Benefit Booklet

New Mexico State University
PPO 500 Plan
A Guide to Your Preferred Provider Option (PPO) Health Care Plan

Underwritten by:

Blue Cross and Blue Shield of New Mexico
Customer Assistance

Medical/Surgical Services and Prescription Drugs — When you have questions or concerns, call BCBSNM Monday through Friday from 6 A.M.– 8 P.M. and 8 A.M.– 5 P.M. on Saturdays and most holidays or visit the NMSU Designated Service Unit (DSU) in Albuquerque. (If you need assistance outside normal business hours, you may call the NMSU DSU telephone number and leave a message. An NMSU DSU representative will return your call by 5 P.M. the next business day.) You should also use the telephone number below when requesting a prior approval. You may either call toll-free: 1-866-369-NMSU (6678) or visit our Albuquerque offices at: 4373 Alexander Blvd. NE.

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

BCBSNM, Attn: NMSU DSU
P.O. Box 27630
Albuquerque, NM 87125-7630

Mental Health and Chemical Dependency: Prior Approvals and Customer Service — For prior approvals and inquiries related to mental health or chemical dependency services, call the BCBSNM behavioral health services administrator:

24 hours/day, 7 days/week: 1-800-583-6372 or (505) 816-6792

Send written inquiries about mental health or chemical dependency services to:

Mesa Mental Health
P.O. Box 90607
Albuquerque, New Mexico 87199-0607

Claims Submission — Claims for medical/surgical and behavioral health (mental health and chemical dependency) services received outside New Mexico should be mailed to the local Blue Cross Blue Shield Plan in the state where services were received.

Medical/surgical services received in NM:

BCBSNM, Attn: NMSU DSU
P.O. Box 27630
Albuquerque, New Mexico 87125-7630

Behavioral health services received in NM:

Claims, Mesa Mental Health
P.O. Box 92165
Albuquerque, New Mexico 87199-2165

Claims for prescription drugs should be sent to the prescription drug plan administrator (the name and address of this administrator is in a separate brochure, which you should have received with your enrollment materials).

Web Site — For provider network data, a copy of the BCBSNM Drug List, claim forms, and other information, or to e-mail your question to BCBSNM, visit the NMSU section of the BCBSNM Web site at: www.bcbsnm.com.

When you locate the Web site address above, click on the triangle (or drop-down menu) next to “–Choose One–” under the question, “Are you a member of one of our largest groups?” (located toward the middle of the page). Choose “New Mexico State University” from the drop-down list and you will be connected to the NMSU home page of the BCBSNM Web site.

For questions about using the Web site, or if you have problems accessing information, call an NMSU DSU representative.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.
To All Eligible Retirees

Welcome to the New Mexico State University (NMSU) PPO 500 Plan, underwritten by Blue Cross and Blue Shield of New Mexico (BCBSNM).

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 manages health care costs while providing you with a comprehensive health care plan.

Please take some time to get to know your NMSU PPO 500 health care plan coverage, including its benefit limits and exclusions, by reviewing this important document and any enclosures. Learning how this Plan works can help you make the best use of your health care benefits. As you read this booklet, please refer to the Glossary for the definitions of terms used in the text.

Note: BCBSNM and NMSU (your “group”) may change the benefits described in this booklet. If that happens, BCBSNM or your group will notify you of those mutually agreed upon changes.

Thank you for selecting BCBSNM for your health care coverage. We look forward to working with you to provide personalized and affordable health care now and in the future.

Sincerely,

Elizabeth A. Watrin
President
Blue Cross and Blue Shield of New Mexico

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

The University reserves the right to increase, decrease, or discontinue any or all provisions under the NMSU Health Care Plan. Any modifications to the Plan will apply to all covered persons, including retirees, who are covered under the Plan at the time of such change.

Feel free to contact Benefit Services (575-646-8000) with any questions you may have.
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Summary of PPO Benefits

Summary only – lists the deductible and out-of-pocket limit options, lists member coinsurance percentage amounts, and provides a brief description of NMSU’s Health Care Plan benefits.

<table>
<thead>
<tr>
<th>PPO Benefits</th>
<th>Member’s Share of Covered Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preferred Provider¹</td>
</tr>
<tr>
<td><strong>Calendar Year Deductible (per individual)</strong></td>
<td>$500 ($1,500/family)</td>
</tr>
<tr>
<td>Family deductible is aggregate of three times individual amount chosen.¹</td>
<td></td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Limit</strong></td>
<td>$2,000 ($5,000 family)</td>
</tr>
<tr>
<td>Includes coinsurance only; NOT deductible, copayments, penalty amounts, or noncovered charges.²</td>
<td></td>
</tr>
</tbody>
</table>

**Office Services**: If listed on this summary, other services received during the office visit to the Primary Preferred Provider (PPP*) or to the PPO Specialist, are subject to deductible and coinsurance as listed below.

<table>
<thead>
<tr>
<th>Service</th>
<th>Preferred Provider¹</th>
<th>Nonpreferred Provider¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Preferred Provider* Office Visit and initial office visit to diagnose pregnancy</td>
<td>$25 copay/visit 40%</td>
<td></td>
</tr>
<tr>
<td>Mental Health/Chemical Dependency services (outpatient/office)</td>
<td>$25 copay/visit 40%</td>
<td></td>
</tr>
<tr>
<td>Specialist Office Visit and initial office visit to diagnose pregnancy</td>
<td>$35 copay/visit 40%</td>
<td></td>
</tr>
<tr>
<td>Office Surgery (including casts, splints, and dressings)</td>
<td>25% 40%</td>
<td></td>
</tr>
<tr>
<td>Allergy Injections, Tests, Serum</td>
<td>25% 40%</td>
<td></td>
</tr>
</tbody>
</table>

**Preventive Services**

- Routine Adult Physicals and Gynecological Exams (ages 18 and older), Mammograms, Routine Colonoscopies, Related Testing (includes routine Pap tests, cholesterol tests, urinalysis, etc.), and Immunizations

- Plan pays 100% (deductible waived) up to $400, thereafter, services are subject to copays, deductible, or coinsurance

**Well-Child Care**: Routine Vision or Hearing Screenings (only through age 17); Routine Testing, and Immunizations

- Plan pays 100% (deductible waived) up to $250, thereafter, services are subject to copays, deductible, or coinsurance

**Acupuncture Treatment** (benefit max. $1,500/year)

- 25%

**Ambulance Services: Ground and Emergency Air Transport**

- 25%

**Ambulance Services: Nonemergency Air Transfer**

- 25% 40%

**Autism Spectrum Disorders** (max $36,000 each calendar year; up to $200,000 in a lifetime for all services combined; covered services include physical, speech, and occupational therapy and applied behavioral analysis when part of a prior-approved treatment plan)

- 25% Not Covered

**Cardiac and Pulmonary Rehabilitation**

- 25% Not Covered

**Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services**

- Member share based on place of treatment & type of service 4

**Emergency Room Treatment**

- 25%

**Durable Medical Equipment and Supplies**

- 25% 40%

**Hearing Aids and Related Services**: Hearing aids for members under age 21 are paid at 100% of covered charges up to a maximum of $2,200 per ear during any 3-year period; exams and testing are subject to usual cost-sharing provisions. These services are not covered for members age 21 and older.

**Home Health Care/Home I.V. Services** (benefit max. 100 visits/year)

- 25%

**Hospice Services** (lifetime max. $10,000)

- 25%

**Lab, X-Ray, MRI, CT Scan, PET Scan and Basic Diagnostic Tests**

- 25%

* A Primary Preferred Provider is a physician or other professional provider in one of the following categories of practice: Family or General Practice, Internal Medicine, Pediatrics, Obstetrics and Gynecology, and Gynecology Only. A “PPP” is a Primary Preferred Provider in the preferred provider network.

See footnotes on back.

iv
NMSU DSU Customer Service: 1-866-369-NMSU (6678)
**PPO Benefits** — There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.

<table>
<thead>
<tr>
<th><strong>Member’s Share of Covered Charges</strong></th>
<th><strong>Preferred Provider</strong></th>
<th><strong>Nonpreferred Provider</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Hospital/Facility Services</strong></td>
<td>(See “Short-Term Rehabilitation” for physical rehabilitation and skilled nursing facility admissions and “Transplant Services,” if applicable.)</td>
<td></td>
</tr>
<tr>
<td>Medical/Surgical, Mental Health/Chemical Dependency, Maternity-Related Room and Board, and Covered Ancillaries</td>
<td>25%&lt;sup&gt;5&lt;/sup&gt;</td>
<td>40%&lt;sup&gt;5&lt;/sup&gt;</td>
</tr>
<tr>
<td>Maternity Services (also see “Inpatient Hospital/Facility Services”)</td>
<td>25%&lt;sup&gt;5&lt;/sup&gt;</td>
<td>40%&lt;sup&gt;5&lt;/sup&gt;</td>
</tr>
<tr>
<td>Routine Nursery/Pediatrician Care for Covered Newborns</td>
<td>25%&lt;sup&gt;5&lt;/sup&gt;</td>
<td>40%&lt;sup&gt;5&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Outpatient Facility/Physician</strong> (including surgical procedures related to pregnancy and family planning; and nonroutine colonoscopies)</td>
<td>25%&lt;sup&gt;4,5&lt;/sup&gt;</td>
<td>40%&lt;sup&gt;4,5&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Prosthetics and Orthotics</strong></td>
<td>25%&lt;sup&gt;4,6&lt;/sup&gt; (Unlimited benefit)</td>
<td>40%&lt;sup&gt;4,6&lt;/sup&gt; (Benefit max. $1,000/year)</td>
</tr>
<tr>
<td><strong>Short-Term Rehabilitation</strong>: Inpatient and Outpatient - Occupational, Physical, and Speech Therapy; including Physical Rehabilitation and Skilled Nursing Facility (Lifetime max. 60 days/visits per condition for all services combined.)</td>
<td>25%&lt;sup&gt;4,5&lt;/sup&gt;</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Smoking/Tobacco Cessation Counseling (90 minutes total or 2 group sessions per calendar year)</td>
<td>25%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Spinal Manipulation Services (benefit max. $1,500/year)</td>
<td>25%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Therapy: Chemotherapy, Dialysis, Radiation Therapy, Electroshock Therapy, Narcosynthesis</td>
<td>25%&lt;sup&gt;4&lt;/sup&gt;</td>
<td>40%&lt;sup&gt;4&lt;/sup&gt;</td>
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<td><strong>Transplant Services</strong> (Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.)</td>
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<td>Cornea, Kidney, and Bone Marrow</td>
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<tr>
<td>Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney (Subject to a separate $5,000 out-of-pocket limit per transplant type. Additional benefit maximums also apply. Calendar year deductible does not apply.)</td>
<td>25%&lt;sup&gt;4,5&lt;/sup&gt;</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Urgent Care Facility</strong></td>
<td>25%</td>
<td>40%</td>
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</table>

**FOOTNOTES:**

1 All benefit payments are based on the covered charge as determined by BCBSNM. The deductible must be met before benefit payments are made for most services, except services with a copayment, hearing aids, and certain preventive services. Deductible amounts do not cross-apply in the Preferred Provider and Nonpreferred Provider benefit levels.

2 After a member reaches the applicable out-of-pocket limit, BCBSNM pays 100 percent of most of that member’s covered Preferred or Nonpreferred Provider charges, whichever is applicable. Out-of-pocket amounts do not cross-apply in the Preferred Provider and Nonpreferred Provider benefit levels. (Specified transplant services are subject to a separate out-of-pocket limit.)

3 Initial treatment of a medical emergency is paid at Preferred Provider level. Follow-up treatment and treatment that is not for an emergency is paid at Nonpreferred Provider level.

4 Certain services are not covered if prior approval is not obtained from BCBSNM. A list requiring prior approval is in Section 2.

5 Admission review is required for inpatient admissions. You pay a $300 penalty for covered medical/surgical and/or mental health/chemical dependency facility services if approval is not obtained. Some services, such as transplants and physical rehabilitation, require additional approval. If you do not receive approval for these individually identified procedures and services, benefits for any related admissions will be denied. See a Member’s Benefit Booklet for details.

6 Rental benefits for medical equipment and other items will not exceed the purchase price of a new unit.

**IMPORTANT:** Deductible amounts and coinsurance percentages are applied to BCBSNM’s covered charges, which may be less than the provider’s billed charges. **Preferred providers will not charge you the difference between the covered charge and the billed charge for covered services; nonpreferred providers may.**

BCBSNM is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

See NMSU Prescription Drug Benefit Summary on next page.
### NMSU Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods Summary

Note: Deductible does not apply and copayments and coinsurance are not applied to out-of-pocket. Certain drugs, special medical foods, and enteral nutritional products require prior approval or benefits will be denied.4,7

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<th>Type of Prescription</th>
<th>Percentage of covered charge you pay (coinsurance), if the percentage is between the minimum and maximum copayments:</th>
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<th>Maximum Copayment</th>
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<td>Generic Drug on Drug List</td>
<td>$10 / 7</td>
<td>$10 / 7</td>
<td>$10 / 7</td>
</tr>
<tr>
<td>Brand-Name Drug on Drug List</td>
<td>30% / 7</td>
<td>$25 / 7</td>
<td>$45 / 7</td>
</tr>
<tr>
<td>Not on Drug List</td>
<td>40% / 7</td>
<td>$45 / 7</td>
<td>$80 / 7</td>
</tr>
<tr>
<td>Specialty Pharmacy Drugs</td>
<td>25% / 7</td>
<td>$125 / 7</td>
<td>$250 / 7</td>
</tr>
<tr>
<td><strong>Mail-Order Plan</strong> (up to a 90-day supply or 360 units, whichever is less)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Drug on Drug List</td>
<td>$20 / 7</td>
<td>$20 / 7</td>
<td>$20 / 7</td>
</tr>
<tr>
<td>Brand-Name Drug On Drug List</td>
<td>30% / 7</td>
<td>$50 / 7</td>
<td>$90 / 7</td>
</tr>
<tr>
<td>Not on Drug List</td>
<td>40% / 7</td>
<td>$90 / 7</td>
<td>$160 / 7</td>
</tr>
<tr>
<td><strong>Nonprescription enteral nutritional products and special medical foods</strong> (up to a 30-day supply per 30-day period; requires prior approval)</td>
<td>50% / 7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7 Prescription drugs must be purchased at a pharmacy that participates in the Retail Pharmacy, Specialty Pharmacy, or Mail Order Services programs. (BCBSNM has contracted with a separate program for administration of your prescription drug benefits.) Note: Under this prescription program, if you prefer a brand-name drug that has a generic equivalent or if you or your provider orders a brand-name drug when a generic is available, you will pay the difference in cost between the generic and brand-name drug, in addition to the generic drug copayment.
How to Use This Benefit Booklet

This benefit booklet describes the coverage available to members of this health care plan and benefit limits and exclusions.

Summary of Benefits
Throughout this booklet, you are asked to refer to the Summary of Benefits, beginning on page iv, that shows your specific member cost-sharing amounts and the coverage limitations of your Plan. You will receive a new Summary of Benefits if changes are made to your health care Plan.

Other Benefit-Related Materials
In addition to this booklet you should have the following benefit-related documents:

ID Card — Your NMSU PPO 500 Plan ID card shows that you are a member of a health care plan administered by BCBSNM. The ID card provides the information needed when you require health care services, including mental health/chemical dependency services and prescription drugs, or when contacting an NMSU DSU representative. Carry it with you. Have your ID card handy when you call for an appointment and show it to the receptionist when you sign in for an appointment.

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

Drug Plan Brochure — In addition to this benefit booklet, you should have received a drug plan brochure and a mail-order claim form from the pharmacy benefit manager. These documents provide general, but important, information about your drug plan benefits and how to submit claims, if needed. (BCBSNM has contracted with a separate program for administration of outpatient drug plan benefits.) For information specific to your drug plan coverage, see “Prescription Drugs and Other Items” in Section 3 of this booklet.

Provider Network Directory — The provider network directory is available through the BCBSNM Web site at www.bcbsnm.com. It lists all providers in the BCBSNM preferred provider (PPO) network, including mental health/chemical dependency providers and participating pharmacies. It also provides links to the listings of preferred providers in other states. (If you want a paper copy of a directory, you may request one from Customer Service and it will be mailed to you free of charge.) **Note:** Although provider directories are current as of the date shown at the bottom of each page, they can change without notice. To verify a provider’s status or if you have any questions about how to use the directory, contact an NMSU DSU representative or visit the BCBSNM Web site at www.bcbsnm.com.
For a list of contracting providers outside New Mexico, you may also call the BlueCard Doctor and Hospital Information Line at 1-800-810-BLUE (2583) or visit the national BCBS Web site at www.bcbs.com.

**BlueCard Brochure** — As a member of a PPO health plan administered by BCBSNM, you take your health care plan benefits with you – across the country and, for emergency services, around the world. The BlueCard Program gives you access to preferred providers almost everywhere you travel or live. Almost 90 percent of physicians in the United States contract with Blue Cross Blue Shield Plans, so members can receive health care plan benefits – even when traveling or living outside New Mexico – by using health care providers that contract as preferred providers with their local BCBS Plan. You should have received a brochure describing this program in more detail. It’s a valuable addition to your health care plan coverage. Instructions for locating a preferred provider outside New Mexico are in the brochure or can be found on the BCBSNM Web site at www.bcbsnm.com.

**BlueExtrasSM** — Certain local and national retailers, outlets, and businesses offer BCBSNM health plan members an opportunity to save money on services that are not covered under the health plan. These discount offers and other services are not part of the medical/surgical health care plan benefits described in your benefit booklet and the entities making the offers and the providers of the services may not be affiliated or associated with BCBSNM or your health care plan. However, from time to time, BCBSNM will be announcing such offers by sending manufacturer or retail discount coupons to member households, inserting information into Member Newsletters, or mailing descriptions of various programs being offered to our members by businesses such as health clubs, pharmacies, vision care providers, hearing aid retailers, dentists, etc. These mailings may contain coupons or offers that enable you, at your discretion, to purchase the described product or enroll in a certain program at a discount or at no charge. The retailer, provider, or manufacturer may pay for and/or provide the content for this information. The discounts and services available to members may change at any time and BCBSNM does not guarantee that a particular discount or service will be available at a given time. For details of current discounts available, please contact a Customer Service representative by calling the phone number on the back of your ID card or by visiting our offices in Albuquerque at 4373 Alexander Boulevard NE.

**Using the Informational Graphics**

Graphic symbols are used throughout this benefit booklet to call your attention to certain information and requirements. Some commonly used symbols are:

**Cross-References** — Throughout this benefit booklet, cross-references direct you to read other sections of the booklet when applicable. You will see this symbol next to such references in Section 3.

**Limitations and Exclusions** — Each subsection in Section 3 not only describes what is covered, but may list some limitations and exclusions that specifically relate to a particular type of service. Section 4: General Limitations and Exclusions lists limitations and exclusions that apply to all services. This graphic symbol will be next to limitations or exclusions listed in Section 3.
Admission Review or Other Prior Approval Required — To receive full benefits for some medical/surgical services and prescription drugs, you or your provider must call the NMSU DSU before you receive treatment. Also, if you have a routine delivery and stay in the hospital more than 48 hours, or if you have a C-section delivery and stay in the hospital more than 96 hours, you must call BCBSNM for admission approval before you are discharged. This symbol is a reminder to do so. Call Monday through Friday, 8 A.M. to 5 P.M., Mountain Time. See “Admission Review and Other Prior Approvals” in Section 2 for details.

Note: Prior approvals are not processed after 5 P.M. If you need prior approval assistance between 5 P.M. and 8 A.M. or on weekends, call an NMSU DSU representative at 1-866-369-NMSU (6678).

Emergency Admission Notification — To ensure that benefits are correctly paid and that an admission you believe is emergency-related will be covered, you or your physician or hospital should notify BCBSNM within 48 hours or as soon as reasonably possible following admission. 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 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
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.

Call Mesa Mental Health for Prior Approval — For all mental health and chemical dependency services, you or your physician must call the BCBSNM behavioral health services administrator, Mesa Mental Health, before you schedule treatment. Mesa Mental Health will coordinate covered services with a provider near you. If you do not call before receiving nonemergency services, benefits for covered services will be reduced or denied. Call 7 days a week, 24 hours a day. See Section 2 for details.

Preferred Provider Benefit Only — Certain services (listed below) are eligible for benefits only when received from preferred providers:
- transplant services (Services must be received at a facility that contracts with BCBSNM, the local BCBS Plan, or the national BCBS transplant network, for the transplant being provided.)
- inpatient or outpatient psychotherapy for alcoholism, drug abuse, and mental health services
- outpatient cardiac and pulmonary rehabilitation
- inpatient or outpatient physical, occupational, and speech therapy
- skilled nursing facility services
- acupuncture and spinal manipulation
- preventive/routine services
- smoking/tobacco use cessation counseling

Definitions — This symbol calls attention to definitions of important terms throughout the booklet. More definitions are in the Glossary.
Designated Customer Service

Whenever you have a question about your health plan, contact the NMSU Designated Service Unit (DSU) at the telephone number on the back of your member ID card (and printed at the bottom of every page in this booklet). The DSU is staffed with customer service representatives, claims processors, and managers whose exclusive responsibility is to provide NMSU members with unmatched customer-oriented and knowledgeable service. NMSU DSU representatives are available Monday through Friday from 6 A.M.—8 P.M. and 8 A.M.—5 P.M. on Saturdays and most holidays.

Note: If you need assistance outside normal business hours, you may call the NMSU DSU telephone number and leave a message. An NMSU DSU representative will return your call by 5:00 P.M. the next business day.

NMSU DSU representatives can help with the following:
- answer questions about your benefits
- assist with prior approval requests
- check on a claim's status
- order a replacement ID card, provider directory, benefit booklet, or forms

You also can e-mail the Designated Service Unit via the NMSU section of the BCBSNM Web site, www.bcbsnm.com. When you locate the Web site address, click on the triangle (or drop-down menu) next to “–Choose One–” under the question, “Are you a member of one of our largest groups?” (located toward the middle of the page). Choose “New Mexico State University” from the drop-down list and you will be connected to the NMSU home page of the BCBSNM Web site.

The inside front cover lists the most frequently used telephone numbers and addresses that you will need to make the most of your health care benefits.

To Locate A Preferred Provider — To locate a preferred provider convenient to you, call an NMSU DSU representative, who will connect you with the BlueCard Doctor and Hospital Information Line. If you prefer, you may contact a BlueCard representative directly at 1-800-810-BLUE (2583) or visit the NMSU section of the BCBSNM Web site at www.bcbsnm.com. A BlueCard representative will give you the name and telephone number of a local provider who will be able to call NMSU DSU for eligibility information and will submit a claim to the local BCBS Plan.

Other Member Services — To help you track claims payments, make health care choices, and reduce health care costs, BCBSNM maintains a flexible array of online programs and tools for health care plan members. Our online “Blue Access for Members” tool provides convenient and secure access to claims information and account management features and to various cost comparison tools. While online, members can also access a wide range of health and wellness programs and tools, including a health risk assessment and personalized health updates, and a program in which members can earn merchandise and gift cards for making healthy lifestyle choices and participating in various activities. To access these online programs, go to www.bcbsnm.com, log into Blue Access for Members (BAM) and create a user ID and password for instant and secure access. If you need help accessing the site, call the Blue Access Help Desk toll-free at 888-706-0583, Monday through Friday 7 A.M. to 9 P.M. MT; Saturday 6 A.M. to 2:30 P.M. MT.
Note: Depending on your group’s coverage, you may not have access to all online features. Check with your benefits administrator or call Customer Service at the number on the back of your ID card. BCBSNM assesses the usefulness of various programs regularly, using data about program usage and member feedback to make changes to online tools as needed. Therefore, available programs and program rules are updated, added, or terminated and may change without notice as new programs are designed and/or as our members’ needs change. We encourage you to enroll in Blue Access for Members and check the online features available to you – and check back in as frequently as you like. We are always looking for ways to add value to your health care plan and hope you will find our Web site helpful.

Enrollment Assistance
If you need assistance enrolling, changing an address, terminating coverage, or changing coverage, or if you have any question regarding eligibility in the group Plan, contact NMSU Benefit Services:

New Mexico State University
Attn: Benefit Services
Off-site: PO Box 30001, MSC 3HRS, Las Cruces, NM 88003-8001
Telephone: 575-646-8000
How Your Plan Works

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 (e.g., deductible, coinsurance, copayment, penalty amount) has been calculated, BCBSNM pays the remaining amount of the covered charge, up to maximum benefit limits, if any. The covered charge may be less than the billed charge. Your choice of provider will determine if you will also have to pay the difference between the covered charge and the billed charge.

**Preferred providers** — Health care professionals and facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, or another BCBS Plan as “preferred” or “PPO” providers. These providers have agreed to accept the covered charge for a covered service plus the member’s share (i.e., deductible, coinsurance, copayment, penalty amount, if any) as payment in full.

**Nonpreferred providers** — Providers that have not contracted with BCBSNM, either directly or indirectly, to be part of the “preferred” or “PPO” provider network.

This is a Preferred Provider Option (PPO) Health Care Plan that gives you the opportunity to save money, while providing you choice and flexibility when you need medical/surgical care and preventive services. When you need health care, you have two choices:

- Preferred Provider Services (including a “PPO Primary Provider” or “PPP” office visit option); or
- Nonpreferred Provider Services.

**Note:** A “PPP” is a preferred provider in one of these medical specialties: Family Practice; General Practice; Internal Medicine; Obstetrics/Gynecology; Gynecology; or Pediatrics.

The NMSU PPO 500 Health Care Plan includes these special features:

- You can choose at the time that care is needed whether to see a preferred provider or another provider.
- If you choose to visit a preferred provider, you will receive the higher, Preferred Provider (PPO) benefit level for covered services. (Some transplants are subject to special member cost-sharing arrangements.)
- If you receive covered services from providers outside the preferred provider network, benefits will be paid at the Nonpreferred Provider benefit level. You may also be responsible for any amount above covered charges. (Some services, indicated on the *Summary of Benefits*, are not covered unless received from a preferred provider.) The advantages of choosing a preferred provider when you need medical care are summarized in the table on the next page:
## NMSU PPO 500 Plan

### Section 2: How Your Plan Works

<table>
<thead>
<tr>
<th>Covered Charge vs. Billed Amount</th>
<th>Preferred Provider</th>
<th>Nonpreferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the covered charge is less than the billed amount, the provider will write off the difference. You pay only deductible, coinsurance, copayments, noncovered expenses, and penalty amounts, if any.</td>
<td></td>
<td>A nonpreferred provider may bill you for amounts over the covered charge. You will usually be paid directly for nonpreferred provider services, so you will be responsible for making all payment arrangements to the provider.</td>
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</tbody>
</table>

| Filing Claims | The provider is responsible for filing claims directly to the local BCBS Plan. | You may have to pay the provider in full and submit your own claims; the decision is up to the provider. |

| Available Benefits | All services covered under this Plan are eligible for coverage at the Preferred Provider benefit level indicated on the Summary of Benefits. (Special cost-sharing provisions apply to certain transplants.) | Benefits for some nonemergency services are not available if received from nonpreferred providers. See the Summary of Benefits. |

| Cost-Sharing Differences | PPP office visit charges are not subject to deductible. You pay only a fixed-dollar copayment, not subject to deductible, for office visit charges of a “PPP” (see “Cost-Sharing Features” for details). Other services of a PPP and services of a non-PPP Preferred Provider are subject to an annual deductible and a percentage of covered charges (coinsurance) after the deductible is met. You have an annual out-of-pocket limit, after which services normally subject to deductible and coinsurance, are paid at 100% of the covered charge. The limit includes only coinsurance for Preferred Provider services. | You pay a higher percentage of covered charges and have a higher deductible to meet. You have a higher annual out-of-pocket limit that includes only coinsurance for Non-Preferred Provider services. Nonpreferred providers are not eligible for the fixed-dollar PPP office visit copayment; such services are subject to an annual deductible and coinsurance. Benefits for some services received from Nonpreferred Providers (e.g., durable medical equipment, prosthetics) are limited each year to the amount specified on the Summary of Benefits. |

| Prior Approvals | Preferred providers that contract directly with BCBSNM must request all necessary approvals on your behalf. (Providers that contract with another BCBS Plan may call for approval on your behalf, but you will be responsible for making sure that all approvals are obtained when required.) | Nonpreferred providers may call for prior approvals on your behalf, but you are responsible for making sure that all approvals are obtained when required. |

When you receive treatment or schedule a surgery or admission, ask each of your providers if he/she is a preferred provider. (A physician’s or other provider’s contract may be separate from the facility’s contract. **Your choice of provider can make a difference in the amount you pay for covered services and the benefits available to you.**

### Selecting a Provider

When you need medical care, use the Preferred Provider Network Directory that you received upon enrollment in the NMSU PPO 500 Plan to choose a PPP or other preferred provider. The directory may also list mental health providers (including those specializing in chemical dependency) and participating pharmacies. **Note:** Only those providers listed under Family Practice, General Practice, Internal Medicine, Gynecology, Obstetrics/Gynecology, and Pediatrics are considered PPO Primary Providers (PPPs).

