Benefit Booklet

New Mexico State University Medicare Carveout
for New Mexico State University Retirees and Their Eligible Dependents
Customer Assistance

Customer Service and Claims — 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 5:00 P.M. the next business day.) Please have your ID card handy when calling.

Street address: 4373 Alexander Blvd. NE
Toll-Free Telephone Number: 1-866-369-NMSU (6678)
Send all correspondence and claims* to:
Blue Cross and Blue Shield of New Mexico, Attention: NMSU DSU
Mailing address: P.O. Box 27630
Albuquerque, NM 87125-7630

*Claims for items covered under the separate prescription drug plan should be sent to the prescription drug plan administrator.

Health Services: Prior Approvals — For prior approvals, call a BCBSNM Health Services representative, Monday through Friday, between 8 A.M. and 5 P.M., MST.

BCBSNM Health Services
(505) 291-3585 or 1-800-325-8334

Note: If you need prior approval assistance between 5 P.M. and 8 A.M. or on weekends, call an NMSU DSU representative at 1-866-369-6678.

Web Site — For 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.
To All Eligible Retirees

This benefit booklet contains a summary description of the health care coverage that the New Mexico State University (NMSU) provides in the Carveout Plan, underwritten by Blue Cross and Blue Shield of New Mexico (BCBSNM). These benefits are available to all eligible retirees and their dependents and to eligible surviving dependents of deceased retirees/employees who meet the criteria described in Section 2.

Please take some time to get to know your 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 comprehensive 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.
# Table of Contents

## Customer Assistance
- Inside front cover

## To All Eligible Retirees
- i

## Summary of Benefits: 09/01/08
- iv

## 1 How to Use This Booklet
- 1
  - Summary of Benefits
  - Other Benefit-Related Materials
  - Using the Informational Graphics
  - Designated Customer Service

## 2 Enrollment and Termination
- 4
  - Eligibility and Enrollment Assistance
  - Eligible Retirees
  - Eligible Dependents
  - Notification of Eligibility and Address Changes

## 3 Carveout Plan Basics
- 21
  - Plan Overview
  - Medicare-Covered Services
  - Other Plan-Covered Services
  - Medical Necessity

## 4 Medicare-Covered Services
- 28
  - "Assigned" vs. "Non-Assigned"
  - What is Covered and Not Covered

## 5 Other Plan-Covered Services
- 33
  - Services Not Covered By Medicare
  - Privately Contracting
  - Government Facilities
  - Prior Approvals
  - Covered Services
  - Acupuncture/Spinal Manipulation
  - Ambulance Services
  - Dental-Related/TMJ Services and Oral Surgery
  - Emergency and Urgent Care
  - Home Health Care and Home I.V.
  - Hospice Care
  - Hospital/Other Facility Services
  - Blood Services
  - Inpatient Medical/Surgical
  - Inpatient Physical Rehabilitation
  - Skilled Nursing Facility Services
  - Outpatient Facility Services
  - Lab, X-Ray, Other Diagnostic
  - Massage Therapy
  - Pregnancy-Related/Maternity
  - Mental Health/Chemical Dependency
  - Physician Visits/Medical Care
  - Inpatient Physician Visits
  - Office, Outpatient, and Home
  - Preventive Exams/Routine Tests
  - Rolfing
  - Smoking/Tobacco Use Cessation
  - Supplies, Equipment, Prosthetics
  - Surgery and Related Services
  - Surgeon’s Services
  - Anesthesia Services
  - Assistant Surgeon Services
  - Therapy, Outpatient or Office
  - Cardiac Rehabilitation
  - Chemotherapy, Dialysis, Radiation
  - Physical, Occupational, Speech

## 6 General Limitations and Exclusions
- 63
  - Admissions/Treatments Discontinued
  - Before Effective Date of Coverage
  - Biofeedback
  - Blood Services
  - Cochlear Implants
  - Complications of Noncovered Services
  - Convalescent Care or Rest Cures
  - Cosmetic Services
  - Custodial Care
  - Dental-Related/TMJ Services and Oral Surgery

