HMO New Mexico 1999

A Health Maintenance Organization

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Serving:
Most of New Mexico.
Enrollment in this Plan is limited; see page 7 for requirements.

Enrollment Code:
5H1 Self Only
5H2 Self and Family

Visit the OPM website at http://www.opm.gov/insure

Authorized for distribution by the:

United States Office of Personnel Management

RI 73-703

HMO New Mexico

HMO New Mexico, Inc., 12800 Indian School Road, Albuquerque, New Mexico, 87112 has entered into a contract (CS 2729) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called HMO New Mexico, HMONM, or the Plan.

This brochure is the official statement of benefits on which you can rely. A person enrolled in the Plan is entitled to the benefits stated in this brochure. If enrolled for *Self and Family*, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1999, and are summarized on page 20 of this brochure.

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Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records, and claims statements carefully. If you find that a provider, such as a doctor, hospital, or pharmacy, charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation — sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 1-800-423-1630 statewide or 505-291-6945 in Albuquerque and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

General Information

Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency and out-of-area urgent care situations described on pages 14 and 15. If you are

confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See "If you are hospitalized" on page 2.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about: when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).

- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.

- The FEHB Program provides *Self Only* coverage for the enrollee alone or *Self and Family* coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.

- An enrollee with *Self Only* coverage who is expecting a baby or the addition of a child may change to a *Self and Family* enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the *Self and Family* premium for that time period.

- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.

- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not

determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.

- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to re-enroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

You may also remain enrolled in this Plan when you join a Medicare prepaid plan.

Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800-638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may

convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18- or 36-month period noted above.

Notification and election requirements

Separating employees — Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

Children — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

Former spouses — You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices are available — or chosen — when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the Plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the Plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free

General Information (continued)

extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Certificate of creditable coverage

Under Federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB Plan to cover you. This certificate, along with any certificates you receive from other FEHB Plans in which you may have been enrolled, may reduce or eliminate the length of time a preexisting condition clause can be applied to you by a new non-FEHB insurer. If you do not receive a certificate automatically, you must be given one on request.

Facts About This Plan

This Plan is a comprehensive medical plan, sometimes called a health maintenance organization (HMO). When you enroll in an HMO, you are joining an organized system of health care that arranges in advance with specific doctors and hospitals to give care to members and pays them directly for their services. **Members are required to select a personal doctor from among participating Plan primary care doctors.** You generally must receive a referral from the selected primary care doctor before seeking nonemergency care from other providers of health care services, and benefits are available only when covered services are received from Plan providers (unless prior authorized by HMO New Mexico or received in accordance with the procedures described in the "Emergency Benefits" provision). Exception: You may access any Plan obstetrician/gynecologist for an annual gynecological condition, maternity care, or for gynecological conditions without obtaining a referral. There are no claim forms when Plan doctors are used.

Your decision to join an HMO should be based on your preference for the Plan's benefits and delivery system, not just because a particular provider is in the Plan's network. You cannot change plans because a provider leaves the HMO.

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

Information you have a right to know

All carriers in the FEHB Program must provide certain information to you. If you did not receive information about this Plan, you can obtain it by calling HMO New Mexico at 1-800-423-1630 statewide or 505-291-6945, or you may write HMO New Mexico at P.O. Box 11968, Albuquerque, New Mexico, 87192-0968. You may also contact HMO New Mexico by fax at 505-237-5310 or by E-mail at hmonm@bluemail.com.

Information that must be made available to you, upon request, includes:

- Disenrollment dates for 1997.
- Compliance with State and Federal licensing or certification requirements and the dates met. If noncompliant, the reason for noncompliance.
- Accreditations by recognized accrediting agencies and the dates received.
- Carrier's type of corporate form and years in existence
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

Who provides care to Plan members?

HMO New Mexico offers a network of providers. This network, an individual-practice prepayment plan, covers many New Mexico communities. You select a primary care doctor for yourself and each member of your family. To receive benefits, members must use Plan providers at all times (except in those emergency and out-of-area urgent care situations described under the "Emergency Benefits" provision).

Role of a primary care doctor

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Nonemergency services of other providers are covered only when you have been referred by your primary care doctor, with the following exception(s): A woman may see her Plan obstetrician/gynecologist for her annual routine examination, maternity care, and care of gynecological conditions without a referral. Also, out-of-area urgent care services are covered without a referral from your primary care doctor if received in accordance with the procedures described in the "Emergency Benefits" provision.