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

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

If you did not receive a directory of providers for the state you live in or are traveling and need medical care, call an NMSU DSU representative. The representative will be able to help you locate a provider near you. You may also call the BlueCard Doctor and Hospital Information Line at 1-800-810-BLUE (2583) or visit the BCBSNM Web site at www.bcbsnm.com. If you call the BlueCard Information Line, a BlueCard representative will give you the name and telephone number of a local provider who will be able to call the NMSU DSU for eligibility information and will submit a claim for the services provided to the local BCBS Plan. Preferred providers in other states are also eligible for the PPP office visit copayment if they are considered “PPO Primary Providers” as defined under “Cost-Sharing Features,” below.

Cost-Sharing Features

See “Transplant Services” in Section 3 for more information about the special heart, heart-lung, liver, lung, and pancreas-kidney transplant benefits.

When you visit a PPP in his/her office, the office visit charge is subject to the PPP office visit copayment described below. Other services received during the visit, services of other preferred providers, and the services of nonpreferred providers are subject to the deductible, coinsurance, and out-of-pocket limit provisions.

PPP Office Visit Copayment

**PPP (PPO Primary Provider)** — A preferred provider in one of the following medical specialties only: Family Practice; General Practice; Internal Medicine; Obstetrics/Gynecology; Gynecology; or Pediatrics. PPPs do not include physicians and other health care providers specializing in any other fields such as Obstetrics only, Geriatrics, Pediatric Surgery, or Pediatric Allergy.

When you receive office services from a PPP, you pay only a fixed-dollar amount, or copayment, for his/her covered office visit charge. The copayment is listed on the Summary of Benefits. (No deductible or additional coinsurance is required.) However, all other PPP services, including other services received during the office visit, will be subject to deductible and coinsurance requirements for preferred provider services (unless specified otherwise, below). The PPP office visit copayment does not include most other services received at the time of the visit (e.g., allergy testing or physical therapy); such covered services are subject to the regular deductible and coinsurance provisions for preferred provider services.

Drug Plan Copayments/Coinsurance

When you purchase covered drugs and other items through the drug plan, the amount you pay may be either a fixed-dollar amount or a percentage of the covered charge. In either case, the drug plan coinsurance and copayment amounts are not subject to the deductible or out-of-pocket provisions. See “Prescription Drugs and Other Items” in Section 3 for more information about coinsurance and copayments under the drug plan.
Calendar Year Deductibles

**Deductible** — The amount of covered charges that you must pay each calendar year before this Plan begins to pay its share of the applicable (preferred or nonpreferred) covered charges you incur during the rest of the same calendar year. If the deductible amount remains the same during the calendar year, you pay it only once each calendar year, and it applies to all preferred provider or nonpreferred provider covered services you receive during that calendar year.

See the Summary of Benefits for your deductible amounts.

**Individual Deductibles** — There are two individual deductible amounts indicated on the Summary of Benefits. Once your deductible payments for preferred provider services reach the individual Preferred Provider deductible amount, this Plan will begin paying its share of your covered preferred provider charges. You must meet the higher Nonpreferred Provider deductible before this Plan begins to pay its share of your covered charges from nonpreferred providers.

Covered charges for preferred provider services are **not** applied to the Nonpreferred Provider deductible, nor vice versa.

**Family Deductibles** — An entire family meets an applicable deductible when the total deductible amount for all family members reaches **three times** the applicable individual deductible amount chosen. **Note:** If a member's individual deductible is met, no more charges incurred by that member may be used to satisfy the applicable family deductible.

**What is Not Applied to the Deductibles** — Prescription drug plan and PPP office visit copayments, outpatient mental health and chemical dependency services, and charges for hearing aids and services covered under the “Heart, Heart-Lung, Liver, Lung, Pancreas-Kidney” transplant provision in Section 3, are **not** subject to a deductible. The first $400 in covered charges for routine adult preventive care and the first $250 in covered charges for well-child care is **not** subject to the deductible each year.

**Admissions Spanning Two Benefit Periods** — If a deductible has been met while you are an inpatient and the admission continues into a new year, no additional deductible is applied to that admission’s covered services. However, all other services received during the new year are subject to the deductibles for the new year.

**Timely Filing Reminder** — Most benefits are payable only after BCBSNM’s records show that an applicable deductible has been met. If you file your own claims for services from nonparticipating providers, you must file them within **12 months** of the date of service. Preferred providers and providers that have “participating” provider agreements with BCBSNM will file claims for you and must submit them within a specified amount of time, usually within 180 days. If a claim is returned for further information, resubmit it **within 45 days.** See “Filing Claims” in Section 6 for details.
Coinsurance and Out-of-Pocket Limits

Coinsurance — The percentage of covered charges that you must pay for most covered services after the deductible has been met.

Out-of-pocket limits — The maximum amount of coinsurance that you pay for most covered services in a calendar year. After an out-of-pocket limit is reached, this Plan pays 100 percent of most of your preferred or nonpreferred provider covered charges for the rest of that calendar year, not to exceed any benefit limits.

See the Summary of Benefits for your out-of-pocket limit amounts.

Coinsurance — For most covered services, you must pay a percentage of covered charges as “coinsurance.” After your share has been calculated, this Plan pays the rest of the covered charge, up to maximum benefit limits, if any. You pay a lower percentage of covered charges when you visit a preferred provider.

Remember: The covered charge may be less than the billed charge for a covered service. Preferred providers may not bill you more than the covered charge; nonpreferred providers may.

Out-of-Pocket Limits — Once a member’s coinsurance amounts for preferred provider services reach the individual Preferred Provider limit indicated on the Summary of Benefits, this Plan pays 100 percent of most of that member’s covered preferred provider charges for the rest of the calendar year. The higher Nonpreferred Provider limit must be met before this Plan pays 100 percent of the member’s covered charges for nonpreferred provider services.

Coinsurance for preferred provider services is not applied to the Nonpreferred Provider out-of-pocket limit, nor vice versa.

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

What is Not Included in the Limits — The following amounts are not applied to the out-of-pocket limits and are not eligible for 100 percent payment under this provision:

- penalty amounts; amounts in excess of covered charges (including amounts in excess of annual or lifetime benefit limits); noncovered expenses (including charges for services in excess of annual or lifetime day/visit limitations)
- PPP office visit copayments
- most mental health and chemical dependency services (Certain services received outside New Mexico or coordinated with Medicare as the primary coverage are applied to the limit.)
- deductible amounts
- drug plan copayments and/or coinsurance
- expenses covered under the “Heart, Heart-Lung, Liver, Lung, Pancreas-Kidney” transplant provision (There is a separate $5,000 out-of-pocket limit for certain transplant services. See “Transplant Services” in Section 3 for details.)
Exceptions to Cost-Sharing Provisions

Services of nonpreferred providers will be paid at the Preferred Provider benefit level in the following instances only.

Except as described below, the Preferred Provider benefit level is not available for nonemergency services when received from a nonpreferred provider — even if a preferred provider is not available in your area to perform the services.

Emergency Care Exception — If you visit a nonpreferred provider for emergency room services, the Preferred Provider benefit level is applied only to the initial treatment in the emergency room and (and, if you are hospitalized as an inpatient from the emergency room, the related inpatient hospitalization). Office/urgent care facility services are not considered “emergencies” for purposes of this provision. Follow-up care (which is no longer considered an emergency) and all other covered nonemergency services of a nonpreferred provider, will be covered only at the Nonpreferred Provider benefit level, even if a preferred provider is not available to perform the service. See “Emergency and Urgent Care” in Section 3 for more information.

Unsolicited Providers — In some states, the local BCBS Plan does not offer preferred provider contracts to certain types of providers (e.g., home health care agencies, chiropractors, ambulance providers). These provider types are referred to as “unsolicited providers.” The types of providers that are unsolicited varies from state to state. If you receive covered services from an “unsolicited provider” outside New Mexico, you will receive the Preferred Provider benefit level for those services. However, the unsolicited provider may still bill you for amounts that are in excess of covered charges. You will be responsible for these amounts, in addition to your copayment, deductible, and/or coinsurance.

Ancillary Provider Exception — Once you have obtained prior approval for an inpatient admission to a preferred hospital or treatment facility, your preferred physician or hospital will make every effort to ensure that you receive ancillary services from other preferred providers. If you receive covered services from a preferred physician for outpatient surgery or inpatient medical/surgical care in a preferred hospital or treatment facility, services of a nonpreferred radiologist, anesthesiologist, or pathologist will be paid at the Preferred Provider level and you will not be responsible for any amounts over the covered charge (these are the only three specialties covered under this provision).

If a nonpreferred surgeon or assistant surgeon provides your care or you are admitted to a nonpreferred hospital or other treatment facility, you will be responsible for amounts over the covered charge for any services received from nonpreferred providers during the admission or procedure.

Transition of Care — If your health care provider leaves the BCBSNM provider network (for reasons other than medical competence or professional behavior) or if you are a new member and your provider is not in the provider network when you enroll, BCBSNM may authorize you to continue an ongoing course of treatment with the provider for a transitional period of time not less than 30 days. (If necessary, and ordered by the treating provider, BCBSNM may also authorize transitional care from other out-of-network providers.) The period will be sufficient to permit coordinated transition planning consistent with your
condition and needs. Special provisions may apply if the required transitional period exceeds 30 days. If you have entered the third trimester of pregnancy at the effective date of enrollment, the transitional period shall include post-partum care directly related to the delivery. Call the BCBSNM Customer Service department for details.

Members who extend coverage under an extension of benefits due to disability after the Group Contract is terminated are not eligible to receive prior approval for services of an out-of-network provider. Services of an out-of-network provider are not covered at the in-network level (if any) in such instances of extended coverage.

### Changes to the Cost-Sharing Amounts

Coinsurance percentage amounts, deductibles, copayments, and out-of-pocket limits may change during a calendar year. If changes are made, the change applies only to services received after the change goes into effect. You will receive a revised *Summary of Benefits* and/or a new Plan ID card if changes are made to this Plan.

If your group increases the deductible or out-of-pocket amounts during a calendar year, the new amounts must be met during the same calendar year. For example, if you have met your deductible and your group changes to a higher deductible, you will not receive benefit payments for services received after the change went into effect until the increased deductible is met.

If your group decreases the deductible or out-of-pocket amounts, you will not receive a refund for amounts applied to the higher deductible or out-of-pocket limit.

### Benefit Limits

**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.

There is no general lifetime maximum benefit under this Plan. However, certain services have separate benefit limits per admission, per calendar year, etc. See the *Summary of Benefits* for details.

Generally, benefits are determined based upon the coverage in effect on the day a service is received, an item purchased, or a health care expense incurred. For inpatient services, benefits are based upon the coverage in effect on the date of admission, except that if you are an inpatient at the time your coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date.
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 approval) or receive certain types of services (other prior approvals).

These approval requirements will provide you with assurance that you are being treated in the most efficient and appropriate health care setting and can help manage the rising costs of health care. Please note:

Prior Approval Does Not Guarantee Payment or Validate Eligibility

Prior approval determines only the medical necessity of a specific service and/or an admission and an allowable length of stay. Prior approval does not guarantee benefit payment or your eligibility for coverage. Eligibility and benefits available will be determined based on the date you receive the services. An approval does not guarantee payment or that you will receive the highest level of benefits. Services not listed as covered, services received after your termination date under this Plan, and services that are not medically necessary will be denied.

When You Have Other Coverage

Even when this Plan is not your primary coverage, these approval procedures must be followed. Failure to do so may result in a reduction or in a denial of benefits.

Retroactive Approvals Not Given

Retroactive approvals will not be given and you may be responsible for the charges if approval is not obtained before the service is received.

Note: Requests for prior approval and admission review approval may be denied. Admission review requirements may affect the amounts that this Plan pays for inpatient services, but they do not deny your right to be admitted to any facility and to choose your services.

Preferred Providers in New Mexico — If the attending physician is a preferred provider that contracts directly with BCBSNM, obtaining prior approval is not your responsibility — it is the provider’s. PPPs and other preferred providers in New Mexico must obtain prior approval from BCBSNM (or from Mesa Mental Health, when applicable) in the following circumstances:

- when recommending any nonemergency admission, readmission, or transfer
- when a covered newborn stays in the hospital longer than the mother
- before providing or recommending a service listed under “Other Prior Approvals,” later in this section

Remember: Providers that contract with other Blue Cross Blue Shield Plans are not familiar with the prior approval requirements of BCBSNM. Unless a provider contracts directly with BCBSNM as a preferred provider (i.e., is listed in your BCBSNM provider network directory as a preferred provider), the provider is not responsible for being aware of this Plan’s admission review and other prior approval requirements.
Nonpreferred Providers or Providers Outside New Mexico — If any provider outside New Mexico that has not contracted directly with BCBSNM or a nonpreferred provider in any state recommends an admission or a service that requires prior approval, the provider is not obligated to obtain the prior approval for you. In such cases, it is your responsibility to ensure that approval is obtained. If approval is not obtained before services are received, you will incur a penalty for a covered admission or, for some services, be entirely responsible for the charges. The provider may call on your behalf, but it is your responsibility to ensure that BCBSNM (or Mesa Mental Health, when applicable) is called:

BCBSNM: Monday through Friday, 8 A.M. to 5 P.M., Mountain Time
toll-free at (866) 369-6678

Mesa Mental Health (for mental health and chemical dependency):
(505) 816-6792 or toll-free, at (800) 583-6372

Admission Review Approval

Admission review is required for most admissions before you are admitted to the hospital or skilled nursing, physical rehabilitation, or other treatment facility. If you do not obtain admission review approval within the time limits indicated in the table below, benefits will be reduced or denied as explained below.

<table>
<thead>
<tr>
<th>Type of inpatient admission, readmission, or transfer</th>
<th>When to obtain admission review approval:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonemergency</td>
<td>Before the patient is admitted.</td>
</tr>
<tr>
<td>Emergency, nonmaternity</td>
<td>Within 48 hours of the admission. If the patient’s condition makes it impossible to call within 48 hours, call as soon as possible.</td>
</tr>
<tr>
<td>Maternity-related (including eligible newborns when the mother will not be covered)</td>
<td>Before the mother’s maternity due date, soon after pregnancy is confirmed. However, you should always call within 48 hours of the admission for routine deliveries (96 hours for C-sections). If the mother’s condition makes it impossible to call within 48 (or 96) hours, call as soon as possible.</td>
</tr>
<tr>
<td>Extended stay, newborn (an eligible newborn stays in the hospital longer than the mother)</td>
<td>Before the newborn’s mother is discharged.</td>
</tr>
</tbody>
</table>

How the Approval Procedure Works — When you or your provider call, BCBSNM’s Health Services staff will ask for information about your medical condition, the proposed treatment plan, and the estimated length of stay. The Health Services staff will evaluate the information and notify the attending physician and the facility (usually at the time of the call) if benefits for the proposed hospitalization are approved. If the admission is not approved, you may appeal the decision as explained in Section 6.

Penalty for Not Obtaining Approval — If you or your provider does not call, or if you call and do not receive approval for inpatient benefits, but you choose to be hospitalized anyway, no benefits may be paid or partial payment may be made, as indicated in the table on the following page:
### If, based on a review of the claim:

<table>
<thead>
<tr>
<th>If, based on a review of the claim:</th>
<th>Then:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The admission was <strong>not for a covered service.</strong></td>
<td>Benefits for the facility and all related services are denied.*</td>
</tr>
<tr>
<td>The admission was for an item listed under “Other Prior Approvals” (e.g., physical rehabilitation or high-dose chemotherapy).</td>
<td>Benefits for the facility and all related services are denied.*</td>
</tr>
<tr>
<td>The admission was for any other covered service but hospitalization was <strong>not medically necessary.</strong></td>
<td>Benefits are denied for room, board, and other charges that are not medically necessary.*</td>
</tr>
<tr>
<td>The admission was for any other medically necessary covered service.</td>
<td>Benefits for the facility’s covered services are reduced by $300.*</td>
</tr>
</tbody>
</table>

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

### Other Prior Approvals

In addition to admission review for all inpatient services, prior approval is required for certain other services. Most prior approvals may be requested over the telephone. If a **written** request is needed and you call, an NMSU DSU representative will give you instructions for filing a written request for prior approval.

If prior approval is not obtained for the following services, **benefits will be denied** for all related services:

- **air ambulance** services (unless during a medical emergency)
- **autism spectrum disorders for children**
- **alcoholism or drug abuse** (chemical dependency) services, inpatient and outpatient (Prior approval is obtained from Mesa Mental Health.)
- **cardiac or pulmonary rehabilitation**
- **cardiac CT scans**
- **chemotherapy** (high-dose)
- **dental-related/oral surgery** hospital services (the procedure may not be covered even if benefits for the hospital stay are approved as medically necessary; see Section 3); treatment of **accidental injuries to teeth** (except initial treatment); treatment of **orthognathism**
- **certain drugs** purchased through the prescription drug plan, including **refills** before the supply should have been exhausted and purchases in excess of the maximum supply limitation; drugs for **smoking/tobacco use cessation**
- **durable medical equipment, medical supplies, and prosthetic devices** costing $500 (or more) or requiring **long-term rental**; **orthopedic appliances, orthotics, insulin pumps, and surgically implanted prosthetics**, regardless of total cost
- **nonprescription enteral nutritional products and special medical foods** (These products are purchased through the prescription drug plan.)
- **genetic testing or counseling**
- **home dialysis**
- **home health care** and **home I.V. services**
- **hormone replacement therapy** and other services and tests that may be **infertility-related**
- **hospice care**
Section 2: How Your Plan Works

- certain injections and injectable drugs
- PET scans
- private room charges
- psychiatric intake evaluations and medication checks; electroshock therapy; psychological testing; psychotherapy (Outpatient services require prior approval from Mesa Mental Health or benefits will be denied. For inpatient services that are not related to chemical dependency, you must obtain admission approval or benefits for covered services will be reduced by $300.)
- rehabilitative services (inpatient and outpatient physical, occupational, and speech therapy, including skilled nursing facility and inpatient physical rehabilitation services)
- sleep studies
- smoking/tobacco use cessation medications
- certain surgical procedures (which will require a written request for approval), including:
  - breast reduction
  - breast surgery following a mastectomy (Note: This is the only cosmetic procedure covered under this Plan.)
  - cochlear implants
  - dental-related/oral surgery services (the procedure may not be covered even if benefits for the hospital stay are approved as medically necessary; see Section 3); surgical treatment of accidental injuries to teeth (except initial treatment); orthognathic surgery
  - orthotripsy
  - reconstructive surgical procedures
  - surgical treatments that may be infertility-related, such as opening an obstructed fallopian tube, epididymis, or vas
  - transplants, including pretransplant evaluations

The services listed above may not be approved for payment (for example, due to being experimental, investigational, or unproven, or not medically necessary). It is strongly recommended that you request prior approval for high-cost services in order to reduce the likelihood of benefits being denied after charges are incurred.

The complete list of services requiring prior approval is subject to review and change by BCBSNM. BCBSNM-contracted providers have a list of all procedures and services, including individual surgical procedures and injectable drugs, that require prior approval. If you need a copy of this list, call an NMSU DSU representative.

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/Quality Management**

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

**Health Care Fraud Information**

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

- Be wary of offers to waive copayments, deductibles, or coinsurance. These costs are passed on to you eventually.
- Be wary of mobile health testing labs. Ask what your health care insurance will be charged for the tests.
- Review the bills from your providers and the *Explanation of Benefits* (EOB) you receive from BCBSNM. Verify that services for all charges were received. If there are any discrepancies, call an NMSU DSU representative.
- Be very cautious about giving information about your health care insurance over the phone.

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

This section describes the services and supplies covered by this PPO Health Care Plan, subject to the limitations and exclusions in Sections 2 and 4. All payments are based on covered charges as determined by BCBSNM.

Reminder: It is to your financial advantage to receive care from PPO Primary Providers (PPPs) and other preferred providers.

See the Summary of Benefits for specific member copayments, deductibles, and coinsurance percentages.

Medically Necessary Services

Medically necessary — A service or supply is medically necessary when it is provided to diagnose or treat a covered medical condition, is a service or supply that is covered under the Plan, and is determined by BCBSNM's medical director to meet all of the following conditions:

- it is medical in nature;
- it is recommended by the treating physician;
- it is the most appropriate supply or level of service, taking into consideration:
  - potential benefits;
  - potential harms;
  - cost, when choosing between alternatives that are equally effective; and
  - cost-effectiveness, when compared to the alternative services or supplies;
- it is known to be effective in improving health outcomes as determined by credible scientific evidence published in the peer-reviewed medical literature (for established services or supplies, professional standards and expert opinion may also be taken into account); and
- it is not for the convenience of the member, the treating physician, the hospital, or any other health care provider.

All services must be eligible for benefits as described in this section, not listed as an exclusion, and must meet all of the conditions of “medically necessary” as defined above in order to be covered.

Note: Because a health care provider prescribes, orders, recommends, or approves a service does not make it medically necessary or make it a covered service, even if it is not specifically listed as an exclusion. (BCBSNM, at its sole discretion, will determine medical necessity based on the criteria above.)

See Section 4: General Limitations and Exclusions
Acupuncture/Spinal Manipulation

Acupuncture is covered when administered by a licensed provider acting within the scope of licensure and when necessary for the treatment of an illness or injury. Benefits for acupuncture, including office calls, treatment, and acupuncture when used as an anesthetic, and benefits for spinal manipulation for the treatment of an illness or injury are limited as specified on the Summary of Benefits. Services must be received from a preferred provider in order to be covered.

Exclusions — This Plan does not cover:

- acupuncture or spinal manipulation received from nonpreferred providers
- herbs, homeopathic preparations, or nutritional supplements
- services of a massage therapist or rolfing
- any therapeutic exercise equipment prescribed for home use

See Section 4: General Limitations and Exclusions

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.

This Plan covers ambulance services in an emergency (e.g., cardiac arrest, stroke). When you cannot be safely transported by any other means in a nonemergency situation, medically necessary ambulance transportation to a hospital with appropriate facilities, or from one hospital to another, is also covered.

Air Ambulance — This Plan covers air ambulance 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 determines, on a case-by-case basis, when 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.

Exclusions — This Plan does not cover:

- commercial transport, private aviation, or air taxi services
- services not specifically listed as covered, such as private automobile, public transportation, or wheelchair ambulance
- services ordered only because other transportation was not available or for your convenience

See Section 4: General Limitations and Exclusions
## Autism Spectrum Disorders

**Applied behavioral analysis (ABA)** — Services that include behavior modification training programs that are based on the theory that behavior is learned through interaction between an individual and the environment. The goal of behavior management is to reinforce and increase desirable, functional behaviors while reducing undesirable, “maladaptive” behaviors. Services would not apply to children over the age of seven.

**Autism Spectrum Disorder** — A condition that meets the diagnostic criteria for the pervasive developmental disorders published in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision, also known as *DSM-IV-TR*, published by the American Psychiatric Association, including autistic disorder; Asperger's disorder; pervasive development disorder not otherwise specified; Rhett’s disorder; and childhood integrative disorder.

**Habilitative treatment** — Treatment programs that are necessary to: 1) develop, 2) maintain, and 3) restore to the maximum extent practicable the functioning of an individual. All three conditions must be met in order to be considered habilitative.

For a member **19 years or younger** (or, if enrolled in high school, 22 years old or younger), this Plan covers the habilitative and rehabilitative treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy, and applied behavioral analysis (ABA) when provided by an in-network provider. Providers must be credentialed to provide such therapy. **Note:** ABA services are not indicated for children over the age of seven.

Treatment must be prescribed by the member’s treating physician in accordance with a treatment plan. The treatment plan must be **prior-approved** by BCBSNM; if services are received but were not approved as part of the treatment plan, benefits for covered services will be denied. Once maximum functionality has been reached and no additional improvement is expected, no therapies are covered unless required to maintain that member’s current functionality (that is, in the absence of additional treatment, the patient would suffer a setback). **No benefits are available for any treatments not shown to be habilitative or rehabilitative.**

Benefits for all services for the treatment of autism spectrum disorder are limited for each eligible BCBSNM-insured person to **$36,000** per calendar year and to **$200,000** in total lifetime benefits. Once the annual maximum is reached, no more benefits for autism therapy are provided until the next year. Once a lifetime maximum is reached, no more benefits for autism therapy are provided for that BCBSNM member.

Changing from one plan to another under the same group, reinstating prior BCBSNM coverage, changing employers, changing policyholder or subscriber, or moving from individual coverage to group coverage or vice versa does **not**
reinstate autism benefits once an annual or lifetime maximum is reached for a particular insured member. All amounts payable under this provision are tracked at the member level regardless of the policy number under which charges accrued. For example, if a member is covered under two BCBSNM policies, the maximum annual benefit and the maximum lifetime benefit is not doubled for that member. Regardless of the number of policies under which the member is covered, benefits will not exceed the per member annual and lifetime maximum benefits mandated by law.

Services are subject to usual member cost-sharing features such as deductible, coinsurance, copayments, and out-of-pocket limits - based on place of treatment and type of service. All services are subject to the General Limitations and Exclusions of the member’s Plan except where explicitly mentioned as being an exception. For example, certain autism spectrum disorder services mandated by law are excepted from exclusions such as the “Nonpreferred Provider Services” or “Pre-Existing Conditions” exclusions.

Regardless of the type of therapy received, claims for services related to autism spectrum disorder should be mailed to BCBSNM - not to the behavioral health services administrator.