## Covered Charges
- 30

---

Covered Charges: 30

5 Other Plan-Covered Services: 33

Services Not Covered By Medicare: 33

Privately Contracting: 33

Government Facilities: 34

Prior Approvals: 34

Covered Services: 37

Acupuncture/Spinal Manipulation: 37

Ambulance Services: 37

Dental-Related/TMJ Services and Oral Surgery: 38

Emergency and Urgent Care: 41

Home Health Care and Home I.V.: 41

Hospice Care: 42

Hospital/Other Facility Services: 44

Blood Services: 45

Inpatient Medical/Surgical: 45

Inpatient Physical Rehabilitation: 46

Skilled Nursing Facility Services: 46

Outpatient Facility Services: 46

Lab, X-Ray, Other Diagnostic: 47

Massage Therapy: 47

Pregnancy-Related/Maternity: 47

Mental Health/Chemical Dependency: 48

Physician Visits/Medical Care: 50

Inpatient Physician Visits: 51

Office, Outpatient, and Home: 51

Preventive Exams/Routine Tests: 52

Rolfing: 52

Smoking/Tobacco Use Cessation: 53

Supplies, Equipment, Prosthetics: 53

Surgery and Related Services: 57

Surgeon’s Services: 57

Anesthesia Services: 58

Assistant Surgeon Services: 59

Therapy, Outpatient or Office: 60

Cardiac Rehabilitation: 60

Chemotherapy, Dialysis, Radiation: 60

Physical, Occupational, Speech: 61

Prescription Drugs and Other Items: 61

6 General Limitations and Exclusions: 63

Admissions/Treatments Discontinued: 63

Before Effective Date of Coverage: 63

Biofeedback: 63

Blood Services: 63

Cochlear Implants: 63

Complications of Noncovered Services: 63

Convalescent Care or Rest Cures: 64

Cosmetic Services: 64

Custodial Care: 64

Dental-Related/TMJ Services and Oral Surgery: 64
Domiciliary Care .................................. 64
Duplicate (Double) Coverage .................. 65
Experimental, Investigational, Unproven .... 65
Food or Lodging Expenses ........................ 66
Foot Care ......................................... 66
Government Facility Services .................... 66
Hair Loss Treatments ............................... 66
Hearing Exams, Procedures, or Aids ........... 66
Hypnotherapy ...................................... 66
Infertility Services/Artificial Conception ..... 67
Late Claims Filing .................................. 67
Learning Deficiencies/Behavioral ............... 67
Limited Services/Covered Charges .............. 67
Local Anesthesia .................................... 67
Long-Term or Maintenance Therapy ........... 67
Medical Policy Determinations .................. 68
Medically Unnecessary Services ............... 68
Medicare-Denied Services ........................ 68
No Legal Payment Obligation .................... 68
Noncovered Providers of Service ............... 68
Nonmedical Expenses ............................. 69
Nonparticipating Facility Services ............. 70
Obesity Treatment .................................. 70
Post-Termination Services ....................... 70
Prescription Drugs and Other Items ........... 70
Prior Approval Not Obtained ..................... 70
Private Duty Nursing Services .................. 70
Private Room Expenses ........................... 71
Services Not Identified ............................ 71
Sex-Change Operations or Services ............ 71
Sexual Dysfunction Treatment ................. 71
Supplies, Equipment, and Prosthetics ......... 71
Surgery and Related Services ................... 71
Therapy and Counseling Services .............. 71
Thermography ...................................... 72
Transplant Services ................................ 72
Travel or Transportation .......................... 72
Vision Services ..................................... 72
War-Related Conditions ........................... 72
Weight Management ................................ 72
Work-Related Conditions ......................... 73

7 Claims, Claims Payments, Appeals .......... 74
  Filing Claims ..................................... 74
  An Important Note ................................ 74
  If You Have Other Coverage ................... 74
  Medicare-Covered Facility Services .......... 75
  Medicare-Covered Professional ............... 75
  Services Not Covered by Medicare .......... 75
  Itemized Bills .................................... 76
  Where to Send Claim Forms ..................... 77
  Advance Benefit Information .................... 77
  How Payments Are Made ........................ 77
  BlueCard Program ................................ 78
  Medicaid .......................................... 79
  Assignment of Benefits ........................ 79
  Accident-Related Hospital Services ........ 79
  Overpayments .................................... 79
  Request for Medicare Reconsideration ...... 79
  Request for BCBSNM Reconsideration ....... 80
  Arbitration ....................................... 80
  Application Statement .......................... 80
  BlueExtrasSM ..................................... 81
  Disclosure and Release of Information ...... 81
  Entire Contract ................................... 81
  Changes to the Benefit Booklet ............... 81
  Disclaimer of Liability ........................ 82

8 Glossary ......................................... 83

COBRA Continuation Coverage ................ 95
Summary of Benefits: 09/01/08

The following are the highlights of the NMSU Carveout Plan. Any services received must be medically necessary to be covered.

<table>
<thead>
<tr>
<th>Benefit Highlights</th>
<th>Services Covered by Medicare</th>
<th>Services Not Covered By Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>When provider accepts Medicare assignment or facility is Medicare-participating, you pay:</td>
<td>When provider does not accept Medicare assignment or facility is not Medicare-participating, you pay:</td>
</tr>
<tr>
<td>Highlights of Cost-Sharing Features</td>
<td>Calendar year deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Calendar year out-of-pocket limit</td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td>All Medicare deductible &amp; coinsurance amounts are paid in full; there is no out-of-pocket amount.</td>
<td>Includes the annual Plan deductible of $100 and the 20% coinsurance amounts paid by you under this level of coverage; does not include amounts over the covered charge or noncovered services.</td>
</tr>
<tr>
<td>Your copayment/coinsurance after the calendar year deductible</td>
<td>None</td>
<td>20% of Medicare’s limiting charge (115% of Medicare allowable)</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited (Certain services are subject to calendar year and/or lifetime maximums.)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Description of Service and Limitations</th>
<th>When Assignment is Accepted, You Pay:</th>
<th>Assignment Not Accepted</th>
<th>Services Not Covered by Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHYSICIAN SERVICES</td>
<td></td>
<td>Assignment Not Accepted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient and Office Medical/ Surgical</td>
<td>Office visits, including allergy testing and treatment, surgery, radiologist, pathology</td>
<td>-0-</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>Preventive services, including gynecological exam and flu shots</td>
<td>-0-</td>
<td>20%</td>
<td>20% (additional $200 per calendar year maximum)</td>
</tr>
<tr>
<td></td>
<td>Chemotherapy, radiation therapy, other therapeutic services</td>
<td>-0-</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>Laboratory &amp; x-ray (including routine Pap tests and mammograms if preventive services benefit is exhausted)</td>
<td>-0-</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>Emergency room visit</td>
<td>-0-</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Inpatient Medical/Surgical</td>
<td>Medical visits, consultations, surgeon, assistant, radiology, anesthesiologist, pathologist</td>
<td>-0-</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>HOSPITAL/TREATMENT FACILITY SERVICES</td>
<td>Hospitalization (includes semi-private room, board, drugs, medications, and ancillaries)</td>
<td>-0-</td>
<td>N/A - Medicare will not pay nonparticipating hospitals or other treatment facilities</td>
<td>After Medicare reserve days have been used, 20% of BCBSNM’s covered charge for up to 365 more days</td>
</tr>
<tr>
<td>Inpatient Hospital/SNF Services</td>
<td>Skilled nursing facility/inpatient rehabilitation services</td>
<td>-0-</td>
<td>N/A - Medicare will not pay nonparticipating hospitals or other treatment facilities</td>
<td>After Medicare benefit used up, 20% (limited to an additional 60 days per calendar year)</td>
</tr>
<tr>
<td>Emergency Room and Outpatient Facility</td>
<td>Emergency room, including lab, x-ray, treatment room, ancillaries</td>
<td>-0-</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>Outpatient treatment room, lab, x-ray, operating room</td>
<td>-0-</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td>Type of Service</td>
<td>Description of Service and Limitations</td>
<td>When Assignment is Accepted, You Pay:</td>
<td>Your Share After Deductible</td>
<td></td>
</tr>
<tr>
<td>---------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------</td>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assignment Not Accepted</td>
<td>Services Not Covered by Medicare</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Physician and skilled nursing services</td>
<td>-0-</td>
<td>N/A - Medicare will not pay nonparticipating home health care or hospice agencies</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>After Medicare benefit used up, 20% (limited to an additional 120 days per calendar year)</td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Home/inpatient care</td>
<td>-0-</td>
<td>20% (limited to $7500 in additional coverage)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient services</td>
<td></td>
<td>-0-</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Inpatient services</td>
<td></td>
<td>-0-</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OTHER SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Urgent care center</td>
<td>-0-</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td>Ambulance</td>
<td>-0-</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic</td>
<td>Chiropractic care (up to $1500 per calendar year for all payments made for chiropractic services)</td>
<td>-0-</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DME/Supplies</td>
<td>Durable medical equipment, prosthetics, appliances</td>
<td>-0-</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy</td>
<td>Physical, occupational, and speech therapy services</td>
<td>-0-</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services Not Covered by Medicare</td>
<td>Rolfling and massage therapy</td>
<td></td>
<td>20% (each limited to $750/calendar year)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acupuncture</td>
<td></td>
<td>20% (limited to $1500 per calendar year)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dental-related and TMJ/CMJ services</td>
<td></td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Out-of-country covered services (resident or traveling)</td>
<td></td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nonparticipating facility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Smoking/tobacco use cessation counseling (Choice of two group sessions or 90 minutes of counseling/calendar year)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>VA facility, Inpatient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>VA facility, Outpatient</td>
<td>-0-</td>
<td>Plan deductible only</td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes:**

