility and benefits in effect at the time you receive services. Services not listed as covered and services that are not medically necessary will be denied.

If you lose coverage under this plan, benefits are not allowed for any service received after coverage ends (except as specified under "Post-Termination Services" in *Section 5*), even if prior approval was obtained from BCBSNM.

***Services of PCPs and Point-of-Service Providers*** — If the attending physician is a PCP or a point-of-service specialist, obtaining prior approval is not your responsibility — it is the physician's responsibility. PCPs and point-of-service providers must obtain admission review approval for all nonemergency admissions or transfers they are recommending. They must also obtain prior approval before providing or recommending the services listed under "Other Prior Approvals" and **before** issuing a referral to a non-point-of-service provider for whose services you expect to receive the PCP-coordinated level of benefits.

The following information about admission review and other prior approval procedures applies only if you are self-coordinating care or receiving prior-approved, PCP-coordinated care from a non-point-of-service provider who is recommending services not already approved by your PCP and BCBSNM.




***Self-Coordinated Services/Services of Non-Point-of-Service Providers*** — If you are self-coordinating care or a non-point-of-service provider recommends an admission or one of the services listed under "Other Prior Approvals," **you** are responsible for ensuring that approval is requested. If approval is not obtained **before** services are received, benefits may be reduced or denied. Non-point-of-service providers are **not** responsible for obtaining approvals on your behalf. The physician may call on your behalf, but it is **your responsibility** to ensure that BCBSNM is called.

## Admission Review Approval

Admission review approval is required in the following situations for any nonemergency or nonpregnancy-related admission **before** you are admitted to the hospital (or for a newborn, before the mother is discharged):

- any inpatient admission
- any transfer from one facility to another
- a readmission for any reason
- newborn stays longer than the mother in the hospital

When you or your provider call, BCBSNM's Health Services staff will ask for information about the patient's medical condition, the proposed treatment plan, and the estimated length of stay. The Health Services staff will evaluate the information and notify you or the attending physician (usually at the time of the call) if benefits for the proposed hospitalization are approved.

***Penalty for Not Obtaining Approval*** — If you do not call, or if you call and BCBSNM does not approve inpatient benefits, but you choose to be hospitalized anyway, no benefits may be paid or partial payment may be made:

| If, based on a review of the claim: | Then: |
|---|---|
| The admission was a medically necessary covered service. | Benefits for the facility's covered services are **reduced by $300.*** |
| The admission was for a covered service but hospitalization was not medically necessary. | Benefits are denied for room, board, and other charges that are not medically necessary.* |
| The admission was not for a covered service. | No payment is made.* |

* The admission review penalty of $300 and charges for noncovered services are **not** applied to the deductible or to the out-of-pocket limit.

Admission review requirements may affect the amounts that this plan pays for inpatient services, but do not deny your right to be admitted to any facility and to choose your services.

When admission review has been completed and you or the attending physician has been told that inpatient benefits are approved, payment is made as explained in the *Summary of Benefits and Copayments* and *Section 4* of this benefit booklet.

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

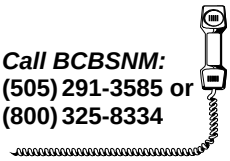
***Self-Coordinated Emergency or Pregnancy-Related Admissions*** — If you are admitted for emergency or pregnancy-related care (and choose to not inform your PCP), you are responsible for ensuring that BCBSNM is called with admission information **within 48 hours** of the admission, unless your condition makes it impossible to do so. If the call is not made within 48 hours of an emergency- or pregnancy-related admission (or on the next workday following a 48-hour period that falls on a weekend or holiday), benefits for covered facility services will be **reduced by $300.** (If you are pregnant, you should call BCBSNM **before** your maternity due date, soon after your pregnancy is confirmed.)

## Other Prior Approvals

In addition to admission review for all medical/surgical inpatient services, prior approval is required for the following self-coordinated services (or when provided by or recommended by a non-point-of-service provider, either in-network or out-of-network).

If prior approval is not obtained, **benefits will be denied** for all related services. Services that are not medically necessary or are noncovered will also be denied. **Retroactive approvals will not be given. You may be responsible for all charges if approval is not obtained before the service is received.**

The complete list of services requiring prior approval is subject to review and change by BCBSNM.



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

***Services Requiring Prior Approval*** — If prior approval is not obtained for the following services, **no benefits** will be available for them:

- **air ambulance** services (unless during a medical emergency)
- **chemotherapy** (high-dose)
- **dental-related** hospital services (all inpatient and outpatient); **TMJ** disorders treatment; surgical treatment of **prognathism;** treatment of **accidental injuries to sound natural teeth** (except initial treatment)
- **durable medical equipment,** medical supplies, and prosthetic devices costing more than **$500** or requiring **long-term rental; orthopedic appliances, orthotics, insulin pumps, and surgically implanted prosthetics,** regardless of total cost
- **health education** and counseling programs received from a provider who is not your PCP; diabetes self-management educational programs
- **home dialysis; home health** and **home I.V.** services; **hospice care**
- certain **injections** (such as growth hormone or interferon alfa-2) received in a physician's office (BCBSNM-contracted providers have a list of injectable drugs requiring prior approval. If you need this list, call the BCBSNM Health Services department.)
- **infertility services**
- **MRAs; PET scans; genetic testing or counseling; sleep disorder and bone density studies**
- **prescription drug refills** before the normal period of use has expired, including replacement of drugs that have been lost, stolen, destroyed,

or misplaced; **certain injectable drugs** or **other drugs** purchased through the "Prescription Drugs" provision

- **private duty nursing**
- rehabilitative services (outpatient and office **acupuncture, chiropractic services, physical, occupational, and speech therapy, and cardiac and pulmonary rehabilitation)**
- **surgeries** (all inpatient and certain outpatient), including cosmetic breast reconstruction, cochlear implants, reconstructive surgery, transplants, and pretransplant evaluations (BCBSNM-contracted providers have a list of procedures requiring prior approval. If you need 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, readmissions, and extended stay newborn hospitalizations or the $300 admission review penalty will apply to covered facility services. 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, BCBSNM may require a written request. BCBSNM 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 benefit booklet or any other coverage that applies on the date of service.

## Utilization Review and 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.

## Health Care Fraud Information

Insurance fraud results in cost increases for medical plans. You can help:

- 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 medical plan will be charged for the tests.
- Always review the bills from your providers and the *Explanation of Benefits* (EOB) you receive from BCBSNM. Verify that services for all charges were received. If there are any discrepancies, call a BCBSNM Customer Service representative.
- Be very cautious about giving information about your medical plan over the phone.

If you suspect fraud, contact a BCBSNM Customer Service representative.

# 4 Covered Services

This section describes the services and supplies covered by the BluePremier POS plan, which are also subject to the limitations and exclusions in *Sections 3* and *5*. All covered expenses are subject to the copayment, deductible, coinsurance, and out-of-pocket limit provisions described in *Section 3*. All payments are based on the maximum allowable fee as determined by BCBSNM. **Reminder:** It is to your financial advantage to receive care from PCPs and in-network providers.


*See the* Summary of Benefits and Copayments *for your specific copayment amounts, deductibles, and coinsurance percentages.*

## Medically Necessary Services

*Medically necessary* — A term used to describe technologies, services, or supplies that BCBSNM determines are:

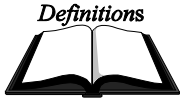
- medically appropriate, considering the patient's age and health, for the symptoms and diagnosis or treatment of the medical condition, illness, or injury;
- provided for the diagnosis, or the direct care and treatment of the member's medical condition, illness, or injury;
- in accordance with standards of sound medical practice;
- not primarily for the convenience of the member, the member's family, or the member's provider; and
- the most appropriate supply or level of service that can safely be provided to the member (e.g., the member requires inpatient acute care due to the nature of the services rendered or of the member's condition, and the member cannot receive safe or adequate care as an outpatient).

To be covered, services must be medically necessary as defined above unless such services are specifically listed as covered in this benefit booklet.

**Note:** The decision as to whether a service is medically necessary is based on generally accepted medical or surgical standards. **The fact that a provider may prescribe, order, recommend, or approve a service does not, by itself, make it medically necessary or a covered service, even though it is not specifically listed as an exclusion.**

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

# Ambulance Services




*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.

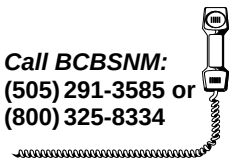
*Tertiary care facility* — A hospital unit that provides complete perinatal care (occurring in the period shortly before and after birth), and intensive care of intrapartum (occurring during childbirth or delivery) and perinatal high-risk patients. This hospital unit also has responsibilities for coordination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

When you cannot be safely transported by any other means in a non-emergency situation, medically necessary ambulance transportation by an ambulance service provider to a hospital with appropriate facilities, or from one hospital to another, is covered.

In an emergency situation (e.g., cardiac arrest, stroke), the plan also covers ambulance services. See "Emergency and Urgent Care" for details on obtaining emergency care.


Benefits are **not** available for:

- commercial transport, private aviation, or air taxi services
- transportation services that are not specifically listed as covered, such as private automobile, public transportation, or wheelchair ambulance
- ambulance services required **only** because other transportation was not available or for the patient's convenience



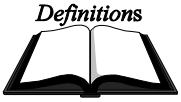

***Air ambulance*** — Ground ambulance is usually the approved method of transportation. Air ambulance transportation is covered only when terrain, distance, or your physical condition requires the use of air ambulance services, or for high-risk maternity and newborn transport to tertiary care facilities. To be covered, nonemergency air ambulance services require **prior approval** from BCBSNM.

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

**See Section 5: General Limitations and Exclusions.**

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

# Dental-Related Services



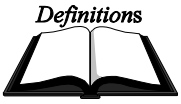

*Dental services* — Services performed for treatment of conditions related to the teeth or structures supporting the teeth.

**The PCP-coordinated level of benefits is available only for the treatment of craniomandibular or TMJ disorders. PCP-coordinated benefits are not available for any other dental services (if a point-of-service or other in-network oral surgeon provides such services, benefits are self-coordinated in-network; otherwise, benefits are self-coordinated out-of-network.)**


*For oral surgery benefits, see "Surgical Services and Other Procedures."*

The following services are the only dental services that are eligible for benefits under this plan.

## Dental and Facial Accidents




*Accidental injury* — A bodily condition that is not the result of illness but is caused solely by external, traumatic, and unforeseen means. Accidental injury does not include disease or infection. Dental injury caused by chewing, biting, or malocclusion is **not** considered an accidental injury.

*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 are **not** considered sound natural teeth. (Your provider will be required to submit x-rays taken prior to the dental or surgical procedure in order for BCBSNM to determine whether the tooth was considered “sound.”)


*For accidental injuries to the temporomandibular joint, see "TMJ Services."*


Benefits for covered services for the treatment of accidental injuries to the jaw, mouth, face, or sound natural teeth are based on the type of service (e.g., diagnostic services or surgery) and are subject to the same limitations, exclusions, and copayment, deductible, and coinsurance requirements that would apply to similar services when not dental-related. To be covered, initial treatment for the injury must be sought **within 72 hours** of the accident.

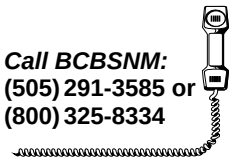

To be covered, any services required after the initial treatment of the injury must receive **prior approval,** requested **in writing,** from BCBSNM and must be received **within 12 months** of the date of accident. When alternative dental or surgical procedures or prosthetic devices are available, benefits are based upon the least costly procedure or prosthetic device.

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

## Hospitalization for Dental Services

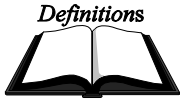
Benefits are available for ambulatory surgery facility or hospital room expenses and/or ancillary services related to dental services **only** if the patient has a nondental, physical condition that makes hospitalization medically necessary. **Note:** The dentist's services for the dental procedure may not be covered.

Hospital expenses related to dental services are not covered at the PCP-coordinated level of benefits. You can only receive coverage for such expenses under the self-coordinated level of benefits. However, any covered services received for the nondental physical condition during the hospitalization may be eligible for PCP-coordinated benefits.




**Reminder:** If hospital services are recommended by any non-point-of-service provider, you are responsible for obtaining **admission review approval** for the admission or **prior approval** for outpatient services to receive maximum benefits. (See "Medical/Surgical Admission Review and Other Prior Approvals" in *Section 3*.)

## TMJ Services




*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.


Benefits are available, when a **written request** for prior approval is approved by BCBSNM, for standard diagnostic, therapeutic, surgical, and nonsurgical treatment of TMJ disorders or injuries, which may include:

- diagnostic examination and associated x-rays
- medications dispensed in a dentist's or physician's office
- physical therapy and dental splints
- orthodontic appliances and treatment, crowns, bridges, or dentures for treatments **only if** required as the result of an accidental injury to sound natural teeth and involving the temporomandibular joint

Benefits are **not** available for self-coordinated TMJ services that have not been **prior-approved** by BCBSNM. **Nonstandard diagnostic, therapeutic, and surgical treatments of TMJ disorders are not covered under any circumstances.**

## Exclusions


Benefits are **not** available for:

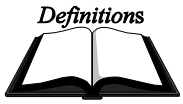
- duplicate or "spare" appliances
- personalized restorations or cosmetic replacement of serviceable restorations

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

- dental treatment and surgery, including but not limited to extraction of teeth, or application or cost of devices or splints, unless such treatment is required due to an accidental injury (See "Dental and Facial Accidents" and "TMJ Services.")
- oral or dental procedures not specifically listed as covered such as, but not limited to, removal of impacted teeth; dental services required as the result of a covered medical or surgical procedure (e.g., chemotherapy or radiation therapy); removal of tori or exostoses; any dental or oral surgical procedures involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for fitting or the continued use of dentures
- materials (such as precious metals) that are more expensive than necessary to restore damaged teeth
- artificial devices and/or bone grafts for denture wear

**See Section 5: General Limitations and Exclusions.**

# Diagnostic Services




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

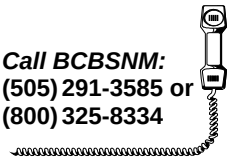

*For treatment of an accidental injury or other emergency, also see "Emergency and Urgent Care."*

*For allergy testing benefits, see "Physician Visits/Medical Care."*

*For services related to routine physicals or preventive care, see "Preventive Services."*

*For services related to infertility, family planning, maternity, or newborn care, see "Maternity/Reproductive Services and Newborn Care."*

*For invasive diagnostic surgical procedures such as biopsies and endoscopies, or any procedure that requires the use of an operating or recovery room, see "Surgical Services and Other Procedures."*



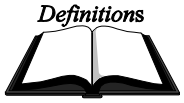

Benefits are available for the following diagnostic services, including pre-admission testing:

- x-ray and radiology services, ultrasound, and imaging studies (**Note:** To be covered, bone density and sleep disorder studies, PET scans, and MRAs require **prior approval** from BCBSNM.)
- laboratory and pathology tests
- EKG, EEG, and other electronic diagnostic medical procedures

**See Section 5: General Limitations and Exclusions.**

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

# Emergency and Urgent Care




*Emergency care* — Medical or surgical procedures, treatments, or services received immediately after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to his/her health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part; or disfigurement. (Care must be sought within 48 hours of the accidental injury or emergency occurrence in order to be considered emergency care.)


*For treatment of accidental injury to the mouth, jaw, or teeth, see "Dental-Related Services."*

*For ambulatory surgical facility or inpatient hospital treatment, see "Hospital/Other Facility Services."*

*For surgical treatment, see "Surgical Services and Other Procedures."*

*Also see other subheadings in this* Section 4 *for benefits when applicable.*

## Emergency Care

For all emergency care received in an emergency room, you are responsible for paying the emergency room copayment specified on the *Summary of Benefits and Copayments*, in addition to the applicable coinsurance and, for self-coordinated services, the annual deductible (if not already met). However, if emergency care results in an immediate admission to the hospital, the emergency room copayment is waived. The hospital admission copayment will apply in such cases.

**Use of an emergency center for nonemergency services is NOT covered. However, services will not be denied if you, in good faith and possessing average knowledge of health and medicine, seek care for what reasonably appears to be an emergency — even if your condition is later determined to be a nonemergency condition.**

***PCP-Coordinated Emergency Care*** — Like all other care, emergency care needs to be coordinated by your PCP in order for you to receive the PCP-coordinated level of benefits. When your PCP is not available, he/she will arrange for another physician to handle your care.

**Call Your PCP Within 48 Hours**

If you are unable to call your PCP before receiving initial treatment for an emergency, call your PCP within **48 hours** of treatment or as soon as possible. If your PCP agrees that an emergency existed, he/she provides BCBSNM with referral information and covered services are paid at the PCP-coordinated benefit level. (If you have not established a relationship with a PCP, the PCP is not obligated to provide you this service.) If your PCP does not agree that the services meet the definition of an emergency (or you have not established a relationship with a PCP), the self-coordinated level of benefits applies to covered services.

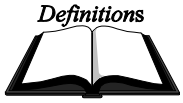
**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

***Self-Coordinated Emergency Care*** — If you do not call your PCP **within 48 hours** of the initial treatment of an **emergency** (including hospitalization), benefits are paid at the self-coordinated benefit level. If you **do** call your PCP within 48 hours but he/she does not agree that the services meet the definition of an emergency (or you had not previously established a relationship with your chosen PCP), the self-coordinated benefit level applies to covered services.

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

**Reminder:** If you are **admitted** because of an emergency and the admission is not PCP-coordinated, BCBSNM must be called **within 48 hours** of the admission (or as soon as reasonably possible) with hospital admission information or benefits for covered facility services will be **reduced by $300.** (See "Medical/Surgical Admission Review and Other Prior Approvals" in *Section 3*.)

## Urgent Care




*Urgent care* — Medically necessary medical or surgical procedures, treatments, or services received in an urgent care center or other provider's office for a condition that is not life-threatening but that requires prompt medical attention to prevent a serious deterioration in your health (e.g., high fever, cuts requiring stitches). (Services received in an emergency room or other trauma center will be considered for coverage as an "emergency.")

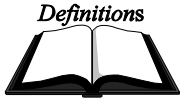
***PCP-Coordinated Urgent Care*** — You may receive urgent care services from your PCP or at your PCP's direction. If your PCP is not available, he or she has arrangements with other physicians to handle his/her patient's care; you can get a referral for urgent care from your PCP's covering physician. **Remember:** If you have not established a relationship with your chosen PCP before needing urgent care services, you may have to self-coordinate your care.

**Note:** The urgent care copayment specified on your *Summary of Benefits and Copayments* will apply to medical visits received in an urgent care center (including hospital-based urgent care centers), and urgent care visits or after-hours visits received in a professional provider's office. (Other services received during the visit are subject to applicable copayments based on type of service; for example, diagnostic services and medical supplies.) To receive benefits for services received in an emergency room (subject to the emergency room copayment), the condition requiring treatment must meet the definition of an "emergency." See "Emergency Care," on the previous page.

***Self-Coordinated Urgent Care*** — If you do not have a referral from your PCP but obtain urgent care anyway, you will receive self-coordinated benefits for covered urgent care services.

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

# Home Health Care/Home I.V. Services

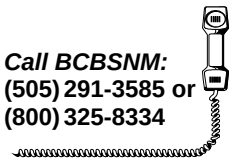



*Home health care services* — Covered services, as listed below, that are provided according to a treatment plan by a certified home health care agency under active physician and nursing management to eligible members at home. Registered nurses must coordinate the services on behalf of the home health care agency and the patient's physician.

*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.).


*For medical equipment or supplies, see "Supplies, Equipment, and Prosthetics."*

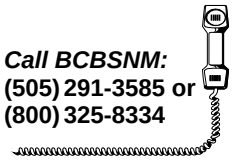
Home health care and home I.V. services provided to a homebound member (one who is unable to receive medical care on an outpatient basis) are covered if the services are provided under the direction of the patient's physician and nursing management is through a BCBSNM-approved home health care agency. For self-coordinated services, benefits are available for up to the number of days specified on the *Summary of Benefits and Copayments*. There is no benefit maximum for PCP-coordinated home health care or home I.V. services.




Before you receive home health care or home I.V. services, you, your PCP or attending physician, or the home health care agency must obtain **prior approval** from BCBSNM. Benefits are **not** available for services without prior approval.

The following services are covered when provided by an approved home health care agency during a covered visit in the patient's home:

- skilled nursing care provided on an intermittent basis by a registered nurse or licensed practical nurse
- physical, occupational, or respiratory therapy by licensed or certified physical, occupational, or respiratory therapists, and speech therapy provided by an American Speech and Hearing Association certified therapist
- total parenteral and enteral nutrition when requiring a physician's prescription
- medical supplies
- intravenous medications and other prescription drugs ordinarily not available through a retail pharmacy if **prior approval** is received from BCBSNM (If drugs are *not* provided by the home health care agency, see "Prescription Drugs.")
- skilled services by a qualified aide to do such things as change dressings and check blood pressure, pulse, and temperature



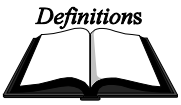

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**


Benefits are **not** available for:

- services provided primarily for the convenience of the member or the member's family
- 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*.)
- care provided by a nurse who ordinarily resides in the member's home or is a member of the patient's immediate family
- oxygen, oxygen equipment, durable medical equipment, prosthetics, and ostomy supplies (See "Supplies, Equipment, and Prosthetics.")

**See Section 5: General Limitations and Exclusions.**

## Hospice Care




*Hospice care* — An alternative way of caring for terminally ill individuals in the home or institutional setting, which stresses controlling pain and relieving symptoms. Hospice care focuses on the patient/family as the unit of care and addresses physical, social, psychological, and spiritual needs of the patient. Supportive services are offered to the family before and after the death of the patient.

*Hospice benefit period* — A period of time during which hospice benefits are available and defined as beginning on the date the attending physician certifies that the member is terminally ill, and ending 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 the member must maintain his/her coverage throughout the hospice benefit period.

*Skilled nursing care* — Care that consists of services that can be provided only by someone with at least the qualifications of a licensed practical nurse or registered nurse.

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

Inpatient and home hospice services for a terminally ill member received during a hospice benefit period are covered when provided by a hospice program approved by BCBSNM. For all hospice care, benefits are limited to the amount specified on the *Summary of Benefits and Copayments,* which includes amounts paid for both PCP-coordinated (Tier 1) and self-coordinated (Tier 2) services combined.

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**


Before you receive hospice care, you, the attending physician, or the hospice agency must request **prior approval** from BCBSNM. Prior approval requires a **written** treatment program approved by the attending physician. Self-coordinated hospice services are **not** covered without prior approval.