Exclusions — This Plan does not cover:
- services that have not been prior-approved by BCBSNM
- any experimental, long-term, or maintenance treatments not required under state law
- Sensory Integration Therapy (SIT) or Auditory Integration Therapy (AIT)
- medically unnecessary or nonhabilitative services under any circumstance
- applied behavioral analysis (ABA) for children over the age of seven
- any services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on the state and local boards for providing specialized education and related services to children 3 to 22 years old who have autism spectrum disorder
- respite services or care
- music therapy, vision therapy, or touch or massage therapy
- floor time
- facilitated communication
- elimination diets; nutritional supplements; intravenous immune globulin infusion; secretin infusion
- chelation therapy, Hypnotherapy, animal therapy, or art therapy

Dental-Related/TMJ Services and Oral Surgery

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

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

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The Preferred Provider benefit level is not available for nonemergency services, including treatment of dental and facial accidents, oral surgery, or hospital services, when received from a nonpreferred provider—even if a preferred provider is not available in your area to perform the services.

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The following services are the only dental services and oral surgery procedures covered under this Plan. When alternative procedures or devices are available, benefits are based upon the least costly, medically appropriate procedure or device available.

**Dental and Facial Accidents**—Benefits for covered services for the treatment of accidental injuries to the jaw, mouth, face, or sound natural teeth are generally subject to the same limitations, exclusions, and member cost-sharing provisions that would apply to similar services when not dental-related (e.g., x-rays, medical supplies, surgical procedures).

To be covered, initial treatment for the injury must be sought within 72 hours of the accident. Any services required after the initial treatment must receive prior approval, requested in writing, from BCBSNM and be received within 12 months of the date of accident in order to be covered.

**Facility Charges and General Anesthesia for Dental-Related Services**—This Plan covers inpatient or outpatient hospital expenses (including ambulatory surgical centers) and hospital and physician charges for administration of general anesthesia for noncovered, medically necessary dental-related services if the patient requires hospitalization for one of the following reasons:

- Because of the patient’s physical, intellectual, or medical condition(s), local anesthesia is not the best choice.
- Local anesthesia is ineffective because of acute infection, anatomic variation, or allergy to local anesthesia.
- The patient is a member age 19 or younger who is extremely uncooperative, fearful, or uncommunicative; his/her dental needs are too significant to be postponed; and lack of treatment will be detrimental to the child’s dental health.
- Because oral-facial or dental trauma is so extensive, local anesthesia would be ineffective.
- There is a medically necessary dental procedure—not excluded by any *General Limitation or Exclusion* listed in the benefit booklet such as for work-related,
Call BCBSNM for Approval: (505) 291-3585 or (800) 325-8334

Pre-existing, or cosmetic services, etc. – that requires the patient to undergo general anesthesia or be hospitalized.

All hospital services for dental procedures must be prior-approved by BCBSNM. Note: Unless listed as a covered procedure in this section, the dentist’s services for the procedure will not be covered. Reminder: If hospital services are recommended by any nonpreferred provider in an emergency, you are responsible for obtaining prior approval in order to receive maximum benefits. (See “Admission Review and Other Prior Approvals” in Section 2.)

**Oral Surgery** — Covered services include surgeon’s charges for the following procedures only:
- medically necessary orthognathic surgery if prior approval for the service is received from BCBSNM
- 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
- removal or biopsy of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of mouth when pathological examination is required

**TMJ/CMJ Services** — This Plan covers standard diagnostic, therapeutic, surgical, and nonsurgical treatments of temporomandibular joint (TMJ) or craniomandibular joint (CMJ) disorders or accidental injuries. Covered services may include orthodontic appliances and treatment, crowns, bridges, or dentures only if services are required because of an accidental injury to sound natural teeth involving the temporomandibular or craniomandibular joint.

**Exclusions** — This Plan does not cover oral or dental procedures not specifically listed as covered such as, but not limited to:
- nonstandard services (diagnostic, therapeutic, or surgical)
- surgeon’s or dentist’s charges for a noncovered dental-related service
- hospitalization or general anesthesia for the patient’s or provider’s convenience
- any service related to a dental procedure that is not medically necessary or that is excluded under this plan for reasons other than being dental-related, even if hospitalization and/or general anesthesia is medically necessary for the procedure being received (e.g., cosmetic procedures, experimental procedures, services received after coverage termination, services related to pre-existing conditions, work-related injuries, etc.)
- removal of tori, exostoses, or impacted teeth
- dental services that may be related to, or required as the result of, a medical condition or procedure (e.g., chemotherapy or radiation therapy)
- procedures involving orthodontic care, the teeth, dental implants, periodontal disease or condition, or preparing the mouth for dentures
- duplicate or “spare” appliances
- personalized restorations, cosmetic replacement of serviceable restorations, or materials (such as precious metals) that are more expensive than necessary to restore damaged teeth
Section 3: Covered Services

NMSU PPO 500 Plan

- dental treatment or surgery, such as extraction of teeth or application or cost of devices or splints, unless required due to an accidental injury and covered under “Dental and Facial Accidents” or “TMJ/CMJ Services”
- artificial devices and/or bone grafts for denture wear

See Section 4: General Limitations and Exclusions

Emergency and Urgent Care

Emergency — Medical or surgical procedures, treatments, or services delivered 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. (In addition, services must be received in an emergency room, trauma center, or ambulance to qualify as an emergency.)

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

For accidental injury to the mouth, jaw, teeth, or TMJ, see “Dental-Related/TMJ Services and Oral Surgery.” Also see other subheadings when applicable (such as “Hospital/Other Facility Services”).

Emergency Care

Acute medical emergency care is available 24 hours per day, 7 days a week. If emergency room treatment is administered by either a preferred or non-preferred provider, benefits for the initial treatment are subject to the Preferred Provider deductible and coinsurance provisions. If you are hospitalized within 48 hours of an emergency, the entire, related hospitalization (as long as you remained covered under this Plan) is considered part of the initial treatment. (Nonparticipating providers may bill you for amounts in excess of covered charges.)

Covered services for nonpreferred provider follow-up care, including services received after you are discharged from the hospital or emergency room, are always paid at the Nonpreferred Provider benefit level.

Note: Services received in an emergency room that do not meet the definition of an “emergency” may be reviewed for appropriateness and may be denied.

Inpatient Admission Notification Required — If you are admitted as an inpatient from an emergency room or within 48 hours of the related emergency room visit, you (or a family member or your doctor) should notify BCBSNM within 48 hours of the admission (or as soon as reasonably possible) with hospital admission information in order to ensure that benefits will be paid correctly. (See “Admission Review and Other Prior Approvals” in Section 2.)
Urgent Care

Urgent care is covered as any other type of service. If services are received in an emergency room or other trauma center, the condition must meet the definition of an “emergency” in order to be covered.

Outside the Service Area — When you are traveling, or if you have an eligible family member living outside the New Mexico/El Paso service area, you can take advantage of the contracts that other Blue Cross and Blue Shield (BCBS) Plans have with their local health care providers. For a list of contracting providers outside New Mexico, contact the local BCBS Plan or call an NMSU DSU representative, who will connect you with the BlueCard Doctor and Hospital Information Line. If you prefer, you may contact a BlueCard representative directly at 1-800-810-BLUE (2583).

See Section 4: General Limitations and Exclusions

Hearing Aids/Related Services for Children Under Age 21

This benefit plan covers the cost of hearing aids, the fitting and dispensing fees for hearing aids and ear molds, up to a maximum amount of $2,200 per hearing impaired ear every 36 months for members under 21 years old. This 36-month benefit period begins on the date the first covered hearing aid-related service is received and payable under this provision and ends 36 months later. The next benefit period for the impaired ear begins 36 months after the first hearing aid-related service (e.g., fitting cost, ear mold, etc.) OR on the date the next hearing-aid related service for that ear, whichever length of time is greater.

Benefits for hearing-aid related services under this provision are not subject to the coinsurance or copayment amount. Benefits for hearing-aid related services will be provided at 100 percent of the covered charges. (Other covered services, such as hearing examinations and audiometric testing related to a hearing aid need for members under 21 years old are subject to the coinsurance and copayment provisions for office services and diagnostic testing. Benefits for these additional services are not applied to the 36-month maximum benefit available for hearing aids.) Routine hearing examinations and related services are not covered for members age 21 and older.

Home Health Care/Home I.V. Services

For oxygen, ostomy supplies, and medical equipment, see “Supplies, Equipment, and Prosthetics.”

Conditions and Limitations — If you are homebound (unable to receive medical care on an outpatient basis), home health care and home I.V. services are covered. Benefits are limited as specified on the Summary of Benefits. Services must be provided under the direction of a physician and nursing management
Section 3: Covered Services

 must be through a home health care agency approved by BCBSNM. A visit is one period of home health service of up to four hours.

Prior Approval Required — Before you receive home health care or home I.V. therapy, you, your physician, or home health care agency must obtain prior approval from BCBSNM. This Plan does not cover home health care or home I.V. services without prior approval.

Covered Services — The following services are covered, subject to the limitations and conditions above, when provided by an approved home health care agency during a covered visit in your home:
- skilled nursing care provided on an intermittent basis by a registered nurse or licensed practical nurse
- physical, occupational, or respiratory therapy provided by licensed or certified physical, occupational, or respiratory therapists
- speech therapy provided by an American Speech and Hearing Association certified therapist
- 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 and Other Items.”)
- parenteral and enteral nutritional products that can only be legally dispensed by the written prescription of a physician and are labeled as such on the packages (If not provided by the home health care agency or if products do not require a prescription, see “Prescription Drugs and Other Items.”)
- medical supplies
- skilled services by a qualified aide to do such things as change dressings and check blood pressure, pulse, and temperature

Exclusions — This Plan does not cover:
- care provided primarily for your or your family’s convenience
- homemaking services or care that consists mostly of bathing, feeding, exercising, preparing meals for, moving, giving medications to, or acting as a sitter for the patient (See the “Custodial Care” exclusion in Section 4.)
- services provided by a nurse who ordinarily resides in your home or is a member of your immediate family
- nonprescription enteral nutritional products (See “Prescription Drugs and Other Items” for details about possible benefits for these products.)

See Section 4: General Limitations and Exclusions

Hospice Care

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

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

**Conditions and Limitations** — This Plan covers inpatient and home hospice services for a terminally ill member received during a hospice benefit period when provided by a hospice program approved by BCBSNM. Hospice care benefits are limited as specified on the Summary of Benefits.

If you need an extension of the hospice benefit period, the hospice agency must provide a new treatment plan and the attending physician must recertify your condition to 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.

**Prior Approval Required** — Before you receive hospice care, you, your attending physician, or the hospice agency must request prior approval from BCBSNM. This Plan does not cover hospice services without prior approval.

**Covered Services** — This Plan covers the following services, subject to the limitations and conditions above, under the hospice care benefit:

- 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
- 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 and Other Items.”)
- medical social services provided by a qualified individual with a degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training, and experience (Such services must be recommended by a physician to help the member or his/her family deal with a specified medical condition.)
- services of a home health aide under the supervision of a registered nurse and in conjunction with skilled nursing care
- nutritional guidance and support, such as intravenous feeding and hyperalimentation
- respite care for a period not to exceed 5 continuous days for every 60 days of hospice care and no more than two respite care periods during each hospice benefit period (Respite care provides a brief break from total care-giving by the family.)

**Exclusions** — This Plan does not cover:

- food, housing, or delivered meals
- medical transportation
Section 3: Covered Services

- homemaker and housekeeping services; comfort items
- private duty nursing
- pastoral, spiritual, or bereavement counseling
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this Plan
- care or services received after the member’s coverage terminates

The following services are not hospice care benefits but may be covered elsewhere under this Plan: acute inpatient hospital care for curative services, durable medical equipment, physician visits unrelated to hospice care, and ambulance services.

See Section 4: General Limitations and Exclusions

■ Hospital/Other Facility Services

If applicable, see:
“Dental-Related/TMJ Services and Oral Surgery”
“Emergency and Urgent Care”
“Hospice Care”
“Maternity/Reproductive Services and Newborn Care”
“Psychotherapy: Mental Health and Chemical Dependency”

For inpatient physician medical visits, see “Physician Visits/Medical Care.”

For physical rehabilitation and skilled nursing facility services, see “Short-Term Rehabilitation.”

See other subheadings in this section that apply to the type of services required during an admission, such as “Surgery and Related Services” or “Transplant Services.”

Blood Services

This Plan covers the processing, transporting, handling, and administration of blood. This Plan covers directed donor or autologous blood storage fees only when the blood is used during a scheduled surgical procedure. This Plan does not cover blood replaced through donor credit.

Inpatient Services

Admission — The period of time between the dates when a patient enters a facility as an inpatient and is discharged as an inpatient. (If you are an inpatient at the time your coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date.)

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

Medical detoxification — Treatment in an acute care facility for withdrawal from the physiological effects of chemical dependency (alcoholism or drug abuse).

Admission Review Approval Required — If hospitalization is recommended by a nonpreferred provider, you are responsible for obtaining admission approval. If you do not follow the admission review procedures outlined in Section 2,
benefits will be **reduced or denied** as explained under “Admission Review and Other Prior Approvals” in Section 2.

**Covered Acute Care Services** — For acute inpatient medical or surgical care received during a covered hospital admission, this Plan covers semiprivate room or special care unit (e.g., ICU, CCU) expenses and other medically necessary services provided by the facility. (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. BCBSNM must give **prior approval** for medically necessary private room charges to be covered.)

**Medical Detoxification** — This Plan also covers medically necessary hospital services related to medical detoxification from the effects of alcoholism or drug abuse (usually limited to three days in an acute care hospital). See “Psychotherapy: Mental Health and Chemical Dependency” for information about benefits for alcoholism and drug abuse rehabilitation.

**Exclusions** — This Plan does **not** cover:
- private room expenses, unless your medical condition requires isolation for protection from exposure to bacteria or diseases (e.g., severe burns or conditions that require isolation according to public health laws)
- admissions related to noncovered services or procedures (See “Dental-Related/TMJ Services and Oral Surgery” for an exception.)
- extended care facility admissions or admissions to similar institutions
- admissions for rehabilitative treatment, such as oxygen therapy (For physical rehabilitation benefits, see “Short-Term Rehabilitation.”)

**Outpatient or Observation Services**
Coverage for outpatient or observation room services depends on the type of service received (e.g., “Lab, X-Ray, Other Diagnostic Services”) or on special circumstances (e.g., “Emergency and Urgent Care”).

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**Lab, X-Ray, Other Diagnostic Services**

**Diagnostic services** — Procedures such as laboratory and pathology tests, x-rays, and EKGs 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 services received during a covered inpatient admission, see “Hospital/Other Facility Services.”

For allergy testing benefits, see “Physician Visits/Medical Care.”

If applicable, also see these topics:
- “Dental-Related/TMJ Services and Oral Surgery”
- “Preventive Services”
- “Emergency and Urgent Care”
- “Transplant Services”

For invasive diagnostic procedures such as biopsies and endoscopies or any procedure that requires the use of an operating or recovery room, see “Surgery and Related Services.”
Section 3: Covered Services

This Plan covers diagnostic services, including preadmission testing, that are related to an illness or injury. Covered services include:

- psychological testing that has been prior-approved by Mesa Mental Health (Call 1-800-583-6372.)
- x-ray and radiology services, ultrasound, and imaging studies
- laboratory and pathology tests
- EKG, EEG, and other electronic diagnostic medical procedures
- genetic testing, with prior approval from BCBSNM (Tests such as amniocentesis or ultrasound to determine the sex of an unborn child are not covered; see “Maternity/Reproductive Services and Newborn Care.”)
- infertility-related testing, with prior approval from BCBSNM (See “Maternity/Reproductive Services and Newborn Care.”)
- PET (Positron Emission Tomography) scans and cardiac CT scans, with prior approval from BCBSNM
- home sleep disorder studies, with prior approval from BCBSNM (If services must be performed on an inpatient basis, admission approval is required.)
- audiometric (hearing) and vision tests for the diagnosis and/or treatment of an accidental injury or an illness

Note: All services, including those for which prior approval is required, must meet the standards of medical necessity criteria established by BCBSNM and will not be covered if excluded for any reason under this health care plan. Some services requiring prior approval will not be approved for payment.

See Section 4: General Limitations and Exclusions

Maternity/Reproductive Services and Newborn Care

See other subheadings in this section for services received during a covered pregnancy or admission, such as “Hospital/Other Facility Services.”

For oral contraceptive coverage, see “Prescription Drugs and Other Items.”

Like benefits for other conditions, member cost-sharing amounts for pregnancy, family planning, infertility, and newborn care are based on the place of service and type of service received.

Family Planning/Infertility-Related Services

Family Planning — Covered family planning services include FDA-approved devices and other procedures such as:

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

Infertility-Related Services — This Plan covers the following infertility-related treatments when prior approval is received from BCBSNM (note that the following procedures only secondarily also treat infertility):

- in vitro fertilization (IVF)
- intracytoplasmic sperm injection (ICSI)
-卵子捐赠 (oocyte donation)
- gamete donation
- donor sperm
- donor egg
- donor uterus
- 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

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

Diagnostic testing, when prior approval is received from BCBSNM, is covered only to diagnose the cause of infertility. Once the cause has been established and the treatment determined to be noncovered, no further testing is covered. For example, this Plan will cover lab tests to monitor hormone levels following the hormone replacement treatment listed as covered above. However, daily ultrasound sounds to monitor ova maturation are not covered since the testing is being used to monitor a noncovered infertility treatment.

Exclusions — In addition to services not listed as covered above, this Plan does not cover:
- sterilization reversal for males or females
- infertility treatments or related services, including artificial conception or insemination
- contraceptive devices that do not require a prescription, including over-the-counter contraceptive products such as condoms and spermicide

Pregnancy-Related/Maternity Services

All NMSU members, including covered children are eligible for pregnancy-related or maternity coverage.

If you are pregnant, you should call BCBSNM before your maternity due date, soon after your pregnancy is confirmed. If you are receiving services out-of-network, you are responsible for making sure that BCBSNM is notified within 48 hours of admission for a routine delivery or within 96 hours for a C-section delivery (or as soon as possible). If not notified within this time period and your admission extends beyond 48 hours or 96 hours (as applicable), benefits for covered facility services will be reduced by $300. See “Admission Review and Other Prior Approvals” in Section 2.

Covered Services — Covered services include:
- hospital or other facility charges for semiprivate room and ancillary services, including the use of labor, delivery, and recovery rooms (This Plan covers all medically necessary hospitalization, including at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a C-section delivery.)
- routine or complicated delivery in your home, licensed birthing center, or hospital, including prenatal and postnatal medical care of an obstetrician, certified nurse-midwife, or licensed midwife (Expenses for prenatal and postnatal care are included in the total covered charge for the actual delivery or completion of pregnancy. The office visit during which a pregnancy is confirmed is subject to the member cost-sharing provisions that apply to any other office visit. Note: Home births are not covered at the Preferred Provider level of coverage unless the provider is credentialed to provide the service and has a preferred provider contract with his/her local BCBS Plan.)
- pregnancy-related diagnostic tests, including genetic testing or counseling if **prior-approved** by BCBSNM (Services must be sought due to a family history of a sex-linked genetic disorder or to diagnose a possible congenital defect caused by a present, external factor that increases risk, such as advanced maternal age or alcohol abuse. For example, tests such as amniocentesis or ultrasound to determine the sex of an unborn child are not covered.)
- necessary anesthesia services by a provider qualified to perform such services, including acupuncture used as an anesthetic during a covered procedure and administered by a physician, a licensed doctor of oriental medicine, or other practitioner as required by law
- services of a physician who actively assists the operating surgeon in performing a covered procedure when the procedure requires an assistant
- miscarriage or medically necessary therapeutic termination of pregnancy prior to full term (Elective termination of pregnancy is not covered unless medically necessary to protect the life of the mother.)

### Newborn Care

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

See Section 7 for details about enrolling your newborn.

If you have coverage for your newborn child, the initial routine newborn care is covered. **Note:** If the parent of the newborn is an eligible child of the subscriber (i.e., the newborn is the subscriber’s grandchild), services for the newborn are **not** covered. If both the baby’s and the mother’s charges are eligible for coverage under this Plan, no additional deductible for the newborn is required for the initial routine hospital nursery services (i.e., if the covered newborn is discharged on the same day as the mother).

**Extended Stay Newborn Care** — A newborn who is enrolled for coverage within the time limits specified in Section 7 is also covered if he/she stays in the hospital longer than the mother.

If the newborn is in a nonpreferred facility or if the pediatrician is a nonpreferred provider, you must ensure that BCBSNM is called **before** the mother is discharged from the hospital. If you do not, benefits for the newborn’s covered facility services will be reduced by **$300**. The baby’s services will be subject to a separate deductible, coinsurance, and out-of-pocket limit.

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See Section 4: General Limitations and Exclusions
Medical Therapy

When billed by a facility during a covered admission, covered therapy is paid in the same manner as other covered services billed by the facility (see “Hospital/Other Facility Services”).

Chemotherapy and Radiation Therapy
This Plan covers the treatment of malignant disease and other medical conditions by standard chemotherapy and/or by radiation therapy. **High-dose chemotherapy treatments must receive prior approval from BCBSNM in order to be covered.**

**Cancer Clinical Trials** — If you are a participant in a phase II, III, or IV approved “cancer clinical trial” (see Glossary) that is being conducted in New Mexico, you may receive coverage for certain “routine patient care costs” (see Glossary) incurred in the trial. It does not include trials designed to test toxicity or disease pathophysiology, but must have a therapeutic intent and be provided as part of a study being conducted in a cancer clinical trial in New Mexico. In order to be considered for possible coverage, the persons conducting the trial must provide BCBSNM with notice of when the member enters and leaves a qualified clinical trial and must accept BCBSNM’s covered charges as payment in full (this includes the Plan’s payment plus your share of the covered charge).

The routine patient care costs that are covered must be the same services or treatments that would be covered if you were receiving standard cancer treatment. Benefits also include FDA-approved prescription drugs that are not paid for by the manufacturer, distributor, or provider of the drug. (Member cost-sharing provisions described in “Prescription Drugs and Other Items” will apply to these benefits.)

**Dialysis**
This Plan covers the following services when received from a dialysis provider or, when **prior approval** is received from BCBSNM, in your home:
- renal dialysis (hemodialysis)
- continual ambulatory peritoneal dialysis (CAPD)
- apheresis and plasmapheresis
- the cost of equipment rentals and supplies for home dialysis

**Cardiac and Pulmonary Rehabilitation**
This Plan covers outpatient cardiac rehabilitation programs initiated within six months of a cardiac incident and outpatient pulmonary rehabilitation services. **Prior approval** must be obtained from BCBSNM or benefits will be denied.

**Services must be received from a preferred provider in order to be covered.** This Plan does not cover these services when received from non-preferred providers.
Section 3: Covered Services

Physician Visits/Medical Care

If applicable, see these topics:
- “Acupuncture/Spinal Manipulation”
- “Dental-Related/TMJ Services and Oral Surgery”
- “Emergency and Urgent Care”
- “Hospice Care”
- “Maternity/Reproductive Services and Newborn Care”
- “Medical Therapy” (for cardiac and pulmonary rehabilitation, chemotherapy, radiation therapy, and dialysis)
- “Preventive Services”
- “Psychotherapy: Mental Health and Chemical Dependency”
- “Short-Term Rehabilitation” (for physical, occupational, speech therapy, and skilled nursing facility visits)
- “Surgery and Related Services” or “Transplant Services”

This section describes benefits for nonsurgical, nonroutine medical visits to a health care provider for evaluating your condition and planning a course of treatment. See the topics referenced above for more information regarding a particular type of service.

This Plan covers medically necessary care provided by a physician or other professional provider for an illness or injury. **Your choice of provider can make a difference in the amount you pay.** (See Section 2.)

Office Visits and Consultations

Member cost-sharing amounts for services received in a physician’s office are based on the type of service received while in the office. Services covered under this provision include allergy care, therapeutic injections, office visits, consultations (including second or third surgical opinions), and examinations, and other nonroutine medical procedures — when not related to hospice care or payable as part of a surgical procedure. (See “Hospice Care” or “Surgery and Related Services” if the medical visits are related to either of these services.)

**Allergy Care** — This Plan covers direct skin (percutaneous and intradermal) and patch allergy tests, radioallergosorbent testing (RAST), covered charges for allergy serum, and appropriate FDA-approved allergy injections administered in a provider’s office or in a facility.

**Diabetes Self-Management** — This Plan covers diabetes self-management training if you have diabetes or an elevated blood glucose due to pregnancy. Training must be prescribed by a health care provider and given by a certified, registered, or licensed health care professional with recent education in diabetes management. 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

See “Prescription Drugs and Other Items” for benefits for insulin and oral agents to control blood glucose levels, needles, syringes, and test strips; see “Supplies, Equipment, and Prosthetics” for other covered supplies and equipment required due to diabetes.
Injections and Injectable Drugs — This Plan covers most FDA-approved therapeutic injections administered in a provider’s office. However, some injectable drugs are covered only when prior approval is received from BCBSNM. Your BCBSNM-contracted provider has a list of those injectable drugs that require prior approval. If you need a copy of the list, contact an NMSU DSU representative. (When you request prior approval, you may be directed to purchase self-injectable medications through the prescription drug plan.)

BCBSNM reserves the right to exclude any injectable drug currently being used by a member. Proposed new uses for injectable drugs previously approved by the FDA will be evaluated on a medication-by-medication basis. Call an NMSU DSU representative if you have any questions about this policy.

Mental Health Evaluation Services — This Plan covers medication checks and intake evaluations for mental health and chemical dependency (alcoholism and drug abuse) when prior-approved by Mesa Mental Health. See “Psychotherapy: Mental Health and Chemical Dependency” for psychotherapy and other therapeutic service benefits.

Inpatient Medical Visits
With the exception of dental-related services (see “Dental-Related/TMJ Services and Oral Surgery”), this Plan covers the following services when received on a covered inpatient hospital day:

- visits for a condition requiring only medical care, unless related to hospice care (See “Hospice Care.”)
- consultations (including second opinions) and, if surgery is performed, inpatient visits by a provider who is not the surgeon and who provides medical care not related to the surgery (For the surgeon’s services, see “Surgery and Related Services” or “Transplant Services.”)
- medical care requiring two or more physicians at the same time because of multiple illnesses
- initial routine newborn care (care of a healthy child immediately following his/her birth that includes pediatrician standby care at a C-section) for a newborn added to coverage within the time limits specified in Section 7 (See “Maternity/Reproductive Services and Newborn Care” for details and for nonroutine, extended stay benefits.)

See Section 4: General Limitations and Exclusions

Prescription Drugs and Other Items

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

Drug List — A list of prescription drugs that are preferred for use by the BCBSNM for pharmacy benefits. You pay either the “Generic” or “Brand-Name” copayment for drugs on the BCBSNM Drug List. You pay a higher copayment for drugs not listed on the Drug List and for specialty pharmacy drugs. The BCBSNM Drug List, including the list of medications on the specialty pharmacy drug list, are subject to periodic review and change by BCBSNM. (BCBSNM-contracted preferred...
providers should have received a copy of the Drug List. If you need a list of commonly prescribed drugs on the Drug List, request it from an NMSU DSU representative or visit the BCBSNM Web site at www.bcbsnm.com.) Please note that some drugs are considered “specialty pharmacy drugs” and must be purchased through the specialty pharmacy provider in order to be covered.

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

**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.

**Genetic inborn error of metabolism** — A rare, inherited disorder that is present at birth; if untreated, results in mental retardation or death, and requires that the affected person consume special medical foods.