1. You are always responsible for noncovered services, Plan deductible and coinsurance, and amounts over the BCBSNM covered charge.
2. Some services require prior approval from BCBSNM if Medicare does not cover the service. If services are received without prior approval in a facility that does not participate with Medicare, you have no Medicare or Plan benefits except for limited emergency benefits (you must request approval for emergency services within 48 hours of initial treatment). See Section 5 in a member’s benefit booklet for a list of services requiring prior approval.

NOTE: Prescription drugs are covered through Medicare Part D (BlueMedicare Rx). Information about the drug plan is in a separate brochure or you may call 1-877-838-3875 for assistance.
How to Use This Booklet

This benefit booklet describes the benefits and limitations of the NMSU Carveout Plan.

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 Carveout Plan ID card shows that you are a member of a health care plan provided and/or administered by BCBSNM. The ID card provides the information needed when you require health care services, including mental health/chemical dependency services, or when contacting an NMSU DSU representative. Carry it with you. Have both your Medicare ID card and your NMSU Plan ID card handy when you call for an appointment and show it to the receptionist when you sign in for an appointment. You will need to use your Blue Medicare Rx ID card when buying prescription drugs.

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

Using the Informational Graphics
Symbols are used throughout this benefit booklet to call your attention to certain information and requirements. Some commonly used symbols are:

Definitions
This symbol calls attention to definitions of important terms throughout the booklet. More definitions are in the Glossary.
Limitations and Exclusions
Each subsection in Section 5 not only describes what is covered, but may list some limitations and exclusions that specifically relate to a particular type of service. Section 6: 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 5.

Admission Review or Other Prior Approval Required
To receive full benefits for some Plan-covered services that are not covered by Medicare, you or your provider must call the BCBSNM Health Services department before you receive treatment. This symbol is a reminder to do so. Call Monday through Friday, 8 A.M. to 5 P.M., Mountain Time. See Section 3 for details. 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.)

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).

Call Within 48 Hours — To receive full benefits for emergency admissions to nonparticipating facilities, you (or your provider) must notify BCBSNM within 48 hours of admission (or as soon as possible). 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.

Cross-References
Throughout this benefit booklet, cross-references direct you to read other sections of the booklet or the Summary of Benefits when applicable. You will see this symbol next to all such references.
Designated Customer Service
Whenever you have a question about your medical/surgical 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 staff have exclusive responsibility 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. 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.

NMSU DSU representatives can help with the following:
- answer questions about your medical/surgical health plan benefits
- assist with medical/surgical prior approval requests
- check on a medical/surgical claim’s status
- order a replacement medical/surgical health plan ID card, benefit booklet, or forms

You can also 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.

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 Benefit Services:

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

Eligibility and Enrollment Assistance
In order to be eligible for coverage under this Plan, the member must be a retiree from NMSU (as defined below), the eligible dependent of a retiree, or an eligible surviving dependent of a retiree or employee, and:

- be enrolled in, and eligible for primary coverage under both Parts A and B of Medicare (regardless of age), or
- be age 65 or older (regardless of Medicare enrollment).

If you are over age 65 and do not have both Parts of Medicare, no coverage is available through the NMSU Medicare Carveout retiree health care plan, although you may be eligible for continued coverage under one of the provisions listed under “How Coverage May Continue.

Regular Group Coverage — New Mexico State University determines the eligibility of all members covered under the group plan (which includes retirees and their dependents, and surviving dependents who are eligible for continued coverage under the group). NMSU is also responsible for all administrative policies regarding premium deduction or premium collection for members covered under the group plan. 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
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

Eligible Retirees
An employee who officially retires from the University and receives a benefit from the Educational Retirement Board (ERB) 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 enrollment.) Only time enrolled as a regular employee (or as the spouse of an active, regular employee if both you and your spouse were both employed by NMSU) will be counted toward the ten-year requirement.

You are also eligible if you are already retired and are covered under another NMSU health care plan.

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 up 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.

**Eligible Dependents**

*Eligible dependents* — 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 NMSU Benefit Services for eligibility criteria for domestic partners.)
- the subscriber’s unmarried **child** through the end of the month in which the child becomes age **25**
- the subscriber’s unmarried child age 25 or older who was enrolled as a dependent at the time of reaching the age limit, and who is medically certified as **disabled** and chiefly dependent upon the subscriber for support and maintenance (Such condition must be certified by a physician and BCBSNM. Also, a child may continue to be eligible for
coverage beyond the dependent age limit only if the condition began before or during the month in which the child would lose coverage due to his/her age. NMSU must receive written notice of the disabling condition before the end of the month during which the child’s coverage would otherwise end.)

*Child* — A child is considered to be a specific age on the first day of the month following his/her birthday, and includes an unmarried:
- natural or legally adopted child of the subscriber
- child under age 18 placed in the subscriber’s home for purposes of adoption
- stepchild of the subscriber if the subscriber has primary care of the stepchild (e.g., the child lives with the subscriber)
- child for whom the subscriber is the legal guardian
- child for whom the subscriber must provide coverage because of a court 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
  - if the child has been placed in the domestic partner’s household as part of an adoptive placement

Eligible dependents cannot participate in the NMSU program unless the eligible retiree participates (although the dependent may later continue participation for a limited period of time under COBRA or as a surviving dependent). **Note:** If all eligible members of a retiree’s family do not qualify for enrollment in the NMSU Carveout Plan, the unqualified member(s) will be enrolled in the NMSU PPO 250 Plan if not enrolled in Medicare.