If you need an extension of the hospice benefit period, the hospice agency must provide a new treatment plan and the attending physician must re-certify your condition to BCBSNM. No more than two hospice benefit periods will be approved. **Note:** An extension of the hospice benefit period does **not** increase the total amount of benefits payable under this provision.

Benefits are available for the following hospice services provided by an approved hospice program during a covered home visit:

- visits from hospice physicians
- skilled nursing care by a registered nurse or licensed practical nurse
- physical and occupational therapy by licensed or certified physical or occupational therapists, and speech therapy provided by an American Speech and Hearing Association certified therapist
- medical supplies (If supplies are *not* provided by the hospice agency, see "Supplies, Equipment, and Prosthetics.")
- drugs and medications for the terminally ill patient (If drugs are *not* provided by the hospice agency, see "Prescription Drugs.")
- 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 for purposes of assisting the member or family in dealing 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 five days for every 60 days of hospice care — no more than two respite care stays are available during a hospice benefit period (*Respite care* provides a brief break from total care-giving by the family.)
- bereavement counseling for immediate family members if ordered and received under the hospice program within three months of the death of the member covered under this plan (A maximum of three counseling sessions will be covered.)


Benefits are **not** available for the following services:

- food, housing, or delivered meals
- volunteer services

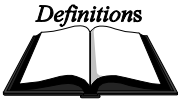
**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

- medical transportation
- homemaker and housekeeping services; comfort items
- pastoral and spiritual counseling
- supportive services or bereavement counseling provided to the family of a terminally ill patient when the patient is not a member of this medical plan

The following services are **not** hospice care benefits but may be covered elsewhere under this plan: acute inpatient hospital care for curative services, durable medical equipment, private duty nursing, nonhospice care physician visits, and ambulance services.

**See Section 5: General Limitations and Exclusions.**

## Hospital/Other Facility Services




*Ancillary services* — Services and supplies (in addition to room expenses) that a facility regularly makes available for the treatment of a patient's condition. Such services include, but are not limited to:

- use of operating room, recovery room, emergency room, treatment rooms, and related equipment
- drugs and medicines
- medical supplies (including dressings and supplies, sterile trays, casts, and splints used in lieu of a cast)
- diagnostic and therapeutic services
- durable medical equipment owned by the facility and used during a covered admission or outpatient visit
- blood processing and transportation costs, blood handling charges, and administration

*General condition* — A disease, illness, or other condition not related to mental illness or chemical dependency.

*Medical care* — Nonsurgical health care services provided for the diagnosis and treatment of illness, injury, and other general conditions.


*For services related to chemical dependency or mental illness, see* Section 10.

*If hospitalization is required for a dental procedure, also see "Dental-Related Services" for additional information and limitations.*

*For emergency services, also see "Emergency and Urgent Care."*

*For inpatient treatments related to hospice care, see "Hospice Care."*

*This section also applies to maternity-related services received in an inpatient, outpatient, or freestanding facility (such as a birthing center). See "Maternity/Reproductive Services and Newborn Care" for more information.*

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

*For outpatient physical rehabilitation services, see "Short-Term Rehabilitation, Outpatient and Office Services."*

*If services are related to an organ transplant, see "Transplant Services."*

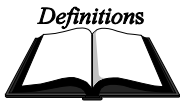
*See other subheadings in this section for limitations that apply to the specific type of service required, such as "Surgical Services and Other Procedures."*

## Blood Services

Coverage is available for processing, transporting, handling, and administration of blood. (**Note:** Directed donor or autologous blood storage fees are covered only when the blood is used during a scheduled surgical procedure.)

Benefits are **not** available for blood replaced through donor credit.

## Inpatient Medical/Surgical Admissions

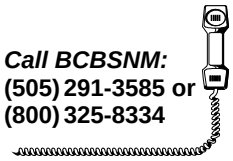



*Admission* — The period of time between the dates when a patient enters a facility as an inpatient and is discharged as an inpatient. For benefit determination purposes, the date of admission is considered the date of service for the hospitalization and all related inpatient services.

*Room expenses* — Expenses that include the cost of the patient's room, general nursing services, and meal services for the patient.

*Skilled nursing facility* — A state-licensed facility providing inpatient nursing care at the level that requires a registered nurse to deliver or supervise the delivery of care for a continuous 24-hour period.

*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.



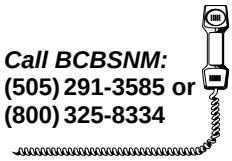

***Admission Review Required*** — **Reminder:** If an admission is self-coordinated or is being recommended by a non-point-of-service provider, you are responsible for obtaining admission review approval. Also, you must obtain admission review approval if you are transferred from one inpatient facility to another or readmitted to a facility for any reason. If your covered newborn stays in the hospital longer than the mother, BCBSNM must be called **before** the mother is discharged. If admission review approval is not obtained, benefits for covered facility services will be **reduced by $300.**

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

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

***Emergency Admissions*** — For emergency and pregnancy-related admissions, you must notify your PCP or BCBSNM **within 48 hours** of the admission. If your PCP is not notified within 48 hours (or as soon as reasonably possible), you will receive self-coordinated benefits for covered services. If admission approval is not obtained from BCBSNM for self-coordinated admissions **within 48 hours** (or as soon as reasonably possible), benefits for covered facility services will be **reduced by $300.** (See "Medical/Surgical Admission Review and Other Prior Approvals" in *Section 3*.)

***Covered Services*** — When you receive acute inpatient pregnancy-related, surgical, or medical care in a hospital for a general condition, covered services received during the admission include:




- semiprivate or special care unit room expenses (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. **Prior approval** must be received from BCBSNM in order for medically necessary private room charges to be covered.)
- other ancillary services provided by the facility


Benefits are **not** available for:

- private room expenses, unless the patient's medical condition requires isolation for protection from exposure to bacteria or diseases (e.g., severe burns and conditions that require isolation according to public health laws)
- admissions related to noncovered services or procedures (see "Dental-Related Services" for an exception)
- extended care facility admissions or admissions to similar institutions
- admissions primarily for the purpose of receiving therapeutic or rehabilitative treatment, such as physical, occupational, or oxygen therapy (For skilled nursing facility and other inpatient physical rehabilitation benefits, see "Physical Rehabilitation Services," below.)


***Physical Rehabilitation Services*** — Benefits are available for long-term rehabilitation in a skilled nursing facility or rehabilitation hospital. All inpatient services for physical rehabilitation purposes are limited to a maximum of **100 days per condition.** (Self-coordinated services are further limited to a maximum of **70 days per condition;** the additional 30 days are available only for PCP-coordinated services.)

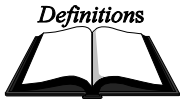
No inpatient hospital copayment or deductible will be taken for skilled nursing facility or other inpatient physical rehabilitation admissions.

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**


Benefits are **not** available for:

- maintenance therapy or care provided after the patient has reached his/her rehabilitative potential as determined by BCBSNM (see the "Long-Term and Maintenance Therapy" exclusion in *Section 5*)
- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay

## Outpatient Medical/Surgical Services

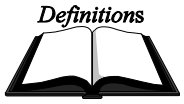



*Outpatient services* — Medical/surgical services received in the outpatient department of a hospital, emergency room, birthing center, ambulatory surgical facility, freestanding dialysis facility, or other covered outpatient treatment facility.

Coverage for outpatient ancillary services and related physician or other professional provider services for the treatment of illness, accidental injury, or a covered pregnancy depends on the type of service received (for example, see "Diagnostic Services") or on special circumstances (see "Emergency and Urgent Care").

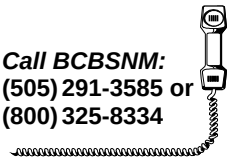
**See Section 5: General Limitations and Exclusions.**

# Kidney Dialysis




*Dialysis* — The treatment of an acute or chronic kidney ailment during which impurities are mechanically removed from the body with dialysis equipment.


*When received during a covered admission and billed as part of the facility service, dialysis is covered in the same manner as the room expenses and other ancillary services (see "Hospital/Other Facility Services").*




All of the following therapeutic services are covered when received in a dialysis facility or, when **prior approval** is received from BCBSNM, in the patient's home:

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

**See Section 5: General Limitations and Exclusions.**

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

# Maternity/Reproductive Services and Newborn Care

*Maternity services* — Services and supplies required for the diagnosis and care of a pregnancy, including complications of pregnancy, and for routine delivery services (including scheduled C-sections).

*Complications of pregnancy* include, but are not limited to:

- placenta abruptio and placenta previa; premature rupture of membranes; threatened abortion or threatened miscarriage when the pregnancy does not terminate; spontaneous termination of pregnancy
- acute exacerbations of heart condition and/or diabetes; nephritis or pyelitis of, or aggravated by, pregnancy (inflammation of the kidney and ureter occurring in pregnancy)
- hyperemesis gravidarum (pernicious vomiting related to pregnancy)
- severe toxemia, with or without seizures
- ectopic pregnancy


*See other subheadings in this* Section 4 *for services received during a covered pregnancy or by a newborn, such as "Diagnostic Services" or "Hospital/Other Facility Services."*

*For benefits for oral contraceptives, see "Prescription Drugs."*

## Family Planning

Covered family planning services are limited to:

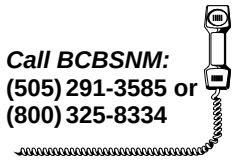
- injection of Depo-Provera for birth control purposes
- diaphragm, including fitting
- NORPLANT device, including surgical implantation and removal
- IUDs or cervical caps, including fitting, insertion, and removal
- surgical sterilization procedures such as vasectomies or tubal ligations


Benefits are **not** available for:

- reversal of a prior sterilization
- over-the-counter contraceptive products such as condoms and spermicide

## Infertility Services

The following infertility-related treatments are covered when **prior-approved** by BCBSNM (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 deficient, naturally occurring hormones **if** there is documented evidence of a deficiency of the hormone being replaced

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

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

Infertility **testing** is covered when **prior-approved** by BCBSNM but only to diagnose the cause of infertility. Once the cause has been established and the treatment determined to be noncovered, no further infertility testing is covered. For example, semen analysis, diagnostic laparoscopy, and hysterosalpingography are covered when the patient has a general complaint of infertility. Such tests are covered since, prior to testing, there is no reason to believe that the infertility is not caused by an organic dysfunction (such as a blocked fallopian tube). This plan will also cover testing related to one of the covered treatments listed above (such as lab tests to monitor hormone levels). However, daily ultrasounds to monitor ova maturation are **not** covered since, at this point, the cause of infertility is well established and the testing is being used to monitor a noncovered infertility treatment.


Benefits are **not** available for:

- surgical sterilization reversal for males or females
- 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, or embryo transfer; drugs for induced ovulation; or other artificial methods of conception
- Gamete Intrafallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT)
- cost of donor sperm
- infertility treatments and related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization

## Maternity Services


Under Family or Two-Party coverage, a covered dependent daughter also has coverage for maternity services. The newborn child of a dependent son or daughter does **not** qualify as a dependent under this plan. (See *Section 2* for instructions on adding dependents to coverage.)

Coverage for maternity services includes:

- hospital or other facility charges for semiprivate room expenses and ancillary services, including the use of labor, delivery, and recovery rooms (Coverage is available for all medically necessary hospitalization, including at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a C-section delivery.)
- pregnancy-related diagnostic tests
- routine or complicated delivery (including prenatal and postnatal medical care)

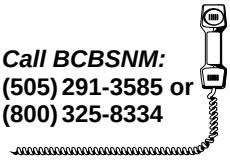
**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

- 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 as may be required by law
- services of a physician who actively assists the operating surgeon in performing a covered procedure when the procedure requires an assistant
- spontaneous, therapeutic, or elective termination of pregnancy prior to full term

Prenatal and postnatal care is included in the covered charge for the actual delivery or completion of pregnancy. If maternity coverage changes during a pregnancy, you receive the benefits in effect on the day the service is received.


Benefits are **not** available for:

- services of an assistant only because the hospital or other facility requires such services, or 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 BCBSNM as requiring the services of more than one assistant surgeon
- services of a physician who is on standby unless the procedure is identified by BCBSNM as requiring the services of a standby physician (*Standby* means a physician is available if services are needed.)
- genetic testing or counseling (e.g., tests or discussion of family history or test results to determine the sex or physical characteristics of an unborn child), unless such testing or counseling has received **prior approval** from BCBSNM and is 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 commonly increases risk (such as advanced maternal age or alcohol abuse)




***PCP-Coordinated Maternity Care*** — To receive PCP-coordinated benefits, the delivery and related services must be from a PCP or point-of-service women's health care provider. (A referral is not required if you choose a point-of-service women's health care provider to provide your maternity care. However, if a women's health care provider who is not also your PCP recommends the services of another specialist, your **PCP** must provide a referral for the services, or the women's health care provider must receive **prior approval** from BCBSNM to refer you directly. If an appropriate referral is not received for the services, you will receive the self-coordinated level of benefit for covered services.) The PCP or point-of-service women's health care provider must notify BCBSNM of any admissions.

The office visit to a PCP during which a pregnancy is confirmed is subject to the office visit copayment amount. There will be no additional copayments or coinsurance to pay for nonfacility services related to your pregnancy.

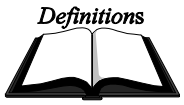
**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

Inpatient hospital delivery charges are subject to the hospital admission copayment and coinsurance indicated on your *Summary of Benefits and Copayments.*

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

***Self-Coordinated Maternity Care*** — If an admission for a pregnancy-related condition is not PCP-coordinated, you are responsible for notifying BCBSNM **within 48 hours** of the admission (or as soon as reasonably possible). If BCBSNM is not notified within this time period, benefits for covered facility services will be **reduced by $300.** (See "Medical/Surgical Admission Review and Other Prior Approvals" in *Section 3*.)

## Newborn Care



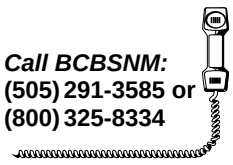

*Routine newborn care* — Care of a healthy child immediately following his/her birth that includes:

- routine hospital nursery services
- routine medical care in the hospital after delivery
- pediatrician standby care at a cesarean section procedure
- services related to circumcision of a male newborn


*Please refer to "Adding Dependent Children" in* Section 2 *for details on newborn coverage.*

If you have coverage for your newborn child, his/her initial routine newborn care is covered. No additional hospital copayment is required if the newborn is discharged on the same day as the mother. Except for this initial routine nursery care for the newborn, any benefits for the baby are subject to the baby's own copayments, deductibles, coinsurance, and out-of-pocket limits.

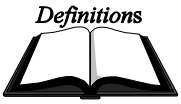
***Nonroutine Newborn Care: PCP-Coordinated Extended Stay*** — An eligible newborn is also covered for nonroutine medical or surgical services. To receive PCP-coordinated benefits for an extended stay, the newborn's pediatrician must be a point-of-service PCP (the PCP is responsible for notifying BCBSNM of the extended stay). Copayment amounts are based on the type of service received. For example, if surgery is required, see "Surgical Services and Other Procedures" for more information. An additional hospital copayment **is** required if the newborn remains in the hospital longer than his/her mother.




***Nonroutine Newborn Care: Self-Coordinated Extended Stay*** — If your eligible newborn stays in the hospital longer than the mother for nonroutine medical or surgical services, and the newborn's pediatrician is not a point-of-service PCP, you are responsible for ensuring that BCBSNM is called **before** the mother is discharged from the hospital, or benefits for the newborn's covered facility services will be **reduced by $300.**

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

# Physician Visits/Medical Care




*General condition* — A disease, illness, or other condition not related to mental illness, alcoholism, or drug abuse.

*Medical care* — Nonsurgical services provided for the diagnosis and treatment of illness, injury, and other general conditions.


*For the treatment of chemical dependency or mental illness, see* Section 10.

*For care received in an emergency room or urgent care center, see "Emergency and Urgent Care."*

*For visits related to home health or hospice care, see "Home Health Care/Home I.V. Services" or "Hospice Care."*

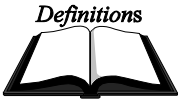
*For maternity-related and other reproductive services such as family planning services, see "Maternity/ Reproductive Services and Newborn Care."*

*For routine physicals, immunizations, and related testing, see "Preventive Services."*

*For outpatient/office acupuncture, chiropractic services, cardiac and pulmonary rehabilitation, and physical, occupational, and speech therapy, see "Short-Term Rehabilitation, Outpatient and Office Services." For inpatient physical rehabilitation services, see "Hospital/Other Facility Services" for important limitations.*

Benefits are available for medical care for general conditions if necessary for the treatment of an illness, disease, or injury. **Your choice of a PCP or other point-of-service provider, or an in-network or out-of-network provider, can make a difference in the amount you pay.** (See *Section 3*.)

## Home and Office Visits and Consultations




*Gynecology-related services* — Services related to the treatment of the female reproductive system. Such services do **not** include services for the treatment of other body systems, such as the urinary tract, the abdomen (for instance, pain of unknown origin), or the breast.

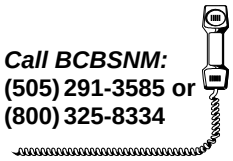

*For routine gynecology services, see "Preventive Services."*

Benefits are available for medical care for general conditions if necessary for the treatment of an illness, disease, or injury. Covered services include:

- office and home visits and examinations — when not related to hospice care or payable as part of a surgical procedure (see “Hospice Care” and “Surgical Services and Other Procedures”)
- consultations and second or third surgical opinions
- FDA-approved therapeutic injections administered in a provider’s office (Some injectable drugs are specifically limited in coverage by BCBSNM medical policy; see “Injectable Drugs,” on the next page.)
- audiometric (hearing) and vision tests required for the diagnosis and/or treatment of an accidental injury or an illness

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

***Allergy Care*** — Benefits are available for direct skin (percutaneous and intradermal) and patch allergy tests and RAST (radioallergosorbent testing), including appropriate FDA-approved serum and allergy injections administered in a provider's office or in a facility. (For PCP-coordinated services, there is no copayment for allergy injections.)

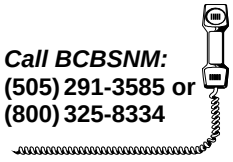



***Diabetic Services*** — If you have diabetes or elevated blood glucose due to pregnancy, diabetes self-management training provided by a certified, registered, or licensed health care professional with recent education in diabetes management is covered when **prior-approved** by BCBSNM. Covered services 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

***Gynecology-Related Services*** — You are not required to obtain a PCP referral for the services of a point-of-service women's health care provider **if** the services are for a well-woman exam or are maternity- or gynecology-related. The PCP-coordinated level of benefits will be available for covered services in such cases. However, if a women's health care provider (who is not also your PCP) recommends the services of another specialist, your **PCP** must provide a referral for the services, or the women's health care provider must receive **prior approval** from BCBSNM to refer you directly. If an appropriate referral is not received for the services, you will receive the self-coordinated level of benefit for covered services.

**If you visit a women's health care provider for primary care services (e.g., cold or flu symptoms, or abdominal pain), and the provider is not your PCP, you will receive the self-coordinated level of benefits for covered services if no referral was obtained from your PCP.**




***Injectable Drugs*** — Certain injectable drugs (such as growth hormone and interferon alfa-2) are covered only when **prior approval** is received from BCBSNM. Your point-of-service provider has a list of those injectable drugs that require prior approval. If you would like a copy of the list, contact a BCBSNM Health Services representative.

BCBSNM reserves the right to exclude any injectable drug currently being used by a member that is not specifically listed as covered. Proposed new uses for injectable drugs previously approved by the FDA will be evaluated on a medication-by-medication basis. Call a BCBSNM Health Services representative if you have any questions about this policy.

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

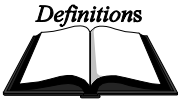
## Inpatient Physician Medical Visits

With the exception of dental-related services (see "Dental-Related Services"), the following services when required for a general condition and received on a covered inpatient hospital day are also covered and, when PCP-coordinated, are **not** subject to a copayment:

- visits that are not related to hospice care (see "Hospice Care") and that are for a condition requiring **only** medical 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 benefits for the surgeon's services, see "Surgical Services and Other Procedures.")
- medical care requiring two or more physicians at the same time because of multiple illnesses
- medical care for an eligible newborn (Also see "Maternity/Reproductive Services and Newborn Care.")

**See Section 5: General Limitations and Exclusions.**

# ■ Prescription Drugs




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

*Drug formulary* — A list of prescription drugs that is approved for use by BCBSNM. Benefits are available for drugs listed in the BCBSNM formulary at a lower copayment amount than are drugs that are not listed on the BCBSNM formulary (called "nonformulary"). The formulary is subject to periodic review and change by BCBSNM. BCBSNM-contracted providers should have a received a copy of the formulary. If you need a copy, request it from a BCBSNM Customer Service representative.

*Generic drug* — The chemical equivalent of a brand-name prescription drug. According to United States Food and Drug Administration (FDA) regulations, brand-name and generic drugs must meet the same standards for safety, purity, strength, and quality. A generic drug is usually available from multiple sources and is not protected by a patent.

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

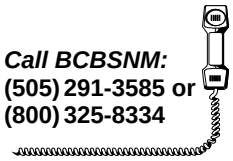
*Participating pharmacy* — A retail supplier that has contracted with BCBSNM or its authorized representative to dispense prescription drugs and medicines to plan members, and that has contractually accepted the terms and conditions as set forth by BCBSNM and/or its authorized representative.

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

*Prescription drugs and medicines* — Those that are taken at the direction and under the supervision of a provider and require a prescription before being dispensed. All drugs and medicines must be approved by the FDA, and must not be "experimental or investigative" (see "Experimental or Investigative Services" in *Section 5*).

The following prescription drugs (including insulin) are covered only when dispensed by a participating pharmacy or ordered through the Mail Service Program (unless required as the result of an emergency, as defined in "Emergency and Urgent Care"):

- prescription drugs (including compounded medications of which at least one ingredient is a prescription drug and oral contraceptives), unless listed as an exclusion
- self-administered injectable insulin, glucagon, Imitrex, and anaphylactic kits (These are the only injectable medications covered unless **prior approval** is received from BCBSNM.)
- insulin needles, syringes, and supplies (e.g., lancets and test strips) (There is a separate copayment for each item purchased.)




Prescription refills in excess of the number specified by the physician and those requested more than one year following the physician's original order date cannot be refilled. Call BCBSNM for instructions on obtaining a greater supply if you are leaving home for more than a 30-day period of time.