**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 covered prescription drugs and medicines, insulin, diabetic supplies, special medical foods, and enteral nutritional products to Plan members, and that has contractually accepted the terms and conditions as set forth by BCBSNM and/or its authorized representative. Some participating pharmacies are contracted with BCBSNM to provide specialty pharmacy drugs to Plan members; these pharmacies are called “specialty pharmacy providers” and some drugs must be dispensed by these specially contracted pharmacy providers in order to be covered.

**Prescription drugs and medicines** — Those that are taken at the direction and under the supervision of a provider, that require a prescription before being dispensed, and are labeled as such on their packages. All drugs and medicines must be approved by the FDA, and must not be experimental, investigational, or unproven. (See the “Experimental, Investigational, or Unproven Services” exclusion in Section 4.)

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

**Specialty pharmacy drugs** — Specialty pharmacy drugs must meet at least two of the following criteria: a) they are high cost, b) they are for use in limited patient populations or indications, c) they are typically self-injected, d) they have limited availability, require special dispensing, or delivery and/or patient support is required and, therefore, they are difficult to obtain via traditional pharmacy channels, e) complex reimbursement procedures are required, and/or f) a considerable portion of the use and costs are frequently generated through office-based medical claims.
Covered Medications and Other Items — This Plan covers the following drugs, supplies, and other products through this prescription drug plan provision only when dispensed by a participating pharmacy under the Retail Pharmacy Program or Specialty Pharmacy Drug Program (unless required as the result of an emergency, as defined) or ordered through the Mail Order Service:

- prescription drugs and medicines (including prescriptive oral agents for controlling blood sugar levels and prescription contraceptive medications), insulin, glucagon, and prescription contraceptive devices purchased from a participating pharmacy, unless listed as an exclusion (Note: Prescription contraceptive devices fitted or inserted by, and purchased directly from, a physician are payable under the “Family Planning” benefit of your medical/surgical Plan.)
- specialty pharmacy drugs such as, but not limited to, self-administered injectable drugs such as growth hormone, Copaxone, and Avonex (Most injectable drugs require prior approval from BCBSNM. Some self-administered drugs, whether injectable or not, are identified as specialty pharmacy drugs and may have to be acquired through a participating specialty pharmacy provider in order to be covered.)
- insulin needles, syringes, and diabetic supplies (e.g., glucagon emergency kits, autolet, lancets, lancet devices, blood glucose and visual reading urine and ketone test strips) (There is a separate copayment for each item purchased.)
- nonprescription enteral nutritional products and special medical foods only when either: 1) delivered by a medically necessary enteral access tube that has been surgically placed (e.g., gastrostomy, jejunostomy) or 2) meeting the definition of special medical foods used to treat and to compensate for the metabolic abnormality of members with genetic inborn errors of metabolism in order to maintain their adequate nutritional status (Benefits for nonprescription products are subject to a 50 percent copayment and must have prior approval from BCBSNM.)
- two 90-day courses of treatment with FDA-approved prescription drugs to assist you with quitting tobacco use or smoking when prior-approved by BCBSNM (Starting any course of prescription drug therapy counts as one entire course of drug therapy – even if you discontinue or fail to complete the course. Therefore, if you purchase a one-month supply of a prescription drug for smoking cessation and do not continue the drug beyond one month, you will have used up one entire 90-day course of treatment with the 30-day supply.)

Other Prior Approvals — Certain prescription drugs, injectable medications, and specialty pharmacy drugs may require prior approval from BCBSNM. A list of drugs requiring prior approval is available on the BCBSNM Web site at www.bcbsnm.com. Your physician can request the necessary prior approval.

Member Copayments — For covered prescription drugs (including specialty pharmacy drugs), insulin and diabetic supplies, enteral nutritional products, and special medical foods, you pay a specified percentage of covered charges (listed on the Summary of Benefits), for each prescription filled or item purchased (not to exceed the supply limitations described later). The amount you pay (excluding enteral nutritional products and special medical foods) will never exceed the maximum copayment listed. If the percentage (other than for nutritional products) is less than the minimum copayment listed, you will be responsible for
Section 3: Covered Services

paying the minimum copayment amount or the actual retail price, whichever is less. Coinsurance and/or copayments under this prescription drug plan are not subject to the Plan deductible or out-of-pocket limit provisions.

If you request a brand-name drug when an FDA-approved generic equivalent is available, you will be required to pay the difference between the brand-name and generic drug, plus the generic drug copayment amount. The copayments are listed on the Summary of Benefits.

**Minimums and Maximums** — The following is an example of how the minimum and maximum copayment amounts work when you purchase a generic drug on the BCBSNM Drug List through the retail pharmacy program:

<table>
<thead>
<tr>
<th>Minimum = $10</th>
<th>Retail Cost</th>
<th>20%</th>
<th>Your Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum = $20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication A</td>
<td>$8</td>
<td>$2</td>
<td>Since $2 is less than the minimum copayment of $10, you pay the actual cost of $8.</td>
</tr>
<tr>
<td>Medication B</td>
<td>$40</td>
<td>$8</td>
<td>Since $8 is less than the minimum copay of $10, you pay the minimum copay of $10.</td>
</tr>
<tr>
<td>Medication C</td>
<td>$80</td>
<td>$16</td>
<td>Since $16 is between the minimum copay of $10 and the maximum copay of $20, you pay the full 20% (or $16).</td>
</tr>
<tr>
<td>Medication D</td>
<td>$200</td>
<td>$40</td>
<td>Since $40 is greater than the maximum copay of $20, you pay only the maximum copay of $20.</td>
</tr>
</tbody>
</table>

**Retail Pharmacy/Specialty Pharmacy Program**

All items covered under this provision of your PPO 500 Health Care Plan must be purchased from a participating retail pharmacy. Some drugs must be purchased from a participating specialty pharmacy provider in order to be covered. (Refer to your provider directory for a list of participating pharmacies and specialty pharmacy providers. If you do not have a directory, call the NMSU DSU for a list or visit the BCBSNM Web site.)

You must present your BCBSNM Plan ID card to the pharmacist at the time of purchase to receive this benefit. Note: You do not receive a separate prescription drug ID card; use your BCBSNM ID card to receive all medical/surgical and prescription drug services covered under this Plan. You can use your ID card to purchase covered items only for yourself and covered family members. When coverage for you or a family member ends under this Plan, the ID card may not be used to purchase drugs or other items for the terminated member(s).

If you do not have your ID card with you or if you purchase your prescription or other covered item from a nonparticipating provider in an emergency, you must pay for the purchase in full and then submit a claim directly to the BCBSNM prescription drug plan administrator. (You should have received the address of the administrator among the materials you received upon enrollment. If you did
not, see “Filing Claims” in Section 6, call an NMSU DSU representative for the address and a claim form, or visit the BCBSNM Web site at www.bcbsnm.com.)

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

**Retail Pharmacy Copayments/Coinsurance** — When you need to fill a prescription, simply go to a participating pharmacy and show the pharmacist your Plan ID card and pay the necessary copayment. The percentage of charges (including the minimum and maximum copayments) you pay at the retail pharmacy are listed on the *Summary of Benefits*.

**Supply Limitations** — During any 30-day period, for each copayment listed on the *Summary of Benefits*, you can obtain up to a 30-day supply or 120 units (e.g., pills), whichever is less, of a single prescription drug or other item covered under this provision of your health care plan. If more than 120 units are needed to reach a 30-day supply, **prior approval** is required. For oral contraceptives, the supply is limited to one menstrual cycle (normally 28 days). For commercially packaged items (such as an inhaler, a tube of ointment, or a blister pack of tablets or capsules), you will pay the applicable copayment/coinsurance for a 30-day supply (usually one packaged item).

**Mail Order Service**

Except for supply limitations and enteral nutritional products, all items that are covered under the Mail-Order Service are the same items that are covered under the Retail Pharmacy Program and are subject to the same limitations and exclusions. **Items covered through a specialty pharmacy provider are not covered through the Mail Order Service.** To use the Mail Order Service, follow the instructions outlined in the materials provided to you in your enrollment packet. (If you do not have this information, call an NMSU DSU representative.)

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

**Mail-Order Program Copayments/Coinsurance** — You pay the same percentage of covered charges, but your minimum and maximum copayment amounts are twice the minimum and maximum copayments under the Retail Pharmacy Program (you receive up to three times the number of units per copayment). Specialty pharmacy drugs are **not** available through the mail-order program.

**Supply Limitations** — During any 90-day period, for each copayment listed on the *Summary of Benefits*, you can obtain up to a 90-day supply or 360 units (e.g., pills), whichever is less, of a single prescription drug or other item covered under this prescription drug plan. If less than a 90-day supply is ordered, two copayments
will still apply as indicated on the *Summary of Benefits*. If more than 360 units are needed to reach a 90-day supply, prior approval is required. For commercially packaged items (such as an inhaler, a tube of ointment, or a blister pack of tablets or capsules), you will pay the applicable copayment/coinsurance for a 90-day supply (usually three packaged items).

**Exclusions**

This Plan does **not** cover:

- nonprescription and over-the-counter drugs (unless specifically listed as covered) including herbal or homeopathic preparations, or prescription drugs that have over-the-counter equivalents (Equivalents have the same strength and cause similar action on bodily tissues. This exclusion includes nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum.)
- drugs (or other items covered only under the prescription drug plan) purchased from a nonparticipating pharmacy or obtained from any other provider that does not participate under the prescription drug plan unless eligible for benefits in an emergency situation
- refills before the normal period of use has expired, in excess of the number specified by the physician, or requested more than one year following the physician’s original order date (Prescriptions cannot be refilled until at least 75 percent of the previously dispensed supply will have been exhausted according to the physician’s instructions. Call BCBSNM for instructions on obtaining a greater supply if you are leaving home for more than a 30-day period of time.)
- compounded medications, regardless of whether or not one or more ingredients in the compound requires a prescription (Note: Non-commercially available compounds are those made by mixing or reconstituting ingredients in a manner or ratio that is inconsistent with United States Food and Drug Administration-approved indications provided by the ingredients’ manufacturers and are included in this exclusion.)
- replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced
- infertility medications
- drugs or other items intended for treatment of sexual or erectile dysfunction
- therapeutic devices or appliances, including support garments and other non-medicinal substances
- medications or preparations used for cosmetic purposes (such as preparations to promote hair growth or medicated cosmetics), including tretinoin (sold under such brand names as Retin-A) for cosmetic purposes
- nonprescription enteral nutritional products that are taken by mouth or delivered by a temporary naso-enteric tube (e.g., nasogastric, nasoduodenal, or nasojejunal tube), unless the patient meets criteria for genetic inborn errors of metabolism and the product is prior-approved by BCBSNM
- shipping, handling, or delivery charges
- prescription drugs required for international travel or work
- appetite suppressants or diet aids; weight reduction drugs; food or diet supplements and medication prescribed for body building or similar purposes

**Brand-Name Exclusion** — Some equivalent drugs are manufactured under multiple brand-names. In such cases, BCBSNM may limit benefits to only one of
the brand equivalents available. If you do not accept the brand that is covered under this Plan, the brand-name drug purchased will not be covered under any benefit level.

See Section 4: General Limitations and Exclusions

Preventive Services

For diabetic self-management services, see "Physician Visits/Medical Care."

This Plan covers the following services when received from preferred providers in accordance with national medical standards, the American Academy of Pediatrics, and the U.S. Preventive Services Task Force:

- routine physical, breast, and pelvic examinations
- routine adult and pediatric immunizations (including human papillomavirus vaccinations (HPV) for members aged 9 through 26)
- an annual routine gynecological examination and low-dose mammogram screenings, papilloma virus screening, and cytologic screening (a PAP test or liquid-based cervical cytopathology)
- periodic blood hemoglobin, blood pressure, and blood glucose level tests
- periodic blood cholesterol or periodic fractionated cholesterol level including a low-density lipoprotein (LDL) and a high-density lipoprotein (HDL) level; periodic stool examination for the presence of blood; periodic left-sided colon examination of 35 to 60 centimeters or colonoscopy; periodic colorectal screening; and periodic glaucoma eye tests
- well-child care, including well-baby and well-child screening for diagnosing the presence of autism spectrum disorder (This routine service is not limited by the $36,000 annual or $200,000 lifetime maximum benefit for autism spectrum disorders; see “Autism Spectrum Disorders” for additional covered services.)
- vision and hearing screenings in order to detect the need for additional vision or hearing testing in children through age 17 when received as part of a routine physical exam (A screening does not include an eye exam, refraction, or other test to determine the amount and kind of correction needed.)
- health education and counseling services, if recommended by your physician, to include an annual consultation to discuss lifestyle behaviors that promote health and well-being

The services listed above are not limited as to the number of times you may receive the service in any given period or as to the age of the patient (except when a service is inappropriate for the patient’s age group, such as providing a pediatric immunization to an adult). You and your physician are encouraged to determine how often and at what time you should receive preventive tests and examinations and you will receive coverage according to the benefits and limitations of your health care plan.

Cost-Sharing Provisions — This Plan pays 100 percent of the first $400 in covered charges for routine adult care and 100 percent of the first $250 in covered charges for well-child care (through age 17) each year. After the applicable maximum has been reached, routine and preventive services are subject to
the Preferred Provider deductible, coinsurance, and out-of-pocket limit provisions.

Exclusions — This Plan does not cover:

- routine or preventive services of a nonpreferred provider
- employment physicals, insurance examinations, or examinations at the request of a third party (the requesting party may be responsible for payment); premarital examinations; sports or camp physicals; any other nonpreventive physical examination
- immunizations or medications required for international travel
- hepatitis B immunizations when required due to possible exposure during the member’s work
- routine hearing examinations, hearing aids, or any related service or supply for members age 21 and older (for hearing aid and related services for children under age 21, see “Supplies, Equipment, and Prosthetics,” later in this section); routine eye exams or eye refractions; hearing or visual screening for members over age 17
- psychiatric, psychological treatment or medication
- psychotherapy

See Section 4: General Limitations and Exclusions

Psychotherapy: Mental Health and Chemical Dependency

Alcoholism or drug abuse — Conditions defined by patterns of usage that continue despite occupational, marital, or physical problems that are related to compulsive use of alcohol or drugs. Alcoholism and drug abuse may also be defined by significant risk of severe withdrawal symptoms if the use of alcohol or drugs is discontinued. Drug abuse does not include nicotine addiction or alcohol use.

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

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

Intensive outpatient program (IOP) — Distinct levels or phases of treatment that are provided by a certified/licensed chemical dependency or mental health program. IOPs provide a combination of individual, family, and/or group therapy in a day, totaling nine or more hours in a week.

Mental illness, mental disorder — A clinically significant behavioral or psychological syndrome or condition that causes distress and disability and for which improvement can be expected with relatively short-term treatment. Mental illness does not include developmental disabilities, drug or alcohol abuse, or learning disabilities.
Other providers — Clinical psychologists and the following masters-degreed psychotherapists (an independently licensed professional provider with either an M.A. or M.S. degree in psychology or counseling): licensed independent social workers (L.I.S.W.); licensed professional clinical mental health counselors (L.P.C.C.); masters-level registered nurse certified in psychiatric counseling (R.N.C.S.); licensed marriage and family therapist (L.M.F.T.). For chemical dependency services, a provider also includes a licensed alcohol and drug abuse counselor (L.A.D.A.C.).

For nontherapeutic services (e.g., intake evaluations, medication checks), see “Physician Visits/Medical Care.” For psychological testing, see “Lab, X-Ray, Other Diagnostic Services.”

Medical Necessity — In order to be covered, treatment must be medically necessary and not experimental or investigational. Therapy must be:

- required for the treatment of a distinct mental disorder as defined by the latest version of the Diagnostic and Statistical Manual published by the American Psychiatric Association; and
- reasonably expected to result in significant and sustained improvement in your condition and daily functioning; and
- consistent with your symptoms, functional impairments, and diagnoses, and in keeping with generally accepted national and local standards of care; and
- provided to you at the least restrictive level of care.

Covered Services/Providers — Covered services include solution-focused evaluative and therapeutic mental health services (including individual and group psychotherapy) received in a psychiatric hospital, an IOP, or an alcoholism treatment program that complies with applicable state laws and regulations, and services rendered by psychiatrists, licensed psychologists, and other providers (as defined on the previous page). See your provider directory for a list of contracting providers, call an NMSU DSU representative, or check the Mesa Mental Health Web site at www.mesamentalhealth.com.

Prior Approval Required — All therapy must be prior-approved by Mesa Mental Health. If you do not receive prior approval for inpatient services related to chemical dependency, benefits for all related services will be denied. If you do not receive prior approval for inpatient services that are not related to chemical dependency, benefits for covered facility services will be reduced by $300. Outpatient services received without prior approval will be denied, regardless of diagnosis. See “Admission Review and Other Prior Approvals” in Section 2 for details.

Benefit Limits — Benefits for inpatient and outpatient psychotherapy (whether required due to mental illness, chemical dependency, or any other covered condition) and related adjunctive services are subject to your regular deductible and out-of-pocket limits, to the lifetime maximum dollar benefit, and to the same copayments or coinsurance amounts that are applied to similar services for medical conditions as specified on the Summary of Benefits. For services that do not have equivalents in the medical treatment category, copayments are as follows:

- Intensive Outpatient Programs (IOP): Member share for each visit is same as for office visits
- Partial hospitalization: Member share is same as for inpatient hospitalization

**Exclusions** — This Plan does **not** cover:

- care that has not been **prior-approved** by Mesa Mental Health
- psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education
- services performed or billed by a school, halfway house, or residential treatment facility, group home, foster care, day treatment, or their staff members
- long-term therapy or therapy for the treatment of chronic mental health or incurable conditions for which treatment produces minimal or temporary change or relief – except that medication management for chronic conditions is covered (Chronic conditions are conditions such as, but not limited to, autism, Down’s Syndrome, and developmental delays.)
- maintenance therapy or care provided after you have reached your rehabilitative potential
- biofeedback, hypnotherapy, or behavior modification services
- religious counseling; marital counseling
- custodial care (See the “Custodial Care” exclusion in Section 4.)
- any care that is patient-elected and is not considered medically necessary
- care that is mandated by court order or as a legal alternative, and lacks clinical necessity as diagnosed by a licensed provider; services rendered as a condition of parole or probation
- special education, school testing and evaluations, counseling, therapy, or care for learning deficiencies or educational and developmental disorders; behavioral problems unless associated with manifest mental illness or other disturbances
- non-national standard therapies, including experimental as determined by the mental health professional practice
- the cost of any damages to a treatment facility
- charges associated with any episode of alcoholism or drug abuse for which you did not complete the prescribed continuum of care

**See Section 4: General Limitations and Exclusions**

**Short-Term Rehabilitation**

(Physical, Occupational, Speech Therapy - Inpatient and Outpatient, Including Skilled Nursing Facility)

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

*See “Acupuncture/Spinal Manipulation,” if applicable.*

**Prior Approval Required** — To be covered, all inpatient (including services received in a physical rehabilitation or skilled nursing facility), outpatient, office,
and home-based short-term rehabilitation services must receive prior approval from BCBSNM. Services required due to reinjury or aggravation of an injury are also covered but must receive a separate prior approval from BCBSNM, even if therapy was authorized for the original injury. Services received without prior approval will be denied. See “Admission Review and Other Prior Approvals” in Section 2.

Services are not covered when received from nonpreferred providers.

Covered Services — Subject to the conditions, limitations, and exclusions below, this Plan covers the following services when prescribed and/or provided by a preferred provider for the treatment of injury or illness:

- occupational therapy performed by a licensed occupational therapist
- physical therapy performed by a physician, licensed physical therapist, or other professional provider licensed as a physical therapist (such as a doctor of oriental medicine or chiropractor)
- speech therapy, including audio diagnostic testing, performed by a properly accredited speech therapist for the treatment of communication impairment or swallowing disorders caused by disease, trauma, congenital anomaly, or a previous treatment or therapy
- inpatient physical rehabilitation and skilled nursing facility services

Conditions of Coverage — To be eligible for benefits, therapies must meet the following conditions:

- Services must be received from preferred providers.
- There is a documented condition or delay in recovery that can be expected to measurably improve with short-term therapy within two months of beginning active therapy.
- Improvement would not normally be expected to occur without intervention.

Benefit Limits — Benefits are limited as specified on the Summary of Benefits. (A “day” or visit” is equivalent to one inpatient hospital day, one outpatient therapy visit, or one office therapy visit.) You may use any combination of covered therapy services to arrive at your 60-unit benefit.

Exclusions — This Plan does not cover:

- services of a nonpreferred provider
- maintenance therapy or care provided after you have reached your rehabilitative potential except as required under New Mexico state law (See “Autism Spectrum Disorders” in the Covered Services section and the “Long-Term or Maintenance Therapy” exclusion in the General Limitations and Exclusions section.)
- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay, except as required by law and described under “Autism Spectrum Disorders” in the Covered Services section of your booklet (See the Claims Payments and Appeals section for reimbursement of certain services provided to eligible children by the Department of Health.)
- private room expenses
- services of a massage therapist or rolfing
Section 3: Covered Services

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- diagnostic, therapeutic, rehabilitative, or health maintenance services provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered provider
- therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights)
- speech therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic; other speech services that can be carried out by the patient, the family, or caregiver/teacher
- long-term therapies (Therapies are long-term if measurable improvement is not possible within two months of beginning active therapy, except as required under New Mexico state law. This Plan does not cover long-term therapy even if you have not yet used or exhausted maximum benefits. See the “Long-Term or Maintenance Therapy” exclusion in the General Limitations and Exclusions section.)

See Section 4: General Limitations and Exclusions

Smoking/Tobacco Use Cessation

This Plan covers smoking and tobacco use cessation treatment, limited to the following counseling services received from preferred providers and drug therapy that has been prior-approved by BCBSNM (subject to member cost-sharing provisions applicable to the type of service received, such as prescription drugs, counseling, etc.):

- diagnostic services to identify tobacco use, use-related conditions, and dependence
- two 90-day courses of prior-approved treatment with FDA-approved prescription drugs to assist you with quitting tobacco use or smoking (see “Prescription Drugs and Other Items” for benefit details)
- a choice of cessation counseling of up to 90 minutes total provider contact time or two multi-session group programs per calendar year (Covered counseling is restricted to programs that meet minimum requirements established by the NM Public Regulation Commission; see the Glossary for minimum cessation counseling requirements.)

Starting any course of prescription drug therapy or cessation counseling constitutes one entire course of drug therapy or cessation counseling – even if you discontinue or fail to complete the course. For example, if you purchase a one-month supply of a prescription drug for smoking cessation and do not continue the drug beyond one month, you will have used up one entire 90-day course of treatment with the 30-day supply.

To locate a provider that is approved to provide counseling sessions, you may call an NMSU DSU representative, or you may ask your personal physician about obtaining a prescription for smoking cessation drugs.

Exclusions — This Plan does not cover the following services:

- cessation counseling or treatment received from nonpreferred providers or drug therapy that has not received prior approval
- acupuncture, biofeedback, or hypnotherapy for smoking/tobacco use cessation
Supplies, Equipment, and Prosthetics

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

For diabetic supplies such as needles, syringes, and test strips, see “Prescription Drugs and Other Items.”

For supplies or equipment used during an inpatient or outpatient stay, see “Hospital/Other Facility Services.”

(See Section 4: General Limitations and Exclusions)

To be covered, items must be medically necessary and ordered by a health care provider. If you have a question about items not listed in this section, please call the NMSU DSU.

Prior approval from BCBSNM is required for:

- **specific items** listed in this section
- **long-term rental** of an item
- when total charges for an item equal $500 or more (Total charges means either the total purchase price of the item or total rental charges for the estimated period of use.)

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

- insulin pump supplies
- injection aids, including those adaptable to meet the needs of the legally blind
- insulin pumps if prior approval is received from BCBSNM
- medically necessary pediatric appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics that have been prior-approved by BCBSNM, custom molded inserts, replacement inserts, preventive devices, and shoe modifications
- blood glucose monitors, including those for the legally blind

Reminder: Prior approval is required for items costing $500 or more or requiring long-term rental. For additional diabetic supply coverage (e.g., insulin needles and syringes, autolet, test strips, glucagon emergency kits), see “Prescription Drugs and Other Items.”

Durable Medical Equipment and Appliances — This Plan covers the following items (prior approval is required for items costing $500 or more or requiring long-term rental):

- orthopedic appliances (prior approval is required, regardless of total cost)
- oxygen and oxygen equipment, wheelchairs, hospital beds, crutches, and other necessary durable medical equipment
lens implants for aphakic patients (those with no lens in the eye) and soft lenses or sclera shells (white supporting tissue of eyeball)

- either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) when necessary to replace lenses absent at birth or lost through cataract or other intraocular surgery or ocular injury, to treat conditions related to genetic inborn errors of metabolism, or prescribed by a physician as the only treatment available for keratoconus (Duplicate glasses/lenses are not covered. Replacement is covered only if a physician or optometrist recommends a change in prescription due to a change in your medical condition.)

- cardiac pacemakers
- stethoscopes and blood pressure monitors
- replacement of items only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- the rental of (or at the option of BCBSNM, the purchase of) durable medical equipment (including repairs to such purchased items), when prescribed by a covered health care provider and required for therapeutic use

**Note:** Benefits for durable medical equipment received from a nonpreferred provider are limited each year to the amount indicated on the *Summary of Benefits.* (The limitation does not apply to oxygen or oxygen equipment.) Benefits for durable medical equipment received from a preferred provider are not limited.

**Medical Supplies** — This Plan covers the following medical supplies, 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, elastic supports when billed by a physician or other provider during a covered office visit
- slings

**Orthotics and Prosthetic Devices** — This Plan covers functional orthotics only for patients having a locomotive problem or gait difficulty resulting from mechanical problems of the foot, ankle, or leg. (A functional orthotic is used to control the function of the joints.) **Prior approval is required or benefits will be denied.** This Plan also covers 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
- 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 items 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 and up to **four** mastectomy brassieres per calendar year
- up to **six pair** of support hose per calendar year when prescribed by a physician for the treatment of varicose veins
When alternative prosthetic devices are available, the allowance for a prosthesis will be based upon the least costly item.

**Note:** Benefits for orthotics and prosthetics received from a nonpreferred provider are limited each year to the amount indicated on the Summary of Benefits. (The limitation does not apply to breast prosthetics.) Benefits for prosthetics and orthotics received from a preferred provider are not limited.

**Exclusions** — This Plan does **not** cover, regardless of therapeutic value, items such as, but not limited to:
- air conditioners, biofeedback equipment, humidifiers, purifiers, self-help devices, or whirlpools
- items that are primarily nonmedical in nature such as Jacuzzi units, hot tubs, exercise equipment, heating pads, hot water bottles, or diapers
- nonstandard or deluxe equipment, such as motor-driven wheelchairs, chair-lifts, or beds when standard equipment is available and adequate
- external prosthetics that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing
- repairs to items that you do not own
- comfort items such as bedboards, beds or mattresses of any kind, bathtub lifts, overbed tables, or telephone arms
- repair costs that exceed the rental price of another unit for the estimated period of need, or repair or rental costs that exceed the purchase price of a new unit
- dental appliances (See “Dental-Related/TMJ Services and Oral Surgery” for exceptions.)
- accommodative orthotics (deal with structural abnormalities of the foot, accommodate such abnormalities, and provide comfort, but do not alter function)
- orthopedic shoes, unless joined to braces (Diabetic members may be eligible to receive benefits for these items. Call the NMSU DSU for details.)
- equipment or supplies not ordered by a health care provider, including items used for comfort, convenience, or personal hygiene
- duplicate items; repairs to duplicate items; or the replacement of items because of loss, theft, or destruction
- voice synthesizers or other communication devices
- eyeglasses or contact lenses and the costs related to prescribing or fitting of glasses or contact lenses, unless listed as covered; sunglasses, special tints, or other extra features for eyeglasses or contact lenses
- routine hearing examinations, hearing aids, or any related service or supply for members age 21 and older
- syringes or needles for self-administering drugs (Coverage for insulin needles and syringes and other diabetic supplies not listed as covered in this section is described under “Prescription Drugs and Other Items.”)
- items that can be purchased over-the-counter, including but not limited to dressings for bed sores or burns, gauze, and bandages
- contraceptive devices that do not require a prescription, including over-the-counter contraceptive products such as condoms and spermicide
- items not listed as covered
Section 3: Covered Services

- costs for items received from a nonpreferred provider that exceed the maximum benefit

See Section 4: General Limitations and Exclusions

Surgery and Related Services

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

For accidental injuries to the jaws, mouth, or teeth, oral surgery, or treatment of TMJ or CMJ disorders or injuries, see “Dental-Related/TMJ Services and Oral Surgery.”