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 a dependent under this coverage. Unless listed as an eligible dependent above, no other family member, relative, or person is eligible for coverage as a dependent.

**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 Dependents” for more information.
Children — Only those dependent children who were covered at the time of retirement may continue coverage after the employee retires. Dependent children cannot be added at a later date except as specified under “Adding Dependents,” later in this section. Surviving dependent contract holders may not add new family members to coverage at any time.

Dependents Who are Not Eligible — A subscriber’s spouse, domestic partner, or child is not an eligible dependent 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 a dependent 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 a dependent’s eligibility (such as a change in Medicare eligibility status, employment 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 a continuation provision 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 dependents, 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.
If the subscriber has a dependent who has been covered under another NMSU health care Plan due to not having both Medicare Part A and Part B or due to being under age 65, the subscriber must also submit an enrollment/change form to NMSU Benefit Services just prior to the dependent becoming age 65 or newly eligible for primary coverage under Medicare in order for the dependent to be transferred into this Carveout Plan. If the dependent is over age 65 and is not enrolled in both Parts of Medicare, he/she is not eligible for NMSU health plan coverage, but may be eligible for continued coverage through one of the options offered under “How Coverage May Continue.”

When Coverage Begins
Coverage under this Plan begins on the date of the employee’s retirement and/or on the first day of the month in which the retiree/survivor begins to receive Medicare benefits (whichever comes first). Your NMSU Carveout Plan ID card indicates the subscriber's name under this Carveout Plan. (The subscriber may be the dependent of a retiree who is not yet eligible for Medicare or who is under age 65. In such cases, separate ID cards and benefit materials are issued.)

Premium Payments
If the 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, loss of prior coverage, dependent 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 Dependents — If a retiree dies, the surviving eligible spouse and his/her surviving dependent children who were covered at the time of the retiree’s death may continue coverage for a limited period of time (see “Coverage Termination” for more information). Surviving dependents 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. The affected members and NMSU will not be notified of such terminations. (If NMSU the employer fails to submit premium payments to BCBSNM, it is the employer’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 your employer. BCBSNM may change premium amounts according to any of the following:
- changes in federal and state law,
- changes to coverage classifications (for example, to a new age category or geographic location, or from a single dependent coverage to a two dependent 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 Dependents
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 dependent contract holders and domestic partners may not add new dependents to coverage.
Adding a New Spouse or Domestic Partner — New spouses or domestic partners acquired by a retiree after retirement may be added to either the NMSU PPO 250 or the NMSU Carveout Plan, as applicable, under certain circumstances. The new spouse or domestic partner will not be added no later than 31 days following the one-year marriage/domestic partnership anniversary.

In order to add a new spouse or domestic partner, a completed and signed enrollment/change form and proof of birth must be submitted to NMSU Benefit Services, along with a copy of the marriage certificate or domestic partnership documentation. The new spouse or domestic partner will not be added until the first of the month following one year after the date that Benefit Services receives the completed and signed form and the copy of the marriage certificate or domestic partnership documentation.

There will be no University contributions to the additional premium costs (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 or domestic partner 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 or domestic partner coverage becomes effective, the new spouse or domestic partner will not be eligible for health insurance coverage through NMSU as a surviving spouse/domestic partner.

New Spouses or Domestic Partners of Continuation Subscribers — Federal continuation plan subscribers may add new spouses or domestic partners to coverage (if such addition would have been allowed under the coverage immediately preceding the continuation policy) by submitting a completed and signed enrollment/change form to the federal COBRA administrator (HCSC). Surviving spouses/domestic partners and children who are covered under the survivor’s continuation policy may not add new spouses, domestic partners, or children to federal continuation coverage.

Adding Children — Retirees/retiree spouses may add dependent children to coverage (into the NMSU PPO 250 Plan) 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 a dependent within 31 days of birth. This will ensure that the newborn is added to your membership records as a dependent 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 (obtaining coverage for the child in the NMSU PPO 250 Plan) in order for newborn care to be covered. The baby will then be covered from birth.

**Note:** If the parent of the newborn is a dependent 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 dependent 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 dependent 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 dependent’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 Applicants

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 dependent children added to coverage more than 31 days after becoming eligible, or a new spouse or step-child 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 a dependent 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 dependents, or their surviving dependents.

**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.

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 dependents ends on midnight on the last day of the month following one of these events (except in the case of fraud):

- 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 and signed 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 loss of enrollment in **Medicare** (if under age 65), or due to the retiree returning to active employment at NMSU, he/she will be required to switch to an NMSU Plan for which he/she is eligible. If the member is enrolled in
only one Part of Medicare, he/she may be eligible to continue coverage only as specified under “How Coverage May Continue.”

- **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 30 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 30-day grace period will be billed to the subscriber.)
- **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 dependents, BCBSNM and NMSU may terminate the coverage of the subscriber and his/her dependents 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 dependent children may remain covered under the NMSU health care plan under certain circumstances. Contact Benefit Services for details. If the surviving dependents are not eligible for continued coverage, coverage ends on the last day of the month following the subscriber’s death.)
- **At the beginning of the month when a retiree returns to active employment with NMSU** (In such cases, the subscriber and his/her dependents must switch to other NMSU Plan coverage for which they are eligible.)
- **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 employee’s/retiree’s/surviving dependent’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.
Additional Dependent Termination Reasons
In addition, coverage will end for any dependent in the following circumstances:

- When a child (including a surviving dependent child) no longer qualifies as a dependent under the Plan (e.g., a child is removed from placement in the home, marries, or reaches the dependent age limit).
- The date of a final divorce decree or legal separation for a spouse.
- The date the domestic partnership ends.
- The date the dependent enters the armed forces for more than 30 days (or as provided by law). Coverage for a member in the armed forces will also end when the maximum continuation period under these circumstances has been exhausted per NMSU personnel policies.

To remove an ineligible dependent 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 a dependent is being removed from 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.

Regardless of when the enrollment/change form is received, claims for services received after the member’s termination date will be denied.