Choosing your doctor

The Plan's provider directory lists primary care doctors (general practitioners, family practitioners, obstetricians/gynecologists, pediatricians, and internists) with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Member Services Department at 505-291-6945 in Albuquerque or 1-800-423-1630. You can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: **When you enroll in this plan, services (except for those received in accordance with the procedures described in the "Emergency Benefits" provision) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider cannot be guaranteed**.

If you enroll, you will be asked to complete a primary care doctor selection form and send it directly to the Plan, indicating the name of the primary care doctor(s). Members may change their doctor selection by notifying the Plan 30 days in advance.

If you are receiving services from a doctor who leaves the Plan, the Plan will pay for covered services until the Plan can arrange with you for you to be seen by another participating doctor.

Referrals for specialty care

In order to receive benefits, you **must** receive a referral from your primary care doctor **before** seeing any other doctor or obtaining special services (except for services received in accordance with the procedures described in the "Emergency Benefits" section, for specified obstetric/gynecological services received from Plan providers, or when your primary care doctor has designated another doctor to see his or her patients). Referral to a Plan specialist is given at the primary care doctor's discretion; if non-Plan specialists or consultants are required, the primary care doctor will make arrangements for appropriate referrals.

All follow-up care must be provided or authorized by the primary care doctor. **Do not return to the specialist for a second visit unless your primary care doctor has arranged for, and the Plan has issued an authorization for, the referral in advance.** If you do not have a referral, benefits will be denied.

If you have a chronic, complex, or serious medical condition that causes you to see a Plan specialist frequently, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist. The Plan's medical staff will evaluate exceptions to the standard referral policy, and if approved, the treatment plan developed will permit you to visit your specialist without the need to obtain further referrals.

Authorizations

The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose, or treat your illness or condition. Your Plan doctor must obtain the Plan's determination of medical necessity before you may be hospitalized or referred for specialty care services, or obtain follow-up care from a specialist.

Facts About This Plan (continued)

For new members

If you are already under the care of a specialist who is a Plan provider, you must still obtain a referral from a Plan primary care doctor for the care to be covered. If the doctor who originally referred you to this specialist is now your Plan primary care doctor, you need only call to explain that you are now an HMO New Mexico Plan member and ask that you be referred for your next appointment. Please contact HMO New Mexico as soon as you join HMO New Mexico, so the HMO can make the arrangements needed.

If you are selecting a new primary care doctor and want to continue with this specialist, you must schedule an appointment so that the primary care doctor can decide whether to treat the condition directly or refer you back to the specialist.

Hospital care

If you require hospitalization, your primary care doctor or authorized specialist will make the necessary arrangements and continue to supervise your care.

Out-of-pocket maximum

Copayments are required for most benefits. However, copayments will not be required for the remainder of the calendar year after your out-of-pocket expenses for services provided or arranged by the Plan reach **$3,300** per *Self Only* enrollment or **$8,700** per *Self and Family* enrollment. This copayment maximum does not include the copays incurred in the outpatient and inpatient treatment of substance abuse, the copays incurred in the outpatient treatment of mental conditions, the $25 per day copay incurred in the inpatient treatment of mental conditions, inpatient admission copays, or the costs of prescription drugs.

You should maintain accurate records of the copayments made, as it is your responsibility to determine when the copayment maximum is reached. You are assured a predictable maximum in out-of-pocket costs for covered health and medical needs. Copayments are due when services are rendered.

Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Experimental/ investigative determinations

A product or procedure is considered **not** experimental or investigational if it meets all of the following conditions:

- It has final approval from the appropriate government regulatory bodies.
- The scientific evidence permits conclusions concerning the effect of the technology on health outcomes.
- The technology improves the net health outcome.
- The technology is as beneficial as any established alternatives.

The investigational process may not be required if the research and experimental stage of development is completed and the improvement in net health outcome is attainable outside the investigational setting.

Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures that may be recommended by Plan providers.

The Plan's service area

The service area for this Plan, where Plan providers and facilities are located, is described below. You may enroll in this Plan if you live or work inside the service area or live in the geographic area described below.

Benefits for care outside the service area are limited to emergency and urgent care services, as described on pages 14 and 15.