If applicable, also see these topics:
- “Hospital/Other Facility Services”
- “Maternity/Reproductive Services and Newborn Care” (for deliveries, C-sections, surgical sterilization and limited infertility-related treatments)
- “Transplant Services”

You are responsible for obtaining admission review and/or other prior approval when necessary (see Section 2).

Surgeon’s Services

Covered services include surgeon’s charges for a covered surgical procedure.

Cochlear Implants — This Plan covers cochlear implantation of a hearing device (such as an electromagnetic bone conductor) to facilitate communication for the profoundly hearing impaired, including training to use the device. You must submit a written request for prior approval to BCBSNM before treatment begins. This Plan does not cover cochlear implant services without prior approval.

Mastectomy Services — This Plan covers medically necessary hospitalization related to a covered mastectomy (including at least 48 hours of inpatient care following a mastectomy and 24 hours following a lymph node dissection). This Plan also covers cosmetic breast surgery, when prior-approved by BCBSNM and received within 12 months of a mastectomy for breast cancer (unless a later procedure is approved as medically appropriate by BCBSNM). Covered services are limited to:
- cosmetic surgery of the breast/nipple on which the mastectomy was performed, including tattooing procedures; and
- the initial surgery of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications following the mastectomy, including treatment of lymphedema.

This Plan does not cover subsequent procedures to correct unsatisfactory cosmetic results attained during the initial breast/nipple surgery or tattooing, or breast surgery that has not received prior approval from BCBSNM.
Reconstructive Surgery — Reconstructive surgery improves or restores bodily function to the level experienced before the event that necessitated the surgery, or in the case of a congenital defect, to a level considered normal. Such surgeries may have a coincidental cosmetic effect. This Plan covers reconstructive surgery when required to correct a functional disorder caused by:

- an accidental injury
- a disease process or its treatment (For breast surgery following a mastectomy, see “Mastectomy Services,” above.)
- 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)

You or your physician must obtain prior approval, requested in writing, from BCBSNM before the reconstructive service is provided. If the procedure (including any reconstructive service listed under “Dental-Related/TMJ Services and Oral Surgery”) has not received prior approval, the surgery and all related charges will be denied. Cosmetic procedures and procedures that are not medically necessary, including all services related to such procedures, will also be denied.

Exclusions — This Plan does not cover:

- cosmetic or plastic surgery or procedures, such as breast augmentation, rhinoplasty, and surgical alteration of the eye that does not materially improve the physiological function of an organ or body part (unless covered under “Mastectomy Services,” above)
- procedures to correct cosmetically unsatisfactory surgical results or surgically induced scars
- refractive keratoplasty, including radial keratotomy, or any procedure to correct visual refractive defect
- unless required as part of medically necessary diabetic disease management, trimming of corns, calluses, toenails, or bunions (except surgical treatment such as capsular or bone surgery)
- sex change operations or complications arising from transsexual surgery
- subsequent surgical procedures needed because you did not comply with prescribed medical treatment or because of a complication from a previous noncovered procedure (such as a noncovered organ transplant, sex change operation, or previous cosmetic surgery)
- any reconstructive procedure, orthognathic surgery, breast reduction, orthotripsy, cochlear implant, or cosmetic breast surgery that has not received prior approval from BCBSNM
- obesity treatment, including the surgical treatment of morbid obesity
- 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 an assistant surgeon and the standby physician actually assists

Anesthesia Services

This Plan covers necessary anesthesia services, including acupuncture used as an anesthetic, when administered during a covered surgical procedure by a physician, certified registered nurse anesthetist (CRNA), a licensed doctor of oriental medicine (for acupuncture), or other practitioner as required by law. (See “Acupuncture/Chiropractic Services” for information about acupuncture benefits.)
Exclusions — This Plan does not cover 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.

Exclusions — This Plan does not cover:
- services of an assistant only because the hospital or other facility requires such services
- services performed by a resident, intern, or other salaried employee or person paid by the hospital
- services of more than one assistant surgeon unless the procedure is identified by BCBSNM as requiring the services of more than one assistant surgeon

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 re-implanting 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, and received within one year of the transplant or retransplant.

Prior Approval Required — Prior approval, requested in writing, must be obtained from BCBSNM before a pretransplant evaluation is scheduled. A pretransplant evaluation is not covered if prior approval is not obtained from BCBSNM. If approved, a BCBSNM case manager will be assigned to you (the transplant recipient candidate) and must later be contacted with the results of the evaluation.

If you are approved as a transplant recipient candidate, you must ensure that prior approval for the actual transplant is also received. None of the benefits described here are available unless you have this prior approval.

Facility Must Be in Transplant Network — Benefits for covered services will be approved only when the transplant is performed at a facility that contracts with BCBSNM, another Blue Cross Blue Shield (BCBS) Plan, or the national BCBS transplant network, for the transplant being provided. Your BCBSNM case manager will assist your provider with information on the exclusive network of contracted facilities and required approvals. Call the NMSU DSU for information on these BCBSNM transplant programs.
Effect of Medicare Eligibility on Coverage — If you are now eligible for — or are anticipating receiving eligibility for — Medicare benefits, you are solely responsible for contacting Medicare to ensure that the transplant will be eligible for Medicare benefits.

Organ Procurement or Donor Expenses — If a transplant is covered, this Plan also covers the surgical removal, storage, and transportation of an organ acquired from a cadaver. If there is a living donor that requires surgery to make an organ available for a covered transplant, this Plan covers expenses incurred by the donor for surgery, organ storage expenses, and inpatient follow-up care only.

This Plan does not cover donor expenses after the donor has been discharged from the transplant facility. Coverage for compatibility testing prior to organ procurement is limited to the testing of cadavers and, in the case of a live donor, to testing of the donor selected.

Bone Marrow, Cornea, or Kidney

The following transplant procedures are covered if prior approval is received from BCBSNM:
- 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 not experimental, investigational, or unproven
- cornea transplant
- kidney transplant

Covered services related to the above transplants are subject to the usual cost-sharing features and benefit limits of this Plan (e.g., copayments; deductible, coinsurance, and out-of-pocket limits; annual home health care maximums).
Reminder: A transplant received at a facility that does not directly or indirectly contract with BCBSNM to provide transplant services is not covered.

Heart, Heart-Lung, Liver, Lung, Pancreas-Kidney

This Plan also covers services for a heart, heart-lung, liver, lung, or pancreas-kidney transplant. Services must be prior-approved in order to be covered.

In addition to the general provisions of this “Transplant Services” section, the following benefits, limitations, and exclusions apply to this coverage for one year following the date of the actual transplant or retransplant. After one year, services are subject to usual Plan benefits and must be covered under other provisions of the Plan in order to be considered for benefit payment:

Recipient Travel and Per Diem Expenses — If BCBSNM requires you (i.e., the transplant recipient) to temporarily relocate outside of your city of residence to receive a covered transplant, this Plan covers travel to the city where the transplant will be performed. Also, a standard per diem benefit ($125) will be allocated for food and lodging expenses for one additional adult traveling with you (the transplant recipient). If the transplant recipient is an eligible child under the age of 18, this Plan covers travel and per diem expenses for two adults to accompany the child.
Travel expenses and standard per diem allowances are limited to a combined total combined lifetime maximum benefit of $10,000 per transplant. Your case manager may approve travel and per diem food and lodging allowances based upon the total number of days of temporary relocation, up to the maximum $10,000 benefit.

Travel expenses are not covered and per diem allowances are not paid if you choose to travel to receive a transplant for which travel is not considered medically necessary by the case manager.

**Cost-Sharing Features** — Covered services are subject to 20 percent coinsurance and to a separate $5,000 per transplant out-of-pocket limit. (After the coinsurance for services related to a single transplant reaches $5,000, all further services related to the transplant and received within one year of the transplant will be paid at 100 percent of covered charges, up to maximum benefit amounts, if any.) There is also no deductible to meet. If you require a retransplant, these cost-sharing provisions renew starting from the date of the retransplant procedure. **Reminder:** A transplant received at a facility that does not contract directly or indirectly with BCBSNM to provide transplant services is not covered.

**Exclusions** — This Plan does not cover:

- any transplant or organ-combination transplant not listed as covered
- implantation of artificial organs or devices (mechanical heart); nonhuman organ transplants
- care for complications of noncovered transplants or follow-up care related to such transplants
- services related to a transplant that did not receive prior approval from BCBSNM
- services related to a transplant performed in a facility not contracted directly or indirectly with BCBSNM to provide the required transplant
- 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 under “Prescription Drugs and Other Items.”)
- donor expenses after the donor has been discharged from the transplant facility
- lodging, food, beverage, or meal expenses that are not covered by the per diem allowance, if available
- travel or per diem expenses:
  - incurred more than five days before or more than one year following the date of transplantation
  - if the recipient’s case manager indicates that travel is not medically necessary
  - related to a bone marrow, cornea, or kidney transplant
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; telephone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- expenses charged only because benefits are available under this provision (such as transportation received from a member of your family, or from any other person charging for transportation that does not ordinarily provide such services in return for payment)
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 3: Covered Services for specific benefit limits and exclusions.

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

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

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.

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, transplant, or experimental procedure).

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

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

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

**Exception:** Cosmetic breast/nipple surgery required due to a mastectomy that occurred less than 12 months before the planned cosmetic procedure may be covered. However, prior approval, requested in writing, must be obtained from BCBSNM for such services. Also, prior-approved reconstructive surgery, which may have a coincidental cosmetic effect, may be covered when required as the result of accidental injury, illness, or congenital defect. See Section 3 for details.

**Custodial Care — This Plan does not cover** custodial care, or care in a place that is primarily your residence when you do not require skilled nursing. This Plan does not cover services to assist in activities of daily living (such as sitter’s or homemaker’s services), or services not requiring the continuous attention of skilled medical or paramedical personnel, regardless of where they are furnished or by whom they were recommended.

**Dental-Related/TMJ Services and Oral Surgery —** In addition to services excluded by the other general limitations and exclusions listed throughout this Section 4, see “Dental-Related/TMJ Services and Oral Surgery” in Section 3 for additional exclusions.

**Domiciliary Care — This Plan does not cover** domiciliary care or care provided in a residential institution, treatment center, halfway house, or school because your 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 or that would have been paid by Medicare as the primary carrier if you were entitled to Medicare, had applied for Medicare, and had claimed Medicare benefits. See Section 5 for more information. Also, if your prior coverage has an extension of benefits provision, this Plan will not cover charges incurred after your 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, Investigational, or Unproven Services — This Plan does not cover** any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical practice, as defined on the next page, or those considered experimental, investigational, or unproven, unless for acupuncture rendered by a licensed doctor of oriental medicine or unless specifically listed as covered under “Autism Spectrum Disorders” or under “Cancer Clinical Trials” in Section 3 and mandated by law. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted when services were administered, the service is experimental.
and will not be covered. To be considered experimental, investigational, or unproven, one or more of the following conditions must be met:

- The device, drug, or medicine cannot be marketed lawfully without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the device, drug, or medicine is furnished.
- Reliable evidence shows that the treatment, device, drug, or medicine is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.
- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug, or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

The guidelines and practices of Medicare, the FDA, or other government programs or agencies may be considered in a determination; however, approval by other bodies will neither constitute nor necessitate approval by BCBSNM.

Reliable evidence means only published reports and articles in authoritative peer-reviewed medical and scientific literature; the written protocol or protocols used by the treating facility, or the protocol(s) of another facility studying substantially the same medical treatment, procedure, device, or drug; or the written informed consent used by the treating facility or by another facility studying substantially the same medical treatment, procedure, device, or drug.

Experimental, investigational, or unproven does not mean cancer chemotherapy or other types of therapies that are the subjects of ongoing phase IV clinical trials.

The service must be medically necessary and not excluded by any other contract exclusion.

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

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

Note: If you disagree with BCBSNM’s decision regarding any item or service, you may file a complaint. You may also request an external review of the BCBSNM decision at any time. See “Request for Reconsideration” in Section 6.

Food or Lodging Expenses — This Plan does not cover food or lodging expenses, except for those that are eligible for a per diem allowance under the “Transplant Services” provision in Section 3 and not excluded by any other provision in this Section 4.
Genetic Testing or Counseling — This Plan does not cover genetic counseling or testing, unless the testing has received prior approval from BCBSNM. See “Maternity Services and Newborn Care” in Section 3 for details. Tests such as amniocentesis or ultrasound to determine the sex of an unborn child are not covered.

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, or Aids — This Plan does not cover audiometric (hearing) tests unless: 1) required for the diagnosis and/or treatment of an accidental injury or an illness, or 2) covered as a preventive screening service for children through age 17, or 3) covered as part of the hearing aid benefit for members under age 21 and described under “Supplies, Equipment, and Prosthetics” in Section 3. (A screening does not include a hearing test to determine the amount and kind of correction needed.) This Plan does not cover hearing aids or ear molds, fitting of hearing aids or ear molds, or any related service or supply for members age 21 and older. For members under age 21, see “Supplies, Equipment, and Prosthetics: Hearing Aids and Related Services” in Section 3. (For surgically implanted devices, see “Surgery and Related Services” in Section 3.)

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

Infertility Services/Artificial Conception — This Plan does not cover services related to, but not limited to, procedures such as: artificial conception or insemination, 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, Gamete Intrafallopian Transfer (GIFT) or Zygote Intrafallopian Transfer (ZIFT), embryo transfer, drugs for induced ovulation, or other artificial methods of conception. This Plan does not cover the cost of donor sperm, costs associated with the collection, preparation, or storage of sperm for artificial insemination, or donor fees.

This Plan does not cover infertility testing, treatments, or related services, such as hormonal manipulation and excess hormones to increase the production of mature ova for fertilization. This Plan does not cover reversal of a prior sterilization procedure. (Certain treatments of medical conditions that sometimes result in restored fertility may be covered; see “Maternity Services and Newborn Care” in Section 3.)

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. (Preferred providers and providers that have a “participating” provider agreement with BCBSNM will file claims for you and must submit them within a specified amount of time, usually within 180 days.) If a claim is returned for further information, resubmit it within 45 days. See “Filing Claims” in Section 6 for details.

See additional exclusions related to specific types of covered services in Section 3.
Learning Deficiencies/Behavioral Problems — This Plan does not cover special education, counseling, therapy, diagnostic testing, treatment, or any other service for learning deficiencies or chronic behavioral problems, whether or not associated with a manifest mental disorder, retardation, or other disturbance. See “Autism Spectrum Disorders” in Section 3 for details about mandated coverage for children with these diagnoses.

Limited Services/Covered Charges — This Plan does not cover amounts in excess of covered charges or services that exceed any maximum benefit limits listed in this benefit booklet, any amendments, riders, addenda, or endorsements, and/or on the Summary of Benefits.

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 or Maintenance Therapy — This Plan does not cover long-term therapy, even if medically necessary and even if any applicable benefit maximum has not yet been reached. (Therapies are considered long-term if significant improvement is not possible within two months of beginning active therapy.) Note: This exclusion does not apply to benefits for medication or medication management or to certain services to be covered under New Mexico state law for children with autism spectrum disorders.

This Plan does not cover maintenance therapy or care or any treatment that does not significantly improve your function or productivity, or care provided after you have reached your rehabilitative potential (unless therapy is covered during an approved hospice benefit period). In a dispute about whether your rehabilitative potential has been reached, you are responsible for furnishing documentation from your physician supporting his/her opinion. Note: Even if your rehabilitative potential has not yet been reached, this Plan does not cover services that exceed maximum benefit limits.

Medical Policy Determinations — Any technologies, procedures, or services for which medical policies have been developed by BCBSNM, are either limited or excluded as defined in the medical policy (see “Medical policy” in the Glossary). Exception: The fact that this Plan covers certain services that are excluded under BCBSNM medical policy and certain services defined as experimental or as maintenance therapy but which must be covered under New Mexico state law (such as cancer clinical trials and applied behavioral analysis) does not mean that any other services will be, or should be, covered when contraindicated by BCBSNM medical policy. Only covered acupuncture and those services mandated by state law will be excepted from this BCBSNM standard medical policy exclusion.

Medically Unnecessary Services — This Plan does not cover services that are not medically necessary as defined in Section 3 unless such services are specifically listed as covered (e.g., see “Preventive Services” or “Autism Spectrum Disorders” in Section 3).
BCBSNM determines whether a service or supply is medically necessary and whether it is covered. Because a provider prescribes, orders, recommends, or approves a service or supply does not make it medically necessary or make it a covered service, even if it is not specifically listed as an exclusion. (BCBSNM, at its sole discretion, determines medical necessity.)

**No Legal Payment Obligation — This Plan does not cover** services for which you have no legal obligation to pay or that are free, including:
- charges made only because benefits are available under this Plan
- services for which you have received a professional or courtesy discount
- volunteer services
- services provided by you for yourself or a covered family member, by a person ordinarily residing in your household, or by a family member
- physician charges exceeding the amount specified by CMS when primary benefits are payable under Medicare

*Note:* The “No Legal Payment Obligation” exclusion above does not apply to services received at Department of Defense facilities or covered by 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 your immediate family or a person normally residing in your home
- physician, other person, supplier, or facility (including staff members) that are not specifically listed as covered in this benefit booklet, such as a:
  - health spa or health fitness center (whether or not services are provided by a licensed or registered provider)
  - halfway house
  - massage therapist
  - private sanitarium
  - extended care facility or similar institution
  - 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

**Nonmedical Expenses — This Plan does not cover** nonmedical expenses (even if medically recommended and regardless of therapeutic value), including costs for services or items such as, but not limited to:
- adoption or surrogate expenses
- vocational or training services and supplies
- mailing and/or shipping and handling
- educational programs such as behavior modification and arthritis classes (Some diabetic services and other educational programs may be covered; see “Preventive Services” and “Physician Visits/Medical Care” in Section 3 for details.)
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- missed appointments; “get-acquainted” visits without physical assessment or medical care; telephone consultations; provision of medical information to perform admission review or other prior approvals; filling out of claim forms; copies of medical records; interest expenses
- modifications to home, vehicle, or workplace to accommodate medical conditions; voice synthesizers; other communication devices
- membership at spas, health clubs, or other such facilities
- personal convenience items such as air conditioners, humidifiers, or exercise equipment, or personal services such as haircuts, shampoos, guest meals, and television rentals
- personal comfort services, including homemaker and housekeeping services, except in association with respite care covered during a hospice admission
- immunizations or medications required for international travel
- moving expenses or other personal expenses (e.g., laundry or dry cleaning expenses; telephone calls; day care expenses; taxicab or bus fare; vehicle rental expenses; parking expenses; personal convenience items)
- physicals or screening exams and immunizations given primarily for insurance, licensing, employment, camp, weight reduction programs, medical research programs, sports, or for any nonpreventive purpose
- hepatitis B immunizations when required due to possible exposure during the member’s work
- court- or police-ordered services unless the services would otherwise be covered or services rendered as a condition of parole or probation
- the cost of any damages to a treatment facility that are caused by the member
- psychoanalysis or psychotherapy that you may use as credit toward earning a degree or furthering your education

Nonpreferred Provider Services — This Plan does not cover

the following services when received from a nonpreferred provider: routine adult preventive and well-child care; smoking/tobacco use cessation counseling; acupuncture, spinal manipulation, outpatient cardiac or pulmonary rehabilitation, inpatient or outpatient physical, speech, or occupational therapy, skilled nursing facility services, inpatient or outpatient psychotherapy, or transplants

Nonprescription Drugs — This Plan does not cover

outpatient nonprescription or over-the-counter drugs, medications, ointments, or creams, including herbal or homeopathic preparations, or prescription drugs that have over-the-counter equivalents, except for those products specifically listed as covered in Section 3. (Equivalents have the same strength and cause similar action on bodily tissues.) This exclusion includes nonprescription items for smoking and tobacco use cessation such as nicotine patches and nicotine gum.

Nutritional Supplements — This Plan does not cover

vitamins, dietary/nutritional supplements, special foods, formulas, mother’s milk, or diets, unless: 1) a prescription is required for the product, or 2) it is a product that meets the specific conditions set forth for coverage under the “Prescription Drugs and Other Items” in Section 3.

Obesity Treatment — This Plan does not cover

surgical, dietary, or medical treatment of obesity under any circumstance.

See additional exclusions related to specific types of covered services in Section 3.
Post-Termination Services — This Plan does not cover any service received or item or drug purchased after your coverage is terminated, even if: 1) prior approval for such service, item, or drug was received from BCBSNM, or 2) the service, item, or drug was needed because of an event that occurred while you were covered.

Pre-Existing Conditions — For members who are subject to this provision, this Plan does not cover any pre-existing conditions for up to six months following their initial enrollment eligibility date. (A late applicant accepted for coverage is not covered for pre-existing conditions for up to 18 months following his/her initial enrollment eligibility date.) See “Pre-Existing Conditions Limitation” in Section 7.

Prescription Drugs and Other Items — In addition to services excluded by the other general limitations and exclusions listed throughout this Section 4, see “Prescription Drugs and Other Items” in Section 3 for additional exclusions.

Prior Approval Not Obtained When Required — This Plan does not cover certain services if you do not obtain prior approval from BCBSNM before those services are received. See “Admission Review and Other Prior Approvals” in Section 2.

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

Private Room Expenses — This Plan does not cover private room expenses, unless your 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). Private room charges must be prior-approved by BCBSNM to be covered.

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

Sexual Dysfunction Treatment — This Plan does not cover services related to the treatment of sexual dysfunction.

Supplies, Equipment, and Prosthetics — In addition to services excluded by the other general limitations and exclusions listed throughout this Section 4, see “Supplies, Equipment, and Prosthetics” in Section 3 for additional exclusions.

Surgery and Related Services — In addition to services excluded by the other general limitations and exclusions listed throughout this Section 4, see “Surgery and Related Services” in Section 3 for additional exclusions.

Therapy and Counseling Services — This Plan does not cover therapies and counseling programs other than the therapies listed as covered in this booklet. In addition to treatments excluded by the other general limitations and

See additional exclusions related to specific types of covered services in Section 3.
exclusions listed throughout this Section 4, see “Short-Term Rehabilitation,” “Smoking/Tobacco Use Cessation,” “Acupuncture/Spinal Manipulation,” and “Psychotherapy” in Section 3 for additional exclusions. **This Plan does not cover** services such as, but not limited to:

- recreational, sleep, crystal, primal scream, sex, and Z therapies
- self-help, stress management, codependency, and weight-loss programs
- smoking/tobacco use counseling programs of preferred providers that do not meet the standards set by the NM Public Regulation Commission or that are received from nonpreferred providers
- services of a massage therapist or rolfing
- therapy for chronic conditions such as, but not limited to, cerebral palsy or developmental delay
- transactional analysis, encounter groups, and transcendental meditation (TM); moxibustion; sensitivity or assertiveness training
- vision therapy; orthoptics
- pastoral, spiritual, or bereavement counseling
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this Plan
- any therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights)
- speech therapy for dysfunctions that self-correct over time; speech services that maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic or therapeutic; other speech services that can be carried out by the patient, the family, or caregiver/teacher

**Thermography — This Plan does not cover** thermography (a technique that photographically represents the surface temperatures of the body).

**Transplant Services —** Please see “Transplant Services” in Section 3 for specific transplant services that are covered and related limitations and exclusions. In addition to services excluded by the other general limitations and exclusions listed throughout this Section 4, **this Plan does not cover** any other transplants (or organ-combination transplants) or services related to any other transplants.

**Travel or Transportation — This Plan does not cover** travel expenses, even if travel is necessary to receive covered services unless such services are eligible for coverage under “Transplant Services” in Section 3. **This Plan does not cover:**

- commercial transport, private aviation, or air taxi services
- services not specifically listed as covered, such as private automobile, public transportation, or wheelchair ambulance
- services ordered only because other transportation was not available or for your convenience
- medical transportation

Also see the exclusions under “Transplant Services.”
Veteran’s Administration Facility — **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.

**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 glasses or lenses, unless listed as covered (see “Supplies, Equipment, and Prosthetics” in **Section 3**). **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 related to an illness or accidental injury sustained during combat or active military service.

**Weight Management** — **This Plan does not cover** weight-loss or other weight-management programs, dietary control, or surgical or medical obesity treatment.

**Work-Related Conditions** — **This Plan does not cover** services resulting from work-related illness or injury, or charges resulting from occupational accidents or sickness covered under:
- occupational disease laws
- employer’s liability
- municipal, state, or federal law (except Medicaid)
- Workers’ Compensation Act

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

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

**Note:** This “Work-Related Conditions” exclusion does not apply to an executive employee or sole proprietor of a professional or business corporation if, under any applicable state law, the individual has affirmatively elected not to accept the provisions of the New Mexico Workers’ Compensation Act or any similar provisions in his/her state of residence. You must provide documentation showing that you have waived Workers’ Compensation and are eligible for the waiver. (The

See additional exclusions related to specific types of covered services in **Section 3**.
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 3.
Coordination of Benefits (COB)

Other valid coverage — All other group and individual (or direct-pay) insurance policies or health care benefit plans (including 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 4.

This Plan contains a coordination of benefits (COB) provision that prevents duplication of payments. When you are enrolled in any other valid coverage, the combined benefit payments from all coverages cannot exceed 100 percent of BCBSNM’s covered charges.

If you are also covered by Medicare, special COB rules may apply. Contact an NMSU DSU representative for more information. If you are enrolled in federal continuation coverage, coverage ends at the beginning of the month when you become entitled to Medicare or when you become insured under any other valid coverage (unless a pre-existing conditions limitation applies).

When this Plan is secondary, all provisions (such as obtaining prior approval) must be followed or benefits may be denied or reduced. Note: This Plan is secondary to any employee plan.

The following rules determine which coverage pays first:

Dental Services — If you also have dental plan coverage, any claims for services that are covered under the dental plan must be submitted first to the dental plan administrator for benefit determination.

No COB Provision — If the other valid coverage does not include a COB provision, that coverage pays first.

Medicare — If the other valid coverage is Medicare and Medicare is not secondary according to federal law, Medicare pays first.

Subscriber/Eligible Family Member — If a member is covered as the subscriber under one coverage and as an eligible family member under another, the subscriber’s coverage pays first. Exception: If Medicare is secondary to the plan of an active worker covering the Medicare beneficiary as an eligible family member, then that plan determines its benefits first, then Medicare, and last, the plan covering the Medicare beneficiary as the subscriber.