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

Reminder: Enrollment/change forms for 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:
Voluntary Discontinuance of Coverage
To remove a dependent from coverage before his/her loss of eligibility or to voluntarily terminate your own coverage, you must submit a completed and signed enrollment/change form to NMSU (or to the federal continuation plan administrator, if applicable). Coverage will end at midnight on the last day of the month the signed and completed enrollment/change form is received by Benefit Services. Your premiums will be adjusted as stated under “Premium Payments,” earlier in this section.

Retirees and their dependents (including surviving spouses/dependents) and continuation subscribers/dependents who are voluntarily terminated before losing eligibility may not re-enroll at any time and are not eligible for any federal continuation or conversion coverage.

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. The affected members and NMSU will not be notified of such terminations. (If NMSU fails to submit premium payments to BCBSNM, it is NMSU’s responsibility to advise members of BCBSNM plan termination.)

Re-Enrollment
A retiree who returns to work full-time and later re-retires may only continue coverage for dependents who were continuously covered under the NMSU Health Plan for at least ten consecutive years. (Coverage as the dependent of a retiree does not count toward the ten-year requirement.) If coverage is voluntarily discontinued by a retiree or surviving dependent contract holder for self or for any covered dependent, the retiree and/or the dependent 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 plan offered by BCBSNM. **Note:** Late applications are not 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, the covered dependents of retirees and surviving dependent 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. The member 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 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.

**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 family members of retirees. 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, the retiree’s dependent(s) may continue coverage in the medical plan following certain “qualifying events.”
Dependents 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 dependent 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 dependent 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 dependent under the medical plan
- Medicare entitlement of retiree that causes dependents to lose continuation coverage (NOTE: This provision is not applicable to NMSU retirees or their dependents.)

The definition of “qualified beneficiary” for COBRA purposes also includes a child born to, or placed for adoption with, a covered employee/retiree during the period of the employee’s/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 dependent child eligibility status, death of the subscriber, termination of employment, reduction in hours, or termination of employer contributions. Any other reason is considered voluntary.)
- a dependent who was removed from coverage by the subscriber while the dependent was still eligible
- any member whose 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 employees (or to the eligible class to which you belong, such as to retirees or surviving dependents), 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 dependent 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.

When the 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 Benefit Services.

Maximum Continuation Periods — This law requires that dependents be afforded the opportunity to maintain continuation coverage for 36 months if an event such as death, divorce, legal separation, or child's loss of eligibility due to a change in age causes the dependent to lose his/her health plan coverage.

Cost of Continuation Coverage — The cost of the coverage will include any portion previously paid by NMSU and 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 employees or to the eligible class to which you belong, such as to retirees or surviving dependents. (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 dependents 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 dependents (or it is satisfied by him or her) due to HIPAA.
- The continuation period expires.
You, as a continuation member (such as a divorced spouse of a retiree) enroll in and become covered by Medicare Part A or B. (Eligible dependents who were covered under your continuation plan when you enrolled in Medicare would then be eligible 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).

**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 on July 1 of each year or on any date that the Plan is amended. Written notice of any such change will be given to you 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 or state continuation coverage expires
a dependent loses coverage for one of the following reasons:
- divorce or legal separation from the subscriber
- disqualification of the member under the definition of a dependent
- death of the subscriber
- an employee becomes primary under Medicare — leaving dependents without coverage (NOTE: This is not applicable to persons covered under the NMSU Medicare Carveout plan.)

The subscriber and any eligible dependents 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 Supplemental 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.
Carveout Plan Basics

The New Mexico State University (NMSU) Carveout Plan gives you choice for your medical care plus the opportunity to save money.

Plan Overview

When you need covered services, you can choose to visit any eligible health care provider you want and still receive benefits. You also have a wide range of additional benefits for services that are not covered by Medicare.

Medicare-Covered Services

See Section 4 for details on this portion of the Carveout Plan.

This Plan will cover any service that is covered by Medicare. (Note: Some benefits are limited and Plan payments cannot exceed those limits. For example, chiropractic benefits are limited to $1500 per calendar year.) Also, there are advantages to choosing a provider that is Medicare-participating or who accepts Medicare assignment:

Assigned Services — If you visit a provider that is Medicare-participating or that accepts Medicare assignment, you will have no out-of-pocket expenses. The Carveout Plan will pay your Medicare deductible and coinsurance amounts in full.

Non-Assigned Services — If you visit a nonparticipating provider or one that does not accept Medicare assignment, covered charges will be subject to a calendar year $100 Plan deductible and 20 percent Plan coinsurance. In some instances, you will also be responsible for paying amounts over the covered charge, which is not applied to the out-of-pocket limit. See “Cost-Sharing Features” on page 22 for more information.

Other Plan-Covered Services

See Section 5: Other Plan-Covered Services for details on this portion of the Carveout Plan.

Services that are not covered by Medicare may also be eligible for benefits under this Plan. See Section 5 for a list of non-Medicare-covered services that are covered by the Plan (services must be medically necessary and not listed as an exclusion in Section 6). These expenses are subject to the same annual Plan deductible and Plan coinsurance
as are Medicare-covered services that are subject to deductible and coinsurance. **Note:** If you privately contract with a provider, the Plan will calculate amounts that would have been paid by Medicare and deduct those amounts from the billed charge for a covered service in order to arrive at a Plan benefit payment, subject to Plan deductible and coinsurance.

**Medical Necessity**

The NMSU Carveout Plan helps pay health care expenses that are medically necessary and for those preventive and routine services specifically covered in the Plan.

**Medicare-Covered Services** — For Medicare-covered services, when Medicare makes a determination whether particular health care services are covered under its program, BCBSNM will use Medicare's decision in determining secondary benefits.

**Other Plan-Covered Services** — For non-Medicare covered services, 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 when services are not covered by Medicare.)

**Cost-Sharing Features**

When you receive Medicare-covered health care services from a provider that accepts Medicare assignment, you have no out-of-pocket expenses. There is no Plan deductible to meet and your share of Medicare-covered services is paid in full by the Plan. This section applies only to Medicare-covered services received from providers that do not accept Medicare assignment and to services covered by the Plan that are not covered by Medicare.

For most Medicare-covered services from providers that do not accept Medicare assignment and for services covered by the Plan but not covered by Medicare, each member must meet an annual Plan deductible and pay a percentage of covered charges (Plan co-insurance), until the annual Plan out-of-pocket limit is reached. This section describes these cost-sharing features.

**Deductible**

*Deductible* — The amount of covered charges that each member must pay in a calendar year before the Plan begins to pay its share of Medicare-covered services received from providers that do not accept Medicare assignment and most other services covered by the Plan.