If you or a covered family member move outside the service area, or further away from the service area, you may enroll in another approved plan, or apply for the "Guest Membership" option offered by HMO New Mexico (see below). It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

The service area for this Plan includes the following areas: Bernalillo, Catron, Chaves, Colfax, Curry, DeBaca, Doña Ana, Grant, Guadalupe, Hidalgo, Lea, Lincoln, Los Alamos, Luna, Mora, Otero, Quay, Rio Arriba, Roosevelt, Sandoval, San Miguel, Santa Fe, Sierra, Socorro, Taos, Torrance, and Valencia Counties.

Guest Membership

If you are temporarily working or residing out of state for at least 90 days, you are eligible for Guest Membership for up to 180 days of membership in one of the many participating Blue Cross and Blue Shield HMOs. Also, covered family members residing in another state for at least 90 days may also enroll for coverage in the out-of-state, host HMO Plan for as long as this Plan is being offered through FEHB, or until the dependent is no longer eligible for coverage (e.g., reaches dependent age limit or subscriber terminates coverage). Under either option, the local HMO provides all of the services and access available through their Plan.

Note: A member covered under another HMO's Guest Membership is subject to the eligibility criteria of this HMO New Mexico Plan; however, such members will receive a benefit booklet and summary from the host HMO Plan. The benefits and coverage limitations and exclusions of this benefit booklet will not apply to guest members of another HMO Plan. Also, guest members of another Plan cannot enroll in temporary continuation coverage (TCC) directly through the other Plan. In such cases, the member should contact HMO New Mexico as soon as possible after learning that his/her coverage will cease in order to minimize any possibility of temporarily losing a Guest Membership during the transfer of coverage.

For more information, call the HMO New Mexico Member Services Department in Albuquerque at 505-291-6945, or toll-free at 1-800-423-1630. You may also contact the Plan by fax at 505-237-5310 or by E-mail at hmonm@bluemail.com.

Reciprocity

HMO New Mexico is part of a national network of Blue Cross and Blue Shield HMOs — HMO Blue-USA. Using the HMO Blue-USA network through the "Away From Home Care" program, out-of-area urgent care can be obtained in areas served by other Blue Cross and Blue Shield HMOs affiliated with HMO Blue-USA. For more information about receiving urgent care away from home, see "Emergency Benefits" on pages 14 and 15.

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. **No oral statement of any person shall modify or otherwise affect the benefits, limitations, and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan, or be used in the prosecution or defense of a claim under this Plan.** This brochure is the official statement of benefits on which you can rely.

Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

Arbitration of claims

Any claim for damages for personal injury, mental disturbance, or wrongful death arising out of the rendition of or failure to render services under this contract must be submitted to binding arbitration.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and complete all necessary documents and authorizations requested by the Plan.

Medicare

If you or a covered family member is enrolled in this Plan and Medicare Part A and/or Part B, the Plan will coordinate benefits according to Medicare's determination of which coverage is primary. However, this Plan will not cover services, except those received in accordance with the procedures described in the "Emergency Benefits" provision, unless you use Plan providers. You must tell your Plan that you or your family member is eligible for Medicare. Generally, that is all you will need to do, unless your Plan tells you that you need to file a Medicare claim.

Group health insurance and automobile insurance

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance, or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply; to receive HMO benefits for nonemergency and in-

General Limitations (continued)

area urgent care services, your primary care provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities, and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

General Exclusions

All benefits are subject to the limitations and exclusions in this brochure. Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness or condition as discussed under "Authorizations" on page 6. The following are excluded:

- Care by non-Plan doctors or hospitals except for authorized referrals, emergencies, or out-of-area urgent care services received in accordance with the procedures described in the "Emergency Benefits" provision;
- Expenses incurred while not covered by this Plan;
- Services furnished or billed by a provider or facility barred from the FEHB Program;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Procedures, treatments, drugs, or devices that are experimental or investigational;
- Procedures, services, drugs, or supplies related to sex transformations; and
- Procedures, services, drugs, or supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.

Medical and Surgical Benefits

What is covered?

A comprehensive range of preventive, diagnostic, and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; you pay a $10 office visit copay, (but no copay for immunizations or injections, or laboratory tests and X-rays). Within the service area, house calls will be provided if in the judgment of the Plan doctor such care is necessary and appropriate; you pay nothing for a doctor's house call or for home visits by nurses and health aides.