If you have other valid group coverage and Medicare, contact the other carrier’s customer service department to find out if the other coverage is primary to Medicare. There are many federal regulations regarding Medicare Secondary Payer provisions, and other coverage may not be subject to those provisions.

Eligible Child — For an eligible child whose parents are not separated or divorced, the coverage of the parent whose birthday falls earlier in the calendar...
year pays first. If the other coverage does not follow this rule, the father’s coverage pays first.

Eligible Child, Parents Separated or Divorced — For an eligible child of divorced or separated parents, benefits 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.** If the parents share joint custody, and the court decree does not state which parent is responsible for the health care expenses of the child, the plans follow the rules that apply to children whose parents are not separated or divorced.

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 benefits, a change in the entity that pays, provides, or administers the benefits, or a change from one type of plan to another.)

Responsibility for Timely Notice

BCBSNM is not responsible for coordination of benefits if timely information is not provided.

Facility of Payment

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

Right of Recovery

Regardless of who was paid, whenever benefit payments made by BCBSNM exceed the amount necessary to satisfy the intent of this provision, 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.

Reimbursement

If you or one of your covered family members incur expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for covered services described in your benefit booklet, you agree:

- BCBSNM has the right to reimbursement for all benefits provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of that sickness or injury, in the amount of the total covered charges for covered services for which BCBSNM provided benefits to you or your covered family members.
- BCBSNM is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits BCBSNM provided for that sickness or injury.

- BCBSNM shall have the right to first reimbursement out of all funds you, your covered family members or your legal representative, are or were able to obtain for the same expenses for which BCBSNM has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that BCBSNM may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.
Filing Claims

You must submit claims within 12 months after the date services or supplies were received. A claim submitted more than 12 months after the service was received will not be accepted under any circumstance. If a claim is returned for further information, resubmit it within 45 days.

Important Note About Filing Claims — This section addresses the procedures for filing claims and appeals. The instructions in no way imply that filing a claim or an appeal will result in benefit payment and do not exempt you from adhering to all of the provisions described in this benefit booklet. All claims submitted will be processed by BCBSNM according to the patient’s eligibility and benefits in effect at the time services are received. Whether inside or outside New Mexico and/or the United States, you must meet all admission review and prior approval requirements or benefits may be reduced or denied as explained in Section 2. Covered services are the same services listed as covered in Section 3 and all services are subject to the limitations and exclusions listed throughout this booklet.

If You Have Other Coverage — When you have other coverage that is “primary” over this Plan, you need to file your claim with the other coverage first. (See Section 5: COB and Reimbursement.) After your other coverage (including health care insurance, dental or vision plan, Medicare, automobile or other liability insurance, Workers’ Compensation, etc.) pays its benefits, a copy of their payment explanation form must be attached to the claim sent to BCBSNM or to the local BCBS Plan, as instructed under “Where to Send Claim Forms,” on the next page.

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

Participating and Preferred Providers

Your “preferred” provider has two agreements with BCBSNM — one is the preferred contract and the other is a “participating” provider contract. Some providers have only the participating provider contract and are not considered preferred. However, all participating and preferred providers file claims with BCBSNM (or with their local BCBS Plan) and payment is made directly to them. Be sure that these providers know you have health care coverage administered by BCBSNM. Do not file claims for these services yourself.

Preferred providers (and participating providers) also have specific timely filing limits in their contracts with BCBSNM, usually 180 days. The contract language lets providers know that they may not bill the employer or any member if they do not meet that filing limit for a service and the claim for that service is denied.
Nonparticipating Providers

A nonparticipating provider is one that has neither a “preferred” or a “participating” provider agreement. If your nonparticipating provider does not file a claim for you, submit a separate claim form for each family member as the services are received. Attach itemized bills and, if applicable, your other coverage’s payment explanation, to a Member Claim Form. (Forms can be printed from the BCBSNM Web site or requested from an NMSU DSU representative.) Complete the claim form using the instructions on the form. (See special claims filing instructions for out-of-country claims under “Where to Send Claim Forms,” below.)

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

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

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

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

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

Where to Send Claim Forms

If your nonparticipating provider does not file a claim for you, you (not the provider) are responsible for filing the claim. Remember: Participating and preferred providers will file claims for you; these procedures are used only when you must file your own claim.

Services in United States, Canada, Jamaica, U.S. Virgin Islands, and Puerto Rico — If a nonparticipating provider will not file a claim for you, ask for an itemized bill and complete a claim form the same way that you would for services received from any other nonparticipating provider. Mail the claim forms and itemized bills to BCBSNM at the address below (or, if you prefer, you may send to the local Blue Cross Blue Shield Plan in the state where the services were received):

Blue Cross and Blue Shield of New Mexico
P.O. Box 27630
Albuquerque, New Mexico 87125-7630
Mental Health/Chemical Dependency Claims —

Mesa Mental Health
P.O. Box 92165
Albuquerque, NM 87199-2165

Drug Plan 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 designated 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. If not included in your enrollment materials, you can obtain the name and address of the drug plan administrator and the necessary claim forms from an NMSU DSU representative or on the BCBSNM Web site (www.bcbsnm.com).

Services Outside the United States, U. S. Virgin Islands, Jamaica, Puerto Rico, or Canada — For covered inpatient hospital services received outside the United States (including Puerto Rico, Jamaica, and the U.S. Virgin Islands) and Canada, show your Plan ID card issued by BCBSNM. BCBSNM participates in a claim payment program with the Blue Cross and Blue Shield Association. If the hospital has an agreement with the Association, the hospital files the claim for you to the appropriate Blue Cross Plan. Payment is made to the hospital by that Plan, and then BCBSNM reimburses the other Plan.

You will need to pay up front for care received from a doctor, a participating outpatient hospital, and/or a nonparticipating hospital. Then, complete an International Claim Form and send it with the bill(s) to the BlueCard Worldwide Service Center (the address is on the form). The International Claim Form is available from BCBSNM, the BlueCard Worldwide Service Center, or on-line at:

www.bcbs.com/coverage/bluecard/bluecard-worldwide.html

The BlueCard Worldwide International Claim Form is to be used to submit institutional and professional claims for benefits for covered services received outside the United States, Puerto Rico, and the U.S. Virgin Islands. For filing instructions for other claim types (e.g., dental, prescription drugs, etc.) contact your Blue Cross and Blue Shield Plan. The International Claim Form must be completed for each patient in full, and accompanied by fully itemized bills. It is not necessary for you to provide an English translation or convert currency.

Since the claim cannot be returned, please be sure to keep photocopies of all bills and supporting documentation for your personal records. The member should submit an International Claim Form (available at www.bcbs.com), attach itemized bills, and mail to BlueCard Worldwide at the address below. BlueCard Worldwide will then translate the information, if necessary, and convert the charges to United States dollars. They also will contact BCBSNM for benefit information in order to process the claim. Once the claim is finalized, the Explanation of Benefits will be mailed to the subscriber and payment, if applicable, will be made to the subscriber via wire transfer or check. Mail international claims to:
Claims Payment Provisions

After a claim has been processed, the subscriber will receive an *Explanation of Benefits* (EOB). The EOB indicates what charges were covered and what charges, if any, were not. **Note:** If a Qualified Child Medical Support Order (QCMSO) is in effect, the QCMSO provisions will be followed. For example, when the member is an eligible child of divorced parents, the custodial parent may receive the payment and the EOB.

**Participating and Preferred Providers** — Payments for covered services usually are sent directly to PPPs and other network (preferred or participating) providers. The EOB you receive explains the payment.

**Nonparticipating Providers** — If services are received from a nonparticipating provider in New Mexico, payments are usually made to the subscriber (or to the applicable alternate payee when a QCMSO is in effect). The check will be attached to an EOB from BCBSNM that explains BCBSNM'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 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. No person may execute any power of attorney to interfere with BCBSNM's right to pay the subscriber instead of anyone else.

**Covered Charge** — Provider payments are based upon preferred provider and participating provider agreements and covered charges as determined by BCBSNM. For services received outside of New Mexico, covered charges may be based on the local Plan practice (e.g., for out-of-state providers that contract with their local Blue Cross Blue Shield Plan, the covered charge may be based upon the amount negotiated by the other Plan with its own contracted providers). You are responsible for paying copayments, deductibles, coinsurance, any penalty amounts, and noncovered expenses. For covered services received in foreign countries, BCBSNM will use the exchange rate in effect on the date of service in order to determine billed charges.

**Provider Payment Examples** — The two following examples demonstrate the difference between your liability for services from an in-network provider versus an out-of-network provider. See your *Summary of Benefits* for your Plan's coinsurance amount, if any, which may be higher for out-of-network providers (if covered under your Plan).
**Example 1.** In-Network Provider Claim Payment (Plan pays 75 percent; deductible is met):

<table>
<thead>
<tr>
<th>Provider's billed charge</th>
<th>$10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Charges</strong> (maximum amount that can be considered for benefit payment)</td>
<td>$8,000</td>
</tr>
<tr>
<td><strong>BCBSNM payment to provider (75% of $8,000)</strong></td>
<td>$6,000</td>
</tr>
<tr>
<td><strong>Member coinsurance</strong> (25% of $8,000) applied to the out-of-pocket limit</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Amount over the covered charge</strong> - the in-network provider writes off the difference between billed amount and covered charge</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total amount due from the member</strong> (coinsurance only):</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

**Example 2.** Out-of-Network Provider Claim Payment (Plan pays 60 percent; deductible is met):

<table>
<thead>
<tr>
<th>Provider's billed charge</th>
<th>$10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Charges</strong> (maximum amount that can be considered for benefit payment)</td>
<td>$8,000</td>
</tr>
<tr>
<td><strong>BCBSNM payment to provider (60% of $8,000)</strong></td>
<td>$4,800</td>
</tr>
<tr>
<td><strong>Member coinsurance</strong> (40% of $8,000) applied to the out-of-pocket limit</td>
<td>$3,200</td>
</tr>
<tr>
<td><strong>Amount over the covered charge</strong> - the member is responsible for all costs incurred over the covered charges and these amounts do not apply to your out-of-pocket limits</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Total amount due from the member</strong> (coinsurance only):</td>
<td>$5,200</td>
</tr>
</tbody>
</table>

**BlueCard Program** — Other Blue Cross and Blue Shield Plans outside of New Mexico ("Host Blue") may have contracts with certain providers in their service areas. Under BlueCard, when you receive covered health care services outside of New Mexico from a Host Blue contracting provider that does not have a contract with BCBSNM, the amount you pay for covered services is calculated on the lower of:

- the billed charges for your covered services, or
- the negotiated price that the Host Blue passes on to BCBSNM.

Here’s an example of how this calculation could work. Suppose you receive covered medical services for an illness while you are on vacation outside of New Mexico. You show your identification card to the provider to let him or her know that you are covered by BCBSNM. The provider has negotiated with the Host Blue a price of $80, even though the provider’s standard charge for this service is $100. In this example, the provider bills the Host Blue $100. The Host Blue, in turn, forwards the claim to BCBSNM and indicates that the negotiated price for the covered service is $80. BCBSNM would then base the amount you must pay for the service — the amount applied to your deductible, if any, and your coinsurance percentage — on the $80 negotiated price, not the $100 billed charge. So, for example, if your coinsurance is 20 percent, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a covered service.
Please Note: The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Look at your Summary of Benefits for your payment responsibilities under this Plan.

Often, this “negotiated price” is a simple discount that reflects the actual price the Host Blue pays. Sometimes, it is an estimated price that takes into account special arrangements the Host Blue has with an individual provider or a group of providers. Such arrangements may include settlements, withholds, non-claims transactions, and/or other types of variable payments. The “negotiated price” may also be an average price based on a discount that results in expected average savings (after taking into account the same special arrangements used to obtain an estimated price). Average prices tend to vary more from actual prices than estimated prices.

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

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

Drug Plan Copayments and Coinsurance — For claims submitted to the prescription drug plan administrator for reimbursement, you are paid the lesser of: 1) the sum of the drug ingredient cost, the dispensing fee that would be payable to a participating pharmacy, and any sales tax minus the applicable copayment or coinsurance, or 2) the pharmacy’s retail price minus the applicable copayment or coinsurance.

Early Developmental Delay and Disability — For covered eligible children under age 4 who are also eligible for services under the Department of Health’s (DOH) “Family, Infant, and Toddler” (FIT) program (as defined in 7.30.8, NMAC), your BCBSNM health care plan will reimburse the DOH for certain medically necessary early intervention services that are provided as part of an individualized family service plan under the FIT program by personnel who are licensed and certified for the DOH’s FIT program. The maximum reimbursement under the BCBSNM health care plan is limited to $3,500 per year. However, amounts paid to DOH for such services are not included in any annual or lifetime benefit maximums under the health care plan. Claims for services payable to the DOH under this provision will be honored only if submitted to BCBSNM by the DOH.

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

Overpayments — If BCBSNM makes an erroneous benefit payment for any reason (e.g., provider billing error, claims processing error), BCBSNM and the providers of care may recover overpayments from you. If you do not refund the overpayment, BCBSNM reserves the right to withhold future benefits to apply to
the amount that you owe to BCBSNM, and to take legal action to correct pay-
ments made in error.

**Grievances (Complaints)**

If you have an inquiry or a concern about any prior authorization request, claims payment, claims that have been denied or only partially paid, the quality of care you receive, the cancellation of your coverage, or any other review decisions made by BCBSNM, call a BCBSNM Customer Service representative for assistance. Many complaints or problems can be handled informally by calling, writing, or e-
mailing BCBSNM Customer Service. If you are not satisfied with the initial response, you can request internal review as described below.

If you make an oral grievance, a BCBSNM Customer Service representative will assist you. The Managed Health Care Bureau of the New Mexico Insurance Division is also available to assist you with grievances, questions, or complaints. Call:

1-888-427-5772 or (505) 827-3928

You may designate a representative to act for you in the internal review. Your designation of a representative must be in writing in order to protect against disclosure of information about you except to your authorized representative. You, your guardian or representative, or a provider acting on your behalf can contact a BCBSNM Customer Service representative in person, by letter, by e-mail, or by telephone if you have an inquiry or complaint about a prior authorization request, a claim payment or denial, or any other issue. If you make an inquiry or complaint or file a grievance under the following procedures, you will not be subject to retaliatory action by BCBSNM. **Note:** This is a summary of the procedures. You may request a more detailed written explanation of these procedures by calling BCBSNM Customer Service.

**Grievance Procedures**

If you are not satisfied with the initial decision made by BCBSNM, you can request internal review. Within **180 days** after you receive notice of a BCBSNM decision (payment, denial, or partial denial) on a claim or a prior authorization request, call or write BCBSNM Customer Service and explain your reasons for disagreeing with the decision. If you do not submit the request for internal review within the 180-day period, you waive your right to internal review, unless you can satisfy BCBSNM that matters beyond your control prevented you from timely filing the request. You may also ask to see relevant documents and you may submit written issues, comments and additional medical information as part of the internal review.

**Adverse Determination Grievance** — This is a summary of the grievance procedure that applies to “adverse determinations” made by BCBSNM regarding a request for a health care service.

*Adverse determination* — An “adverse determination” means a decision made either pre-service or post-service by BCBSNM that a health care service re-
quested by a provider or member has been reviewed and, based upon the infor-
mation available, does not meet the requirements for coverage or medical
necessity and the requested health care service is either denied, reduced, or
terminated.
Section 6: Claims Payments and Appeals

If your request for a health care service has been denied in whole or in part, you may request internal review of the adverse determination. The internal review will be either “expedited” or “standard.”

If required by the medical exigencies of the request, BCBSNM will conduct an “Expedited Review” and will render a decision as soon as practicable, but not later than 72 hours from receipt of the request.

If not medically exigent, BCBSNM will conduct a “Standard Review.” If the request for internal review is made before you receive the health care service (“pre-service request for review”), the entire internal review process shall be completed within 20 working days of receipt of the request for internal review. If the request for internal review is made after you receive the health care service (“post-service request for review”), the entire internal review shall be completed within 40 working days of the request for internal review. BCBSNM may extend the review period 10 working days in pre-service cases and 20 working days in post-service cases.

If the BCBSNM medical director or the appropriate designee of the medical director upholds the adverse determination, BCBSNM will notify you of that decision by telephone (if available) and by mail and will ask whether you want to pursue an “internal panel review” of the decision. If you elect to pursue internal panel review, BCBSNM will notify you of the date, time, and location that the panel will convene and will make arrangements for you to participate by phone or in person, if necessary. BCBSNM will not unreasonably deny your request for a postponement. The internal panel decision will be provided to you by telephone and in writing within the time frames set forth above, subject to any extensions or postponements.

Administrative Grievance — This is a summary of the grievance procedure followed by BCBSNM for any oral or written complaint about any aspect of the benefit plan other than a request for health care service including, without limitation:
- administrative practices of BCBSNM that affect the availability, delivery or quality of health care services;
- claims payment, handling, or reimbursement for health care services; and
- termination of coverage.

If you are dissatisfied with a decision, action, or inaction of BCBSNM, you have the right to request an initial internal review of the administrative grievance orally or in writing. A BCBSNM representative will complete the internal review and mail a written decision to you within 15 working days of receipt of the administrative grievance. The decision will be binding unless you request reconsideration of the internal review within 20 working days of your receipt of the initial decision.

Upon receipt of your request for reconsideration of the internal review, BCBSNM will appoint a reconsideration committee to schedule and hold a hearing. Arrangements will be made for you to participate in the hearing in person or by telephone. The hearing shall be held within 15 working days after receipt of your request for reconsideration and the decision of committee will be provided to you in writing within 7 working days after the hearing. BCBSNM will not unreasonably deny your request for a postponement.
BCBSNM Contacts

For more information, contact:

BCBSNM Appeals Unit
P.O. Box 27630
Albuquerque, NM 87125-9815

Telephone (toll-free): (800) 205-9926
e-mail: See Web site at www.bcbsnm.com
Fax: (505) 816-3837

External Appeals

If you are still not satisfied after having completed the BCBSNM inquiry, appeals, and grievance procedures, you have the option of taking one or more of the following steps. (You may not take legal action to recover benefits under this Plan until 60 days after BCBSNM has received the claim or prior authorization request in question. Also, you may not take any legal action after three years from the date that the claim in question must be filed with BCBSNM.)

Review by the NM Superintendent of Insurance — If you are dissatisfied with the BCBSNM internal review of your grievance or appeal decision, you have the right to request an external review by the New Mexico Superintendent of Insurance by filing a written request within 20 working days of receipt of the written decision from BCBSNM. You may file your request by:

- Mail to the Superintendent of Insurance, Attention: Managed Health Care Bureau - External Review Request, New Mexico Public Regulation Commission, P.O. Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269;
- Fax to Managed Health Care Bureau-External Review Request at (505) 827-4734;
- E-mail to mhcb.grievance@state.nm.us (subject: “External Review Request”);
- Online by using a Division of Insurance Complaint Form at http://www.nmprc.state.nm.us; or
- If required by the medical exigencies of the case, by telephone at 1-888-427-5772 or (505) 827-3928.

You will need to provide a copy of the BCBSNM decision; a fully executed release form authorizing the Superintendent to obtain any necessary medical records from BCBSNM or other health care provider; and any other supporting documentation. You may contact the Managed Health Care Bureau to assist you in this process by calling toll-free at 1-888-427-5772.

Arbitration

If a dispute about coverage, benefits, or handling of claims or appeals continues after you have followed and exhausted the appeals and grievance process set forth above, including having completed the external review process under the Superintendent of Insurance, the issue or claim may be submitted to arbitration. The rules for arbitration shall be the “Commercial Arbitration Rules” developed by the American Arbitration Association. You may obtain a copy of these rules
from a Customer Service representative. The rules are also available from the American Arbitration Association’s Web site (www.adr.org).

No action at law or in equity may be brought or arbitration demand made less than 60 days after BCBSNM has received the claim for benefits or prior approval request, or later than three years after the date that the claim for benefits should have been filed with BCBSNM.

You may not make an arbitration demand or take legal action to recover benefits under this Plan until 60 days after BCBSNM has received the claim or prior approval request in question. Also, you may not make an arbitration demand or take any legal action after three years from the date that the claim in question must be filed with BCBSNM.

■ **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.

If due to circumstances not within the control of BCBSNM or a participating provider (such as partial or complete destruction of facilities, war, riot, disability of a participating provider, or similar case), BCBSNM and the provider will have no liability or obligation if medical services are delayed or not provided. BCBSNM and participating providers will, however, make a good-faith effort to provide services.

■ **Research Fees**

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

■ **Sending Notices**

All notices to you are considered to be sent to and received by you when deposited in the United States mail with first-class postage prepaid and addressed to NMSU or to the subscriber at the latest address on BCBSNM membership records. NMSU may also send notices to employees via campus mail and to retirees via United States mail.
Enrollment and Termination Information

Enrollment Assistance
You are responsible for advising the appropriate party of any address change, any change that may affect your or a family member's eligibility, and of any changes to a covered family member's name. You are also responsible for requesting changes to your coverage by submitting signed and completed enrollment/change forms to the appropriate party. Your contact for billing and premium, enrollment, eligibility, and termination assistance depends upon whether you are covered under the regular group plan coverage, or a federal continuation coverage due to COBRA:

Regular Group Coverage — NMSU is responsible for all administrative policies regarding premium deduction or premium collection for members covered under the group plan. Note: COBRA premiums are collected by Health Care Service Corporation (HCSC). If you need assistance enrolling, changing an address, terminating coverage, or changing coverage, or if you have any question regarding eligibility in the group plan or your premiums for group coverage, contact:

New Mexico State University
Attn: Benefit Services
Off-site: PO Box 30001, MSC 3HRS, Las Cruces, NM 88003-8001
Telephone: 575-646-8000

COBRA Continuation Coverage — Members covered under a federal continuation plan due to COBRA should direct questions to:

Health Care Service Corporation
P.O. Box 2387
Danville, IL 61834-2387
1-888-541-7107

Premiums for federal continuation coverage should be mailed to:

Health Care Service Corporation
21806 Network Place
Chicago, IL 60673-1218

Who Is Eligible

Member — Each enrollee (the subscriber and any eligible family member) who is enrolled for coverage and entitled to receive benefits under this Plan in accordance with the terms of the Group Master Contract. Throughout this booklet, “you” and “your” refer to each member.

Subscriber — The person whose retirement from NMSU is the basis for enrollment eligibility, or the person in whose name the contract is issued. “Subscriber” may also encompass other persons in a nonemployee relationship with NMSU (e.g., COBRA members, surviving eligible family member contract holders).
Eligible Retirees and Their Eligible Family Members

This Plan covers only those retirees and their eligible family members who are under age 65 and not entitled to Medicare. **Exception:** Members who are entitled to Medicare due to end-stage renal disease may continue coverage in this PPO 500 Plan for the period during which Medicare is secondary to Plan coverage according to federal regulation. After this coordination time period is exhausted, the member must switch to the NMSU Medicare Carveout Plan.

**Retiree** — An employee who officially retires from the University and receives a benefit from the Educational Retirement Board (ERB) or Alternative Retirement Plan immediately upon termination of employment may receive health insurance benefits after retirement if the retiree was enrolled in the Plan for ten consecutive years in regular status just prior to retirement. (Persons eligible under the Alternative Retirement Plan must meet the regular ERB eligibility rules, immediately begin receiving a benefit, and have been enrolled in the Plan for ten consecutive years in regular status just prior to retirement.) Only time enrolled as a regular employee (or as the spouse of an active, regular employee if both you and your spouse are employed by NMSU) will be counted toward the ten-year requirement.

If a retiree rescinds their retirement with the ERB or ARP to become re-employed by NMSU in a regular employment status, the retiree must maintain NMSU health insurance coverage during the re-employment period and re-retire at a later date. The retiree/employee will meet the eligibility requirements under this Plan to re-enroll on the retiree health plan upon re-retirement provided the following conditions are met:

- the retiree/employee maintains continuous health insurance coverage with NMSU from retirement to employment to re-retirement (minus any applicable waiting periods); and
- the retiree/employee re-retires and immediately begins collecting retirement benefits from the ERB or ARP upon re-retirement.

**Spouses or Domestic Partners** — Spouses or domestic partners of eligible retirees covered at the time of retirement may continue coverage after the employee’s retirement. Retirees may also add coverage for spouses or domestic partners acquired after retirement. See “Adding Eligible Family Members” for more information.

**Children** — Only those eligible children who were covered at the time of retirement may continue coverage after the employee retires. Eligible children acquired after retirement may **not** be added at a later date, except as specified under “Adding Eligible Family Members,” later in this section. Surviving eligible family member contract holders may not add new family members to coverage at any time.

**Medicare-Eligible Retirees and Retirees’ Eligible Family Members** — Except during the limited period of time in which this Plan is primary over Medicare due to federal regulations regarding coverage for patients with end-stage renal disease, retirees and/or their eligible family members who are enrolled in Part A and Part B of Medicare may **not** enroll in this NMSU PPO 500 Plan and may not continue coverage in this Plan after becoming eligible for
Medicare. In such cases, the member with Parts A and B of Medicare will be required to switch to the NMSU Medicare Carveout Plan. Members who are enrolled in only one Part of Medicare are not eligible for coverage under any NMSU retiree health plan.

For example, a retiree’s eligible family member who has Medicare due to end-stage renal disease is primary under this Plan for only 30 months following the date of his/her first dialysis treatment. The eligible family member would switch to the NMSU Carveout Plan after the 30-month period.

Eligible retirees and their eligible family members (including eligible survivor family members) who are under age 65 and not enrolled in Medicare may continue coverage in this NMSU PPO 500 Plan.

Eligible Family Members

**Eligible family members** — Family members of the subscriber, limited to the following persons:

- the subscriber’s **legal spouse**
- the subscriber’s **domestic partner** (To be recognized as domestic partners by New Mexico State University, both individuals must meet all the criteria established by NMSU personnel policies, sign an **Affidavit of Domestic Partnership** form, and submit any necessary documentation to the Department of Human Resources. Please contact Benefit Services for eligibility criteria for domestic partners.)
- the subscriber’s eligible **child** through the end of the month in which the child reaches age **26** (Once a covered child reaches age 26, the child is automatically removed from coverage and rates adjusted accordingly.)
- the subscriber’s **unmarried** child age **26** or older who was enrolled as the subscriber’s covered child in this health plan at the time of reaching the age limit, and who is medically certified as **disabled** and chiefly dependent upon the subscriber for support and maintenance, and incapable of self-sustaining employment by reason of his/her disability (Such condition must be certified by a physician and BCBSNM.) Also, a child may continue to be eligible for coverage beyond age **26** only if the condition began before or during the month in which the child would lose coverage due to his/her age. NMSU must receive written notice of the disabling condition before the end of the month during which the child’s coverage would otherwise end.)

**Eligible child** — The following family members of the subscriber through the end of the month during which the child turns age 26:

- natural or legally adopted child of the subscriber
- child under age 18 placed in the subscriber’s home for purposes of adoption (including a child for whom the subscriber is a party in a suit in which the adoption of the child by the subscriber is being sought)
- stepchild of the subscriber
- child for whom the subscriber must provide coverage because of a court order or administrative order pursuant to state law
- child of a domestic partner:
  - if either of the domestic partners is the biological parent of the child
  - if either or both partners are adoptive parents of the child
A child meeting the criteria above is an “eligible child” whether or not the subscriber is the custodial or noncustodial parent, and whether or not the eligible child is claimed on income tax, employed, married, attending school, or residing in the subscriber’s home, except that:

- A child age 19 or older who has other group coverage available to him/her - whether through the child’s own employer or through the child’s spouse’s employer - is not eligible under this health plan. The child need not be enrolled in such available group coverage in order to be excluded as an eligible family member.