Once the amounts applied to your deductible in a single calendar year reach $100, your deductible for that calendar year is met. If the deductible amount remains the same during the calendar year, you pay it only once each year, and it applies to all covered services.

*Admissions Spanning Two Years* — If the deductible is met while you are an inpatient and the admission continues into a new calendar 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 Plan deductible for the new calendar year.

*Timely Filing Reminder* — Most benefits are payable only after BCBSNM’s records show that your annual Plan deductible has been met. If you must file your own claim, you must file it within 12 months of the date of service. BCBSNM-participating providers will file claims
for you and must submit them within a specified amount of time, usually within 90 days. If a claim is returned for further information, resubmit it within 45 days. See “Filing Claims” in Section 6 for details.

**What is Not Subject to the Deductible** — Covered inpatient services received at a Veterans’ Administration, Department of Defense, or other government facility for a nonservice-connected condition are not subject to the Plan deductible.

**Coinsurance**

*Coinsurance* — The percentage of the covered charge — after the deductible has been met — that you are required to pay for most Medicare-covered services received from providers that do not accept Medicare assignment and for most other services that are covered by the Plan.

Your coinsurance for covered services that are subject to this provision is 20 percent of the covered charge.

Medicare’s payment (or, if you privately contract with a provider, Medicare’s estimated payment), your Plan deductible, and your Plan coinsurance are subtracted from covered charges to determine the Plan’s payment amount; BCBSNM pays the remainder of covered charges. The covered charge may be less than the provider’s total billed charge for a covered service, and the provider may or may not be able to bill you for the balance. (See “Covered Charges: Provider Does Not Accept Medicare Assignment” in Section 4 and “BCBSNM Maximum Allowable Fee” in Section 5 for details.)

The following services are not subject to this coinsurance provision:

- Medicare-covered services from Medicare providers who accept assignment
- non-Medicare-covered services that are covered by the Plan and received at a Veterans’ Administration, Department of Defense, or other government facility for a nonservice-connected condition (The Carveout Plan pays 20 percent of the covered charges for outpatient services, after the Plan deductible is met. For inpatient services, the Carveout Plan pays up to an amount equal to the Medicare Part A hospital deductible.)
- other inpatient facility charges that are covered by the Plan but are not covered by Medicare
Out-of-Pocket Limit

*Out-of-pocket limit* — The amount of Plan deductible and coinsurance that each member must pay in a calendar year before BCBSNM begins paying 100 percent of covered charges for the remainder of that calendar year, up to maximum benefit amounts, if any.

Once the Plan deductible and coinsurance that is applied to your out-of-pocket limit in a single calendar year reaches $500, your out-of-pocket limit is met and no more Plan deductible or coinsurance will be due from you for the remainder of that calendar year.

The out-of-pocket limit includes only the Plan deductible and coinsurance amounts for covered services. Expenses in excess of covered charges, charges incurred at government facilities, charges that would have been covered by Medicare had the member not privately contracted with a provider, and noncovered expenses are not included in calculating the out-of-pocket limit, and these amounts are not eligible for 100 percent payment under this provision.

Changes to the Cost-Sharing Amounts

If your Plan 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 had met a previously lower deductible and you change to a higher deductible, you will not receive benefit payments until the increased deductible is met. If your deductible or out-of-pocket amounts decrease, you will not receive a refund for any amounts applied to the higher deductibles or out-of-pocket amounts.

Coinsurance percentage amounts may also change during a calendar year. If changes are made to this Plan, the change applies only to services received after the change goes into effect. You will receive a revised Summary of Benefits if changes are made to this Plan.

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 beginning on page iv and refer to Section 5: Other Plan-Covered Services.
Generally, benefits are determined based upon the coverage in effect on the day a service is actually provided, a prescription is filled, or a health care expense is 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.

**Coordination of Benefits (COB)**

*Other valid coverage* — All other insurance policies, including Medicare and other Medicare complementary or supplemental policies, both group and nongroup (but not Medicaid, or Indian Health Service coverages, which are secondary to this Plan), that provide payments for medical services.

For work-related injuries or illnesses, refer to “Work-Related Conditions” in Section 6.

Medicare benefits and benefits from any other valid coverages that you may have are determined first, and benefits available from this Plan will be reduced accordingly.

When you are eligible for benefits under any other valid coverage, the combined benefit payments from all coverages cannot exceed 100 percent of the covered expenses.

If you receive more than you should have when benefits are coordinated, you are expected to repay any overpayment.

**Reimbursement**

If you or one of your covered dependents 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 dependents.
- 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 dependents 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.

[Heading: Health Care Fraud Information]

Insurance fraud results in increased health care costs. You can help:
• Be wary of offers to “waive deductibles, copayments, or coinsurance.” These costs are passed on to you eventually.
• Always review the Explanation of Benefits (EOB) or remittance advice you receive from BCBSNM. Verify that all charges were incurred. If there are any discrepancies, call an NMSU DSU representative.
• Be very cautious about giving information about your health insurance coverage over the telephone.

If you suspect fraud, please contact an NMSU DSU representative.

The use of fraudulent or false means to obtain benefits or to aid or attempt to aid any ineligible person in obtaining any benefit under an NMSU Plan will terminate all NMSU coverage. BCBSNM may recover benefits paid or may treat such benefits as properly paid. BCBSNM may make reasonable adjustments in any refund of premium that may result from the above circumstances.
Medicare-Covered Services

This section describes the services and supplies covered by Medicare and the NMSU Carveout Plan. Covered services and supplies are also subject to the limitations and exclusions in Section 6. All covered expenses from providers that do not accept Medicare assignment are subject to the deductible, coinsurance, and out-of-pocket limit provisions described in Section 3. All payments are based on covered charges as described under “Covered Charges” on page 30, and coordinated with other valid coverage that you may have (see “Coordination of Benefits” in Section 3).

“Assigned” vs. “Non-Assigned”

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

For Medicare-covered services, you can choose to see a provider who accepts Medicare assignment or a provider who does not accept assignment. (All Medicare-participating providers accept Medicare assignment. Nonparticipating physicians and other professional providers may accept a one-time Medicare assignment on a claim-by-claim basis.)