***Member Copayments and Other Costs*** — You do not pay a deductible or coinsurance amounts for prescription drugs. You pay a copayment (explained below) for each prescription filled.

Copayments are **not** included in any out-of-pocket limit, and are not eligible for reimbursement once an out-of-pocket limit is reached.

**Brand-Name vs. Generic Drug Costs:** Many brand-name drugs have generic equivalents. When a generic equivalent is available, the benefit for a prescription drug is limited to the cost of the generic equivalent, less the applicable copayment. Therefore, if you or the provider requests the brand-name drug when there is an FDA-approved generic equivalent available, **you must pay the difference in cost between the brand-name and the generic equivalent,** plus the applicable formulary or nonformulary copayment:

- **Formulary drug copayments:** The copayment for a brand-name formulary drug is higher than the copayment for a generic formulary drug (see the *Summary of Benefits and Copayments* for copayment amounts). In addition, if you or your provider requests a brand-name formulary drug that has a generic equivalent, you will be required to

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

pay the generic copayment plus the difference in cost between the brand-name and the generic drug.

- **Nonformulary drug copayment:** The copayment is the same for a nonformulary drug regardless of whether or not it is a brand-name drug or a generic drug (see the *Summary of Benefits and Copayments* for the copayment amount). However, if you or your provider requests a brand-name nonformulary drug that has a generic equivalent, you must also pay the difference in cost between the brand-name drug and the generic drug.

**Note:** If the retail price of a prescription drug is less than the required copayment, you pay the actual retail price.


***Supply Limitations*** — For the copayments listed on your *Summary of Benefits and Copayments* under "Prescription Drugs," you can obtain the following supply of a single prescription drug:

1. Until 11/1/99: Under either the Retail Pharmacy Program or the Managed Prescription Mail Service, for drugs produced in commercial package sizes (such as inhalers, tubes of ointments, or blister packs of tablets or capsules) you must pay one applicable copayment (formulary vs. nonformulary, generic vs. brand-name) per package, regardless of the days' supply the package represents. (Effective 11/1/99, disregard this item 1 and apply items 2 and 3, below, to all drugs.)
2. For other drugs purchased under the Retail Pharmacy Program, you can obtain a maximum of a **30-day** supply. For oral contraceptives, the supply is limited to one menstrual cycle (normally 28 days).
3. For other drugs purchased under the Managed Prescription Mail Service, you can obtain a maximum of a **90-day** supply. Your copayment amount for each **30-day** mail-order supply of a prescription drug is the same as the copayment for a 30-day supply dispensed by a participating retail pharmacy. (The copayment for a **31-day to a 90-day** supply is only two times the copayment required for a 30-day supply.)

***Retail Pharmacy Program*** — Prescriptions must be purchased from a participating retail pharmacy. (Refer to your directory of participating pharmacies or call BCBSNM Customer Service for a list of participating pharmacies.) **You must present your plan ID card to the pharmacist at the time of purchase to receive this benefit.** You can use your ID card to purchase prescription drugs only for yourself and covered family members.

If you do not have your ID card with you or if you purchase your prescription from a nonparticipating provider in an **emergency,** you must pay for the prescription in full and then submit the claim directly to BCBSNM's prescription drug plan administrator (see "Filing Claims" in *Section 7*).

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

The reimbursement for these prescription drug claims is 100 percent of the charge for the generic drug (or if a brand-name drug does not have a generic equivalent, for the brand-name drug) minus the copayment amount. (If the reimbursement price is the same as or less than the copayment amount required, there is no payment to you.)

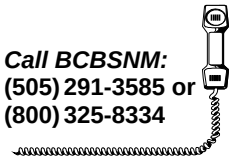
***Managed Prescription Mail Service*** — Except for supply limitations, prescription drugs, including insulin, that are covered under the Managed Prescription Mail Service are subject to the same limitations and exclusions that apply to the Retail Pharmacy Program.

To use the Managed Prescription Mail Service, follow the instructions outlined in the materials provided to you in your enrollment packet.

**Note:** Prescription drugs may **not** be mailed outside the United States. If you are leaving the country and need an extended supply of medication, call BCBSNM Health Services at least **two weeks** before you intend to leave. (If you require more than a 90-day supply, you may be asked to provide proof of continued enrollment eligibility.)


***Exclusions*** — Benefits are **not** available for:

- nonprescription and over-the-counter drugs, including herbal or homeopathic preparations, and prescription drugs that have over-the-counter bioequivalents — unless specifically **prior-approved** by BCBSNM (Bioequivalents have the same strength and cause similar action on bodily tissues.)
- unless **prior-approved** by BCBSNM, refills before the normal period of use has expired, including replacement of drugs that have been lost, stolen, destroyed, or misplaced
- prescriptions purchased from a nonparticipating pharmacy or other provider unless eligible for benefits in an emergency situation
- infertility medications; Nicorette, nicotine patches, or any other drug containing nicotine or other smoking deterrent medications; appetite suppressants or diet aids
- prescription drugs approved by the FDA for, or otherwise intended for, the treatment of sexual or erectile dysfunction
- therapeutic devices or appliances, including support garments and other nonmedicinal substances (regardless of intended use), insulin pump supplies (see “Supplies, Equipment, and Prosthetics” for benefit information), or birth control devices (see “Maternity/Reproductive Services and Newborn Care: Family Planning”)
- medications or preparations used for cosmetic purposes (such as preparations to promote hair growth or medicated cosmetics); tretinoin (sold under such brand names as Retin-A) for cosmetic purposes
- delivery charges

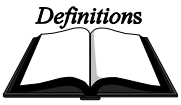



**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

- charges for the administration or injection of any drug, including allergens or allergy shots (For coverage information, see "Physician Visits/Medical Care.")
- prescription refills in excess of the number specified by the physician and those requested more than one year following the physician's original order date (Call BCBSNM for instructions on obtaining a greater supply if you are leaving home for more than a 30-day period of time.)

**See Section 5: General Limitations and Exclusions.**

# Preventive Services




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

*Well-child care* — Periodic health and developmental assessments and screenings, immunizations, and physical exams provided to children who have no symptoms of current illness, and as recommended by the American Academy of Pediatrics, the State of New Mexico, and the U.S. Preventive Services Task Force.


*For maternity-related and family planning services, see "Maternity/Reproductive Services and Newborn Care."*

The services listed in this section are covered, subject to the copayment or deductible and coinsurance provisions specified on the *Summary of Benefits and Copayments*. **Adult preventive services are covered only when PCP-coordinated;** most services for children (through age 18) are covered when either self-coordinated or PCP-coordinated.

**Claims filed under this provision must clearly show that the office visit and tests were for routine or preventive care.**


## Adult Preventive Services

Routine physical examinations and associated testing are covered when **PCP-coordinated only** (see exception for annual gynecological exam, Pap test, and mammogram under "Self-Coordinated Services," on the next page) and include the following services:

- routine physical, breast, and pelvic examinations
- routine immunizations in accordance with the State of New Mexico and the U.S. Preventive Services Task Force

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

- low-dose mammography screenings based on medically accepted standards
- an annual routine gynecological examination and Pap tests in accordance with national medical standards (You may go directly to any point-of-service contracted women's health care provider for an annual routine gynecological examination and Pap test **without** a referral and receive the PCP-coordinated level of benefits.)
- periodic tests to determine blood hemoglobin, blood pressure, blood glucose level
- periodic blood cholesterol level tests, or periodic fractionated cholesterol level including a low-density lipoprotein (LDL) and a high-density lipoprotein (HDL) level in accordance with recommendations of the U.S. Preventive Services Task Force
- periodic stool examination for the presence of blood for members age 40 or older in accordance with recommendations of the U.S. Preventive Services Task Force
- periodic glaucoma eye tests for members age 35 or older in accordance with recommendations of the U.S. Preventive Services Task Force
- periodic left-sided colon examinations of 35 to 60 centimeters for members age 45 or older in accordance with recommendations of the U.S. Preventive Services Task Force

***PCP-Coordinated Services*** — When performed in the physician's office, physical examinations are subject to an office visit copayment. There is no additional copayment or coinsurance for immunizations or routine testing or screening. **There is no benefit maximum for PCP-coordinated preventive services.**


***Self-Coordinated Services*** — Generally, there are **no benefits** for self-coordinated adult preventive services. However, you may self-coordinate a routine **annual gynecological exam, mammogram,** and/or **Pap test** and charges will be subject to the self-coordinated deductible and coinsurance amount. (You will receive the PCP-coordinated level of benefits when such services are self-coordinated to a point-of-service women's health care provider.)

## Child Preventive Services

Routine physical examinations and associated testing are covered and include the following services:


- well-child care as recommended by the American Academy of Pediatrics
- routine immunizations in accordance with the American Academy of Pediatrics
- routine physical examinations
- routine vision screenings to detect the need for visual correction for members through age 18 but **only if PCP-coordinated**
- routine hearing screenings to detect the need for hearing correction for members through age 18 but **only if PCP-coordinated**

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

***PCP-Coordinated Services*** — When performed in the physician's office, physical examinations are subject to an office visit copayment (there is no copayment for well-baby and well-child visits for children up to age six). There is no additional copayment or coinsurance for immunizations or routine testing or screening. **There is no benefit maximum for PCP-coordinated preventive services.**

***Self-Coordinated Services*** — Benefits are available for self-coordinated preventive services for children through age 18 and are not subject to the annual deductible. **There is no benefit maximum** for physical exams, immunizations, and routine tests.

## Health Education and Counseling

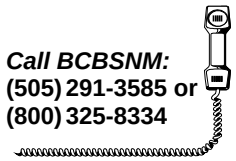

Health education and health counseling services are covered if recommended by your PCP and include an annual consultation with a professional provider to discuss lifestyle behaviors that promote health and well-being. Health education and counseling services that are not provided directly by your PCP must receive **prior approval** from BCBSNM in order to be covered. Medically necessary diabetes self-management education programs are covered if **prior approval** for such services is received from BCBSNM.


## Exclusions

Benefits are **not** available for:

- employment physicals, insurance examinations, or examinations at the request of a third party (the requesting party may be responsible for payment); premarital examinations; sports, camp, or school physicals; examinations or immunizations given primarily for licensing, weight reduction programs, or medical research programs; any other nonpreventive physical examination
- immunizations or medications required for international travel or work
- hepatitis B immunizations when required due to possible exposure during the member's work
- routine hearing or eye examinations, hearing aids, or any related service or supply; eye refractions; hearing or visual screening for members age 19 and over

**See Section 5: General Limitations and Exclusions.**




# Private Duty Nursing

Private duty professional nursing by a registered graduate nurse or a Licensed Vocational Nurse is covered when **prior-approved** by BCBSNM. To be covered, the care must be furnished while:

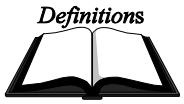
**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

- intensive nursing care is required in the treatment of an acute sickness or injury
- the patient is not in either a hospital or any other health care institution that provides nursing care

Self-coordinated services are limited for each member to the amount specified on the *Summary of Benefits and Copayments*. There is no maximum benefit for PCP-coordinated private duty nursing services.

**See Section 5: General Limitations and Exclusions.**

## Short-Term Rehabilitation, Outpatient and Office Services




*Acupuncture* — The use of needles inserted into the human 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.

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

*Chiropractic office services* — Any service or supply administered by a chiropractor.

*Home-based services* — Physical rehabilitation services received in the home but not connected to a formal home health or hospice care treatment plan. (When related to home health or hospice care, benefits are based on the "Home Health Care/Home I.V. Services" or "Hospice Care" provisions of this plan, as applicable.)

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

*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.

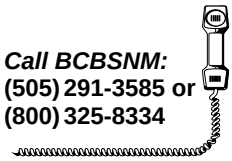
*Pulmonary rehabilitation* — An individualized, supervised physical conditioning program. Occupational therapists teach patients how to pace themselves, conserve energy, and simplify tasks. Respiratory therapists train patients in bronchial hygiene, proper use of inhalers, and proper breathing.

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

*Short-term rehabilitation* — A broad term used to describe acupuncture, chiropractic, cardiac and pulmonary rehabilitation, and occupational, physical, and speech therapy techniques that are medically necessary to restore and improve lost bodily functions following illness or injury. Physical rehabilitation does not include chemical dependency rehabilitation.

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


*For additional definitions, limitations, and exclusions related to outpatient hospital/facility services, and for inpatient physical rehabilitation benefits, see "Hospital/Other Facility Services."*




To be covered, all outpatient, office, and home-based short-term rehabilitation treatments must receive **prior approval** from BCBSNM. Short-term rehabilitation required due to reinjury or aggravation of an injury is also covered but must receive a separate **prior approval** from BCBSNM, even if therapy was authorized for the original injury.


Coverage is available for outpatient, office, and home-based treatments not to exceed the number of days specified on the *Summary of Benefits and Copayments* (with a limit of three modalities per day) per member per condition. The maximum benefit includes both PCP-coordinated (Tier 1) and self-coordinated (Tier 2) services combined. The services must be received within two months from the date that short-term rehabilitation begins. (This two-month period may be extended if prior-approved by BCBSNM; however, an extension of the two-month period does not increase the number of days allowed for a particular condition.)

All of the following short-term rehabilitation services are covered when medically necessary for the treatment of accidental injury or illness:

- occupational therapy performed by a licensed occupational therapist
- physical therapy performed by a physician or licensed physical therapist
- speech therapy, including audio diagnostic testing, performed by a properly accredited speech therapist
- pulmonary rehabilitation
- cardiac rehabilitation programs received within **six months** of the cardiac incident
- office services provided by a licensed chiropractor or doctor of oriental medicine who acts within the scope of licensure and according to the standards of acupuncture or chiropractic medicine

To be eligible for benefits, therapies must meet the following conditions:

- There is a documented condition or delay in recovery that can be expected to improve with therapy within two months of the initial treatment.
- Improvement would not normally be expected to occur without intervention.

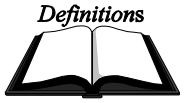
**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**


Benefits are **not** available for:

- maintenance therapy or care provided after the patient has reached his/her rehabilitative potential as determined by BCBSNM (See the "Long-Term and Maintenance Therapy" exclusion in *Section 5*.)
- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay
- any diagnostic, therapeutic, rehabilitative, or health maintenance service provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered provider
- any 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; 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; or stuttering
- long-term therapies (Therapies are considered long-term if significant improvement is not possible within a two-month period. See "Hospital/Other Facility Services" for long-term inpatient rehabilitation benefits.)

**See Section 5: General Limitations and Exclusions.**

## Supplies, Equipment, and Prosthetics




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

*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.

*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.

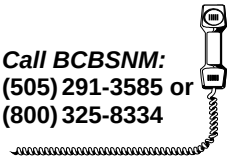
*Orthopedic appliance* — An individualized rigid or semirigid support that eliminates, restricts, or supports motion of a weak, injured, deformed, or diseased body part; for example, functional hand or leg brace, Milwaukee brace, or fracture brace.

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


*For contraceptive devices, see "Maternity/Reproductive Services and Newborn Care: Family Planning."*

*For supplies or equipment used during an inpatient or outpatient stay, see "Hospital/Other Facility Services." (Supplies or equipment that are dispensed by a facility for use outside of the facility are subject to the provisions of this "Supplies, Equipment, and Prosthetics" section.)*

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**



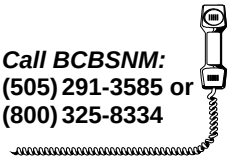

In addition to the prior approval requirements for specific items listed in this section, **prior approval** from BCBSNM is required for long-term rental of an item, and when total charges for either the rental or purchase of an item is equal to or greater than **$500.** (*Total charges* means either the total purchase price of the item or total rental charges for the estimated period of use.)

If you have a question about durable medical equipment, supplies, prosthetics, or appliances not listed in this section, please call the BCBSNM Health Services Department.

***Diabetic Supplies and Equipment*** — The following supplies are covered for diabetic members and individuals with elevated blood glucose levels due to pregnancy, not to exceed a **30-day supply** purchased during any 30-day period:

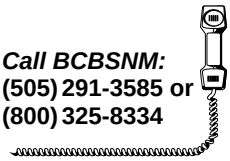
- autolet, lancets, and lancet devices; syringes and needles
- blood glucose and visual reading urine and ketone test strips
- injection aids, including those adaptable to meet the needs of the legally blind; insulin pump supplies

The following equipment is also covered for diabetic members and individuals with elevated blood glucose levels due to pregnancy:




- insulin pumps if **prior approval** is received from BCBSNM
- 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
- glucagon emergency kits
- blood glucose monitors, including those for the legally blind

***Durable Medical Equipment, Appliances, and Supplies*** — When medically necessary and ordered by a provider, benefits are available for the following items:




- medical supplies and durable medical equipment owned by the facility and used during a covered admission or during a covered office or outpatient visit
- orthopedic appliances which have received **prior approval** from BCBSNM
- oxygen and oxygen equipment, wheelchairs, hospital beds, crutches, and other necessary medical equipment
- lenses 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, or prescribed by a physician as the only method of treatment available for the treatment of keratoconus (Further replacement is covered only if a physician or optometrist recommends a change in prescription.)

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

- cardiac pacemakers
- the rental of (or at the option of BCBSNM, the purchase of) durable medical equipment, including repairs, when prescribed by a covered health care provider and required for therapeutic use

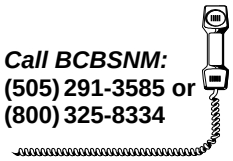
***Medical Supplies*** — The following medical supplies are covered, not to exceed a **30-day supply** purchased during any 30-day period:

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


***Orthotics*** — Benefits are available for 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 and is covered only when **PCP-coordinated** and prescribed by a physician or podiatrist. **In order to be covered, prior approval must be received from BCBSNM.**


Benefits are **not** available for accommodative orthotics, which are used to deal with structural abnormalities of the foot, accommodate such abnormalities, and provide comfort, though not altering function. (See "Diabetic Supplies" for more information about orthotics and other items available to diabetic members.)

***Prosthetic Devices*** — When medically necessary and ordered by a provider, benefits are available for the following items:




- surgically implanted prosthetics or devices, including penile implants required as a result of illness or injury, if **prior approval** for such items is received from BCBSNM
- 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, equipment, or appliances 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 least costly prosthetic device available.

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

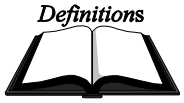

***Supplies, Equipment, and Prosthetics Exclusions*** — Benefits are **not** available for, regardless of therapeutic value, items such as, but not limited to:

- air conditioners, biofeedback equipment, exercise equipment, humidifiers, purifiers, self-help devices, or whirlpools
- equipment that is primarily nonmedical in nature such as waterbeds, Jacuzzi units, hot tubs, exercise equipment, heating pads, hot water bottles, or diapers
- nonstandard or deluxe equipment, such as motor-driven wheelchairs, chairlifts, or beds; external prosthetics that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing
- repairs to equipment or prosthetics that are not owned by the member
- comfort items such as bedboards, hospital beds or mattresses, flotation mattresses, bathtub lifts, overbed tables, adjustable beds, telephone arms
- cost of repairs that exceeds the rental price of another unit for the estimated period of need or that exceeds the purchase price of a new unit
- dental appliances (see “Dental-Related Services” for exceptions)
- accommodative orthotics
- orthopedic shoes, unless joined to braces (Diabetic members may be eligible to receive benefits for these items when prescribed by a physician or podiatrist; call BCBSNM Health Services for details.)
- medical equipment such as sphygmomanometers, stethoscopes, and blood pressure monitors
- medical equipment or supplies not ordered by a health care provider, including items used for comfort, convenience, or personal hygiene
- duplicate equipment or repairs to duplicate equipment; the replacement of medical equipment, prosthetics, or orthopedic appliances if required due to loss, theft, or destruction
- voice synthesizers or other communication devices
- eyeglasses or contact lenses and the costs related to prescribing or fitting of glasses or lenses, unless specified as covered above; sunglasses, special tints, and other extra features for eyeglasses or contact lenses
- hearing aids and ear molds, fitting of hearing aids or ear molds, related services, and supplies (For surgically implanted devices for the profoundly hearing impaired, see “Surgical Services and Other Procedures.”)
- orthopedic appliances and medical supplies that can be purchased over-the-counter, including but not limited to dressings for bed sores and burns, gauze, and bandages
- items not specifically listed as covered

**See Section 5: General Limitations and Exclusions.**

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

# Surgical Services and Other Procedures




*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, and pre- and post-operative care, including recasting.

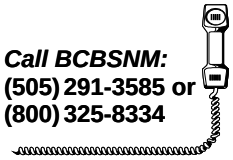
*Outpatient surgery* — Any surgical service that is performed in an ambulatory surgical facility or the outpatient department of a hospital, but **not** including a procedure performed in an office or clinic. Outpatient surgery includes any procedure that requires the use of an ambulatory surgical facility or an outpatient hospital operating or recovery room.


*For accidental injuries to the jaws, mouth, or teeth, or for the treatment of TMJ disorders or injuries, see "Dental-Related Services."*

*For services related to an organ transplant, also see "Transplant Services."*

*If you undergo a surgical procedure in a hospital (inpatient or outpatient) or other facility, see "Hospital/Other Facility Services" for more information.*

*For pregnancy-related services, including surgical sterilization procedures, also see "Maternity/Reproductive Services and Newborn Care."*




**When self-coordinating care, or if a non-point-of-service provider recommends surgery, you are responsible for obtaining admission review and/or other prior approval when necessary (see *Section 3*).**

## Surgeon's Services

Covered surgical services include surgeon's charges for a covered surgical procedure:


***Cochlear Implants*** — Benefits are available for cochlear implantation of a hearing device (such as an electromagnetic bone conductor) to facilitate communication for the profoundly hearing impaired, including any necessary training required to use the device. (You must submit a **written request for prior approval** to BCBSNM before treatment begins; benefits are **not** available without prior approval.)

***Mastectomy Services*** — Benefits are available for all medically necessary hospitalization related to a covered mastectomy including at least

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

48 hours of inpatient care following a mastectomy and 24 hours following a lymph node dissection.

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

Cosmetic breast reconstruction, including surgery on the other breast to produce a symmetrical appearance, when **prior-approved** by BCBSNM, is covered, but limited to the initial surgical procedure to re-establish symmetry between breasts following a mastectomy that occurred no more than **12 months** prior to the breast reconstruction (unless a later reconstruction is approved as medically appropriate by BCBSNM). Benefits also include **prior-approved** prostheses; treatment of physical complications following the mastectomy, including lymphedemas; and for the **initial** nipple reconstruction/tattooing procedure related to a covered breast reconstruction. (Additional procedures to correct unsatisfactory cosmetic results are **not** covered.)