The following services are covered and are subject to the applicable inpatient, outpatient, or office visit copay unless stated otherwise:

- Preventive care, including well-baby care and periodic check-ups
- Mammograms are covered as follows: for women age 35 through 39, one mammogram every five years; for women age 40 through 49, one mammogram every one or two years; and for women age 50 and older, one mammogram every year. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Outpatient surgery not performed in a doctor's office; you pay a **$125** copay
- Contraceptive diaphragms and implanted time-release medications, such as Norplant. For contraceptive diaphragms and Norplant and other internally implanted time release medications, you pay a one-time copay of **$10 per prescription** when received or implanted in the physician's office. When a device is implanted during a covered hospitalization, there is no additional charge beyond the applicable $250 admission copay, the $125 outpatient surgery copay, and/or the $100 maternity copay. There is a limit of one prescription every five years for implanted medications, and there will be no refund of any portion of the copay if the implanted medication is removed before the end of its expected life.
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery, and postnatal care by a Plan doctor

  You pay a **$100** copay for the delivery, in addition to a **$250** inpatient admission copay (subject to an annual maximum of $500 per *Self Only* enrollment and $750 per *Self and Family* enrollment). The $100 maternity copay does not count toward the annual inpatient admission copay maximum. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a *Self Only* or *Self and Family* enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a *Self and Family* enrollment.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including test and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints
- Cornea, heart, heart/lung, kidney, liver, single lung, double lung and pancreas transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors. Transplants are covered when both the transplant evaluation and the transplant are approved by HMO New Mexico. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.

- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity
- Orthopedic devices, such as braces and foot orthotics; you pay **$25 per item or device**. These items may be purchased or rented at the Plan's discretion.
- Prosthetic devices, such as artificial limbs and lenses following cataract removal; you pay **$25 per item or device.**
- Vision and hearing examinations to determine the need for correction for members under age 18
- Durable medical equipment, such as wheelchairs and hospital beds; you pay **$25 per item or device**. These items may be purchased or rented at the Plan's discretion.
- Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need. There is no copay for home health care services.
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you except where noted.

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. Benefits are also available, when **prior authorized** by HMO New Mexico, for standard diagnostic, therapeutic, surgical, and nonsurgical treatment of TMJ disorders or injuries. Treatment may include diagnostic examination and associated x-rays; medications dispensed in a dentist's or physician's office; and physical therapy and dental splints. Orthodontic appliances and treatment, crowns, bridges, or dentures are covered only for treatments required as the result of an accidental injury to sound natural teeth and involving the temporomandibular joint. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery.

Short-term rehabilitative therapy (chiropractic services, physical, speech, and occupational therapy) is provided on an inpatient or outpatient basis (including services received in a skilled nursing facility) for up to 60 days per condition if significant improvement can be expected within two months; you pay **$250** per admission (subject to an annual maximum of $500 per *Self Only* enrollment and $750 per *Self and Family* enrollment) and a **$10** copay per outpatient session. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

Diagnosis and treatment of infertility, including artificial insemination and fertility drugs, is covered; you pay **$250** per admission (subject to an annual maximum of $500 per *Self Only* enrollment and $750 per *Self and Family* enrollment) and a **$10** copay per office visit. The following types of artificial insemination are covered: intravaginal insemination (IVI); intracervical insemination (ICI); and intrauterine insemination (IUI). Cost of donor sperm is not covered. Other assisted reproductive technology (ART) procedures, such as in-vitro fertilization and embryo transfer are not covered.

Cardiac rehabilitation following a heart transplant, bypass surgery, or a myocardial infarction, is provided with prior Plan authorization; you pay a **$250** hospital admission copay (subject to an annual maximum of $500 per *Self Only* enrollment and $750 per *Self and Family* enrollment) for inpatient care and a **$10** copay for each outpatient cardiac rehabilitation visit.

Medical and Surgical Benefits (continued)

What is not covered?

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically induced sterility
- Surgery primarily for cosmetic purposes
- Transplants not listed as covered
- Hearing aids
- Long-term rehabilitative therapy
- Homemaker services
- Convenience or deluxe items, disposable supplies, physicians' equipment, or the rental of durable medical equipment in an inpatient facility which normally provides these items at no additional charge

Hospital Care Benefits

What is covered?