It is important to understand the difference between Medicare-participating facilities and nonparticipating facilities, and between providers that accept Medicare assignment and those that do not. Also important is the difference in Plan coverage between Medicare-covered services and services that are not covered by Medicare, and how benefits (or covered charges) will be calculated in each instance.

Participating Facilities — Participating facilities are those that have contracted with Medicare to provide services to Medicare beneficiaries. Such facilities include acute care hospitals, skilled nursing facilities, home health care agencies, hospice programs, rural health clinics, comprehensive outpatient rehabilitation facilities, community mental health centers, and end-stage renal disease dialysis centers.

Other Participating Providers — Other (nonfacility) participating providers (e.g., physicians, podiatrists, and other professional providers) are those that have signed agreements with Medicare to accept Medicare assignment (accepting Medicare assignment means the provider agrees to accept the Medicare-approved amount as payment in full).

Nonparticipating Facilities — Medicare does not cover services provided by facilities that do not participate with Medicare (nonparticipating facilities). Important: If you visit a nonparticipating facility (which
includes all facilities outside the Medicare territorial limits), you must obtain prior approval from BCBSNM or the services will not be covered by the Plan (except for limited emergency services at a hospital). If approved by BCBSNM, services will be covered as “Other Plan-Covered Services” in the next section of this booklet.

Other Nonparticipating Providers — Nonparticipating providers are those that have Medicare provider identification numbers but who have not signed agreements with Medicare to accept the Medicare-approved amount as payment in full. However, on a claim-by-claim basis, nonparticipating providers may agree to accept the Medicare-approved amount. If the provider does not accept assignment, Medicare will usually impose a “limiting charge” beyond which physicians cannot bill you.

Non-Medicare Providers — Non-Medicare providers are those that do not have Medicare provider identification numbers. Medicare will not pay for services received from these providers. With the exception of doctors of oriental medicine (acupuncturists), massage therapists, and rolfers, you must obtain prior approval from BCBSNM before receiving services from these providers or the services will not be covered under the Carveout Plan. If approved by BCBSNM, services will be covered as “Other Plan-Covered Services” in the next section of this booklet.

Selecting a Provider
Before obtaining health care services, check the Medicare-Participating Provider/Supplier Directory. You receive maximum benefits when you obtain your services from providers that accept Medicare assignment, either because they are participating or because they are nonparticipating but have accepted a one-time assignment.

If you do not have a current Medicare-Participating Provider/Supplier Directory, you can obtain one free of charge from your local Medicare carrier or you can ask your local Medicare carrier for names of some Medicare-participating providers in your area. (Call your local Social Security Administration office for more information.) You may also want to ask your provider if he/she accepts Medicare assignment before you receive services. For Medicare-covered services, your choice of a participating or nonparticipating provider may make a difference in the amount you pay.

What is Covered and Not Covered
Benefits are available under this “Medicare-Covered Services” provision for all services approved by Medicare. No benefits are available under this or any other provision of the Plan for charges related to:
- chiropractic services over the Plan benefit of $1500 per calendar year
- rolfing or services of a massage therapist over the Plan benefit of $750 per calendar year
Note: Services that are not covered under either Medicare Part A or Part B are not eligible for benefits under this “Medicare-Covered Services” provision but may be covered under the “Other Plan-Covered Services” provision (see Section 5).

Covered Charges
All benefits are based on “covered charges” as described below. This is the greatest amount which BCBSNM uses to calculate Plan benefit payments and member deductible and coinsurance, if applicable:

Provider Accepts Medicare Assignment
For Medicare-covered services from providers accepting Medicare assignment, the covered charge is Medicare’s approved amount. The provider cannot charge you for amounts greater than the Medicare-approved amount.

This Plan includes an incentive to visit providers that accept Medicare assignment. All participating providers accept assignment; nonparticipating providers may accept a one-time Medicare assignment on a claim-by-claim basis).

Members who receive their Medicare-covered services from providers that accept Medicare assignment will have no Plan deductible or coinsurance to pay. The Plan will pay 100 percent of the covered charge (equal to the Medicare-approved amount) less Medicare’s payment:

Assigned Claim Payment Example:
You receive Medicare-covered services from a provider that accepts Medicare assignment. (There is no Plan deductible or coinsurance applied to these Medicare-covered services.)

<table>
<thead>
<tr>
<th>Provider’s billed charge</th>
<th>$200.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered charge = Medicare-approved amount</td>
<td>$175.00</td>
</tr>
<tr>
<td>Medicare deductible: ($175 - $100 = $75 balance)</td>
<td>- $100.00</td>
</tr>
<tr>
<td>Medicare’s payment (80% of $75)</td>
<td>- $60.00</td>
</tr>
<tr>
<td>Plan’s payment = 100% of Medicare-approved amount less Medicare’s payment ($175 - $60)</td>
<td>$115.00</td>
</tr>
<tr>
<td>Balance due from member (Provider cannot charge more than the Medicare-approved amount)</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

Provider Does Not Accept Medicare Assignment
When a physician or other professional provider does not accept Medicare assignment, the covered charge is calculated using one of the two methods described on the next two pages, and is subject to Plan deductible and coinsurance:
Plan Deductible and Coinsurance — If you receive services from a provider that does not accept Medicare assignment, the Plan will require an annual deductible and pay 80 percent of the covered charge — less Medicare’s payment. You pay the remaining 20 percent as Plan coinsurance, which is applied to the annual Plan out-of-pocket limit. (See Section 3: Carveout Plan Basics for more information.) You may also be responsible for paying any amounts greater than the covered charge, depending on whether or not Medicare set the “limiting charge” used for paying Plan benefits.

Medicare Limiting Charge — For most Medicare-covered services from physicians that do not accept Medicare assignment, the covered charge is the Medicare limiting charge that is set by Medicare. The provider cannot charge you for amounts greater than the limiting charge (which is greater than the Medicare-approved amount). You are responsible for this difference between the Medicare-approved amount and the limiting charge. BCBSNM considers this amount, in addition to your Medicare deductible and coinsurance, when determining benefit payments.

Medicare Limiting Charge Payment Example:

You receive services from a physician that does not accept Medicare assignment and the Medicare/Plan deductible has been satisfied. (Medicare imposes a limiting charge.)