**Limitations and Exclusions**

Benefits are **not** available for:

- subsequent cosmetic procedures to establish symmetry between a remaining breast and a prosthesis
- the reconstruction of a cosmetically unsatisfactory nipple reconstruction or tattooing
- breast reconstruction that has not received prior approval from BCBSNM

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

- external or intraoral cutting and draining of cellulitis (not including treatment of dental-related abscesses)
- incision of accessory sinuses, salivary glands, or ducts
- lingual frenectomy
- surgical correction of prognathism with handicapping malocclusion (a marked projection of the lower jaw that interferes with chewing) if **prior approval** for the service is received from BCBSNM
- removal or biopsy of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of mouth when pathological examination is required

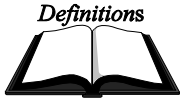
*Call BCBSNM:*
**(505) 291-3585 or**
**(800) 325-8334**

**Limitations and Exclusions**

Benefits are **not** available for oral or dental procedures not specifically listed as covered such as, but not limited to:

- removal of impacted teeth
- dental services required as the result of a covered medical or surgical procedure (e.g., chemotherapy or radiation therapy)
- removal of tori or exostoses
- any dental or oral surgical procedures involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for fitting or the continued use of dentures

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**




***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. Reconstructive surgery is covered when it is required to correct a **functional** disorder caused by one of the following conditions:

- an accidental injury
- a disease process or its treatment (For cosmetic services required as a result of a mastectomy, see "Mastectomy Services," on the previous page.)
- 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)


Further, you or your physician must obtain **prior approval, requested in writing,** from BCBSNM **before** the reconstructive service is provided. **Reconstructive surgery provided without prior approval is not covered.** (Cosmetic procedures and procedures that are not medically necessary will also be **denied.**)

Self-coordinated inpatient reconstructive procedures are also subject to admission review requirements; if admission review approval is not obtained in such cases and the procedure is covered, benefits for the facility's covered charges will be **reduced by $300.**


***Surgical Services Exclusions*** — Benefits are **not** available for the following procedures or services related to such procedures:

- reconstructive procedures that have not received prior approval from BCBSNM
- breast reductions
- cosmetic or plastic surgery or procedures, such as breast augmentations, rhinoplasties, surgical alteration of the eye, orthognathic jaw surgery, and surgical correction of prognathism, that BCBSNM determines are not required to materially improve the physiological function of an organ or body part — unless covered under "Mastectomy Services"
- reconstruction of surgically induced scars or the reconstruction of a cosmetically unsatisfactory nipple reconstruction or tattooing
- obesity treatment, including the surgical treatment of morbid obesity
- refractive keratoplasty, including radial keratotomy, or any procedure to correct visual refractive defect
- removal of corns, bunions (except surgical treatment such as capsular or bone surgery), or calluses, or trimming of toenails
- sex change operations or complications arising from transsexual surgery
- subsequent surgical procedures to correct further injury or illness resulting from the member's noncompliance with prescribed medical treatment or to care for or correct a complication due to a previous

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

noncovered procedure (such as a noncovered organ transplant, sex change operation, or previous cosmetic surgery)
- the insertion of artificial organs, or services related to transplants not specifically listed as covered under "Transplant Services"
- standby services, unless the procedure is identified by BCBSNM as requiring the services of a standby physician (*Standby* means a physician is available if services are needed.)

## Anesthesia Services

Covered services include necessary anesthesia services administered by a physician or certified registered nurse anesthetist (CRNA) during a covered surgical procedure. Anesthesia includes acupuncture used as an anesthetic during a covered surgical procedure and administered by a physician, a licensed doctor of oriental medicine, or as required by law.


Benefits are **not** available for local anesthesia. (Coverage for surgical procedures includes an allowance for local anesthesia because it is considered a routine part of the surgical procedure.)

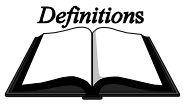
## Assistant Surgeon Services

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.


Benefits are **not** available for:
- 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 BCBSNM as requiring the services of more than one assistant surgeon

**See Section 5: General Limitations and Exclusions.**

# ■ Therapies: Chemotherapy and Radiation

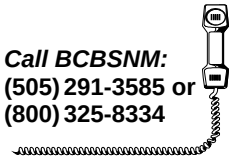



*Chemotherapy* — Drug therapy administered as treatment for malignant conditions and diseases of certain body systems.

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

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

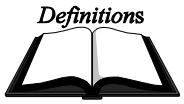

*When received during a covered admission and billed as part of the facility service, therapy charges are covered in the same manner as the room expenses and other ancillary services (see "Hospital/Other Facility Services").*




Treatment of disease by standard chemotherapy and/or radiation therapy is covered when performed in the outpatient department of a hospital, freestanding treatment facility or clinic, or provider's office. **High-dose chemotherapy treatments must receive prior approval from BCBSNM in order to be covered.**

**See Section 5: General Limitations and Exclusions.**

## Transplant Services




*Transplant* — A surgical process that involves the removal of an organ from one person and placement of the organ into another. Transplant can also mean removal of organs or tissue from a person for the purpose of treatment and reimplanting the removed organ or tissue into the same person.

*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.


*Covered cardiac surgeries, such as valve replacements and pacemaker insertions, are covered under "Surgical Services and Other Procedures."*

*Also see specific subheadings in this* Section 4 *for additional benefits and limitations, such as "Hospital/Other Facility Services."*


**Prior approval,** requested **in writing,** must be obtained from BCBSNM **before** a pretransplant evaluation is scheduled. A case manager will be assigned to the member (transplant recipient) and must later be contacted with the results of the evaluation. A pretransplant evaluation is **not** covered if prior approval to receive the service is not obtained from BCBSNM.

If the member is a transplant recipient candidate, he/she must ensure that **prior approval** for the actual transplant is received from BCBSNM. None of the benefits described here are available unless the member has this prior approval.

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

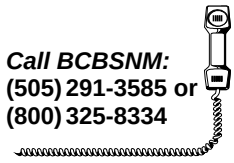
***Facility Must be Approved by BCBSNM*** — Coverage is available only when the transplant is performed at a facility with a transplant program approved by BCBSNM (or, in the case of a member with primary Medicare coverage, in a Medicare-certified transplant facility). The case manager will work with the member's provider to determine the most appropriate facility for the procedure. Call the BCBSNM Health Services Department for information on BCBSNM-approved programs.

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

***Organ Procurement or Donor Expenses*** — Organ acquisition or procurement costs for the surgical removal, storage, and transportation of an organ acquired from a cadaver are covered. If there is a living donor that requires surgery to make an organ available (e.g., kidney or liver), coverage is available only for expenses incurred by the donor for travel (if covered under the "Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney" provision, and required and approved by the case manager), surgery, organ storage expenses, and initial inpatient follow-up care.

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 actual donor selected. No coverage is available for donor expenses after the donor has been discharged from the transplant facility.

## Bone Marrow, Cornea, Kidney, and Specified Liver




The following transplant procedures are covered if **prior approval** is received from BCBSNM. Usual plan cost-sharing features apply to covered services (see the *Summary of Benefits and Copayments* for benefit details):

- bone marrow transplant for a member with aplastic anemia, leukemia, severe combined immunodeficiency disease (SCID), or Wiskott-Aldrich syndrome, and other conditions determined by BCBSNM to be medically necessary and nonexperimental/noninvestigational
- cornea transplant
- kidney transplant
- liver transplant for members under age 18 who have biliary atresia or other end-stage liver disease

Services received under this provision of the plan are subject to and applied to other benefit limitations of your plan (e.g., PCP-coordinated copayments and coinsurance; self-coordinated copayments, deductible, coinsurance, and out-of-pocket limits; annual home health care maximums; short-term rehabilitation limits). See the *Summary of Benefits and Copayments* for these benefit limitations and maximums.

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**


## Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney

**Prior-approved** transplants of the **heart, heart-lung, liver, lung, or pancreas-kidney** are also covered. In addition to the general provisions of this "Transplant Services" section, the following benefits, limitations, and exclusions apply to services covered under this "Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney" transplant provision:


***Recipient Travel, Food, and Lodging Expenses*** — If BCBSNM requires the transplant recipient to temporarily relocate outside of his/her city of residence to receive a covered transplant, coverage is available for travel to the city where the transplant will be performed. Also, a standard per diem benefit **($125 per person)** will be allocated for food and lodging expenses for the recipient and one additional adult. (If the transplant recipient is a dependent child under the age of 18, travel and per diem expenses for **two** adults to accompany the member are available.)


Travel and standard per diem allowances for the recipient and the accompanying adult(s) are limited to a lifetime maximum benefit of **$10,000** per transplant. The member's 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.

Travel, food, and lodging expenses are **not** covered if the recipient voluntarily chooses to travel outside his/her city of residence to receive a covered transplant for which travel is not considered medically necessary by the case manager.


Coverage is **not** available for travel costs associated with a pretransplant evaluation if the travel occurs more than five days prior to the actual transplant.

***Cost-Sharing Features*** — Covered services are subject to **10 percent** coinsurance and to a separate **$5,000 per transplant** out-of-pocket limit. (After the coinsurance for services related to a covered transplant reaches $5,000 for a single transplant, all further services related to the transplant will be paid at 100 percent of covered charges, up to maximum benefit limitations, if any.) There is no deductible or hospital copayment requirement and no benefit difference for PCP- or self-coordinated services.


## Transplant Exclusions

Benefits are **not** available for:

- any transplant or organ-combination transplant not listed as covered and care for complications of or follow-up care related to such transplants
- implantation of artificial organs or devices (mechanical heart); non-human organ transplants

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

- transplant-related services for a transplant that did not receive prior approval from BCBSNM; transplant-related services if the transplant was performed in a facility not approved by BCBSNM
- expenses incurred by a member of this plan for the donation of an organ to another person
- drugs that are self-administered or for use while at home (These services may be covered elsewhere under this plan; see "Prescription Drugs.")
- travel, transportation, lodging, food, beverage, or meal expenses that are not covered by the per diem allowance, if available
- travel, transportation, lodging, or meal expenses for a heart, heart-lung, liver, lung, or pancreas-kidney transplant if the recipient's case manager indicates that travel is not medically necessary
- travel, food, or lodging expenses related to a transplant covered under the "Bone Marrow, Cornea, Kidney, and Specified Liver" transplant provision
- 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)
- lodging or meal expenses charged to the member only because benefits are available under this provision (such as lodging received from a member of the patient's family, or from any other person charging for accommodations in a place that does not ordinarily take in lodgers in return for payment)

**See Section 5: General Limitations and Exclusions.**

**Except for specified OB/gyn services, you must obtain a referral from your PCP to receive PCP-coordinated benefits for care not directly provided by your PCP.**

# 5 General Limitations and Exclusions

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

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


*Also see* Section 4: Covered Services *for specific benefit limitations and exclusions.*

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

## Artificial Conception/Infertility Services

**This plan does not cover** services related to, but not limited to, procedures such as: artificial conception; in-vitro or in-vivo fertilization; Gamete Intrafallopian Transfer (GIFT) or Zygote Intrafallopian Transfer (ZIFT); "test tube" fertilization; drugs for induced ovulation; costs associated with the collection, preparation or storage of sperm for artificial insemination, including donor fees; or any other artificial methods of conception. (Limited and specific treatments of medical conditions that sometimes result in restored fertility may be covered. See "Maternity/ Reproductive Services and Newborn Care" in *Section 4* for details.)

## Before Effective Date of Coverage

**This plan does not cover** any service received before the member's effective date of coverage, including any portion of an admission that began before the member's effective date of coverage. (An expense is incurred on the date the service or supply was provided or, for inpatient services, on the date that the member was admitted to a facility.)

## Biofeedback

**This plan does not cover** services related to biofeedback.

## Blood Services

**This plan does not cover** directed donor or autologous blood storage fees when the blood is used during a nonscheduled surgical procedure.
**This plan does not cover** blood replaced through donor credit.

## Breast Reduction

**This plan does not cover** procedures related to breast reduction.

**See additional exclusions related to specific types of covered services in *Section 4.***

## Chemical Dependency Services

**Benefits for these services are administered by PBHI.** See *Section 10* for details.

## Complications of Noncovered Services

**This plan does not cover** any services, treatments, or procedures required as the result of complications of a noncovered service, treatment, or procedure (e.g., due to a noncovered sex change operation, cosmetic surgery, or experimental procedure).

## Convalescent Care or Rest Cures

**This plan does not cover** convalescent care or rest cures.

## Cosmetic and Reconstructive Services

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

Examples of cosmetic procedures are: dermabrasion; nipple reconstruction; orthognathic jaw surgery; reconstruction of surgically induced scars; breast augmentation; rhinoplasty; surgical alteration of the eye; surgical correction of prognathism or micrognathism; surgical excision or reformation of sagging skin on any part of the body including, but not limited to, eyelids, face, neck, abdomen, arms, legs, or buttocks; 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 BCBSNM determines are not required to materially improve the physiological function of an organ or body part.


**Exception:** Limited exceptions may be made for cosmetic breast reconstruction required due to a mastectomy that occurred no more than 12 months before the planned reconstruction. However, **prior approval, requested in writing,** must be obtained from BCBSNM for such services. See "Surgical Services and Other Procedures" in *Section 4* for details.

**Note:** 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 4* for details.

## Custodial Care

**This plan does not cover** custodial care, or care in a place that serves the patient primarily as a residence when the patient does not require

**See additional exclusions related to specific types of covered services in *Section 4.***

skilled nursing. **This plan does not cover** services to assist the member 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 and by whom they were recommended.

## Domiciliary Care

**This plan does not cover** domiciliary care or care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

## Duplicate (Double) Coverage

**This plan does not cover** amounts already paid by other valid coverage. See *Section 6* for more information. Also, if a member's prior coverage has an extension of benefits provision, **this plan will not cover** charges incurred after the member's effective date under this plan that are covered under the prior plan's extension of benefits provision.

## Duplicate Testing

**This plan does not cover** duplicative diagnostic testing or overreads of laboratory, pathology, or radiology tests.

## Experimental or Investigative Services

**This plan does not cover** any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical practice, as determined by BCBSNM, and thus considered experimental or investigative. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is experimental and will not be covered. To be considered experimental or investigational, 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.

**See additional exclusions related to specific types of covered services in *Section 4.***

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.

Also, the service must be medically necessary and not excluded by any other contract exclusion.

## Food and Lodging Expenses

**This plan does not cover** food or lodging expenses, unless such services are eligible for coverage under the "Transplant Services" provision in *Section 4*. **This plan does not cover** housing, food, or meal services other than dietary counseling received during a covered home health care or hospice visit or during a covered health education and counseling session.

## Genetic Counseling and Testing

**This plan does not cover** services related to genetic counseling and testing (e.g., tests to determine the sex or physical characteristics of an unborn child or discussion of family history or test results), unless genetic testing has received **prior approval** from BCBSNM and is required 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 commonly increases risk (such as advanced maternal age or alcohol abuse).

## Government Institution/Facility Services

**This plan does not cover** services or supplies furnished by a military medical facility operated by, for, or at the expense of federal, state, or local governments or their agencies, when the service is provided without charge. **This plan 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.

## Hair Loss Treatments

**This plan 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, and Aids

**This plan does not cover** audiometric (hearing) tests unless:

- required for the diagnosis and/or treatment of an accidental injury or an illness, or
- covered as a PCP-coordinated preventive screening service for children through age 18.

**See additional exclusions related to specific types of covered services in *Section 4.***

**This plan does not cover** hearing aids and ear molds, fitting of hearing aids or ear molds, or any related service or supply. (For surgically implanted devices for the profoundly hearing impaired, see "Surgical Services and Other Procedures" in *Section 4*.)

## Hypnotherapy

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


## Late Claims Filing

**This plan does not cover** services submitted for benefit determination if the claim is received by BCBSNM more than **12 months** after the date of service.

## Learning Deficiencies/Behavioral Problems

**This plan does not cover** special education, counseling, therapy, diagnostic testing, or care for learning deficiencies or chronic behavioral problems, whether or not associated with a manifest mental disorder, retardation, or other disturbance.

## Limited Services/Covered Charges

**This plan does not cover** amounts in excess of covered charges or services that are in excess of any benefit maximums or limitations.

## Local Anesthesia

**This plan does not cover** local anesthesia. (Coverage for surgical, maternity, diagnostic, and other procedures includes an allowance for local anesthesia because it is considered a routine part of the procedure.)

## Long-Term and Maintenance Therapy

**This plan does not cover** long-term outpatient, office, or home-based acupuncture, chiropractic, cardiac or pulmonary rehabilitation, or physical, occupational, or speech therapy. (Therapies are considered long-term if significant improvement is not possible within a two-month period.) **This plan does not cover** any 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, unless therapy is received during an approved hospice benefit period. In the case of a dispute about whether the patient's rehabilitative potential has been reached, the member is responsible for furnishing documentation from the patient's physician supporting his/her opinion that the patient's rehabilitative potential has not been reached.

## Medically Unnecessary Services

**This plan does not cover services** that are not medically necessary as defined at the beginning of *Section 4* unless such services are specifically

**See additional exclusions related to specific types of covered services in *Section 4.***

listed as covered in this benefit booklet (e.g., see "Preventive Services" in *Section 4*).

**BCBSNM determines whether a service or supply is medically necessary, and therefore, whether the expense is covered. The fact that a provider has prescribed, ordered, recommended, or approved a service or supply does not make it medically necessary or make the expense a covered charge, even though it is not specifically listed as an exclusion.** Also, the fact that a service may be medically necessary does not make the expense a covered charge; it will be denied if it is excluded under this plan (for example, medically necessary nonprescription drugs are **not** covered).

## Mental Health Services

**Benefits for these services are administered by PBHI.** See *Section 10* for details.

## No Legal Payment Obligation

**This plan does not cover** services for which the member has no legal obligation to pay or that are free, including:

- charges made only because benefits are available under this plan
- services for which the member has received a professional or courtesy discount
- volunteer services
- services provided by the member for him/herself or a covered family member, or by a person ordinarily residing in the patient's household, or by a family member
- physician charges exceeding the amount specified by the Health Care Financing Administration when primary benefits are payable under Medicare

**Note:** This exclusion does not apply to services eligible for benefits under Indian Health Service/Contract Health Services or Medicaid.

## Noncovered Providers of Service

**This plan does not cover** services prescribed or administered by a:

- member of the patient's immediate family or a person normally residing in the patient's home
- physician, other person, supplier, or facility not specifically listed as covered in this benefit booklet, 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
  - massage therapist
  - private sanitarium
  - nursing home or similar institution

**See additional exclusions related to specific types of covered services in *Section 4.***

- residential treatment center (facility where the primary services are the provision of room and board and constant supervision or a structured daily routine for a person who is impaired but whose condition does not require acute care hospitalization)
- 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
- Christian Science practitioner, nurse, or sanitorium

## Nonmedical Expenses

**This plan does not cover** nonmedical expenses, including but not limited to:

- adoption or surrogate expenses
- educational programs such as behavior modification, cardiac classes received outside of a covered cardiac rehab session, or arthritis classes (Some educational programs authorized by a member's PCP may be covered; see "Preventive Services" in *Section 4* for details.)
- vocational or training services and supplies
- mailing and/or shipping and handling expenses
- charges for missed appointments; "get-acquainted" visits without provision of physical assessment or medical care; telephone consultations; provision of medical information to perform admission review; filling out of claim forms; copies of medical records; interest expenses
- modifications to home, vehicle, or workplace to accommodate medical conditions; voice synthesizers or other communication devices
- membership fees at spas, health clubs, or other such facilities, even if medically recommended and regardless of therapeutic value
- personal convenience items such as air conditioners, humidifiers, or physical fitness exercise equipment; personal services such as haircuts, shampoos and sets, guest meals, and radio or television rentals
- personal comfort services, including homemaker and housekeeping services, except in crisis periods or in association with respite care covered during a hospice admission

## Nonprescription Drugs

**This plan does not cover** nonprescription or over-the-counter drugs, medications, ointments, or creams, including herbal or homeopathic preparations, or prescription drugs that have over-the-counter bioequivalents. (Bioequivalents have the same strength and cause similar action on bodily tissues.)

## Nutritional Supplements

**This plan does not cover** vitamins, dietary/nutritional supplements, special foods, formulas, mother's milk, or diets, unless prescribed by a physician (such supplements must require a prescription in order to be covered).

**See additional exclusions related to specific types of covered services in *Section 4.***

## Obesity Treatment

**This plan does not cover** obesity treatment under any circumstance, including dietary, medical, or surgical treatment of obesity.

## Post-Termination Services

**This plan does not cover** services received after a member's coverage under this medical plan is terminated or after coverage provided under 1) the "Extension of Benefits" provision in *Section 2* or 2) state or federal continuation is exhausted — even if a prior approval or admission review approval was received from BCBSNM, **except for** inpatient services related to a covered admission that began before coverage termination. In such cases, coverage for the admission and related inpatient services continues until the earlier of the following events occurs:

- benefits for the admission are exhausted or,
- there is an interruption of the inpatient stay or leave of absence from the facility (regardless of the date of discharge).

## Prior Approval Not Obtained When Required

**This plan does not cover** certain self-coordinated services if the member does not obtain prior approval from BCBSNM before those services are received (see "Medical/Surgical Admission Review and Other Prior Approvals" in *Section 3*).

## Private Room Expenses

**This plan does not cover** private room expenses, unless the patient's medical condition requires isolation for protection from exposure to bacteria or diseases (e.g., severe burns and conditions that require isolation according to public health laws).

## Sex-Change Operations

**This plan does not cover** services related to sex-change operations, reversals of such procedures, or complications arising from transsexual surgery.

## Therapies (Other)

**This plan does not cover** therapies and self-help programs other than the therapies listed as covered in this booklet. Noncovered therapies include but are not limited to:

- recreational, sleep, crystal, primal scream, sex, or Z therapies
- self-help, stress management, smoking cessation, codependency, or weight-loss programs
- massage therapy or rolfing
- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay
- any therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights)

**See additional exclusions related to specific types of covered services in *Section 4.***

- transactional analysis, encounter groups, and transcendental meditation (TM); moxibustion
- sensitivity or assertiveness training
- vision therapy; orthoptics

## Thermography

**This plan does not cover** thermography.

## Transplant Services

Please see "Transplant Services" in *Section 4* for specific transplant services that are covered. **This plan does not cover** any other transplants or services related to such noncovered transplants.