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. You pay a **$250** copayment for each admission (subject to an annual maximum of $500 per *Self Only* enrollment or $750 per *Self and Family* enrollment). All necessary services are covered, including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units
- Blood and blood derivatives

Extended care

Skilled nursing care is covered for up to 60 days per condition. This benefit is described under the short-term rehabilitative therapy section in the "Medical and Surgical Benefits" provision. You pay a **$250** copayment for each admission (subject to an annual maximum of $500 per *Self Only* enrollment or $750 per *Self and Family* enrollment).

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or a hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. There is no copayment for hospice care, but there is a maximum Plan payment per lifetime of **$7500** in covered benefits.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor. There is no copayment for authorized ambulance transportation.

Limited benefits

Acute inpatient detoxification — Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 16 for nonmedical substance abuse benefits.

What is not covered?

- Personal comfort items, such as telephone and television
- Custodial care, rest cures, domiciliary, or convalescent care

Emergency Benefits

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that the Plan may determine are medical emergencies — what they all have in common is the need for quick action.

Emergencies inside and outside the service area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member **must** notify the Plan within 48 hours. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Plan pays . . .

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

To be covered by this Plan, any follow-up care not provided by or recommended by your primary care doctor must be approved by the Plan before the care is received.

You pay . . .

$45 per hospital emergency room visit or **$20** per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copay is waived, and the hospital admission copay applies.

What is urgent care?

Urgent care is services received for a condition that is not life-threatening but that requires prompt medical attention to prevent a serious deterioration in your health.

Urgent care within the service area

If you need urgent care while inside the HMO New Mexico service area, you must call your primary care doctor first. Your primary care doctor will give you instructions on how to proceed. Urgent care received **within** the service area is covered **only** when it is provided by your primary care doctor or by a provider to whom your primary care doctor has referred you.

Urgent care outside the service area

When you are temporarily absent from the service area, you may call your primary care doctor for a referral or access the "Away From Home Care" program and locate an HMO Blue-USA facility near to you.

To be covered by this Plan, any follow-up care not provided by or recommended by your primary care doctor must be approved by the Plan before the care is received.

Away From Home Care: To locate the nearest HMO Blue-USA facility, call 1-800-4-HMOUSA (1-800-446-6872). The HMO Blue-USA operator will tell you if there is a participating HMO in your area, its location, service hours, and the local HMO coordinator's phone number. You then call the local HMO coordinator to find out where to go to obtain care. The coordinator's personal services allow you to access out-of-area care and HMO providers with greater ease and security, avoid unforeseen out-of-pocket expenses, and eliminate claim forms.

If there is not an HMO Blue-USA facility nearby, you may call your primary care doctor to be referred to a facility or other appropriate provider.

Emergency Benefits (continued)

You pay . . .

$20 per urgent care center visit for urgent care services that are covered under this Plan. (Services received in an emergency room will require the $45 emergency room copayment and must meet the definition of a medical emergency.)

What is covered?

- Emergency or urgent care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service approved by the Plan

What is not covered?

- Elective care or nonemergency care provided by non-Plan providers
- Urgent care received from non-Plan providers while within the service area
- Urgent care received outside the service area unless authorized by your primary care doctor or arranged through HMO-Blue USA
- Emergency or urgent care provided outside the service area if the need for care could have been foreseen before leaving the service area
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area

Filing claims for non-Plan providers

If you receive emergency services from a provider that does not contract with the local Blue Cross and/or Blue Shield Plan, you may need to file a claim. With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 18.

Remember: Urgent care services within the service area must always be received from Plan providers; when outside the service area, urgent care must be coordinated by HMO-Blue USA and received from HMO-contracted providers. In either instance, the provider will file claims for you. You should **not** file a claim for services received through the HMO-Blue USA "Away From Home Care" program.

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered?

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient care

Up to **20 outpatient visits** to Plan doctors, consultants, or other psychiatric personnel each calendar year; you pay **$30 per visit** for covered visits — all charges thereafter.

Note: The medical management of mental conditions will be covered under this Plan's "Medical and Surgical Benefits" provision. Related drug costs will be covered under this Plan's "Prescription Drug Benefits" provision and any costs for psychological testing or psychotherapy will be covered under this Plan's "Mental Conditions Benefits" provision. Office visits for the medical aspects of treatment do not count toward the 20-visit outpatient mental conditions limit.

Inpatient care

Up to **30 days** of hospitalization each calendar year; you pay a **$250** copayment per admission (subject to an annual maximum of $500 per *Self Only* enrollment and $750 per *Self and Family* enrollment), plus **$25 for each day** you are in the hospital — all charges thereafter.