- Once the subscriber is no longer a legal guardian of a child or there is no longer a court order to provide coverage to a child, the child must be eligible as a natural child, legally adopted child, or stepchild of the subscriber in order to retain eligibility as a family member under this health plan.

**Covered family member, covered spouse, covered child** — An eligible spouse or eligible child (as defined above) who has applied for and been granted coverage under the subscriber’s policy based on his/her family relationship to the subscriber.

Eligible family members cannot participate in the NMSU program unless the eligible retiree participates (although a surviving spouse and any of the survivor’s eligible children who were covered at the time of the retiree’s death may continue participation. Note: If all eligible members of a retiree’s family do not qualify for enrollment in the NMSU PPO 500 Plan due to being age 65 or older or due to entitlement to Medicare as primary coverage, the unqualified member will be enrolled in the NMSU Carveout Plan. (If the member has only one Part of Medicare, he/she is not eligible to enroll in any NMSU health plan but may choose to continue coverage under one of the continuation options listed under “How Coverage May Continue.”)

NMSU may require acceptable proof (such as copies of income tax forms, legal adoption or legal guardianship papers, or court orders) that an individual qualifies as an eligible family member under this coverage. Unless listed as an eligible family member above, no other family member, relative, or person is eligible for coverage as an eligible family member.

**Family Members Who are Not Eligible** — A retiree’s spouse, domestic partner, or child is not an eligible family member while:

- on active duty in the armed forces of any country (unless eligible for continued coverage for a limited period of time under federal law); or

- covered under this Plan or another plan of benefits provided through NMSU for health care expenses as an employee or retiree or an eligible family member of another employee or retiree.

**Information for Noncustodial Parents** — When a child is covered by the Plan through the child’s non-custodial parent, then the Plan will:
provide such information to the custodial parent as may be necessary for the child to obtain benefits through the Plan;

- permit the custodial parent or the provider (with the custodial parent’s approval) to submit claims for covered services without the approval of the noncustodial parent; and

- make payments on claims submitted in accordance with the above provision directly to the custodial parent, the provider, or the state Medicaid agency, as applicable.

**Notification of Eligibility and Address Changes**

A subscriber must notify Benefit Services of any changes that may affect his/her or an eligible family member’s eligibility (such as a change in Medicare eligibility status, marital status, or age), including a change to a covered family member’s name or address, by indicating such changes on an enrollment/change form and submitting it to Benefit Services. You can obtain this form from NMSU Benefit Services. (Members covered under COBRA continuation obtain forms from an NMSU Designated Service Unit (DSU) representative at BCBSNM and do not submit enrollment/change forms to NMSU; see “How to Continue Coverage” for the applicable address.)

**Applying for Coverage**

An eligible retiree may apply for continued coverage, including his/her eligible family members, by submitting an enrollment/change form to NMSU Benefit Services just prior to retirement. **Note:** BCBSNM and NMSU cannot use genetic information or require genetic testing in order to determine if a condition is pre-existing or to limit or deny coverage.

**When Coverage Begins**

Coverage under this Plan begins on the date of the employee’s retirement. Your NMSU Carveout Plan ID card indicates the subscriber’s name under this NMSU PPO 500 Plan. (The subscriber may be the eligible family member of a retiree who is eligible for Medicare or who is over age 65 and covered under the Medicare Carveout Plan. In such cases, separate ID cards and benefit materials are issued.)

**Change in Health Care Plan** — Your Plan can only be changed for any retiree, retiree’s eligible family member, or surviving eligible family member because you will be attaining age 65 or you are becoming Medicare-eligible.

If you or your eligible family member must change to the Medicare Carveout health care plan, a completed enrollment/change form must be submitted to Benefit Services as soon as possible (or, for continuation members, to HCSC or BCBSNM, as applicable). It is important that you contact Benefit Services in order to confirm your termination under one plan with the effective date under the new plan and to verify your premiums have been adjusted. See “Premium Payments” for details.

**Upon attainment of age 65, NMSU will automatically enroll you and/or your eligible family members in the Medicare Carveout plan and will**
request a copy of your or your eligible family members Medicare card(s).

**Note:** If a retiree or an eligible family member of a retiree/surviving spouse must switch to the Medicare Carveout health care plan for any reason other than reaching age 65, the change will become effective the next first of the month following the date of the event that necessitated the change.

### Premium Payments

If a coverage change results in a higher premium, you will be responsible for paying any additional amounts due beginning from the effective date of the change.

NMSU is solely responsible for premium deductions and premium collection.

**Premium Increases/Decreases —** When a retiree experiences a change in status (including but not limited to: marriage, divorce, childbirth, adoption, Medicaid, family member no longer meeting insurance eligibility rules), the retiree has 31 days from the date of the status change to contact Benefit Services to make coverage changes. All status changes resulting in insurance coverage and/or premium change will be effective the first day of the month following the date of the change in status, except in the case of a newborn or the placement of child(ren) through adoption. For a newborn or placement of child(ren) through adoption, coverage becomes effective the date of birth or date of placement. The addition of a child through birth or placement will result in a full premium being charged for the billing period in which the event occurred.

See “Coverage Termination” for termination dates that apply to specific circumstances. See “Applying for Coverage: Change in Health Care Plan” for dates upon which you can switch enrollment to another plan.

**Premiums for Retirees —** Retiree coverage begins on the date of retirement from the University. NMSU continues to pay a portion of the Plan’s premium (except as listed under “Adding a New Spouse/Domestic Partner”).

**Premiums for Surviving Spouse and His/Her Eligible children —** If a retiree dies, the surviving eligible spouse and his/her surviving eligible children who were covered at the time of the retiree’s death may continue coverage (see “Coverage Termination” for more information). Surviving eligible family members are responsible for paying 100 percent of their premium to NMSU in order to retain coverage.

**Premiums for Continuation Members —** See “How to Continue Coverage” for details.

**Notification —** If the Group Master Contract is terminated or premiums are not submitted, coverage will terminate for all affected members as of the end of the last-paid billing period. BCBSNM will not notify the affected members of such terminations. (If NMSU fails to submit premium payments to BCBSNM, it is NMSU’s responsibility to advise members of BCBSNM Plan termination.)
The required premiums are determined and established by BCBSNM. The percentage of the total premium that you pay is established by NMSU. BCBSNM may change premium amounts according to any of the following:

- changes in federal and state law, or
- changes to coverage classifications (for example, to a new age category or geographic location, or from a single eligible family member coverage to a two eligible family member coverage type), or
- after giving the employer and/or subscriber 60 days’ written notice.

**Premium Refunds** — BCBSNM may not refund membership premiums paid in advance on behalf of a terminated member if:

- the enrollment/change form is not received within 31 days of the change in eligibility status; or
- any claims or capitation amounts have been paid on behalf of the terminated member during the period for which premiums have been paid.

### Adding an Eligible Family Member to Coverage

A retiree may apply only for coverage of a new spouse or domestic partner or a newly born child or child adopted after retirement. Surviving eligible family member contract holders may not add new family members to coverage.

See “Premium Payments” for more information about premium adjustments.

**Adding a New Spouse or Domestic Partner** — New spouses and domestic partners acquired by a retiree after retirement may be added to either the NMSU PPO 500 or the NMSU Carveout Plan, as applicable, under certain circumstances. The new spouse or domestic partner will not be added until one year following the date of marriage or creation of partnership.

In order to add a new spouse or domestic partner, a completed and signed enrollment/change form must be submitted to Benefit Services, along with a copy of the marriage certificate or all required domestic partnership documentation, as applicable. **You have 31 days following your first anniversary date of marriage (or partnership) in which to submit the completed paperwork.**

There will be no University contributions to the additional premium cost (the University will continue to pay applicable premium for the retiree’s coverage), and the retiree will be responsible for paying 100 percent of the premium for the new spouse’s or domestic partner’s coverage.

The new spouse or domestic partner will be eligible for surviving spouse/domestic partner benefits if he/she is a member of the NMSU health plan when the retiree passes away. If the retiree passes away before the new spouse/domestic partner’s coverage becomes effective, the new spouse/domestic partner will not be eligible for health insurance coverage through NMSU as a surviving spouse/domestic partner.

**New Spouses/Domestic Partners of Continuation Subscribers** —

Federal continuation subscribers may add new spouses or domestic partners to
Adding Children — Retirees/retiree spouses may add eligible children to coverage in the following cases. These provisions do not apply to surviving spouses/domestic partners, whether covered under the group plan or under the federal continuation coverage. If a child is not added to coverage within the time frames listed below, the child may not obtain NMSU coverage at a later date.

Newborn Children: Even if you have Family coverage, you should submit an enrollment/change form to add the newborn as an eligible family member within 31 days of birth. This will ensure that the newborn is added to your membership records as an eligible family member in a timely manner and that claims payments will not be delayed unnecessarily. If Family coverage is not in effect, you must change to Family or Retiree/Child(ren) coverage within 31 days of the birth in order for newborn care to be covered. The baby will then be covered from birth.

Note: If the parent of the newborn is an eligible child of the subscriber (i.e., the newborn is the subscriber’s grandchild), benefits are not available for the newborn.

Adopted Children: A child under age 18 placed in the retiree’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 legal adoption without being considered late. Depending on when you submit the application to Benefit Services, the effective date of coverage will be the date of placement in the home or date of legal adoption if you submit the application within 31 days of the applicable event. (Although a child over the age of 18 is not eligible for adoption, an adopted child is covered as any other child, subject to the same eligible child age limitations and restrictions.)

Disabled Children: A retiree’s child who is covered under Medicaid due to disability and who loses his/her Medicaid eligibility may be added to coverage. Proof of the loss of coverage will be required and the retiree has 31 days from the date the child loses Medicaid to add the disabled eligible child. If the 31-day deadline is not met, there will not be an option to add the child at a later date.

Legal Guardianship: Application for coverage must be made for a child for whom the retiree or the retiree’s spouse becomes the legal guardian within 31 days of the court order granting guardianship. If not specified in the court order, the eligible child’s effective date of coverage will be the date the order has been filed as public record with the State, or the effective date of Family or Retiree/Child(ren) coverage, whichever is later.
Late Applicant Provision

Late applicant — Applications from the following enrollees will be considered late:

- anyone who did not enroll within 31 days of becoming eligible for coverage. For example, a newborn child added to coverage more than 31 days after birth when Family coverage is not already in effect, a child added more than 31 days after legal adoption, a domestic partner and/or his/her eligible children added to coverage more than 31 days after becoming eligible, or a new spouse or stepchild added more than 31 days after marriage is considered a late applicant. 

  Note: Even if you have Family coverage, you should submit an enrollment/change form to add a newborn to coverage within 31 days of birth. This will ensure that the newborn is added to your membership records as an eligible family member in a timely manner and that claims payments will not be delayed unnecessarily.

- anyone who voluntarily terminates his/her coverage and applies for reinstatement of such coverage at a later date (except as provided under the USERRA of 1994)

Late applications are not accepted from retirees, their eligible family members, or their surviving eligible family members.

Note: BCBSNM cannot use genetic information or require genetic testing in order to determine if a condition is pre-existing or to limit or deny coverage.

Special Enrollment

Special enrollment — There are certain instances (or “qualifying events”) during which the retiree’s eligible family members, if any, may enroll in the Plan at a later date – or more than 31 days after becoming eligible – and not be considered late applicants. The “special enrollment” period is the period of time during which an otherwise late applicant may apply for coverage outside the annual open enrollment period and/or without increasing the pre-existing conditions waiting period.

You have a limited amount of time during which you may request a special enrollment. If you do not request special enrollment within the time frame described below, you will be considered a late applicant. 

Note: There are no “special enrollments” for persons applying for any continuation, conversion coverage, or extension of benefits due to disability. You must enroll in such coverage timely.

Applying for Special Enrollment — Application for special enrollment must be made within the time period specified below in order to qualify you and/or your eligible family member(s) for a special enrollment right. Please contact your employer for details about special enrollment privileges that apply to you and your eligible family members.

Waiving Coverage — A retiree who declines coverage at retirement and later loses other coverage will not be entitled to special enrollment (and neither will the retiree’s eligible family members).
Coverage Effective Date — If a member is granted a special enrollment due to due to marriage, birth, or adoption, and all required documentation is received timely by the employer, coverage will begin no later than the first day of the month after the employer received the request for special enrollment. However, for a change in family status due to birth of an eligible newborn or adoption of a child, coverage begins on the date of birth or adoption.

If a completed and signed enrollment/change form is not received within the time periods set forth in this section, the retiree’s eligible family members will be considered late applicants and no special enrollment right will be available.

Qualifying Event: Change in Family Status — A retiree who acquires a new eligible family member due to marriage, a domestic partner, birth, adoption, or placement for adoption may apply for a special enrollment in this Plan for family members who are eligible for coverage under this Plan. Application for special enrollment of the retiree’s eligible family members will not be considered late if submitted within 31 days of the marriage, birth, adoption, or placement of the eligible child in the subscriber’s home. If submitted more than 31 days following the change in family status, special enrollment is not available.

- Newborn or Adopted Child: For a change in family status due to birth of an eligible newborn or adoption of a child, coverage begins on the date of birth or adoption (or, if earlier, on the date of placement in the subscriber’s home).
- Marriage: The effective date of coverage for all persons granted a special enrollment due to marriage will be the same as the new spouse’s effective date of coverage, which is one year following the date of marriage, as described under “Adding an eligible family member to Coverage.”

This right to special enrollment upon a change in family status applies to all eligible family members.

Pre-Existing Conditions Limitation

Definition

Benefit exclusion period — The length of time during which benefits will not be available for pre-existing conditions.

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

Initial enrollment eligibility date — A member’s effective date of coverage or the first day of any waiting period imposed on the member by NMSU, whichever is earlier. Since the late applicant provision does not apply to retiree contracts, the initial enrollment eligibility date for spouses added to coverage following retirement is the spouse’s coverage effective date.

Pre-existing condition — A physical or mental condition for which medical advice, medication, diagnosis, care, or treatment was recommended for or received by an applicant within the six-month period before his/her initial enrollment eligibility date. Pregnancy and pregnancy-related diagnoses are not considered pre-existing conditions.
New Spouses or Domestic Partners of Retirees — For a member enrolled within the timeliness limits set forth under “Applying for Coverage” or under “Adding an eligible family member to Coverage,” no benefits are available for any pre-existing condition for six months after the member’s initial enrollment eligibility date.

Late Applicants — Late applications are not accepted.

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

- newborn child (when Family coverage is in effect on the date of birth)
- newborn child added to coverage within 31 days of birth (when Family coverage is not in effect on the date of birth)
- adopted child under age 18 (or child under age 18 placed in the subscriber’s home for the purpose of adoption) and added to coverage prior to or within 31 days of adoption
- a child who was enrolled in any group health plan or other creditable coverage within 31 days of birth or adoption and who has not experienced any significant lapse of coverage (i.e., 95 or more days) prior to enrolling in this health plan

Reduction in Benefit Exclusion Period — The period during which benefits for pre-existing conditions will not be available will be reduced for any member who had comprehensive medical/surgical coverage that was either still in effect, or was terminated within 95 days of, his/her initial enrollment eligibility date under this Plan. The benefit exclusion period will be reduced by at least the length of time he/she was continuously covered under the prior plan. Proof of such prior coverage (e.g., Certificate of Creditable Coverage) is required at enrollment.

You can add up any creditable coverage you had prior to enrollment in this Plan, but if you went for 95 days or more without any creditable coverage (excluding any excepted time periods outlined below), the coverage you had before the break will not be counted. Proof of such prior creditable coverage (e.g., Certificate of Creditable Coverage) is required before credit will be given.

What is Not Considered a Break in Coverage — For purposes of determining any significant break in coverage (i.e., 95 or more days), lapses in coverage due to any of the following situations will not be considered as part of a break:

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

Unless stated otherwise, if you do not elect or do not qualify for continued coverage (see “How to Continue Coverage”), coverage for the subscriber and his/her eligible family members ends on midnight on the earliest of the following dates (except in the case of fraud and unless specifically stated otherwise below, retirees and/or their covered family members are terminated at the end of the month following the date of the event):

- The date the member loses eligibility for coverage according to NMSU’s rules and regulations. If NMSU fails to notify BCBSNM or the subscriber fails to notify NMSU to remove an ineligible person from coverage by submitting a completed enrollment/change form to NMSU, BCBSNM may recover any benefit payments from the subscriber/provider who received such payments that were made on the ineligible person’s behalf. It is the subscriber’s responsibility to notify Benefit Services when a member loses eligibility status. If the member becomes ineligible due to rescinding his/her retirement and returning to active employment at NMSU, he/she will be dropped from the NMSU Retiree Plan.

- When a discontinuance form is signed and received by Benefit Services.

- At the end of the month when NMSU does not receive the premium payment for coverage from the subscriber on time. (Coverage will be suspended if premium is not paid when it is due. If premium is not received within 31 days after its due date, the affected member(s) will be terminated at the end of the last-paid billing period. Any claims received and paid for during the 31-day grace period will be billed to the subscriber.)

- At the end of the month when BCBSNM does not receive the applicable payment from NMSU, according to the agreement set forth in the Group Master Contract, on time. (Coverage will be suspended if amounts are not paid when due. If not received within 60 days after its due date, NMSU or the affected member(s) will be terminated at the end of the last-paid billing period. Any claims received and paid for during the 60-day grace period will be billed both to the subscriber and to NMSU.)

- On the day when the member materially fails to abide by the rules, policies, or procedures of this Plan or fraudulently provides or materially misrepresents information 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 covered family members, BCBSNM and NMSU may terminate the coverage of the subscriber and his/her covered family members retroactively to the date of initial enrollment. The subscriber is liable for any benefit payments made as a result of such improper actions.

- When the subscriber dies. (Surviving eligible spouses, domestic partners, and eligible children may remain covered under the NMSU health care plan under certain circumstances. Contact Benefit Services for details. If the surviving family members are not eligible for continued coverage, coverage ends on the last day of the month following the subscriber’s death.)

- At the end of the month prior to a retiree or his/her eligible family member becoming eligible for Medicare. (Such persons must enroll in the NMSU Carveout Plan. If not enrolled in Parts A and B of Medicare, the retiree and his/her eligible family members may be eligible for continued coverage under “How Coverage May Continue.”)

- At the end of the month prior to a retiree or retiree’s spouse or other eligible family member reaching age 65 (regardless of Medicare enrollment).(Such persons must enroll in the NMSU Carveout Plan if eligible
for Parts A and B of Medicare. Retirees and their eligible family members, including surviving family members, that are not enrolled in Parts A and B of Medicare may be eligible for continued coverage only as specified under “How Coverage May Continue.”)

- On the day when the member acts in a disruptive manner that prevents the orderly business operation of any participating provider or dishonestly attempts to gain a financial or material advantage.

- On the day when group coverage is discontinued for the entire group or for the retiree’s/surviving eligible family member’s enrollment classification.

- When NMSU gives BCBSNM a minimum 30 days’ advance written notice of contract termination, or BCBSNM gives NMSU a minimum 90 days’ advance written notice of contract termination.

If BCBSNM ceases operations, BCBSNM will be obligated to pay for covered services for the rest of the period for which premiums were already paid.

Notification — If the Group Master Contract is terminated or premiums are not submitted, coverage will terminate for all affected members as of the end of the last-paid billing period. BCBSNM will not notify the affected members of such terminations. (If NMSU fails to submit premium payments to BCBSNM, it is NMSU’s responsibility to advise members of BCBSNM Plan termination.)

Additional Family Member Termination Reasons

In addition, coverage will end for any covered family member in the following circumstances:

- When a child (including a surviving eligible child) no longer qualifies as an eligible family member under the Plan (e.g., a child is removed from placement in the home or reaches the eligible child age limit)

- The date of a final divorce decree or legal separation for a spouse

- The date the domestic partnership ends

- The date the eligible family member enters the armed forces for more than 30 days (or as provided by law).

To remove an ineligible family member from coverage, you must submit a completed and signed enrollment/change form to Benefit Services. The affected member will be removed from coverage on the last day of the month following his/her loss of eligibility.

If an eligible family member is being removed from a retiree’s or surviving spouse’s coverage because of losing his/her eligibility under the Plan, you should send the termination request to Benefit Services as soon as possible in order to have premiums adjusted in a timely manner and in order to ensure that claims are not paid for ineligible persons. If claims payments are made for an ineligible member (for example, due to late notification), BCBSNM and the providers of care may recover benefits erroneously paid on behalf of the ineligible person.

If You are a Continuation Member — Members covered under a continuation provision are subject to the same rules as retirees, but do not submit enrollment/change forms to NMSU. See “How to Continue Coverage” for the applicable address.
Reminder: Enrollment/change forms for COBRA federal continuation members are sent to HCSC.

Cancellation Appeals
BCBSNM will not terminate your coverage based solely on your health status or health care needs. If you believe that your coverage is being canceled due to health status or health care requirements, you may appeal cancellation to the NM Public Regulation Commission:

NM Public Regulation Commission, Insurance Division
P. O. Box 1269
Santa Fe, NM 87504-1269

You may also call the Insurance Division toll-free at 1-800-947-4722.

Voluntary Discontinuance of Coverage
To remove an eligible family member from coverage before his/her loss of eligibility or to voluntarily terminate your own coverage, you must submit a completed and signed Discontinuance form to NMSU (or to the state or federal continuation plan administrator, if applicable).

Voluntarily terminated members are not eligible for any federal continuation or conversion coverage.

If you are a retiree, you may voluntarily remove eligible family members from coverage at any time and your premiums will be adjusted as stated under “Premium Payments,” earlier in this section. Coverage will end at midnight on the last day of the month the signed and completed enrollment/change form is received by Benefit Services.

Retirees and their eligible family members (including surviving spouses and/or other eligible family members) and continuation subscribers/eligible family members who are voluntarily terminated before losing eligibility may not re-enroll at any time.

Re-Enrollment
A retiree who returns to work full-time and later re-retires may only continue coverage for eligible family members who were covered under the health plan at the time of re-retirement except as defined in the “Adding an eligible family member to Coverage” section. If coverage is voluntarily discontinued by a retiree or surviving eligible family member contract holder for self or for any covered family member, the retiree and/or the eligible family member may not re-enroll at any time.

Any individual whose previous BCBSNM contract was terminated for good cause is not eligible to re-enroll in this Plan, unless approved in writing by BCBSNM. (Members currently enrolled in continuation coverage may not re-enroll once coverage is terminated, unless eligibility under this Plan is re-established.)
How to Continue Coverage

If you lose coverage under this Plan, you may be able to continue coverage for a limited period of time. If you do not choose federal continuation coverage, your group health insurance will end, although you may still be eligible for continued coverage under an individual conversion plan offered by BCBSNM. **Note:** There are no late applications accepted under these provisions. You must enroll timely to qualify for continued coverage.

Federal Continuation Coverage (COBRA)

NMSU is subject to the provisions for continuation of Plan coverage under the 1985 federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA). Therefore, surviving eligible children, and the covered family members of retirees and surviving eligible children who lose eligibility under this group health care plan may be able to continue as members, without a health statement, for a limited period of time. You must pay premiums from the date of loss of group coverage.

This information is a summary of the law and therefore is general in nature. The law itself and the actual provisions of the medical plan must be consulted with regard to the application of these provisions in any particular circumstances. If you have any questions about the law, please contact NMSU Benefit Services.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage is provided subject to your eligibility for coverage under the medical plan. NMSU reserves the right to terminate your continuation coverage retroactively if you are determined ineligible.

Contact Benefit Services for details about enrolling in continuation coverage.

**Continuation Benefits** — If you choose federal continuation coverage, NMSU is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated retirees or family members. However, if the coverage for regular members changes, your continuation coverage will reflect the same change. For example, if the Plan’s deductible changes for regular members, your deductible will change by the same amount.

**Qualifying Events and Qualified Beneficiaries** — Anyone who voluntarily terminated coverage while still eligible or whose coverage was terminated for good cause (as defined in the Glossary) is not eligible for continued coverage under this provision.

Under provisions of the law, eligible family members(s) may continue coverage in the medical plan following certain “qualifying events.”

Eligible family members may choose to continue coverage until the last day of the month following 36 months after these “qualifying events”:

- an enrolled retiree’s death (However, surviving eligible family member benefits may be available to you as well. If you do obtain survivor spouse coverage, you are not a “qualified beneficiary” under this provision and would not be eligible for continuation coverage once you remarry and lose group coverage. Loss of coverage due to re-marriage of a surviving spouse is not a qualifying
event. A surviving eligible child would be eligible for continuation plan coverage if he/she subsequently loses group plan coverage due to a qualifying event.

- divorce or legal separation from an enrolled retiree (dissolution of domestic partnership is **not** a qualifying event, but domestic partners are eligible for continuation coverage under any other applicable event listed here)
- a child ceases to be an eligible child under the medical plan
- Medicare entitlement by retiree that causes eligible family members to lose continuation coverage (This provision is not applicable to NMSU retirees or their eligible family members. If a retiree becomes entitled to Medicare, the retiree transfers to the NMSU Carveout plan and eligible family members remain under this NMSU PPO 500 plan until either losing eligibility or until retiree loses NMSU coverage. If the retiree loses coverage, continuation coverage is available as stated in this section.)

The definition of “qualified beneficiary” for COBRA purposes also includes a child born to, or placed for adoption with, a covered retiree during the period of the retiree’s continuation coverage. Thus, once the newborn or adopted child is enrolled in continuation coverage pursuant to the Plan’s rules, the child will be treated like all other COBRA-qualified beneficiaries.

**Who is Not Eligible** — Unless approved in writing by BCBSNM, the following persons may **not** enroll in this continued coverage option:

- one who **voluntarily** terminated coverage while still eligible (Involuntary termination includes loss of coverage under the following situations only: legal separation, divorce, loss of eligible child eligibility status, death of the subscriber. Any other reason is considered voluntary.)
- an eligible family member who was removed from coverage by the subscriber while the family member was still eligible
- any member whose BCBSNM health care coverage was terminated for good cause (See the **Glossary**.)
- a surviving spouse who loses coverage due to remarriage

You are also not eligible to enroll for continuation coverage if:

- the employer stops offering this coverage to its retirees or their surviving family members), or
- you do not elect continuation coverage in a timely fashion.

**Notification Responsibilities** — The affected member has the responsibility to inform Benefit Services of a divorce, legal separation, or child losing eligible child status under the medical plan **within 60 days** of the date of the event or the date on which coverage would end under the program because of the event, whichever is later. In all other cases, (e.g., subscriber’s death or Medicare entitlement, divorce or legal separation, or other eligible family member loss of eligibility, such as a surviving spouse’s remarriage) the subscriber, his/her personal representative, or the affected eligible family member is responsible for ensuring that Benefit Services is notified in a timely manner.

When NMSU Benefit Services is notified that one of these events has happened, they will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above, or the date notice of your election rights is sent to you, whichever is later, to elect continuation coverage on the forms provided by NMSU Benefit Services.
Maximum Continuation Periods — This law requires that eligible family members of retirees be afforded the opportunity to maintain continuation coverage for 36 months.

Cost of Continuation Coverage — The cost of the coverage will not be more than 102 percent of the applicable group rate during the period of basic COBRA coverage.