## Travel and Other Transportation Expenses

**This plan does not cover** travel expenses, even if travel is necessary to receive covered services, unless such services are eligible for coverage under the "Transplant Services" provision in *Section 4*. See additional exclusions under "Ambulance Services" in *Section 4*.

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

## Vision Services

**This plan 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 exclusion also applies to eyeglasses, contact lenses, prescriptions associated with such procedures, and costs related to the prescribing or fitting of contact lenses, unless specified as covered in *Section 4*. **This plan does not cover** sunglasses, special tints, or other extra features for eyeglasses or contact lenses.

## War-Related Conditions

**This plan does not cover** any service required as the result of any act of war, or for any illness or accidental injury sustained during combat or active military service.

## Weight-Management Programs/Procedures

**This plan does not cover** weight-loss or other weight-management programs, dietary control, or obesity treatment, including surgical treatment of morbid obesity.

**See additional exclusions related to specific types of covered services in *Section 4.***

## Work-Related Conditions

**This plan does not cover** services resulting from work-related illness or injury. This exclusion from coverage applies to 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

In order to recover benefits for a work-related illness or injury, the member must pursue his/her rights under the Workers' Compensation Act or any of the above provisions that apply, including filing an appeal. This plan may pay claims during the appeal process on the condition that the member signs a reimbursement agreement.

**This plan does not cover** charges for services resulting from a work-related illness or injury, **even if**:

- The member fails to file a claim within the filing period allowed by the applicable law.
- The member obtains care that is not authorized by Workers' Compensation insurance.
- The member's employer fails to carry the required Workers' Compensation insurance. In this case, the employer may be liable for any employee's work-related illness or injury expenses.
- The member fails 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. A member must provide documentation showing that he/she has waived Workers' Compensation and that he/she is 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.

**See additional exclusions related to specific types of covered services in *Section 4.***

# 6 Coordination of Benefits and Subrogation

## Coordination of Benefits (COB)

Definitions

*Other valid coverage* — All other group and nongroup or direct-pay insurance policies or health care benefit plans, which may include Medicare (but excluding Indian Health Service and Medicaid coverages), that provide payments for medical services.


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

This medical plan contains a coordination of benefits (COB) provision that prevents duplication of payments. When you are eligible for benefits under any other valid coverage, the combined benefit payments from all coverages cannot exceed 100 percent of the BCBSNM covered charges. (Contact the prescription drug plan administrator for coordination of benefits for prescription drug services. Do **not** send these claims to BCBSNM.)

If you are covered by both Medicare and this medical plan and are subject to Medicare Secondary Payer provisions, special COB rules apply. Contact a BCBSNM Customer Service representative for more information.

**Note:** When Medicare is the primary coverage, the plan's usual benefit payment (in the absence of other coverage) is reduced by the amount of benefits paid by Medicare. The difference between the plan's usual benefit and Medicare's payment will be the amount payable under this plan. (When the balance is less than or equal to $0.00, no benefit payment will be made under this plan.) Also, when Medicare is the primary coverage and the provider accepts Medicare assignment or is otherwise limited as to the amount that he/she can bill to the Medicare beneficiary, the maximum allowable fee used to calculate this plan's usual benefit payment will be the amount allowed by Medicare. Your liability will be the same as (or in some cases, less than) your liability would have been in the absence of Medicare coverage.

If you are currently covered under state continuation coverage, coverage ceases at the beginning of the month when you turn age 65. If you are currently covered under federal continuation coverage, coverage ceases at the beginning of the month when you become entitled to Medicare. Under either continuation coverage, coverage ceases when you become eligible for any other valid coverage (unless a pre-existing conditions limitation applies under the other coverage).

Limitations and Exclusions

When this plan is secondary, all provisions (such as using a PCP or obtaining prior approval) must be followed. Failure to do so may result in no benefits or reduced benefits under this plan.

The following rules determine which coverage pays first:

***No COB Provision*** — If the other valid coverage does not include a COB provision, that coverage pays first and this medical plan pays secondary benefits.

***Subscriber/Dependent*** — If the member who received care is covered as an employee, annuitant, or other policyholder (i.e., as the subscriber) under one coverage and as a dependent under another, the subscriber's coverage pays first.

**Exception to the Subscriber/Dependent rule:** If the member is also a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a *dependent of an active employee*, then the plan of an active worker covering the Medicare beneficiary as a dependent determines its benefits first, then Medicare, and last, the plan covering the Medicare beneficiary as the subscriber.

If the member has other valid coverage, contact the other carrier's customer service department to determine if the other coverage is primary or secondary to Medicare. There are many federal regulations regarding Medicare Secondary Payer provisions, and other coverage may or may not be subject to those provisions.

***Dependent Child*** — If the member who receives care is a dependent child, the coverage of the parent whose birthday falls earlier in the calendar year pays first. If the other coverage does not follow this birthday rule, then the father's coverage pays first.

***Dependent Child, Parents Separated or Divorced*** — If two or more plans cover a member as a dependent child of divorced or separated parents, benefits for the child are coordinated in the following order:

- *Court-Decreed Obligations.* Regardless of which parent has custody, if a court decree specifies which parent is financially responsible for the child's health care expenses, the coverage of that parent pays first.
- *Custodial/Noncustodial.* The plan of the custodial parent pays first. The plan of the spouse of the custodial parent pays second. The plan of the noncustodial parent pays last.
- *Joint Custody.* When a court decree specifies that the parents share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child follow the rules that are applicable to children whose parents are not separated or divorced.

***Active/Inactive Employee*** — If the member who received care is covered as an active employee under one coverage and as an inactive employee under another, the coverage through active employment pays first. Likewise, if a member is covered as the dependent of an active employee under one coverage and as the dependent of the *same* but *inactive* employee under another, the coverage through active employment pays first.

If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, the next rule applies.

***Longer/Shorter Length of Coverage*** — When none of the above applies, the plan in effect for the longest continuous period of time pays first. (The start of a new plan does not include a change in the amount or scope of a plan's benefits, a change in the entity that pays, provides, or administers the plan's benefits, or a change from one type of plan to another.)

### Responsibility for Timely Notice

This plan is not responsible for coordination of benefits if timely information has not been provided by the complaining party regarding the application of this provision.

### Facility of Payment

Whenever payments that should have been made under this plan have been made under any other plan, BCBSNM will have the right to pay to that other plan any amount BCBSNM determines to be warranted to satisfy the intent of this provision. Any amount so paid will be considered to be benefits paid under this plan, and with that payment BCBSNM will fully satisfy the plan's liability under this provision.

### Right of Recovery

Whenever payments for covered services have been made by this plan and those payments are more than the maximum payment necessary to satisfy the intent of this provision, regardless of who was paid, BCBSNM 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 this plan has paid benefits for that illness or injury, this plan 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 Plan has subrogation rights. This means that the Plan 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 this plan provides benefits, the Plan 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 Plan'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:

4. You must promptly notify BCBSNM of the claim against the third party.

2. If you receive money for the claim by suit, settlement, or otherwise, you or your attorney must reimburse BCBSNM for the amount of benefits provided under this plan or an amount agreed upon with BCBSNM. You may not exclude recovery for medical plan benefits from any type of damages or settlement recovered.

3. You must cooperate in every way necessary to help the Plan enforce its subrogation rights.

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

**Note:** This "Third-Party Liability — Subrogation" provision is not applicable to disputes involving PBHI or their administration of mental health and chemical dependency services. If a dispute arises regarding mental health or chemical dependency services or benefits, see *Section 10*.

# 7 Claims Payments and Appeals

## Filing Claims


You must submit claims for services of a nonparticipating provider **within 12 months** after the date services or supplies were received. Claims for services of a nonparticipating provider that are submitted after the 12-month deadline are not eligible for benefit payments. If a claim is returned for further information, resubmit it **within 90 days.**

***Important: If You Have Other Coverage*** — When you have other coverage (including Medicare or a dental or vision plan) that pays benefits for health care services before this plan pays its benefits (the other coverage is "primary" over this plan), you need to file your claim with the other coverage first.

After your other coverage pays its benefits, a copy of the other coverage's payment explanation form must be attached to the claim sent to BCBSNM. (If services are received outside of New Mexico and other coverage is involved, do **not** send claims to the local BCBS Plan, as instructed under "Where to Send Claim Forms," later in this section.)

If payment is made to you (or your family member) by the other carrier, give your provider a copy of the primary coverage's payment explanation so that your provider can include it with the claim that he/she sends to BCBSNM. (If your out-of-network provider does not file claims for you, attach a copy of the primary coverage's payment explanation to the claim that you send to BCBSNM.)

***Medicare-Covered Facility Services*** — All Medicare-participating providers of Part A services in the state of New Mexico, including skilled nursing facilities and hospices, will submit claims directly to Medicare. To file claims, the facility must have the information from the identification cards issued to you by **both** Medicare and BCBSNM.

It is **not** necessary for you to file a claim for New Mexico facility services with BCBSNM. These claims are automatically submitted by the Medicare Part A intermediary to BCBSNM. An *Explanation of Benefits* will be sent to the subscriber by BCBSNM after BluePremier POS plan benefits have been determined.

If services are not received in New Mexico, you must file the claim, along with the *Explanation of Medicare Benefits* (EOMB), to BCBSNM, **after** Medicare has made its payment.

***Medicare-Covered Non-Facility Services*** — A claim for physician and other professional provider services must be filed **first** with Medicare Part B Medical Insurance. (All providers must file claims for you to Medicare.)

If the services were provided in New Mexico, the Medicare Part B carrier will send an electronic copy of the claim to BCBSNM. You do **not** need to file a claim with BCBSNM for services received in New Mexico.

For services provided outside New Mexico, after Medicare has made its payment and sent an EOMB to you, you must file a copy of the EOMB and all other required claim information with BCBSNM. On the EOMB you receive from Medicare, **print your BCBSNM ID number and your correct mailing address and zip code.** Then make a copy of the EOMB for your records.

Even though providers may file claims on your behalf, it is your responsibility to make sure that the claim is filed with BCBSNM.

## PCPs and Other In-Network Providers

PCPs and other in-network providers file your claims with BCBSNM (or with their local BCBS Plan) and payment is made directly to them. Do **not** file claims for these services yourself. (**Exception:** Providers in Nevada or Colorado should send claims directly to BCBSNM.)

**Note:** If you have other health care coverage that is primary over this medical plan, including Medicare, see "Important: If You Have Other Coverage," on the previous page.

## Out-of-Network Providers

If your out-of-network provider does not file a claim for you, you must submit a separate claim form for each family member. Submit all claims as the services are received. Attach itemized bills to a *Member Claim Form* (see "Itemized Bills," below). Complete the claim form using the instructions on the form. Do not file for the same service twice unless requested by a Customer Service representative. (See special claims filing instructions for out-of-country claims under "Where to Send Claim Forms" on the next page.)

**Note:** If you have other health care coverage that is primary over this medical plan, including Medicare, see "Important: If You Have Other Coverage," on the previous page.

***Itemized Bills*** — Itemized bills must be submitted on the provider's billing forms or letterhead stationery and must show:

- name and address of health care provider
- full name and date of birth of the patient receiving treatment
- date, type of service, diagnosis, and charge for each service (each service must be listed separately)

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. **Correctly itemized bills are necessary for your claim to be processed so that all benefits available under this plan are provided.** If your itemized

bills include services previously filed, identify clearly the new charges that you are submitting.

**Reminder: If you go to a PCP or an in-network provider, the provider will file your claims.**

## 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. *Member Claim Forms* are available from a BCBSNM Customer Service representative. When services are received in New Mexico, Nevada, or Colorado mail the forms and itemized bills to:

**Blue Cross and Blue Shield of New Mexico**
**Attn: LANL DSU**
**P. O. Box 27630**
**Albuquerque, New Mexico 87125-7630**

**Note:** Claims for prescription drugs must be sent to the prescription drug plan administrator (see next page) — **not** to BCBSNM.

***Services Outside New Mexico*** — Claims for covered out-of-network services received outside New Mexico should be sent directly to the BCBS Plan in the state where services were received (unless there is other coverage that is primary, as explained under "Important: If You Have Other Coverage" at the beginning of this section). If a provider outside of New Mexico will not file a claim, ask for an itemized bill and complete it the same way that you would for services received from any other out-of-network provider.

**Exception:** Claims for covered services received in **Nevada or Colorado** should be sent directly to BCBSNM.

***Services Outside the United States*** — Claims for covered services received in Canada or Puerto Rico should be handled the same way as is described in "Services Outside New Mexico," above.

For inpatient facility services received in all other countries, show your BCBSNM ID card. BCBSNM participates in a claims payment program with the Blue Cross and Blue Shield Association. If the facility has an agreement with the Blue Cross and Blue Shield Association, the facility files the claim for you to the appropriate Blue Cross Plan. Payment is made to the facility by that Plan, and then BCBSNM reimburses the other Plan.

For covered services received in countries other than Canada and the United States (including Puerto Rico), for inpatient services at hospitals that do not contract with the Blue Cross and Blue Shield Association, and for all outpatient and office services, you must pay for the services or supplies. Make copies of your itemized bills and translate them into English. Submit the original itemized bills, along with the translation, **to BCBSNM** as described under "Out-of-Network Providers," on page 96.

***Prescription Drug Claims*** — If you purchase a prescription from a nonparticipating pharmacy or other provider in an emergency, or if you do not have your ID card with you when purchasing a prescription, you must pay for the prescription in full and then submit a claim to BCBSNM's prescription drug plan administrator **(do not send these claims to BCBSNM).** The bills or receipts must be issued by the pharmacy and must include pharmacy name and address, drug name, prescription number, and amount charged. The prescription drug receipt(s) should be attached to a *Prescription Drug Claim Form* (available from your Benefits Office or from BCBSNM). Complete the required information using the instructions on the claim form and mail the form and drug receipts to the address on the claim form.

## How Payments Are Made

After a claim has been processed, the subscriber will receive an *Explanation of Benefits* (EOB). (When the member is a dependent child of divorced parents, the custodial parent may receive the EOB.) The EOB indicates what charges were covered and what charges, if any, were not.

***Network Providers*** — Payments for covered services usually are sent directly to PCPs and other in-network providers. The subscriber's EOB explains the payment.

***Out-of-Network Providers*** — If services were received from an out-of-network provider in New Mexico, payments are usually made to the subscriber. The check will be attached to an EOB that explains the plan's payment. In these cases, you are responsible for arranging payment to the provider and for paying any amounts greater than covered charges plus copayments, deductibles, coinsurance, any penalty amounts, and noncovered expenses.

***Medicaid*** — Payment of benefits for members eligible for Medicaid is made to the appropriate state agency or to the Medicaid provider when required by law.

***Assignment of Benefits*** — BCBSNM specifically reserves the right to pay the subscriber directly and to refuse to honor an assignment of benefits in any circumstances (an "assignment of benefits" is a signed statement from you requesting that your benefits be paid directly to the provider of service). No one may execute any power of attorney to interfere with BCBSNM's right to pay the subscriber instead of anyone else.

***Covered Charges*** — The covered charge is the amount allowed for a covered service and may be based upon PCP and in-network provider agreements and maximum allowable fees as determined by BCBSNM. For services received outside of New Mexico, maximum allowable fees may be based on the local Plan practice or, for services received from those providers who do not participate with their local BCBS Plan, on a specified percentile of the Health Insurance Association of America (HIAA) fee schedule amount for the covered service. If a HIAA fee does

not exist for a specific service, this plan will pay up to the BCBSNM maximum allowable fee for the service. You are always responsible for paying all copayments, deductibles, coinsurance, and penalty amounts, and noncovered expenses.

***BlueCard Program*** — When you obtain health care services through the BlueCard Program outside the geographic area BCBSNM serves, the amount you pay for covered services is usually calculated on the **lower** of:

- the actual billed charges for your covered services, or
- the negotiated price that the on-site Blue Cross and/or Blue Shield Plan passes on to BCBSNM.

Often this "negotiated price" will consist of a simple discount. But sometimes it is an estimated final price that factors in expected settlements or other non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be a discount from billed charges that reflects **average** expected savings. The estimated or average price may be prospectively adjusted to correct for over- or underestimation of past prices.

In addition, laws in a small number of states require Blue Cross and/or Blue Shield Plans to use a basis for calculating your payment for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim. When you receive covered health care services in those states, your required payment for these services will be calculated using their statutory methods.

***When Medicare is Primary*** — When Medicare is the primary coverage, Medicare benefits are deducted from the plan's usual benefit to arrive at the amount payable by this plan. When Medicare is primary, this plan's usual benefit is calculated using the Medicare approved amount (when the provider has accepted Medicare assignment), or using the Medicare limiting charge (when the provider has not accepted Medicare assignment). The Medicare approved amount or limiting charge is the maximum amount that the provider can bill the Medicare beneficiary for a covered service.

**Note:** Recently enacted Federal legislation allows physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services (that would otherwise be covered by Medicare) from these physicians or practitioners will need to enter into written "private contracts" with these physicians or practitioners requiring the beneficiary to be responsible for all payments to such providers. Services provided under "private contracts" are not covered by Medicare, and the Medicare limiting charge will not apply.

If you are classified as a retiree by the University of California (or otherwise have Medicare as primary coverage) and enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement with one or more physicians or practitioners, under the law you have in effect

"opted out" of Medicare for the services provided by these physicians or other practitioners. No benefits will be paid by this University of California Plan for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered.

However, if you do sign a private contract with a physician or practitioner, you may see other physicians or practitioners without those private contract restrictions as long as they have not opted out of Medicare.

***Overpayments*** — If BCBSNM makes an erroneous benefit payment for any reason (e.g., provider billing error, claims processing error, retroactive termination of coverage for any reason), BCBSNM and the providers of care reserve the right to recover charges from you for any services received. BCBSNM may offset amounts paid in error against new claims, and the Plan reserves the right to take legal action to correct payments made in error.

## ■ Complaint Procedures

If you have a complaint about any BCBSNM services, the quality of care you receive, the choice of providers you have as a member, the adequacy of the provider network, the cancellation of your coverage, or the outcome of utilization review decisions, call your Customer Service representative for assistance:

**1-800-711-3795 toll-free, or**
**(505) 889-0188 in Albuquerque**

If you file a complaint under the following procedures, you will not be subject to retaliatory action by BCBSNM:

You, your guardian or representative, or a provider acting on your behalf can contact BCBSNM's Customer Service Department in person, by letter, or by telephone when you have a complaint. The Customer Service Department will review the complaint and provide a decision in writing to the complainant within 30 calendar days of receiving the complaint.

If the complainant is not satisfied with the results of the review, the complainant may file a request for appeal with the Customer Service Department, attaching additional information that will support the case.

Customer Service will review the case and involve BCBSNM managers as necessary. The review will be completed within 30 calendar days of receiving the appeal. The complainant and the other people involved will receive a letter about the decision within 7 calendar days of the decision and within 30 calendar days after all necessary information has been submitted. The letter will include a statement of the appeal and reasons for the decisions.

If the complainant is still not satisfied with the results of the review, the complainant may file a grievance.

***Grievance Process*** — You, your guardian or representative, or a provider acting on your behalf may file a grievance within 30 calendar days of the appeal decision.

The grievance will be reviewed by a panel of physicians and/or health care professionals who are trained or practice in the same specialty that would usually manage the type of case being reviewed (but will not include any professional previously involved in the case decision). You can ask your own specialist to participate (at your expense). The grievant can appear in person and can present the case, submit supporting documents, and ask questions. This hearing will be held within 30 calendar days of receiving the grievance request. (If the case is urgent or emergent, the hearing will be held within 24 hours). The grievant will be notified of the date, time and place of the hearing 15 calendar days in advance of the hearing.

BCBSNM will notify the grievant and other pertinent parties of the final decision by letter or other appropriate communication within 30 calendar days of the hearing. (If the case is urgent or emergent, the decision will be communicated within 48 hours of the hearing). The letter will include a statement of the grievance; reasons for the decision; names, titles, and qualifying credentials of the people who made the final decision.

For additional information, please refer to the "Binding Arbitration" provision in *Section 8: General Provisions.*

## ■ Catastrophic Events

In case of fire, flood, war, civil disturbance, court order, strike, or other cause beyond BCBSNM's control, BCBSNM may be unable to process claims or provide prior approval for services on a timely basis. No suit or action in law or equity may be taken against BCBSNM because of a delay caused by any of these events.

If due to circumstances not within the control of BCBSNM or a participating provider, such as partial or complete destruction of facilities, war, riot, prevailing insurrection, disability of a participating provider, or similar case, the provision of medical services is delayed or rendered impractical, the University, BCBSNM, and the provider will have no liability or obligation on account of delay or failure to provide medical service. No suit or action in law or equity may be taken against the University or BCBSNM due to delay on account of any of these events. BCBSNM and participating providers will, however, make a good-faith effort to provide services.

## ■ Research Fees

BCBSNM may 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 either the subscriber at the latest address on BCBSNM membership records or to the employer.

## Member's Legal Expense Obligations

The subscriber and his/her dependents are liable for any actions that may prejudice BCBSNM's rights under this plan. If BCBSNM must take legal action to uphold its rights and prevails in that action, BCBSNM will be entitled to receive and you will be required to pay BCBSNM's legal expenses, including attorneys' fees and court costs.

# 8 General Provisions

## Advance Directives

Advance Directives are written documents (such as a Living Will, Health Care Treatment Directives, and Durable Power of Attorney) that designate a person with the responsibility for making your health care decisions if you are incapable of expressing your own wishes. They also describe the kind of treatment you do and do not want. Members over age 18 have the right to refuse or accept medical care or surgical treatments and to execute Advance Directives.

BCBSNM, providers, and staff do not discriminate care based on whether you have signed any type of Advance Directives.

If you have questions or concerns about Advance Directives, contact your primary care provider or personal physician to discuss these issues.

## Availability of Provider Services

BCBSNM makes no guarantee as to the type of room or services that will be available at any hospital or other facility, nor does BCBSNM guarantee that the services of a particular hospital, physician, or other provider will be available.

## Binding Arbitration

If a dispute about coverage, benefits, or handling of claims continues after you have followed and exhausted the "Complaint Procedures" set forth in *Section 7*, the issue or claim must be submitted to binding arbitration. The rules for arbitration shall be those developed by the American Arbitration Association. You may obtain a copy of these rules from a BCBSNM Customer Service representative.

The decisions in arbitration are binding upon both you and BCBSNM. Judgment on the award given in arbitration may be enforced in any court that has proper authority.

Damages, if any, are limited to the amount of the benefit payment in dispute plus reasonable costs. BCBSNM is not liable for punitive damages or attorney fees.