What is not covered?

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition

Substance abuse

What is covered?

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition, and, to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient care

Up to **30 outpatient visits** per calendar year or **60 visits per lifetime** to Plan providers for treatment; you pay **$30** for covered visits — all charges thereafter.

Inpatient care

Up to **30 days** per calendar year and **60 days per lifetime** in a substance abuse rehabilitation (intermediate care) program in an alcohol detoxification or rehabilitation center approved by the Plan; you pay **$200 per day** during the benefit period — all charges thereafter.

What is not covered?

- Treatment that is not authorized by a Plan doctor

Prescription Drug Benefits

What is covered?

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 34-day supply. You pay a **$10 copay** per prescription unit or refill for formulary drugs and a **$20 copay** for prescription drugs that are not on the HMO New Mexico formulary (nonformulary drugs). When generic substitution is available, but you or your physician request the name brand drug, you pay the price difference between the generic and name brand drug as well as the applicable formulary or nonformulary copay per prescription unit or refill.

You can purchase maintenance drugs through a mail order program. You are subject to the same benefits and limitations as when you purchase prescription drugs from a retail pharmacy. The copayment for a 34-day supply is $10; for a 35-day to 90-day supply, it is $20.

If you are outside of the Plan's service area and obtain a prescription at a non-Plan pharmacy, the Plan will reimburse you the Plan's allowable cost for that drug less the applicable copay. You must file a claim with the Plan for reimbursement.

Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Nonformulary drugs will be covered when prescribed by a Plan doctor and you pay a $20 copayment.

Formulary vs. nonformulary drugs

HMO New Mexico administers a drug formulary, which is developed by our Pharmacy and Therapeutics Committee. The committee is comprised of physicians and pharmacists, and meets quarterly to evaluate drugs for formulary consideration. The decision to include a drug on the formulary is based on several factors:

- Therapeutic uniqueness
- Safety
- Clinical advantages
- Cost

Requests for nonformulary drug coverage to be paid at the formulary copayment benefit are handled on a case-by-case basis. Customers or their providers may request coverage of nonformulary drugs at the formulary copayment benefit by presenting evidence of medical necessity for the use of the drug. The Medical Director or Pharmacy Director makes a decision based on the evidence provided.

Covered medications and accessories include:

- Drugs for which a prescription is required by Federal law
- Oral and injectable contraceptive drugs
- Insulin
- Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape, Benedict's solution, or equivalent, and acetone test tablets
- Disposable needles and syringes needed to inject covered prescribed medication

Intravenous fluids and medication for home use, contraceptive diaphragms, and Norplant devices are covered under "Medical and Surgical Benefits."

Limited benefits

Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits. You pay a $10 copayment up to the dosage limits and all charges above that.

What is not covered?

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Fertility drugs
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Drugs for smoking cessation (nicotine replacement drugs)

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Member Services Department at 505-291-6945 in Albuquerque or 1-800-423-1630 statewide, or you may write to the Plan at P.O. Box 11968, Albuquerque, New Mexico, 87192-0968. You may also contact the Plan by fax at 505-237-5310 or by E-mail at hmonm@bluemail.com.

Disputed claims review

Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the Plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand.

OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide instead (a) the date of your request to the Plan or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim, such as doctors' letters, operative reports, bills, medical records, and explanation of benefit (EOB) forms; and
- Your daytime phone number.

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to:

Office of Personnel Management
Office of Insurance Programs, Contracts Division IV
P.O. Box 436
Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies, or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement — If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

How HMO New Mexico Changes January 1999

Do not rely on this page; it is not an official statement of benefits.

Program-wide changes

- Changes have been made to comply with the President's mandate to implement the recommendations of the Patient Bill of Rights:
  - If you have a chronic, complex, or serious medical condition that causes you to frequently see a Plan specialist, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist, without the need to obtain further referrals (see page 6 for details).
  - A medical emergency is defined as the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care (see page 14).
- The medical management of mental conditions will be covered under this Plan's "Medical and Surgical Benefits" provision. Related drug costs will be covered under this Plan's "Prescription Drug Benefits" provision and any costs for psychological testing or psychotherapy will be covered under this Plan's "Mental Conditions Benefits" provision. Office visits for the medical aspects of treatment do not count toward the 20-visit outpatient mental conditions limit.