Termination of Continuation Coverage — The law provides that your continuation coverage may be terminated for any of the following reasons:

- NMSU no longer provides group health coverage to any of its retirees or surviving eligible family members. (If this Plan is replaced by another health care plan, continuation coverage will also be replaced by the new plan.)

  Exception: If NMSU declares bankruptcy and you are covered under this Plan as a retiree, you and your eligible family members may be eligible for continued coverage.

- The premium for your continuation coverage is not paid on time.

- You become covered by another group plan that begins coverage after your COBRA election that:
  - does not contain any pre-existing condition exclusion or limitation applicable to you, or
  - contains any exclusions or limitations with respect to any pre-existing condition, but it does not apply to you or your covered family members (or it is satisfied by him or her) due to HIPAA.

- The continuation period expires. (If this NMSU plan is still being administered by BCBSNM, you will have the option of changing to the conversion coverage provided by BCBSNM and described on the next page.)

- You enroll in and become covered by Medicare. (Eligible family members who were covered under the continuation plan when you enrolled in Medicare would then be eligible to remain on COBRA continuation for up to 36 months of coverage, starting from the initial qualifying event.)

Once your continuation coverage terminates for any reason, it cannot be reinstated.

Conversion Option — At the end of the continuation coverage period, you must be allowed to enroll in an individual conversion health plan that is provided under the Plan (see below).

COBRA Premium Payments — Under the law, you have to pay the applicable premium for your continuation coverage. Premiums must be sent to:

Health Care Services Corporation
21806 Network Place
Chicago, IL 60673-1218

Premiums for coverage may change annually or on any date that the Plan is amended. Written notice of any such change will be given to NMSU at least 60 days before the effective date of the premium change. There is a grace period of at least 30 days for payment of the regularly scheduled premium (45 days for the initial payment for continuation coverage).
**Customer Service** — The COBRA administrator is Health Care Service Corporation. This corporation collects premium and administers eligibility only. Questions about your billing, premium, or eligibility under COBRA should be directed to:

**Health Care Service Corporation**  
P.O. Box 2387  
Danville, IL 61834-2387  
Toll-Free Telephone Number: 1-888-541-7107

**Reminder:** Do **not** send premiums or claims-related questions to the above address.

**Conversion to Individual Coverage**

Involuntarily terminating members may change to individual (direct-pay) conversion coverage if this employer group health care plan is still in effect and coverage is lost due to one of the following circumstances:

- a member no longer meets the eligibility requirements of the employer sponsoring the plan
- the period of federal continuation coverage expires
- an eligible family member loses coverage for one of the following reasons:
  - divorce or legal separation from the subscriber
  - disqualification of the member under the definition of an eligible family member
  - death of the subscriber

The subscriber and any eligible family members *who were covered* at the time that group coverage was lost are eligible to apply for conversion coverage without a health statement.

BCBSNM must receive your application for conversion coverage **within 31 days** after you lose eligibility under the group/continuation plan. **You must pay conversion coverage premiums from the date of such termination.**

Conversion coverage is **not** available in the following situations:

- when group coverage under this plan was discontinued for the entire group or the employee’s enrollment classification
- when you reside outside of or move out of New Mexico (Call BCBSNM for details on transferring coverage to the Blue Cross Blue Shield Plan in the state where you are living.)

If you are entitled to Medicare, your conversion coverage option is limited to a Medicare Supplement Plan administered by BCBSNM. Depending upon your age and the Plan you select, a health statement may be required and a pre-existing conditions limitation may apply. (The options for members under age 65 are limited.) Call a Customer Service representative for the enrollment options available to you.

The benefits and premiums for conversion coverage will be those available to terminated health care plan members on your coverage termination date. You will receive a new benefit booklet if you change to conversion coverage. (Some benefits of this plan are not available under conversion coverage.) Contact a Customer Service representative for details.
General Provisions

Application Statement
No statement (except a fraudulent statement) you make in any application for coverage that is more than two years old can void this coverage or be used against you in any legal action or proceeding relating to this coverage unless the application or a true copy of it is incorporated in or attached to the contract.

Availability of Provider Services
BCBSNM does not guarantee that a certain type of room or service will be available at any hospital or other facility within the BCBSNM network, nor that the services of a particular hospital, physician, or other provider will be available.

BlueExtrasSM
Certain local and national retailers, outlets, and businesses offer BCBSNM health plan members an opportunity to save money on services that are not covered under the health plan. These discount offers and other services are not part of the medical/surgical health care plan benefits described in your benefit booklet and the entities making the offers and the providers of the services may not be affiliated or associated with BCBSNM or your health care plan. However, from time to time, BCBSNM will be announcing such offers by sending manufacturer or retail discount coupons to member households, inserting information into Member Newsletters, or mailing descriptions of various programs being offered to our members by businesses such as health clubs, pharmacies, vision care providers, hearing aid retailers, etc. These mailings may contain coupons or offers that enable you, at your discretion, to purchase the described product or enroll in a certain program at a discount or at no charge. The retailer, provider, or manufacturer may pay for and/or provide the content for this information. The discounts and services available to members may change at any time and BCBSNM does not guarantee that a particular discount or service will be available at a given time. For details of current discounts available, please contact a Customer Service representative by calling the phone number on the back of your ID card or by visiting our offices in Albuquerque at 4373 Alexander Blvd. NE.

Changes to the Benefit Booklet
BCBSNM may amend this benefit booklet when authorized by an officer of BCBSNM. BCBSNM will give your group at least 30 days’ prior written notice of an amendment to this 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.

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. BCBSNM is not liable for any loss or injury caused by any health care provider by reason of negligence or otherwise.
Disclosure and Release of Information
BCBSNM will only disclose information as permitted or required under state and federal law.

Entire Contract
This benefit booklet (and any amendments, riders, and endorsements), your group enrollment/change application, and your identification card shall constitute the entire contract. All statements, in the absence of fraud, made by any applicant shall be deemed representations and not warranties. No such statements shall void coverage or reduce benefits unless contained in a written application for coverage.

Execution of Papers
On behalf of you and your eligible family members 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 NMSU is that of independent contractors; NMSU is not an agent or employee of BCBSNM, and BCBSNM and its employees are not employees or agents of NMSU.

Member Rights and Responsibilities
As a member enrolled in a managed health care plan administered by BCBSNM, you have these rights:

- The right to available and accessible services when medically necessary
- The right to be treated with courtesy and consideration, and with respect for your dignity and your need for privacy.
- The right to be provided with information concerning BCBSNM’s policies and procedures regarding products, services, providers, appeals procedures and other information about the company and the benefits provided.
- The right to 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 this decision have been explained in language you understand.
- The right to receive from your physician(s) or provider, in terms that you understand, an explanation of your complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, irrespective of BCBSNM’s position on treatment options. If you are not capable of understanding the information, the explanation shall be provided to your next of kin, guardian, agent or surrogate, if able, and documented in your medical record.
The right to prompt notification of termination or changes in benefits, services or provider network.

The right to file a complaint or appeal with BCBSNM or with the New Mexico Superintendent of Insurance and to receive an answer to those complaints in accordance with existing law.

The right to privacy of medical and financial records maintained by BCBSNM and health care providers contracted with BCBSNM, in accordance with existing law.

The right to request information about any financial arrangements or provisions between BCBSNM and its network providers that may restrict referral or treatment options or limit the services offered to members.

The right to adequate access to qualified health professionals for the treatment of covered conditions who are near your work or home within New Mexico.

The right to affordable health care, including the right to seek care from an out-of-network provider, and an explanation of your financial responsibility when services are provided by an out-of-network provider, or provided without required prior approval.

The right to detailed information about coverage, maximum benefits, and 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 receive an approved example of the financial responsibility incurred by you when going out-of-network (see “PPO Plan: Provider Payment Examples,” on page 73, for example).

The right to a complete explanation of why care is denied, an opportunity to appeal the decision to BCBSNM’s internal review, the right to a secondary appeal, and the right to request the assistance of the Superintendent of Insurance.

As a member enrolled in a managed health care plan administered by BCBSNM, you have these responsibilities:

The responsibility to supply information (to the extent possible) that BCBSNM and its network practitioners and health care providers need in order to provide care.

The responsibility to follow plans and instructions for care that you have agreed on with your treating provider or practitioners.

The responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals with your treating provider or practitioner to the degree possible.

**Provider Network**

Network providers are not required to comply with any specified numbers, targeted averages, or maximum durations of patient visits. You will not be held liable to a network provider for any sums owed to the provider by BCBSNM.
Glossary

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

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

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

**Admission** — The period of time between the dates when a patient enters a facility as an inpatient and is discharged as an inpatient. (If you are an inpatient at the time your coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date.)

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

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

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

**Ambulatory surgical facility** — An appropriately licensed provider, with an organized staff of physicians, that meets all of the following criteria:
- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis; and
- provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility; and
- does not provide inpatient accommodations; and
- is not a facility used primarily as an office or clinic for the private practice of a physician or other provider.

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

**Applied behavioral analysis (ABA)** — Services that include behavior modification training programs that are based on the theory that behavior is learned through interaction between an individual and the environment. The goal
of behavior management is to reinforce and increase desirable, functional behaviors while reducing undesirable, “maladaptive” behaviors. Services would not apply to children over the age of seven.

**Autism Spectrum Disorder** — A condition that meets the diagnostic criteria for the pervasive developmental disorders published in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision, also known as *DSM-IV-TR*, published by the American Psychiatric Association, including autistic disorder; Asperger’s disorder; pervasive development disorder not otherwise specified; Rhett’s disorder; and childhood integrative disorder.

**Benefit booklet** — This document or evidence of coverage, which explains the benefits, limitations, exclusions, terms, and conditions of your health coverage.

**Blue Cross and Blue Shield of New Mexico (BCBSNM)** — BCBSNM is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

**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.

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

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

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

**Certified nurse practitioner** — A registered nurse whose qualifications are endorsed by the Board of Nursing for expanded practice as a certified nurse practitioner and whose name and pertinent information is entered on the list of certified nurse practitioners maintained by the Board of Nursing.
**Cessation counseling** — As applied to the “Smoking/Tobacco Use Cessation” benefit described in Section 3, cessation counseling means a program, including individual, group, or proactive telephone quit line, that:

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

**Chemical dependency** — Conditions defined by patterns of usage that continue despite occupational, marital, or physical problems that are related to compulsive use of alcohol, drugs, or other substance. Chemical dependency (also referred to as “substance abuse,” which includes alcoholism and drug abuse) may also be defined by significant risk of severe withdrawal symptoms if the use of alcohol, drugs, or other substance is discontinued. Drug abuse does not include nicotine addiction or alcohol abuse.

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

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

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

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

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

**Consumer Advisory Board** — BCBSNM has established a Consumer Advisory Board to provide input from the member’s point-of-view about BCBSNM’s general operations and internal policies and to identify areas that need improvement.

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

**Cosmetic** — See the “Cosmetic Services” exclusion in Section 4.
**Cost effective** — A procedure, service, or supply that is an economically efficient use of resources, relative to the benefits and harms associated with the procedure, service, or supply. When determining cost effectiveness, the situation and characteristics of the individual patient are considered.

**Covered charge** — See “Claims Payment Provisions” in Section 6.

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

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

**Deductible** — The amount of money that you must pay in a calendar year before this Plan pays benefits for all or part of your remaining covered charges incurred during the rest of the calendar year. Your deductible is indicated on the Summary of Benefits.

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

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

**Dependent** — A person entitled to apply for coverage as specified in Section 7: Enrollment and Termination Information. (See “eligible family member” in Section 7: Enrollment and Termination Information.)

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

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

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

**Domestic partner** — See Section 7.
**Drug abuse** — A condition defined by patterns of usage that continue despite occupational, marital, or physical problems related to compulsive use of drugs or other substance. There may also be significant risk of severe withdrawal symptoms if the use of drugs or other substance is discontinued. Drug abuse does not include nicotine addiction or alcohol abuse.

**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.

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

**Emergency** — Medical or surgical procedures, treatments, or services delivered 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. (In addition, services must be received in an emergency room, trauma center, or ambulance to qualify as an emergency.)

**Experimental, investigational, or unproven** — See the “Experimental, Investigational, or Unproven” exclusion in Section 4.

**Facility** — A hospital (see “Hospital,” on the next page) or other institution (see “Provider,” later in this section).

**Genetic inborn error of metabolism** — A rare, inherited disorder that is present at birth; if untreated, results in mental retardation or death, and requires that the affected person consume special medical foods.

**Good cause** — Failure of the subscriber to pay the premiums 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.

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

**Group** — A bonafide employer covering employees or retirees 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.

**Group Master Application** — The application for coverage completed by NMSU.

**Group Master Contract** — A contract for health care services which by its terms limits eligibility to members of a specified group. The Group Master
Contract includes the group application for coverage and may include coverage for eligible family members.

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

**Home health care agency** — An appropriately licensed provider that both:
- brings skilled nursing and other services on an intermittent, visiting basis into your home in accordance with the licensing regulations for home health care agencies in New Mexico or in the state where the services are provided; and
- is responsible for supervising the delivery of these services under a plan prescribed and approved in writing by the attending physician.

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

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

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

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

**Hospital** — A health institution offering facilities, beds, and continuous services 24 hours a day, 7 days a week. The hospital must meet all licensing and certification requirements of local and state regulatory agencies. Services provided include:
- diagnosis and treatment of illness, injury, deformity, abnormality, or pregnancy
- clinical laboratory, diagnostic x-ray, and definitive medical treatment provided by an organized medical staff within the institution
- treatment facilities for emergency and surgical services either within the institution or through a contractual arrangement with another licensed hospital (These contracted services must be documented by a well-defined plan and related to community needs.)
A hospital is not, other than incidentally, a skilled nursing facility, nursing home, custodial care home, health resort, spa, or sanatorium; is not a place for rest, the aging, or the treatment of mental illness, alcoholism, drug abuse, or pulmonary tuberculosis; ordinarily does not provide hospice or rehabilitation care; and is not a residential treatment facility.

**Identification card (ID card)** — The card BCBSNM issues to the subscriber that identifies the cardholder as a Plan member.

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

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

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

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

**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, miscarriage, or Cesarean section. See “Maternity Services and Newborn Care” in Section 3 for more information.

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

**Medical detoxification** — Treatment for withdrawal from the physiological effects of chemical dependency (alcoholism or drug abuse).

**Medical policy** — A coverage position developed by BCBSNM that summarizes the scientific knowledge currently available concerning new or existing technology, products, devices, procedures, treatment, services, supplies, or drugs and used by BCBSNM to adjudicate claims and provide benefits for covered services. Medical policies are posted on the BCBSNM Web site for review or copies of specific medical policies may be requested in writing from an NMSU DSU representative.

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

**Medically necessary, medical necessity** — See “Medically Necessary Services” at the beginning of Section 3.
Medicare — The program of health care for the aged, end-stage renal disease (ESRD) patients, and disabled persons established by Title XVIII of the Social Security Act of 1965, as amended.

Member — The enrollee (the subscriber or any eligible family member) who is enrolled for coverage and entitled to receive benefits under this Plan in accordance with the terms of the Group Master Contract. Throughout this booklet, the terms “you” and “your” refer to each member.

Mental disorder — A clinically significant behavioral or psychological syndrome or condition that causes distress and disability and for which improvement can be expected with relatively short-term treatment. Mental disorder does not include developmental disabilities, autism spectrum disorders, drug or alcohol abuse, or learning disabilities.

Nonparticipating provider — An appropriately licensed health care provider that has not contracted directly or indirectly, for the service being provided, with BCBSNM.

Nonpreferred provider — Either a provider that: 1) has contracted, for the service being provided, as a “participating” provider, but does not have the special “preferred provider” contract with BCBSNM, or 2) has not contracted with BCBSNM in any capacity for the service being provided (nonparticipating provider). Note: See your Summary of Benefits for those services that are not covered if received from a nonpreferred provider.

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.

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

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.

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.

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

Participating pharmacy — A retail supplier that has contracted with BCBSNM or its authorized representative to dispense covered prescription drugs and medicines, insulin, diabetic supplies, special medical foods, and enteral nutritional products to Plan members, and that has contractually accepted the
terms and conditions as set forth by BCBSNM and/or its authorized representative. They belong to the Retail Pharmacy Network.

**Participating provider** — Any provider (see “Provider,” below) that for the service being provided, contracts with BCBSNM, a BCBSNM contractor or subcontractor, another Blue Cross Blue Shield (BCBS) Plan, or the national BCBS transplant network.

**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).

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

**Physician** — A practitioner of the healing arts, which is defined as a doctor of medicine (M.D.) or osteopathy (D.O.) who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

**Plan** — The New Mexico State University Group PPO 500 Plan, as amended from time to time.

**Podiatrist** — A licensed doctor of podiatric medicine (D.P.M.). A podiatrist treats conditions of the feet.

**PPO Primary Provider (PPP)** — See “Provider,” below.

**Pregnancy-related services** — See “Maternity,” earlier in this section.

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

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

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

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

- **Health care facility**: An institution providing health care services, including a hospital or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing facility, a home health care agency, a diagnostic laboratory or imaging center, and a rehabilitation or other therapeutic health setting.

- **Professional provider**: A physician or health care practitioner, including a pharmacist, who is licensed, certified, or otherwise authorized by the state to provide health care services consistent with state law.
This Plan includes three different networks of providers. A provider may belong to one or more networks, but if you want to visit a network provider, you must choose the provider from the appropriate network:

- **Preferred provider**: These providers have contracted, for the service being provided, with BCBSNM or the behavioral health services administrator to provide services covered under the Preferred Provider level of benefit. They belong to the BCBSNM Preferred Provider (PPO) Network. These providers have agreed to accept the payment provided in accordance with the provisions of the contract.

  - **PPO Primary Provider** or **PPP**: Preferred providers in the following medical specialties only: Family Practice, General Practice; Internal Medicine; Obstetrics/Gynecology; Gynecology; and Pediatrics. PPPs do not include physicians or other health care professionals specializing in any other fields such as Obstetrics only, Geriatrics, Pediatric Surgery, or Pediatric Allergy. Covered PPP office visits are subject to the “PPP Office Visit Copayment” described in Section 2. All other covered services received from these providers, including additional services received during the office visit, are subject to the Preferred Provider deductible, coinsurance, and out-of-pocket limit provisions described in Section 2.

  - **Preferred provider specialists or facilities**: Preferred providers that are not “PPPs” as defined above. When you visit these providers, covered charges are subject to the Preferred Provider deductible, coinsurance, and out-of-pocket limits described in Section 2.

- **Transplant providers**: These providers have contracted with BCBSNM through the Blue Cross and Blue Shield Association to provide transplant services covered under this health care plan. They belong to the National BCBS Transplant Network.

- **Participating pharmacy**: A retail supplier that has contracted with BCBSNM or its authorized representative to dispense covered prescription drugs and medicines, insulin, diabetic supplies, special medical foods, and enteral nutritional products to Plan members, and that has contractually accepted the terms and conditions as set forth by BCBSNM and/or its authorized representative. They belong to the Retail Pharmacy Network.

In all cases, the provider agrees to provide health care services to members with an expectation of receiving payment (other than copayments, coinsurance, or deductibles) directly or indirectly from BCBSNM (or other entity with whom the provider has contracted). A network provider agrees to bill BCBSNM (or other contracting entity) directly and to accept this Plan’s payment (provided in accordance with the provisions of the contract) plus the member’s share (coinsurance, deductibles, copayments, etc.) as payment in full for covered services. BCBSNM (or other contracting entity) will pay the network provider directly. BCBSNM (or other contracting entity) may add, change, or terminate specific network providers at its discretion or recommend a specific provider for specialized care as medical necessity warrants.

**Psychiatric hospital** — A psychiatric facility licensed as an acute care facility or a psychiatric unit in a medical facility that is licensed as an acute care facility. Services are provided by or under the supervision of an organized staff of physicians. Continuous 24-hour nursing services are provided under the supervision of a registered nurse.
Pulmonary rehabilitation — An individualized, supervised physical conditioning program. Occupational therapists teach you how to pace yourself, conserve energy, and simplify tasks. Respiratory therapists train you in bronchial hygiene, proper use of inhalers, and proper breathing.

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

Reconstructive surgery — Reconstructive surgery improves or restores bodily function to the level experienced before the event that necessitated the surgery, or in the case of a congenital defect, to a level considered normal. Such surgeries may have a coincidental cosmetic effect.

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

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

Residential treatment center — See the “Noncovered Providers of Service” exclusion in Section 4.

Respiratory therapist — A person qualified for employment in the field of respiratory therapy. A respiratory therapist assists patients with breathing problems.

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

Routine patient care cost — For purposes of the cancer clinical trial benefit described in Section 3 under “Medical Therapy,” a “routine patient care cost” means a medical service or treatment that is covered under a health plan that would be covered if you were receiving standard cancer treatment, or an FDA-approved drug provided to you during a cancer clinical trial, but only to the extent that the drug is not paid for by the manufacturer, distributor, or provider of the drug. Note: For a covered cancer clinical trial, it is not necessary for the FDA to approve the drug for use in treating your particular condition.) A “routine patient care cost” does not include the cost of any investigational drug, device, or procedure, the cost of a non-health care service that you must receive as a result of your participation in the clinical trial, costs for managing the research, costs that
would not be covered or that would not be rendered if non-investigational treatments were provided, or costs paid or not charged for by the trial providers.

**Routine screening colonoscopy/mammogram** — Tests to screen for occult colorectal and/or breast cancer in persons who, at the time of testing, are not known to have active cancer of the colon or breast, respectively. (If there is a history of colon or breast cancer, for the purposes of the “Preventive Services” benefit, a cancer is no longer active if there has been no treatment for it and no evidence of recurrence for the previous three years.) Routine screening tests are performed at defined intervals based on recommendations of national organizations as summarized in the BCBSNM Preventive Care Guidelines. Routine screening tests do not include tests (sometimes called “surveillance testing”) intended to monitor the current status or progression of a cancer that is already diagnosed.

Routine screening mammography does **not** include “diagnostic mammography” which is a mammogram done after an abnormal finding has first been detected, or screening the opposite breast when the other breast has cancer. Routine colonoscopy does **not** include colonoscopy done for follow-up of colon cancer. A colonoscopy is still considered screening if, during the colonoscopy, previously **unknown** polyps are removed. Colonoscopies performed to remove **known** polyps are not routine screening colonoscopies. Routine screening colonoscopy does not include upper endoscopy (esophagastroduodenal endoscopy), sigmoidoscopy, or computerized tomographic colongraphy (sometimes referred to as “virtual colonoscopy”).

**Note:** BCBSNM Preventive Care Guidelines may be found at our Web site:

www.bcbsnm.com/Members/Health and Wellness

**Short-term rehabilitation** — Occupational, physical, and speech therapy techniques that are medically necessary to restore and improve lost bodily functions following illness or injury. (This does not include alcoholism or drug abuse rehabilitation.)

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

**Skilled nursing facility** — A facility or part of a facility that:
- is licensed in accordance with state or local law; and
- is a Medicare-participating facility; and
- is primarily engaged in providing skilled nursing care to inpatients under the supervision of a duly licensed physician; and
- provides continuous 24-hour nursing service by or under the supervision of a registered nurse; and
- does **not** include any facility that is primarily a rest home, a facility for the care of the aged, or for treatment of chemical dependency, mental disease, or tuberculosis, or for intermediate, custodial, or educational care.
**Special care unit** — A designated unit that has concentrated facilities, equipment, and supportive services to provide an intensive level of care for critically ill patients. Examples of special care units are intensive care unit (ICU), cardiac care unit (CCU), subintensive care unit, and isolation room.

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

**Speech therapist** — A speech pathologist certified by the American Speech and Hearing Association. A speech therapist assists patients in overcoming speech disorders.

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

**Subscriber** — The individual whose retirement from NMSU is the basis for enrollment eligibility, or the person in whose name the contract is issued. The term “subscriber” may also encompass other persons in a nonemployee relationship with NMSU (e.g., COBRA members, surviving eligible family member contract holders).

**Summary of Benefits** — The schedule, beginning on page iv, that defines your copayment, deductible, coinsurance, and out-of-pocket requirements, annual and lifetime benefit limits, and provides an overview of covered services.

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

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

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

**Transplant** — 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, and received within one year of the transplant or retransplant.

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

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your possible right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan.

This notice generally explains:

- COBRA continuation coverage;
- when it may become available to you and your family if your employer group is subject to the provisions of COBRA, and
- what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice gives only a summary of COBRA continuation coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator or see Section 7 of this benefit booklet.

The Plan Administrator of the Plan is named by the employer or by the group health plan. Either the Plan Administrator or a third party named by the Plan Administrator is responsible for administering COBRA continuation coverage. Contact your Plan Administrator for the name, address, and telephone number of the party responsible for administering your COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and eligible children of employees may be qualified beneficiaries. Under the Plan, generally most qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Contact your employer and/or COBRA Administrator for specific information for your Plan.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.
Your eligible children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “eligible child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to NMSU, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse, and eligible children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

The employer must notify the Plan Administrator within 30 days when the qualifying event is:

- The end of employment or reduction of hours of employment;
- The death of the employee;
- With respect to a retired employee health coverage, commencement of a proceeding in bankruptcy with respect to NMSU; or
- The enrollment of the employee in Medicare (Part A, Part B, or both).

For the other qualifying events (divorce or legal separation of the employee and spouse or a eligible child losing eligibility for coverage as a eligible child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact NMSU and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage may last for up to 36 months when the qualifying event is:

- The death of the employee;
- The enrollment of the employee in Medicare (Part A, Part B, or both);
- Your divorce or legal separation; or
- A eligible child losing eligibility as a eligible child.

When the qualifying event is the end of employment or reduction in hours of employment, COBRA continuation coverage generally lasts for up to 18 months for the employee and other qualified beneficiaries (however, if the employee became entitled to Medicare less than 18 months before his/her loss of employment or reduction in hours, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of the employee’s Medicare entitlement). There are two ways in which this 18-month period of COBRA continuation can be extended:
Disability Extension of 18-month Period of Continuation Coverage — If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that your Plan Administrator is notified of the Social Security Administration’s determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Contact NMSU and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage — If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and eligible children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice is properly given to the Plan. This extension may be available to the spouse and any eligible children receiving continuation coverage if the employee or former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated, or if the eligible child stops being eligible under the Plan as a eligible child – but only if the second event would have caused the spouse or eligible child to lose coverage under the Plan had the first qualifying event not occurred.

In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. Contact NMSU and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

If You Have Questions
If you have questions about COBRA continuation coverage, contact the Plan Administrator or the nearest Regional or District Office of the U. S. Department of Labor’s Employee Benefits Security Administration (EBSA). Addresses and phone number of Regional and District EBSA Offices are available through EBSA’s Web site at www.dol.gov/ebsa.

In order to protect your family’s rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Plan Administrator.
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 New Mexico State University (NMSU) and Blue Cross and Blue Shield of New Mexico (BCBSNM) includes the following documents:
- this benefit booklet and any amendments, riders, or endorsements;
- the enrollment/change form(s) for the subscriber and his/her eligible family members; and
- the members' identification card.

In addition, NMSU has important documents that are part of the legal agreement:
- the Group Master Application from the employer; and
- the Group Master Contract between BCBSNM and NMSU.

The above documents constitute the entire legal agreement between BCBSNM and NMSU. 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. You will be notified of any changes to this benefit booklet at least 30 days before the changes become effective.
Blue Cross and Blue Shield of New Mexico
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Web site: www.bcbsnm.com
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