## Changes to the Benefit Booklet

No employee of BCBSNM may change this benefit booklet by giving incomplete or incorrect information, or by contradicting the terms of this benefit booklet. Any such situation will not prevent BCBSNM from administering this benefit booklet in strict accordance with its terms.

## Delivery of Documents

BCBSNM will mail to the subscriber's address as listed on the Enrollment Form (hard copy or electronic), a benefit booklet setting forth the services to which you are entitled and a BluePremier POS plan ID card.

## Disclaimer of Liability

BCBSNM has no control over any diagnosis, treatment, care, or other service provided to you by any facility or professional provider, whether participating or not, and is not liable for any loss or injury caused by any health care provider by reason of negligence or otherwise.

## Execution of Papers

As the subscriber, on behalf of yourself and your dependents you must, upon request, execute and deliver to BCBSNM any documents and papers necessary to carry out the provisions of this plan.

## Independent Contractors

The relationship between BCBSNM and its participating providers is that of independent contractors; physicians and other providers are not agents or employees of BCBSNM, and BCBSNM and its employees are not employees or agents of any participating provider. BCBSNM 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.

The relationship between BCBSNM and the group is that of independent contractors; the employer is not an agent or employee of BCBSNM, and BCBSNM and its employees are not employees or agents of the employer.

## Member Rights and Responsibilities

As a member of this plan, you have the following rights:

- The right to receive all medically necessary care, including emergency and urgent services, provided or arranged by your PCP, and covered under your benefit package, 24 hours a day, 7 days a week.
- The right to be treated with courtesy and consideration, and with respect for your dignity and need for privacy.
- The right to be informed of BCBSNM's policies and procedures regarding products, services, providers, appeals, other information about BCBSNM, and the benefits provided.
- The right to choose a PCP, within the limits of the covered benefits and plan network, including the right to refuse care from specific providers.
- The right to request and receive information, in terms you understand, about diagnosis, treatment, risks of treatment, expected results, and reasonable medical alternatives from your health care provider. If you cannot understand the information, you have the right to have the explanation given to your next of kin or guardian, if available.

- All the rights afforded by law, rule, or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of such a decision have been explained in terms you understand.
- The right to be notified of termination or changes in benefits, services, or provider network.
- The right to file a complaint, appeal, or grievance with BCBSNM and to receive an answer to those complaints within a reasonable time.
- The right to privacy of medical and financial records maintained by BCBSNM and the health care providers contracted with BCBSNM, in accordance with existing law.
- The right to have access to your medical records in accordance with applicable federal and state laws and regulations.
- The right to make suggestions for changes in BCBSNM quality improvement policies and procedures.
- The right to request information about any financial arrangements between BCBSNM and its contracted providers that may restrict referral or treatment options or limit the services offered to members.
- The right to adequate access to qualified health professionals near your work or home within BCBSNM's service area.
- The right to affordable health care, with limits on out-of-pocket expenses, including the right to seek care from a nonparticipating provider, and an explanation of your financial responsibility when services are provided by a nonparticipating provider or provided without required prior approval.
- The right to detailed information about: coverage; maximum benefits; exclusions of specific conditions, ailments, or disorders, including restricted prescription benefits; and all requirements that you must follow for prior approval and utilization review.
- The right to a complete explanation if care is denied, an opportunity to appeal the decision to BCBSNM's internal review, and the right to a secondary appeal and/or grievance.
- The right to coverage that is not changed and to benefits that do not have limitations, exceptions, exclusions, copayments, coinsurance, deductibles, reservations, premium, price, charge differences, or any other changes due to gender, race, color, national origin, ancestry, religion, sexual orientation, marital status, or age.
- The right to be informed of advance directives, and to make choices about medical care consistent with federal and state laws and regulations.

As a member of this plan, you have the following responsibilities:

- The responsibility to provide complete health status information needed by the health care provider.
- The responsibility to keep appointments for care and to give required notice when canceling.
- The responsibility to pay the applicable copayment, deductible, or coinsurance to the health care provider.
- The responsibility to read and understand all materials concerning health benefits and to share this information with the health care provider.

- The responsibility to notify your PCP within 48 hours after receiving emergency care without a referral.
- The responsibility to treat providers and BCBSNM staff with respect and recognition of personal dignity.
- The responsibility to notify BCBSNM immediately if your member ID card is lost or stolen.
- The responsibility to follow the plans and instructions for care that you have agreed on with your practitioner.

## Release of Information

Ordinarily, BCBSNM will not release medical information without your written consent. That information is strictly confidential. BCBSNM may, however, release medical information without notice or consent when:

- Peer and utilization review boards and/or BCBSNM medical consultants need such information, or such information is needed for quality assurance activities to ensure that you are getting appropriate and medically necessary care and that services are among those covered by this plan.
- BCBSNM receives a judicial or administrative subpoena for such information.
- The information is required for: Workers' Compensation proceedings; third-party liability (subrogation) proceedings; or coordination of benefits.
- The information is requested or provided in connection with group utilization data.

BCBSNM cannot release to you any information provided to BCBSNM by a health care provider without the provider's written consent.

You must provide BCBSNM with whatever information is necessary to determine benefits. BCBSNM may obtain information from any insurance company, organization, or person when such information is necessary to carry out the provisions of this plan. Such information may be exchanged without consent of, or notice to, you.

You agree to cooperate at all times (including while hospitalized) by allowing BCBSNM access to your medical records to investigate claims or issues of quality of care, and verify information provided on the Enrollment Form (hard copy or electronic). You also agree to execute whatever documents are necessary in order for BCBSNM to determine benefits under this plan. If you do not cooperate, you forfeit all rights to benefit payments on those claims subject to investigation and acknowledge that your coverage may be canceled.

To help BCBSNM determine which services qualify for benefits, you authorize all providers of health care services to provide BCBSNM with any medically related information pertaining to your treatment.

You waive all provisions of law that are subject to waiver, and which otherwise restrict or prohibit providers of health care services or supplies from disclosing or testifying to such information.

# 9 Glossary

This section defines certain words used throughout this benefit booklet.

***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.

***Admission*** — The period of time between the date a patient enters a facility as an inpatient and the date he or she is discharged as an inpatient. For benefit determination purposes, the date of admission is the date of service for the hospitalization and all related inpatient services.

***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.

***Benefit booklet*** — This document, which explains the benefits, limitations, exclusions, terms, and conditions of your health coverage. The final interpretation of any specific provision contained in this booklet is governed by the Administrative Services Agreement.

***Blue Cross and Blue Shield of New Mexico*** — A nonprofit corporation organized under New Mexico laws, also referred to as BCBSNM or New Mexico Blue Cross and Blue Shield, Inc. BCBSNM is the Claims Administrator of your employer's self-funded medical plan.

***Certified nurse-midwife*** — A person licensed by the board of nursing as a registered nurse and licensed by the New Mexico Department of Health, or with the appropriate state agency in the state where services are received, 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.

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

***Coinsurance*** — The percentage of a covered charge that is your responsibility to pay. For covered services that are subject to coinsurance, you pay the specified percentage of BCBSNM's covered charges after the deductible has been met and/or emergency room/hospital admission copayment (if any) has been paid.

***Complainant*** — A member, or a representative or provider acting on behalf of a member, who files a complaint with the medical plan.

***Copayment*** — The fixed-dollar amount of a covered charge that you pay for prescription drugs, self-coordinated emergency room services and inpatient hospital admissions, and most PCP-coordinated covered services. Benefits payable by BCBSNM are reduced by the amount of the required copayment for the covered service.

***Covered charge*** — See "Covered Charges" in *Section 7*.

***Covered services*** — Services or supplies for which this plan provides benefits. Please refer to *Section 4*.

***Deductible*** — A specified amount of money that you must pay before this plan pays benefits for all or part of your remaining self-coordinated covered charges.

***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.

***Dependent*** — A person entitled to apply for coverage as specified in *Section 2: Enrollment and Termination Information*.

***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.

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

***Emergency*** — Medical or surgical procedures or services received immediately after the sudden onset of what reasonably appears to be a medical condition with symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in jeopardy to his/her health; serious impairment of bodily functions; serious dysfunction of any bodily organ or part; or disfigurement. Examples of emergency conditions include, but are not limited to: heart attack or suspected heart attack, coma, loss of respiration, stroke, acute appendicitis, severe allergic reaction, or poisoning.

***Experimental or investigative*** — See "Experimental or Investigative Services" exclusion in *Section 5*.

***Facility*** — A hospital (see "Hospital," later in this section) or another institution (see "Provider," later in this section).

***Freestanding dialysis facility*** — A provider primarily engaged in providing dialysis treatment, maintenance, or training to patients on an outpatient or home care basis.

***Good cause*** — Failure of the subscriber to pay the premiums, other applicable charges, or employee contribution amounts for coverage; a material failure to abide by the rules, policies, or procedures of this plan; or fraud or material misrepresentation affecting coverage.

***Group*** — A bonafide employer covering employees of such employer for the benefit of persons other than the employer; or an association, including a labor union, that has a constitution and bylaws and is organized and maintained in good faith for purposes other than that of obtaining insurance.

***Home health care agency*** — An appropriately licensed provider that both:

- brings skilled nursing and other services on an intermittent, visiting basis into the member's home in accordance with the licensing regulations for home health care agencies in New Mexico or in the locality where the services are administered; *and*
- is responsible for supervising the delivery of these services under a plan prescribed and approved in writing by the attending physician.

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

***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, and is

not a place for rest, for the aging, for the treatment of mental illness, alcoholism, drug abuse, or pulmonary tuberculosis, and ordinarily does not provide hospice or rehabilitation care, and is not a residential treatment facility.

***Identification card (ID card)*** — The card BCBSNM issues to you that identifies the cardholder as a plan member.

***Independent clinical laboratory*** — A laboratory that performs clinical procedures under the supervision of a physician and that is not affiliated or associated with a hospital, physician, or other provider.

***Legal agreement*** — This benefit booklet (including the *Summary of Benefits and Copayments)*, the Enrollment Form, the Administrative Services Agreement, any amendments or endorsements, and the ID card.

***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.

***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 cesarean section. See "Maternity/Reproductive Services and Newborn Care" in *Section 4* for more information.

***Maximum allowable fee*** — See "Covered Charges" in *Section 7*.

***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.

***Medically necessary, medical necessity*** — See "Medically Necessary Services" at the beginning of *Section 4*.

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

***Member*** — The enrollee (the subscriber or any eligible dependent) who is enrolled for coverage and entitled to receive benefits under this plan in accordance with the terms of the Administrative Services Agreement. "You" and "your" refer to each member.

***Nongroup coverage*** — Health care coverage for one not affiliated in an employer/employee relationship group.

***Nonparticipating provider*** — An appropriately licensed health care provider that has not contracted with BCBSNM or with his/her local Blue Cross and/or Blue Shield Plan.

***OB/gyn services*** — Pregnancy-related services or services related to the treatment of the female reproductive system and provided by a women's health care provider.

***OB/gyn specialist*** — An obstetrician-gynecologist (a physician who is board-eligible or board-certified by the American Board of Obstetricians and Gynecologists or by the American College of Osteopathic Obstetricians and Gynecologists).

***Occupational therapist*** — A person registered to practice occupational therapy. An occupational therapist treats neuromuscular and psychological dysfunction, caused by disease, trauma, congenital anomaly, or prior therapeutic process, through the use of specific tasks or goal-directed activities designed to improve functional performance of the patient.

***Optometrist*** — A doctor of optometry (O.D.) licensed to examine and test eyes and treat visual defects by prescribing and adapting corrective lenses and other optical aids.

***Period of Initial Eligibility (PIE)*** — A PIE starts the day you become eligible for benefits or acquire a newly eligible dependent. A PIE ends on the date 31 days after it begins (or on the preceding business day for the local Benefits Office if the 31st day is on a weekend or holiday).

***Physical therapist*** — A licensed physical therapist. Where there is no licensure law, the physical therapist must be certified by the appropriate professional body. A physical therapist treats disease or accidental injury by physical and mechanical means (regulated exercise, water, light, or heat).

***Physician*** — A doctor of medicine or osteopathy who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

***Physician assistant*** — A skilled person who is a graduate of a physician assistant or surgeon assistant program approved by a nationally recognized accreditation body or who is currently certified by the National Commission on Certification of Physician Assistants, and who is licensed in the state of New Mexico (or by the appropriate state regulatory body) to practice medicine under the supervision of a licensed physician.

***Podiatrist*** — A licensed doctor of podiatric medicine (D.P.M.). A podiatrist treats conditions of the feet.

***Primary care provider (PCP)*** — A physician who supervises, coordinates, and provides initial and basic care to enrollees, who initiates their referral for specialist care, and who maintains continuity of patient care. Primary care providers may include general practitioners, family practice physicians, internists, pediatricians, and obstetricians/gynecologists.

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

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

- **Facility provider:** An institution providing health care services, including a hospital or other licensed inpatient center; an ambulatory surgical or treatment center; a skilled nursing center; a residential treatment center; a home health care agency; a diagnostic, laboratory, or imaging center; or a rehabilitation or other therapeutic health setting.
- **Professional provider:** A physician or other 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.
- **In-network provider:** A provider that has contracted with BCBSNM and has agreed to accept the payment provided in accordance with the provisions of the contract. An in-network provider may or may not be a "point-of-service provider" (see below). Providers that have contracted with other Blue Cross and/or Blue Shield Plans are also considered in-network providers. BCBSNM may add, change, or terminate specific network providers at its discretion or recommend a specific provider for specialized care as medical necessity warrants.
- **Point-of-service provider:** An in-network, non-PCP provider who has a point-of-service contract with BCBSNM. PCPs do not have to obtain prior approval from BCBSNM before giving a referral to a point-of-service provider.
- **Out-of-network provider:** A provider that has not contracted with BCBSNM or with the local Blue Cross and/or Blue Shield Plan.
- **Non-point-of-service provider:** Either an in-network provider that does not have a special point-of-service contract with BCBSNM, or is an out-of-network provider.

***Referral*** — Authorization from your PCP that allows you to seek care or receive services from another health care provider and receive the PCP-coordinated level of benefit for covered services from that provider.

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

***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, for compensation from its patients, 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 "Noncovered Providers of Service" exclusion in *Section 5*.

***Respiratory therapist*** — A person qualified for employment in the field of respiratory therapy. A respiratory therapist assists patients with breathing problems.

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

- is licensed in accordance with state or local law; *and*
- is approved as a Medicare-participating facility; *and*
- is primarily engaged in providing to inpatients skilled nursing care 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 care and treatment of drug abuse, mental disease, or tuberculosis, or for intermediate, custodial, or educational care.

***Speech therapist*** — A speech pathologist certified by the American Speech and Hearing Association. A speech therapist assists patients in overcoming speech disorders.

***Subscriber*** — The individual whose employment or other status, except for family dependency, is the basis for enrollment eligibility, or in the case of a direct-pay continuation contract, the person in whose name the contract is issued. The term "subscriber" may also encompass other persons in a nonemployee relationship with the group if specified in the Administrative Services Agreement (e.g., annuitants, survivor annuitants).

***Summary of Benefits and Copayments*** — The schedule that defines your copayment, deductible, coinsurance, and out-of-pocket requirements, and provides an overview of covered services.

***Urgent care*** — Medically necessary medical or surgical services received in an urgent care center or other provider's office for a condition that is not life-threatening but requires prompt medical attention to prevent a serious deterioration in your health (e.g., high fever, cuts requiring stitches).

***Utilization review*** — A system for reviewing the appropriate and efficient allocation of medical services and hospital resources given or proposed to be given to a patient or group of patients.

***Women's health care provider*** — Either an obstetrician-gynecologist (an OB/gyn specialist), a family practitioner or other physician specializing in women's health, or a certified nurse-midwife, certified nurse practitioner, or physician assistant who specializes in women's health.

# 10 Employee Behavioral Health Benefits Plan

## Introduction

This Summary Plan Description describes the terms and conditions of coverage under this Employee Behavioral Health Benefits Plan ("Plan"). Read this document carefully so that you will have a clear understanding of your Coverage under this Plan. If you have any questions regarding your Coverage or procedures for obtaining Behavioral Health Services, you may call PacifiCare Behavioral Health, Inc. ("PBHI") at 1-800-817-8811. PBHI has entered into an agreement with the University of California ("Plan Sponsor") to provide certain administrative services related to Coverage under this Plan.

All Behavioral Health Services, other than Emergency Treatment and Urgently Needed Services, are subject to prior authorization by PBHI, as described in this Summary Plan Description.

Only Medically Necessary Behavioral Health Services are Covered under this Plan. PBHI has sole and exclusive discretion in interpreting the benefits Covered under this Plan and the other terms, conditions, limitations and exclusions set out in the Administrative Services Agreement and this Summary Plan Description. Plan Sponsor reserves the right to change, interpret, modify, withdraw or add benefits or terminate this Plan, in its sole discretion, without prior notice to or approval by Plan participants. The legal documents governing this Plan consist of only the Administrative Services Agreement, along with this Summary Plan Description. Any change or amendment to this Plan, its benefits or its terms and conditions may be made solely in a written amendment to this Plan, approved by the Plan Sponsor. No person or entity has any authority to make any oral changes or amendments to this Plan.

**The information on these pages is provided by PacifiCare Behavioral Health, Inc. If you have questions about this information, call the Customer Service number at the bottom of this page.**

# Schedule of Behavioral Health Benefits

The Calendar Year Deductible, benefit maximums, benefit level, and lifetime maximums are combined for a member who transfers between the BluePremier point-of-service, worldwide, and HMO New Mexico benefits.

| **Mental Health Services** | |
|---|---|
| Maximum Inpatient Benefit, Per Member Per Lifetime<br>(Combined with Chemical Dependency and Detoxification Maximum) | 130 days |
| **Inpatient, Residential and Day Treatment** | 65 days per Calendar Year* |
| Days to be determined based on the following levels of care:<br>- Inpatient<br>- Residential Treatment<br>- Day Treatment | <br>1 day<br>7/10 of 1 day<br>6/10 of 1 day |
| Calendar Year Deductible Amount | $100 |
| Coverage Level | 80% |
| **Outpatient Treatment** | 50 visits per Calendar Year |
| Copayments:<br>- 1st through the 5th visit<br>- 6th through the 20th visit<br>- 21st through the 50th visit | <br>$ 0 Copayment<br>$20 Copayment<br>$50 Copayment |
| *For purposes of determining the number of treatment days for the maximum inpatient benefit, Residential Treatment days are counted as 70 percent of one day and Day Treatment days are counted as 60 percent of one day. This permits the Member to obtain additional coverage when alternate levels of care are utilized. Number of visits are determined by clinical appropriateness under the Plan's guidelines for Medical Necessity.<br><br>All Mental Health treatment must be Pre-Authorized by PBHI. The number of visits, days, or episodes authorized must be Medically Necessary as defined in this Employee Behavioral Health Benefits Plan. | |

## Eligibility for In-Area and Worldwide Benefits

The in-area or worldwide status of the primary subscriber (employee, annuitant, or survivor annuitant) determines whether the employee/annuitant/survivor annuitant and dependent receive in-area or worldwide behavioral health benefits. However, in-area members who live or travel outside the United States receive emergency PBHI benefits only.

**The information on these pages is provided by PacifiCare Behavioral Health, Inc. If you have questions about this information, call the Customer Service number at the bottom of this page.**

| **Chemical Dependency Rehabilitation** | |
|---|---|
| Maximum Inpatient Benefit, Per Member Per Lifetime (Combined with Mental Health and Detoxification) | 130 days |
| Calendar Year Maximum Benefit | $10,000 |
| **Inpatient, Residential, Day and Outpatient Treatment** (Combined with Detoxification) | 1 treatment episode per Calendar Year* |
| Days to be determined based on the following levels of care:<br>- Inpatient<br>- Residential Treatment<br>- Day Treatment | <br>1 day<br>7/10 of 1 day<br>6/10 of 1 day |
| Calendar Year Deductible Amount (Waived for detoxification and outpatient treatment) | $250 |
| Coverage Level | 80% |
| Non-Compliance Reduction (the percentage by which the Member's coverage level is reduced when the Member leaves the Chemical Dependency Inpatient, Residential Treatment, or Day Treatment program against the medical advice of a PacifiCare Behavioral Health, Inc. Participating Provider). | 30% |
| *For purposes of determining the number of treatment days for the maximum benefit, Residential Treatment days are counted as 70% of one day and Day Treatment days are counted as 60% of one day. This permits the Member to obtain additional coverage when alternate levels of care are utilized. Number of visits are determined by clinical appropriateness under the Plan's guidelines for Medical Necessity.<br><br>All Chemical Dependency treatment must be Pre-Authorized by PBHI. The number of visits, days or episodes authorized must be Medically Necessary as defined in this Employee Behavioral Health Benefits Plan. | |

| **Detoxification** | |
|---|---|
| Maximum Inpatient Benefit, Per Member Per Lifetime (Combined with Mental Health and Chemical Dependency) | 130 days |
| Calendar Year Maximum Benefit | $10,000 |
| Maximum Benefit, Per Member Per Calendar Year (Combined with Inpatient Chemical Dependency) | 1 treatment episode* |
| Calendar Year Deductible Amount | None |
| Coverage Level | 80% |
| * Length of treatment episode(s) are determined by clinical appropriateness under the Plan's guidelines for Medical Necessity.<br><br>All Detoxification Services must be Pre-Authorized by PBHI. The number of visits, days or episodes authorized must be Medically Necessary as defined in this Employee Behavioral Health Benefits Plan. | |

**The information on these pages is provided by PacifiCare Behavioral Health, Inc. If you have questions about this information, call the Customer Service number at the bottom of this page.**

## Medicare Private Contracting Provision

Recently enacted Federal legislation allows physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services (that would otherwise be covered by Medicare) from these physicians or practitioners will need to enter into written "private contracts" with these physicians or practitioners requiring the beneficiary to be responsible for all payments to such providers. Services provided under "private contracts" are not covered by Medicare, and the Medicare limiting charge will not apply.

If you are classified as a retiree by the University of California (or otherwise have Medicare as primary coverage) and enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement with one or more physicians or practitioners, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. No benefits will be paid by this University of California Plan for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered.

However, if you do sign a private contract with a physician or practitioner, you may see other physicians or practitioners without those private contract restrictions as long as they have not opted out of Medicare.