Benefit changes

- This Plan is no longer a Point-of-Service (POS) plan. You may not use non-Plan providers for elective or nonemergency care.
- The out-of-pocket maximum for *Self Only* enrollment is now **$3,300** per calendar year; for *Self and Family* enrollment, the out-of-pocket maximum is now **$8,700** per calendar year.
- Members may now visit a Plan obstetrician/gynecologist for routine gynecological exams, maternity care, and care for gynecological conditions without obtaining a referral.
- Mammograms are now allowed annually for all members 50 years and older.
- Coverage is now available for specified services related to the treatment of temporomandibular joint (TMJ) injuries and disorders. See "Limited Benefits" on page 12.
- Chiropractic services are no longer limited to 20 visits annually. Chiropractic services are now included in the short-term rehabilitative therapy benefit, which is limited for all inpatient and outpatient services combined to 60 days per condition. (X-rays must still be performed at HMO New Mexico X-ray facilities in order to be covered.)
- Prescription drugs are now limited to a 34-day supply per copayment, and the member must pay the difference between brand-name and generic drugs if a generic equivalent is available, in addition to the applicable formulary or nonformulary copayment.
- Coverage for drugs for sexual dysfunction are shown under "Prescription Drug Benefits."
- Skilled nursing facility admissions are now covered for up to 60 days per condition.

Clarifications

- Copayments should always be paid to providers at the time services are received, even when emergency-related.
- Urgent care in the service area must be received through or coordinated by Plan providers to be covered. Urgent care outside the service area may be authorized by calling 1-800-446-6872 to locate the nearest Blue Cross and Blue Shield HMO Plan provider, or by calling your primary care doctor for instructions and a referral.
- Coverage for contraceptive diaphragms and Norplant devices is now shown under "Medical and Surgical Benefits."

Other changes

- The Plan's Service and Enrollment area has been expanded to include Chaves, Grant, Hidalgo, Roosevelt, and Taos Counties.

Summary of Benefits for HMO New Mexico — 1999

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **All services covered under this Plan, with the exception of emergency care and urgent care covered through the "Away From Home Care" program are covered only when provided or arranged by Plan doctors.**

	Benefits	Plan pays/provides	Page
Inpatient Care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care, and complete maternity care. You pay **$250** per admission (up to an annual maximum of $500 per *Self Only* enrollment and $750 per *Self and Family* enrollment).	**13**
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions for up to **30 days** of inpatient care per year. You pay a **$250** copay per admission (up to an annual maximum of $500 per *Self Only* enrollment and $750 per *Self and Family* enrollment) plus a **$25 per day** copayment.	**16**
	Substance Abuse	Up to **30 days** per year in a substance abuse treatment program. You pay **$200 per day** for covered days — all charges thereafter.	**16**
Outpatient Care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. You pay a **$10** copay per office visit; nothing per house call by a doctor.	**11**
	Home Health Care	All necessary visits by nurses and health aides. You pay nothing.	**12**
	Mental Conditions	Up to **20 outpatient visits** per member per year. You pay a **$30** copay per visit — all charges thereafter.	**16**
	Substance Abuse	Up to **30 outpatient visits** per member per year. You pay **$30** per visit — all charges thereafter.	**16**
Emergency Care		Reasonable charges for services and supplies required because of a medical emergency or urgent care. You pay a **$45** copay per emergency room visit, **$20** per urgent care center visit and any charges for services that are not covered by this Plan.	**14**
Prescription Drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. You pay a **$10 copay** per formulary prescription unit or refill.	**17**
Dental and Vision Care		No current benefit.	
Out-of-Pocket Maximum		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of **$3,300** per *Self Only* or **$8,700** per *Self and Family* enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include the coinsurance incurred in the inpatient and outpatient treatment of substance abuse, the coinsurance incurred for the outpatient treatment of mental conditions, the $25 per day copay incurred for the inpatient treatment of mental conditions, inpatient admission copays, or the cost of prescription drugs.	**7**

1999 Rate Information for HMO New Mexico

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to most career U.S. Postal Service employees and do not apply to non-career Postal employees, Postal retirees, certain special Postal employment categories, or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	5H1	$52.45	$17.48	$113.64	$37.88	$62.06	$7.87
Self and Family	5H2	$135.32	$45.10	$293.18	$97.73	$160.12	$20.30