## Definitions

**Assessment Process:** The process by which the PBHI Clinician gathers information to determine Medical Necessity. The Member is asked a series of questions about the current life circumstances that are contributing to his/her lack of psychological well-being. The interview includes specific questions about areas of emotional duress and to what degree there is an impairment of functioning at the Member's work, leisure and daily activities. The information is quantified into a numerical basis to facilitate tracking the quality of treatment and the effectiveness of treatment.

**Behavioral Health Services:** Services rendered or made available to a Member for treatment of Chemical Dependency or Mental Disorders.

**Behavioral Health Treatment Plan:** A written clinical presentation of the Participating Practitioner's diagnostic impressions and therapeutic intervention plans. The Behavioral Health Treatment Plan is submitted routinely to the PBHI Clinician for review as part of the concurrent review monitoring process.

**Behavioral Health Treatment Program:** A structured set of interventions aimed at the treatment and alleviation of Chemical Dependency or Mental Disorders.

**The information on these pages is provided by PacifiCare Behavioral Health, Inc. If you have questions about this information, call the Customer Service number at the bottom of this page.**

**Calendar Year:** The period of time commencing at 12:01 A.M. on January 1 and ending at 12:01 A.M. on the next January 1. Each succeeding like period will be considered a new Calendar Year.

**Calendar Year Deductible:** The amount of Covered Expense a Member is responsible to pay per Calendar Year before benefits become payable under this Employee Behavioral Health Benefits Plan.

**Chemical Dependency:** An addiction of a Member to any drug, alcohol, or chemical substance that can be documented according to the criteria in the DSM-IV. Chemical Dependency does not include addiction to or dependency on tobacco in any form or food substances in any form.

**Chemical Dependency Treatment Program:** A structured medical and behavioral program aimed at the treatment and alleviation of Chemical Dependency.

**Chemical Detoxification:** Routine treatment and stabilization for symptoms resulting from withdrawal from chemical substances, including drugs or alcohol, which does not require intensive nursing, monitoring or procedures such as intravenous fluids. Where such services are a covered benefit, Members must:

- obtain medical clearance from Primary Care Physician prior to receiving Chemical Detoxification from PBHI, and
- receive Chemical Detoxification services from a Participating Provider.

**Contracted Rate:** The rate, or percentage thereof, that the Participating Provider agrees to accept from Plan Sponsor as payment in full for covered services, excluding any applicable Copayments by the Member.

**Copayments:** Fees payable to a Practitioner pursuant to this Plan by the Member at the time of provision of Behavioral Health Services. Such fees are a specific dollar amount.

**Coverage or Covered:** The entitlement by a Member to have this Plan pay for or arrange for Behavioral Health Services.

**Covered Expense:** An expense that:

- is incurred for a Behavioral Health Service provided to a Member while that person is covered under this Plan;
- does not exceed the Maximum Benefit that may apply to the expense; and
- does not exceed the applicable negotiated fees of a Participating Provider.

**Customer Service Department:** The person or persons designated to whom the Member may address questions or complaints. Customer Service may be contacted by telephone at 1-800-817-8811 or in writing at:

**The information on these pages is provided by PacifiCare Behavioral Health, Inc. If you have questions about this information, call the Customer Service number at the bottom of this page.**

**Customer Service Department**
**PacifiCare Behavioral Health, Inc.**
**5990 Sepulveda Blvd., Ste. 400**
**Van Nuys, California 91411**

**Day Treatment Center:** A licensed or certified Facility which provides a Behavioral Health Treatment program on a full or part-day basis pursuant to a written treatment plan approved and monitored by a Practitioner.

**Dependent:** Any individual who is enrolled hereunder, who meets all the eligibility requirements set forth in *Section 2: Enrollment and Termination Information* of this booklet.

**Diagnostic and Statistical Manual-IV (or DSM-IV):** The fourth edition of *Diagnostic and Statistical Manual of Mental Disorders,* which is published by the American Psychiatric Association and which lists the criteria for diagnosis of Chemical Dependency and Mental Disorders.

**Emergency or Emergency Services:** Medically Necessary Behavioral Health Services due to acute symptoms of sufficient severity such that the absence of immediate Behavioral Health Services could reasonably be expected to result in the following:

- immediate harm to self or others;
- placing the Member's health in serious jeopardy;
- serious impairment of the Member's functioning; or
- serious and permanent dysfunction of the Member.

**Emergency Treatment:** The immediate and unscheduled screening, examination and evaluation of a Member by a Practitioner at a Facility to determine if an Emergency exists. If an emergency is found to exist, Emergency Treatment will include the care and treatment by the Practitioner and Facility necessary to relieve or eliminate the Emergency Condition, within the capability of the Facility.

**Experimental or Investigational Treatment:** An unproven procedure or treatment regimen that does not meet the generally accepted standards of usual professional medical practice in the general medical community.

**Facility:** An entity which is duly licensed by the state in which it operates to provide inpatient, residential, day treatment, partial hospitalization or outpatient care for the diagnosis and/or treatment of Chemical Dependency or Mental Disorders.

**Grievance Procedure:** The procedure for reviewing complaints of Members.

**The information on these pages is provided by PacifiCare Behavioral Health, Inc. If you have questions about this information, call the Customer Service number at the bottom of this page.**

**Group Therapy:** Goal-oriented Behavioral Health Service provided in a group setting (6 to 12 participants) by a Participating Practitioner. Group Therapy can be made available to the Member in lieu of individual outpatient therapy when appropriate.

**Inpatient Treatment Center:** An acute care Facility which provides a Behavioral Health Treatment Program in an acute, inpatient setting, pursuant to a written treatment plan approved and monitored by a Practitioner, and which Facility also:

- provides 24-hour nursing and medical supervision;
- has established a written referral relationship with a local hospital for patients beyond its scope of treatment capability; and
- is licensed, certified or approved as such by the appropriate state agency.

**Maximum Benefit:** The maximum amount which this Plan will pay for any authorized Behavioral Health Services provided to Members by Practitioners and Facilities.

**Medical Detoxification:** Treatment for a medical condition resulting from the withdrawal from toxic substances, including drugs or alcohol; such treatment includes a complete history and physical examination and medical supervision of Member's medical records.

**Medical Expenses:** Any costs related to physical illness or injury.

**Medically Necessary Services:** Behavioral Health services or supplies for treatment of an active Mental Disorder or Chemical Dependency, which have been established in accordance with the generally accepted professional standards and the Plan's utilization review committee to be:

- Rendered for the treatment and diagnosis of a severe Mental Disorder or Chemical Dependency, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and limited to severe impairment of a Member's mental, emotional or behavioral functioning on a daily basis;
- Appropriate for the severity of symptoms, consistent with the diagnosis, and otherwise in accordance with the generally accepted medical practice and professionally recognized standards.
- Not furnished primarily for the convenience of the Member, the attending Physician or other provider of service; and
- Furnished at the most appropriate level which may be provided safely and effectively to the Member.
- Designed to diminish the Member's acute symptoms and stabilize the Member's condition in the short term.

**Medicare:** The Hospital Insurance Plan (Part A) and the supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act as amended.

**The information on these pages is provided by PacifiCare Behavioral Health, Inc. If you have questions about this information, call the Customer Service number at the bottom of this page.**

**Medicare Retiree:** A Member who is:

- eligible for Medicare Part A and Part B;
- no longer eligible for benefits as an active employee or a Dependent of an active employee;
- properly enrolled in this Plan; and
- eligible for benefits under this Plan pursuant to the requirements set forth in *Section 2* of this booklet.

**Member:** Any Subscriber or Dependent as described in *Section 2: Enrollment and Termination Information* of this booklet.

**Mental Disorder:** A mental or nervous condition diagnosed by a licensed Practitioner according to the criteria in the DSM-IV and limited to severe impairment of a Member's mental, emotional or behavioral functioning on a daily basis.

**Open Enrollment Periods:** The periods during which all eligible employees and their eligible Dependents may enroll in this Plan.

**Outpatient Treatment Center:** A Facility which provides a Behavioral Health Treatment Program in an outpatient setting, and which Facility is also licensed, certified or approved as such by the appropriate state agency.

**PacifiCare Behavioral Health, Inc. ("PBHI"):** The Administrator that the Plan Sponsor has contracted with for administrative services, including but not limited to premium billing and collection, claims payment, case management, preauthorization and provider access.

**Participating Facility:** A Facility which is under contract with PBHI to provide Behavioral Health Services to Members and has agreed to accept the provisions of the applicable agreement, including the facility-specific compensation, plus any applicable Copayment, as the total compensation.

**Participating Practitioner:** A Practitioner who has entered into a contract with PBHI to provide Behavioral Health Services to Members and who has agreed to accept the provisions of the applicable agreement, including the contractually agreed upon compensation plus any applicable Copayments, as the total compensation.

**PBHI Clinician:** A person licensed as a psychiatrist, psychologist, clinical social worker, marriage family child counselor, nurse or other licensed health care professional with appropriate training and experience in Behavioral Health Services, who is employed or under contract with the PBHI, to perform case management services; such services include, without limitation, assessing Chemical Dependency and Mental Disorders, referring to appropriate facilities and/or practitioners, monitoring

and reviewing care received by Members, participating in provider relations and coordinating Behavioral Health Services benefits for Members.

**Plan:** This Employee Behavioral Health Benefits Plan as stated herein.

**Plan Sponsor:** The University of California.

**Practitioner:** A psychiatrist, psychologist, registered nurse, licensed clinical social worker or a marriage, family and child counselor who is duly licensed under the laws of the appropriate state in which the Member resides and who provides Behavioral Health Services.

**Pre-Authorized Services:** Those Behavioral Health benefits described in the Schedule of Behavioral Health Benefits, and which are Medically Necessary and authorized by a PBHI Clinician.

**Prevailing Rates:** The usual, reasonable and customary rates for a particular Behavioral Health Service in the service area.

**Quality Review:** The PBHI procedure of reviewing complaints related to the quality or appropriateness of Behavioral Health Services provided or arranged by PBHI or a Participating Practitioner.

**Residential Treatment Center:** A Facility which provides a Behavioral Health Treatment Program on a full or part-day basis, pursuant to a written treatment plan approved and monitored by a doctor, and which Facility also:

- provides 24-hour nursing and medical supervision; and
- is licensed, certified or approved as such by the appropriate state agency.

**Schedule of Behavioral Health Benefits:** A detailed description of the Behavioral Health Services which are provided to a Member under this Plan. The Schedule of Behavioral Health Benefits is incorporated herein.

**Subscriber:** The person whose employment or other status, except for family dependency, is the basis for eligibility for Coverage under this Plan. A Subscriber must meet all the applicable eligibility requirements of this Plan.

**Total Disability (or Totally Disabled):** For Members, the persistent inability to reliably engage in any substantially gainful activity by reason of any medically determinable physical or mental impairment resulting from an injury or illness. For Dependents, Totally Disabled is the persistent inability to perform activities essential to the daily living of a person of the same age and sex by reason of any medically determinable physical or mental impairment resulting from an injury or illness. Determination

of Total Disability shall be made by a Participating Practitioner on the basis of a medical examination of the Member and upon concurrence by the Plan's medical director.

**Treatment Episode:** A structured course of treatment authorized by a PBHI Clinician and for which a Member has been provided with a Behavioral Health Treatment Plan, received Behavioral Health Services, and been discharged.

**Treatment Program:** A structured set of interventions aimed at the treatment and alleviation of Mental Disorders or Chemical Dependency.

**Urgently Needed Services:** Medically Necessary services required outside of the Service Area to prevent serious deterioration of a Member's health resulting from an unforeseen illness or injury manifesting itself by acute symptoms of sufficient severity, such that treatment cannot be delayed until the Member returns to the Service Area.

**Utilization Management Program:** A PBHI program which promotes the efficient use of resources and maintains the best possible quality of health care. Duties of the Utilization Management Program include the prospective, current and retrospective review of Behavioral Health Services.

**Visit:** An outpatient session with a Participating Practitioner conducted on an individual or group basis during which a Behavioral Health Treatment Program is conducted.

## ■ Eligibility and Enrollment

Behavioral Health Services will be provided to Members who meet the eligibility requirements stated in *Section 2: Enrollment and Termination Information* and are properly enrolled in this Plan. No services or benefits shall be available to any person not specifically enrolled. Coverage under this Plan is subject to payment of the required contribution by the Subscriber, if any contribution is required.

## ■ Benefits and Conditions for Coverage

Subject to all terms, conditions, exclusions, and limitations set forth in this Plan, all eligible Members shall be entitled to the Behavioral Health Services and benefits described in this Plan.

### Member Obligations

Member shall submit to PBHI for reimbursement any and all claims for Emergency Services and Urgently Needed Services received for covered Behavioral Health Services from a non-participating provider within ninety (90) days of the date of service if possible and in no event later than one (1) year from the date services are provided.

**The information on these pages is provided by PacifiCare Behavioral Health, Inc. If you have questions about this information, call the Customer Service number at the bottom of this page.**

## Pre-Authorization for Behavioral Health Services

Except for Emergency Treatment and Urgently Needed Services, all Behavioral Health Services received by a Member must be pre-authorized by a PBHI Clinician in order to qualify for coverage under this Plan. Members requiring Behavioral Health Services must call PBHI's 24-hour telephone number identified herein to arrange for an appointment with a PBHI Clinician.

A PBHI Clinician will evaluate the nature and severity of the Member's problem for Medical Necessity. If treatment is determined Medically Necessary, the PBHI Clinician will recommend the most appropriate treatment for Member. The PBHI Clinician will contact the Participating Facility or Participating Practitioner regarding the initially authorized Behavioral Health Treatment Program. The PBHI Clinician will only authorize services which are Medically Necessary for the treatment of Mental Disorders or Chemical Dependency.

No benefits are paid for services provided without the prior authorization of the PBHI Clinician, unless such services are Urgently Needed or required because of an Emergency.

## Eligibility for In-Area and Worldwide Benefits

The in-area or worldwide status of the primary subscriber (employee, annuitant, or survivor annuitant) determines whether the employee/annuitant/survivor annuitant and dependent receive in-area or worldwide behavioral health benefits. However, in-area members who live or travel outside the United States receive emergency PBHI benefits only.

## Medicare Private Contracting Provision

Recently enacted Federal legislation allows physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services (that would otherwise be covered by Medicare) from these physicians or practitioners will need to enter into written "private contracts" with these physicians or practitioners requiring the beneficiary to be responsible for all payments to such providers. Services provided under "private contracts" are not covered by Medicare, and the Medicare limiting charge will not apply.

If you are classified as a retiree by the University of California (or otherwise have Medicare as primary coverage) and enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement with one or more physicians or practitioners, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. No benefits will be paid by this University of California Plan for services rendered by these physicians or practitioners with

**The information on these pages is provided by PacifiCare Behavioral Health, Inc. If you have questions about this information, call the Customer Service number at the bottom of this page.**

whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered.

However, if you do sign a private contract with a physician or practitioner, you may see other physicians or practitioners without those private contract restrictions as long as they have not opted out of Medicare.

## Concurrent Review of Behavioral Health Services

Member shall cooperate with PBHI's concurrent reviews of Behavioral Health Services which shall be conducted on a regular basis throughout a Member's Behavioral Health Treatment Program. The purpose of concurrent reviews is to monitor the Behavioral Health Treatment Program to ensure the effectiveness and appropriateness of the level of care, and to determine the necessity of a continuous stay and/or treatment. The PBHI Clinician must authorize all extended lengths-of-stay and transfers to different levels of care as well as any related additional services.

## Reduction in Benefits for Failure to Complete a Chemical Dependency Inpatient Treatment Program

In order to receive the maximum benefits under this Plan for a specific Chemical Dependency Inpatient Treatment Program, Member must complete the entire Chemical Dependency Inpatient Treatment Program. If Member abandons a Chemical Dependency Inpatient Treatment Program prior to the scheduled discharge or transfer authorized by the PBHI Clinician, coverage for the Chemical Dependency Inpatient Treatment Program under this Plan shall be reduced by thirty percent (30%). Member shall be required to reimburse the Participating Practitioner or Participating Facility for this Copayment.

## Copayments

Copayments, when applicable, are an obligation of the Member at the time services are rendered. Failure to pay a Copayment may result in termination of Member's Coverage under this Plan. A schedule of the applicable Copayments for services rendered to Member is set forth in the Schedule of Behavioral Health Benefits.

## Payment for Non-Covered Services

Nothing in this Plan shall prevent the Plan or the Participating Practitioner from collecting Prevailing Rates from the Member for noncovered services or for services rendered due to fraud or misrepresentation by Member.

## Emergency Treatment and Urgently Needed Services

The cost of an Emergency Treatment and Urgently Needed Services shall be covered by this Plan if the following procedures are followed.

**The information on these pages is provided by PacifiCare Behavioral Health, Inc. If you have questions about this information, call the Customer Service number at the bottom of this page.**

***Procedure for Emergency Treatment and Urgently Needed Services*** —

- If Member or someone acting on Member's behalf is unable to contact PBHI prior to going to a Facility for an Emergency Admission and Urgently Needed Services, Member or the person(s) acting on Member's behalf must notify or take reasonable steps to notify PBHI within twenty four (24) hours or as soon as reasonably possible after the Emergency Treatment and Urgently Needed Services to inform PBHI of the location, duration and nature of the Emergency Treatment or Urgently Needed Services.
- If an Emergency Treatment or Urgently Needed Services are rendered at a Facility not designated by PBHI, Member or Member's representative should notify PBHI in writing as soon as possible of the nature and necessity of the Emergency Treatment and Urgently Needed Services and should attach any bills Member has received. Undisputed claims for Emergency Treatment and Urgently Needed Services shall be paid within thirty (30) working days of receipt of a properly completed claim.

  Mail notification and bills to:

  **PacifiCare Behavioral Health, Inc.**
  **Claims Department**
  **23046 Avenida de la Carlota, Ste. 700**
  **Laguna Hills, CA 92653**

- Facility admissions for non-emergency or non-Urgently Needed Behavioral Health Services which have not been authorized by PBHI and visits to non-Participating Practitioner for non-emergency or non-Urgently Needed Behavioral Health Services which have not been authorized by PBHI are not covered under this Plan.

### Continuing or Follow-up Treatment

Continuing or follow-up treatment to an Emergency Treatment or for non-Urgently Needed Services must be coordinated through PBHI. PBHI will require the Member to transfer to a Participating Practitioner or Facility designated by PBHI, provided the transfer does not create an unreasonable risk to the Member's health.

## ■ Acts Beyond the Control of the Plan Sponsor or PBHI

In the event of circumstances not reasonably within the control of the Plan Sponsor or PBHI, such as any major disaster, epidemic, complete or partial destruction of Facility, war, riot, or civil insurrection, which results in the unavailability of the Facilities, personnel or Participating Practitioners, the Plan Sponsor, PBHI, Participating Practitioners and Participating Facilities shall provide or attempt to arrange for Behavioral Health Services insofar as practical, according to their best judgment,

within the limitation of such Facilities and personnel. Neither the Plan Sponsor nor PBHI nor any Participating Practitioner or Participating Facility shall have any liability or obligation for delay or failure to provide or arrange for Behavioral Health Services if such delay or failure is the result of any of the circumstances described above.

## ■ Questions or Complaints

If a Member has questions or a problem regarding services or benefits received by PBHI, simply call PBHI at **1-800-817-8811.** The Member may consult with the Benefits Representative, or this benefit booklet.

If the Member wishes to file a formal complaint in writing, send it to:

**PacifiCare Behavioral Health, Inc.**
**Appeals Department**
**5990 Sepulveda Blvd., Ste. 400**
**Van Nuys, CA 91411**

When a complaint is received either by telephone at 1-800-817-8811 or in writing by a PBHI Member Service Associate, the following procedure will be followed in handling complaints under the Appeals Procedure:

The PBHI Member Service Associate shall document the complaint (received either by telephone or in writing), the date received and the name of the PBHI Member Service Associate recording the complaint. If the complaint is by telephone and the person taking the call is unable to resolve the problem to the Member's satisfaction, the Member will be asked to submit a written complaint. The PBHI Member Service Associate will assist the Member in filing a written complaint if the Member desires the assistance.

All complaints are directed to the Quality Management Manager ("QM Manager"). The QM Manager will conduct an initial review within one business day and refer all complaints that do not involve a quality of care issue to the Appeals Coordinator for review pursuant to the Appeals Procedure. Complaints involving a quality of care issue are referred to the Quality Review process.

### Appeals Procedure

***Level 1*** — After receipt of the complaint from the QM Manager, the Appeals Coordinator shall conduct a review, consulting the appropriate parties, including case managers and relevant providers. Cases needing immediate decisions will be reviewed within 72 hours. Within 30 days of the receipt of the Appeal from the Member, PBHI shall send a written initial determination to the Member.

**The information on these pages is provided by PacifiCare Behavioral Health, Inc. If you have questions about this information, call the Customer Service number at the bottom of this page.**

***Level 2*** — If the Member is dissatisfied with the initial determination, the Member may request a review by the Director of Clinical Services or his or her designee by submitting a written request within fifteen (15) days of the receipt of the initial determination. The Director of Clinical Services shall review the complaint and the Member will receive a written redetermination within fifteen (15) days of the day the request was received by the Director of Clinical Services.

***Level 3*** — If the Member is dissatisfied with the determination by the Director of Clinical Services, the Member may request a hearing before the Member Satisfaction Committee. The request for a hearing must be submitted within thirty (30) days of the receipt of notice by the Director of Clinical Services. An informal hearing shall be held within thirty (30) days of the request for the hearing. The Member shall be notified of the hearing time, date and location at least fifteen (15) days prior to the hearing date. The Member has the option of:

- attending the hearing in person; or
- submitting a written response to the Member Satisfaction Committee within thirty (30) days of the hearing.

***Level 4*** — If the Member is still dissatisfied, the Member may submit a request for binding arbitration to the American Arbitration Association.

If the Member's request is not submitted to the American Arbitration Association within sixty (60) days from the date of receipt of notice from the Member Satisfaction Committee, the decision of the Member Satisfaction Committee shall be final and binding. However, if the Member has legitimate health or other reasons which would prevent the Member from electing binding arbitration within sixty (60) days, the Member will have as long as necessary to accommodate the Member's special needs in order to elect binding arbitration.

**By entering into this agreement, you and your dependents agree to give up your constitutional rights to have any dispute decided in a court of law before a jury and instead accept the use of arbitration for resolving disputes with PBHI.**

## ■ Member Claims Against Participating Practitioners and Facilities

Member acknowledges that Participating Practitioners and Participating Facilities are independent contractors and that the Plan does not assume responsibility for the acts of Participating Practitioners and Participating Facilities as the result of this independent contractor relationship.

**The information on these pages is provided by PacifiCare Behavioral Health, Inc. If you have questions about this information, call the Customer Service number at the bottom of this page.**

Member claims for damages as the result of an injury caused or alleged to have been caused by an act or failure to act by Participating Practitioner, Participating Facility or other provider of Behavioral Health Services are not governed by this Plan. Member may seek any appropriate legal action against such persons and entities deemed necessary.

## Disenrollment for Cause

A Member may be disenrolled for cause if the Member threatens the life or well-being of the Plan's, PBHI's or a Participating Facility's personnel, or of a Participating Practitioner or its personnel, or any Member. A disenrollment for cause shall be effective on the first day of the calendar month following the month in which notice of disenrollment is given to the Member.

## Member Nonliability After Termination

Except for termination of this Plan for any reason, this Plan shall have no further liability to provide benefits to any Member, including, without limitation, those Members who are inpatient in a Facility or are undergoing treatment for an ongoing condition. Member's rights to receive benefits hereunder shall cease upon the effective date of termination.

## Third Party Liability

In the case of injuries caused by any act or omission of a third party, and any complications incident thereto, the benefits of this Plan shall be furnished to a Member. Member agrees, however, to reimburse this Plan, or its nominee, for the cost of all such benefits provided, at Prevailing Rates, immediately upon obtaining a monetary recovery, whether due to settlement or judgment, on account of such injury. Member shall hold any such sum in trust for this Plan, but said sum shall not exceed the lesser of, the amount of the recovery obtained by Member or the reasonable value of all such benefits furnished to Member or on a Member's behalf by this Plan on account of such incident.

Member agrees that this Plan's rights to reimbursement are the first priority claim against any third party. This means that this Plan shall be reimbursed from any recovery before payment of any other existing claims, including any claim by the Member for general damages. This Plan may collect from the proceeds of any settlement or judgment recovered by Member or his or her legal representative regardless of whether the Member has been fully compensated.

Member agrees to cooperate in protecting the interests of this Plan under this provision. Member must execute and deliver to PBHI any and all liens, assignments or other documents which may be necessary or proper

to fully and completely effectuate and protect the right of this Plan, including, but not limited to, the granting of a lien right in any claim or action made or filed on behalf of Member and the signing of documents evidencing same.

Member shall not settle any claim, or release any person from liability, without the written consent of PBHI, wherein such release or settlement will extinguish or act as a bar to this Plan's rights of reimbursement.

In the event PBHI employs an attorney for the purpose of enforcing any part of this Section against a Member based on Member's failure to cooperate with PBHI, the prevailing party in any legal action or proceeding shall be entitled to reasonable attorney's fees.

In lieu of payment as indicated above, PBHI, at its option, may choose that this Plan be subrogated to the Member's rights to the extent of the benefits received under this Plan. This Plan's subrogation right shall include the right to bring suit in the Member's name. Member shall fully cooperate with PBHI when PBHI exercises this Plan's right of subrogation and Member shall not take any action or refuse to take any action which should prejudice the rights of this Plan.

## ■ Nonduplication of Benefits/ Coordination of Benefits

### Workers' Compensation

This Plan shall not furnish to any Member benefits which duplicate the benefits to which such Member is entitled under any applicable workers' compensation law. The Member is responsible for taking whatever action is necessary to obtain payment under workers' compensation laws where payment under that system can be reasonably expected. Failure to take proper and timely action under such circumstances will preclude this Plan from furnishing such benefits on behalf of such Member to the extent that payment of such benefits could have been reasonably expected under workers' compensation laws had such action been taken.

In the event this Plan for any reason provides benefits which duplicate the benefits to which Member is entitled under workers' compensation law, Member agrees to reimburse this Plan for the cost of all such benefits furnished by this Plan, at Prevailing Rates, immediately upon obtaining a monetary recovery, whether due to settlement or judgment. Member shall hold any sum collected as the result of a workers' compensation action in trust for this Plan. Such sum shall not exceed the lesser of the amount of the recovery obtained by the Member or the reasonable value of all benefits furnished to Member or on Member's behalf by this Plan on account of each incident.

**The information on these pages is provided by PacifiCare Behavioral Health, Inc. If you have questions about this information, call the Customer Service number at the bottom of this page.**

Member to cooperate in protecting the interests of this Plan under this provision. Member must execute and deliver to PBHI or its nominee any and all liens, assignments or other documents which may be necessary or proper to fully and completely effectuate and protect the right of this Plan, including, but not limited to, the granting of a lien right in any claim or action made or filed on behalf of Member and signing any documents evidencing such lien. Member's failure to cooperate with this Plan and PBHI in a reasonable manner as provided in this Section may result in such Member's termination from this Plan.

## Medicare Benefits

Member shall furnish information to PBHI concerning Member's eligibility for Medicare (Part A and/or Part B coverage) upon request by the Plan. In those instances set forth below, this Plan shall not furnish benefits which duplicate the benefits to which Member is entitled as a Medicare beneficiary. Should the cost of Behavioral Health Services exceed the coverage of any applicable Medicare coverage, Plan benefits shall be provided over and above such coverage.

If payment is made by this Plan in duplication of the benefits available to Member as a Medicare beneficiary as set forth below, this Plan may seek reimbursement from the insurance carrier, provider, or Member up to the amount this Plan has paid for benefits which duplicate the Medicare coverage.

***Plan is Primary*** — In the following instances, this Plan shall furnish benefits to Members with Medicare coverage, and Medicare shall be responsible for payment only to the extent the services provided to Member are not covered under this Plan:

- **Aged Employees.** Subscribers actively employed age sixty-five (65) or older or any Dependent age sixty-five (65) or older, unless the Subscriber or Dependent elects to retain Medicare as his or her primary insurer;
- **Disabled Employees.** Members eligible for Medicare as the result of a disability;
- **End-Stage Renal Disease Beneficiaries (Initial Period).** Members entitled to Medicare solely on the basis of end-stage renal disease, beginning the earlier of:
  - the month in which the Member initiates a regular course of renal dialysis, or
  - the month in which an individual who receives a kidney transplant could become entitled to Medicare.

***Medicare is Primary*** — In the following instances, this Plan's coverage shall be limited to the costs of Behavioral Health Services which are not covered by Medicare:

- **Medicare Retirees.** Members who meet the definition of Medicare Retiree set forth in Medicare laws and regulations;
- **Members Who Elect Medicare as Primary.** Members for which this Plan would otherwise be primary, but who elect to have Medicare as their primary insurer.

## CHAMPUS Benefits

The Member shall furnish information concerning any applicable benefits from the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) to which Member may be entitled upon request by this Plan. This Plan shall not furnish benefits which duplicate the benefits to which Member is entitled under CHAMPUS.

If payment is made by this Plan in duplication of the benefits available under CHAMPUS, this Plan may seek reimbursement up to the amount this Plan has paid for benefits which duplicate such coverage from CHAMPUS.

## Automobile, Accident, or Liability Coverage

This Plan shall not furnish benefits which duplicate the benefits to which a Member is entitled under any other automobile, accident, or liability coverage. Member is responsible for taking whatever action is necessary to obtain the benefits of such coverage when it is available and shall notify PBHI of such coverage when available. If benefits are furnished by this Plan in duplication of the benefits available to Member under other automobile, accident or liability coverage, this Plan may seek reimbursement to the extent of the reasonable value of the benefits furnished by this Plan from the insurance carrier, provider and Member.

Should the cost of Behavioral Health Services exceed the coverage of any applicable other coverage pursuant to this Section, this Plan shall furnish benefits over and above such coverage.

## Coordination of Benefits ("COB")

This Plan contains a COB provision that prevents duplication of payments. When a Member is eligible for benefits under any other valid coverage, the combined benefit payments from all coverages cannot exceed 100 percent of the Plan's covered expenses. All of the benefits furnished under this Plan are subject to this provision. When this Plan is secondary, all provisions (such as using a Participating Provider, and/or obtaining prior approval) must be followed. Failure to do so may result in no benefits or reduced benefits from PBHI.

The following rules determine which coverage pays first:

***No COB Provision*** —

a) If the other valid coverage does not include a COB provision, that coverage pays first and this Plan pays secondary benefits.

***Subscriber/Dependent*** —

b) The benefits of a Plan which covers the Member as a Subscriber shall be determined before the benefits of a Plan which covers such Member as a Dependent.

***Dependent Child*** —

c) Except as stated in subparagraph d) below the benefits of the Plan of the parent whose month and day of birth occurs earlier in a Calendar Year, shall be determined before the benefits of a Plan of the parent whose month and day of birth occurs later in a Calendar Year. If the other coverage does not follow this birthday rule, then the father's coverage pays first.

***Custodial/Noncustodial Parent*** —

d) In the case of a Member for whom claim is made as a Dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a Dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a Dependent of the parent without custody.

e) In the case of a Member for whom claim is made as a Dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a Dependent of the stepparent. In addition, the benefits of a Plan which covers that child as a Dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a Dependent of the parent without custody.

***Court-Decree Obligations*** —

f) In the case of a Member for whom claim is made as a Dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding rules d) and e), the benefits of a Plan which covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a Dependent child.

***Active/Inactive Employee*** —

g) The benefits of a Plan covering the person as a laid-off or retired employee, or as a Dependent of such person, shall be determined after the benefits of any other Plan covering such person as an employee, other than a laid-off or retired employee, or Dependent of such person; and if either Plan does not have a provision regarding laid-off or retired employees, which results in each Plan determining its benefits after the other, then the next rule applies.

**The information on these pages is provided by PacifiCare Behavioral Health, Inc. If you have questions about this information, call the Customer Service number at the bottom of this page.**

***Longer/Shorter Length of Coverage*** —

h) When rules a) through g) do not establish an order of benefit determination, the benefits of a Plan which has covered the Member for the longer period of time shall be determined before the benefits of a Plan which has covered such Member the shorter period of time.

When this provision operates to reduce the total amount of benefits otherwise payable to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

### Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing of the terms of this provision of this Plan or any provision of similar purpose of any other Plan, this Plan may release to or obtain from any insurance company or other organization or person any information, with respect to any person, which this Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish such information as may be necessary to implement this provision.

### Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, this Plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability under this Plan.

### Right of Recovery

Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, this Plan shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as this Plan shall determine: any persons to or for or with respect to whom such payments were made, any insurers, service plan or any other organizations.

## ■ Miscellaneous Provisions

### Amendments

This Plan and this Summary Plan Description may be amended or terminated at any time in the Plan Sponsor's discretion. Members will receive notice of any amendment to this Plan. No one has the authority to make any oral modifications to this Plan or the Summary Plan Description.

**The information on these pages is provided by PacifiCare Behavioral Health, Inc. If you have questions about this information, call the Customer Service number at the bottom of this page.**

### Notice

All notices, whether to the Plan from Members or to Members from PBHI, must be written and sent through first class mail.

## Covered Services

This Plan will pay for the following Covered Services furnished in connection with the treatment as outlined in the Schedule of Behavioral Health Benefits. Services must be:

- incurred while the Member is eligible for benefits;
- pre-authorized by a PBHI Clinician as Medically Necessary; and
- rendered by a Participating Provider, except in the case of Behavioral Health Services Emergency Treatment and Urgently Needed Services.

Payments are subject to Deductibles, Copayments, percentage payable and Maximum Benefits While Covered as described in the Schedule of Behavioral Health Benefits.

Covered Services include:

- Individualized evaluation of needs, referral into treatment and monitoring by a PBHI Clinician.
- Behavioral Health Services provided at Inpatient Treatment, Residential Treatment, Day Treatment and Outpatient Treatment.
- Services and supplies Medically Necessary for the treatment of the Member apart from professional services, as authorized by a PBHI Clinician.
- Behavioral Health Services provided by PBHI Participating Provider, which are received at a PBHI contracted Facility.
- Outpatient Treatment services.
- Nursing by a Registered Nurse (RN), a Licensed Practical Nurse (LPN), or a Licensed Vocational Nurse (LVN) when Medically Necessary to accompany services provided by a PBHI Participating Provider.
- Practitioner services for individual, group and family therapy provided by a Participating Provider.
- Local ambulance service to and from a Facility in the event of an Emergency or Urgently Needed Services will be paid at usual and customary rates.
- Physical examination and intake history which are indicated and Medically Necessary as determined by a PBHI Clinician.
- Psychological testing when pre-authorized by a PBHI Clinician and provided by a licensed psychologist under contract with PBHI.
- Emergency Treatment and Urgently Needed Services as defined in the Agreement.
- Inpatient laboratory service authorized by a PBHI Clinician related to the approved services.
- Treatment for an eating disorder, as defined by the DSM-IV Reference Guide when Pre-Authorized by a PBHI Clinician.
- Chemical Detoxification.

**The information on these pages is provided by PacifiCare Behavioral Health, Inc. If you have questions about this information, call the Customer Service number at the bottom of this page.**

### Cost Control Reduction

The Percentage Payable is reduced by 30% when a Member leaves any Chemical Dependency Treatment Program prior to the authorization by the Case Manager of the discharge or transfer plan.

## ■ Exclusions and Limitations

No payment will be made for any of the following:

- Any confinement, treatment, service or supply not authorized by a PBHI Clinician, except for Behavioral Health Services Emergency Treatment.
- Any confinement, treatment service or supply not provided for the treatment authorized by a PBHI Clinician.
- Services, treatment and/or supplies that are provided, as a result of Workers' Compensation Law or similar law.
- Services, treatments and/or supplies obtained through or required by any governmental agency or program or any subdivision thereunder including but not limited to services required for treatment of disabilities acquired in the course of military service.
- Weight control programs, treatment for addiction to or dependency on tobacco or nicotine; treatment for caffeine dependency or dependency on any food substance.
- Services, treatments, and/or supplies deemed to be experimental or Investigational by PBHI's Medical Director or his/her designee.
- Treatment for any reading or learning disorder, mental retardation, autism, or other developmental disability, as defined by the DSM-IV.
- Counseling for adoption, custody, family planning or pregnancy in the absence of a mental disorder diagnosis generally recognized and accepted by the medical community and limited to a DSM-IV mental disorder diagnosis.
- Counseling in preparation for or associated with a sex change operation.
- Sexual therapy programs, including without limitation, therapy for sexual addiction, use of sexual surrogate, sexual treatment of sexual offenders or perpetrators of sexual violence in the absence of a mental disorder diagnosis generally recognized and accepted by the medical community and limited to a DSM-IV psychiatric diagnosis.
- Pastoral or Spiritual counseling.
- Dance, poetry, music or art therapy, except within an inpatient or alternative care milieu.
- Non-organic therapies, including but not limited to the following: bio-energetic therapy, confrontation therapy, crystal healing therapy, educational remediation, EMDR, guided imagery, marathon therapy, primal therapy, rolfing, sensitivity training, training analysis (tuitional, orthodox), transcendental meditation, Z therapy.

**The information on these pages is provided by PacifiCare Behavioral Health, Inc. If you have questions about this information, call the Customer Service number at the bottom of this page.**

- Organic therapies, including but not limited to the following: aversion therapy, carbon dioxide therapy, environmental ecological treatment or remedies, herbal therapies, hemodialysis for schizophrenia, vitamin or orthomolecular therapy, narcotherapy with LSD, sedative action electrostimulation therapy.
- Private rooms and/or private duty nursing unless Medically Necessary as determined by a PBHI Medical Director or his/her designee.
- Services which are predominantly for assistance in the activity of daily living, custodial or domiciliary in nature.
- Treatment for conditions often described as compulsive gambling.
- All non-prescription drugs and prescription drugs, except when prescribed by a PBHI Participating Provider in connection with a Member's treatment as an inpatient at a Participating acute care Facility.
- Surgery or acupuncture.
- Services required by court order as a condition of parole or probation, or in lieu of incarceration which are not Medically Necessary.
- Services which are not Medically Necessary for the treatment of Behavioral Health disorders.
- Long-term insight-oriented psychotherapies designed to regress the Member emotionally or behaviorally.
- Personal enhancement, self actualization therapy or other non-Medically Necessary treatment programs.
- Services which are provided by a non-licensed Practitioner or a non-licensed Facility.
- Neurological services and tests, including but not limited to, EEGs, PET scans, beam scans, MRIs, skull x-rays and lumbar punctures.
- Biofeedback in the absence of a Mental Disorder diagnosis.
- Chronic pain unless determined by the PBHI Medical Director or his/her designee to be predominantly of psychological origin.
- Treatments which do not meet national standards for mental health professional practice.
- Treatment sessions provided by telephone or computer internet services.
- Methadone maintenance or treatment.
- Durable medical goods.
- Nutritional counseling.
- Catastrophic illness diagnosis.
- Physical needs from suicide.
- Medical Detoxification.
- Services furnished by a relative.

**The information on these pages is provided by PacifiCare Behavioral Health, Inc. If you have questions about this information, call the Customer Service number at the bottom of this page.**

# 11 Plan Administration

By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts, service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. The terms of those documents apply if information in this booklet is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this booklet and/or the Administrative Services Agreement. What is written in this booklet does not constitute a guarantee of plan coverage or benefits; particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

This section describes how the Plan is administered and what your rights are.

## Sponsorship and Administration of the Plan

The University of California is the Plan sponsor and administrator for the Plan described in this booklet. If you have a question, you may direct it to:

**University of California**
**Human Resources and Benefits**
**300 Lakeside Drive, 5th Floor**
**Oakland, CA 94612-3557**
**1-800-888-8267, extension 70651**

**Medical:** New Mexico Blue Cross and Blue Shield, Inc. (BCBSNM) provides certain administrative services for the medical/hospital/surgical benefits described in this booklet.

Medical/hospital/surgical claims under the Plan are processed by BCBSNM at the following address and phone number:

**Blue Cross and Blue Shield of New Mexico**
**LANL DSU**
**P. O. Box 27630**
**Albuquerque, New Mexico 87125-7630**
**1-800-711-3795**

**Mental Health/Chemical Dependency Benefits:** PacifiCare Behavioral Health, Inc. provides certain administrative services for mental health/chemical dependency benefits.

If you have a question or need to file a claim, you may direct it to:

**PacifiCare Behavioral Health, Inc.**
**5990 Sepulveda Blvd., Ste. 400**
**Van Nuys, California 91411**
**1-800-817-8811**

## Group Contract Number

The Group Contract Numbers for this Plan are: N25011, N25013, N25015

## Type of Plan

This Plan is a health and welfare plan that provides group medical care benefits. This Plan is one of the benefits offered under the University of California's employee health and welfare benefits program.

## Plan Year

The plan year is January 1 through December 31.

## Continuation of the Plan

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. The Plan is not a vested plan. The right to terminate or amend applies to all employees, annuitants and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums, and what portion of the premiums the University will pay. The portion of the premium the University pays is subject to state appropriation which may change or be discontinued in the future.

## Financial Arrangements

The medical/hospital/surgical benefits under the Plan are provided by the University of California on a self-funded basis. Administrative services are provided by BCBSNM under an Administrative Services Agreement. The cost of coverage is shared between you and the University of California.

The mental health/chemical dependency benefits under the Plan are provided by the University of California on a self-funded basis. Administrative services are provided by PacifiCare Behavioral Health, Inc. under an Administrative Services Agreement.

Any dollar amounts remaining in a participant's account will be forfeited to the Plan if the funds are not claimed within three years from the date of issue. If the participant has not accepted the distribution, corresponded in writing regarding the distribution, or indicated an interest in the distribution within three years after it became distributable, the participant may make a claim to the Plan for reimbursement of the forfeited benefit.

## Your Rights Under the Plan

As a participant in a University of California medical plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, or instead of or in addition to, at other locations that may be specified by the Plan Administrator, all Plan documents, including BCBSNM's and PBHI's Administrative Services Agreements.
- Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

## Claims Under the Plan

### Medical

To file a claim or to appeal a denied medical/hospital/surgical claim, refer to *Section 7: Claims Payments and Appeals*.

### Mental Health/Chemical Dependency

Claims under PacifiCare Behavioral Health, Inc. are filed by the PacifiCare Behavioral Health, Inc. provider. It is the responsibility of the members to obtain the pre-authorization necessary to receive services from a PacifiCare Behavioral Health, Inc. provider.

### Binding Arbitration

The following applies to the medical/hospital/surgical benefits described in this booklet:

> After exhaustion of the procedures outlined under "Complaint Procedures" in *Section 7,* unresolved matters must be submitted to an independent arbitrator for review. Please refer to "Binding Arbitration" in *Section 8*.

The following applies to the PacifiCare Behavioral Health, Inc. benefits of the plan described in this booklet:

> Claims for monetary damages for bodily injury, mental/health/chemical disturbance or death out of the alleged rendition or failure to render services by plan physicians or other personnel or facilities must be submitted to binding arbitration instead of a court trial.

## Nondiscrimination Statement

In conformance with applicable law and University policy, the University of California is an affirmative action/equal opportunity employer.

Inquiries regarding the University's affirmative action and equal opportunity policies may be directed to Assistant Vice President, Ellen Switkes, Academic Advancement at (510) 987-9479 (for academic employee-related matters) or to Mattie L. Williams, Business and Finance at (510) 987-0865 (for staff employee-related matters).

Return to Table of Contents

# *Customer Service Assistance*

## Medical/Surgical/Hospital Benefits

**CALL YOUR BCBSNM CUSTOMER SERVICE REPRESENTATIVE**
**(505) 889-0188 in Albuquerque**
**Toll-Free: 1-800-711-3795**

**CUSTOMER SERVICE DEPARTMENT**
**Blue Cross and Blue Shield of New Mexico**
**Attn: LANL DSU**
**12800 Indian School Road, NE**
**Mailing Address: P.O. Box 27630**
**Albuquerque, New Mexico 87125-7630**

**FOR MEDICAL/SURGICAL ADMISSION REVIEW OR OTHER PRIOR APPROVAL, CALL THE BCBSNM HEALTH SERVICES DEPARTMENT**
**(505) 291-3585 in Albuquerque**
**Toll-Free: 1-800-325-8334**

## Mental Health/Chemical Dependency Benefits

**Customer Service Department**
**PacifiCare Behavioral Health, Inc.**
**5990 Sepulveda Blvd., Ste. 400**
**Van Nuys, California 91411**
**1-800-817-8811**

Use this space for information you will need when asking about your BluePremier coverage:

The identification number on my ID card is _____

The group number on my ID card is _____

Return to Table of Contents

# BlueCross BlueShield of New Mexico

**12800 Indian School Rd., NE**
**Mailing Address: P.O. Box 27630**
**Albuquerque, NM 87125-7630**

**M499 (01/99)**