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s billed charge</td>
<td>$300.00</td>
</tr>
<tr>
<td>Medicare-approved amount</td>
<td>$200.00</td>
</tr>
<tr>
<td>Medicare limiting charge (115% of Medicare-approved amount. Provider cannot bill you for more than this amount.)</td>
<td>$230.00</td>
</tr>
<tr>
<td>Plan’s calculation = 80% of the limiting charge of $230</td>
<td>$184.00</td>
</tr>
<tr>
<td>Medicare’s payment (80% of $200)</td>
<td>- $160.00</td>
</tr>
<tr>
<td>Plan’s payment = $184 less Medicare’s payment ($160)</td>
<td>$24.00</td>
</tr>
<tr>
<td>Balance due from member = 20% of limiting charge, which is applied to your Plan out-of-pocket limit.</td>
<td>$46.00</td>
</tr>
</tbody>
</table>
Section 4: Medicare-Covered Services

**BCBSNM-Imposed Limit** — In those few cases in which Medicare does **not** impose a limiting charge (e.g., durable medical equipment), BCBSNM calculates the covered charge as being 115 percent of the Medicare-approved amount. In these cases, the provider can collect the full billed charge from you.

**BCBSNM-Imposed Limit Payment Example:**

You receive Medicare-covered durable medical equipment from a supplier that does **not** accept Medicare assignment and the Medicare and Plan deductibles have been satisfied. (Medicare does **not** impose a limiting charge.)

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s billed charge</td>
<td>$250.00</td>
</tr>
<tr>
<td>Medicare-approved amount</td>
<td>$200.00</td>
</tr>
<tr>
<td>Covered charge (or “BCBSNM-imposed limit”)</td>
<td>$230.00</td>
</tr>
<tr>
<td>Plan’s calculation 80% of the covered charge</td>
<td>$184.00</td>
</tr>
<tr>
<td>Medicare’s payment (80% of $200)</td>
<td>- $160.00</td>
</tr>
<tr>
<td>Plan’s payment</td>
<td>$24.00</td>
</tr>
<tr>
<td>Balance due from member 20% of the covered charge ($46), which is applied to your Plan out-of-pocket limit PLUS the difference between the billed charge of $250 and the covered charge of $230 ($20).</td>
<td>$66.00</td>
</tr>
</tbody>
</table>
Other Plan-Covered Services

This section describes the services and supplies covered by the NMSU Carveout Plan when they are **not covered by Medicare**. If a service is **not** covered by Medicare, BCBSNM will determine what services will be covered and what covered charges will be. These services and supplies are also subject to the limitations and exclusions in Sections 3 and 6. All payments are based on covered charges. (See “BCBSNM Maximum Allowable Fee,” below.)

All benefit determinations will be subject to the BCBSNM **medical necessity** and **prior approval** provisions. (For a full list of services needing prior approval, see “Prior Approvals,” on the next page.)

**Important:** If you receive services at a facility that does not participate with Medicare or if you do not have Part A of Medicare, Medicare will not cover the services. You must obtain **prior approval** from BCBSNM or the services will **not** be covered by the Carveout Plan (except for limited emergency services).

**BCBSNM Maximum Allowable Fee** — If Medicare denied a service that is covered by the Plan, the covered charge for the service is **BCBSNM’s maximum allowable fee** (a fair and reasonable charge for covered services as determined by BCBSNM or total billed charges, whichever is less). If the covered charge is less than the billed charge, the provider may bill you for the difference.

**Plan Deductible and Coinsurance** — The Plan will require an annual **deductible** and pay **80 percent** of covered charges for most services. You pay the remaining 20 percent as Plan coinsurance, which is applied to the annual Plan out-of-pocket limit. (See Section 3: Carveout Plan Basics for more information. Also see “Services Not Covered by Medicare” for exceptions to these cost-sharing features of the Plan.)

**Services Not Covered By Medicare**

When you receive services from a provider that does not contract with Medicare, or when you have privately contracted with a provider (as set forth in section 4507 of the Balanced Budget Act of 1997), BCBSNM will make the determination regarding whether or not a service is covered by the Plan.

**Privately Contracting** — If covered services are not paid by Medicare because you have privately contracted with a provider, benefit
payments for services that would have otherwise been covered by Medicare Part B will be calculated as if Medicare had paid 80 percent of the billed charge for a covered service (this amount is your responsibility and does not accrue to the out-of-pocket limit). The remaining 20 percent of the billed charge is considered deductible and coinsurance, and is applied to the Plan out-of-pocket limit. Once the out-of-pocket limit is met, the Plan pays 20 percent of the billed charge for services that would have been covered by Medicare Part B.

**Government Facilities** — Regardless of your Medicare entitlement, when outpatient services are received at a Veterans’ Administration, Department of Defense, or other government facility for a nonservice-connected condition, the Plan pays 20 percent of covered charges for Plan-covered services, after the Plan deductible is met. For inpatient services, the Plan pays up to an amount equal to the Medicare Part A hospital deductible. You will not be responsible for the balance.

### Prior Approvals

**Prior approval** — A requirement that you or your physician must obtain approval from BCBSNM before you receive certain types of non-Medicare-covered services or procedures, or services from nonparticipating facilities. Without prior approval, benefits for covered services may be reduced or denied.

**Reminder: This information applies only when a service is not covered by Medicare.**

For all admissions and certain other services not covered by Medicare, you must obtain prior approval from BCBSNM before treatment begins. (If you need emergency services not covered by Medicare, BCBSNM must be called within 48 hours of the admission or service date in order for benefits to be available.) 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 denial of benefits.**
Retroactive approvals will not be given and benefits may be denied if you do not obtain approval \textit{before} the service is received.

\textbf{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.

\textbf{How the Approval Procedure Works} — If a provider recommends an admission or one of the services listed under “Services Needing Prior Approval,” below, \textit{you} are responsible for ensuring that approval is requested. If approval is not obtained \textit{before} services are received, benefits may be denied. The provider may call on your behalf, but it is \textit{your responsibility} to ensure that BCBSNM is called.

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, if applicable. 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 service and/or hospitalization are approved. If the admission or service is not approved, you may appeal the decision as explained in Section 7.

\textbf{Penalty for Not Obtaining Approval} — If you do not call, or if you call and do not receive approval for the service or admission in question, but you choose to receive the service or be hospitalized anyway, no benefits may be paid or partial payment may be made.

\textbf{Services Needing Prior Approval} — Prior approval requirements will vary depending on the type of health care provider you choose to visit, on your location at the time services are required, and/or on the provider’s Medicare contract. Please review this information carefully and follow these procedures in order to ensure that you receive maximum benefits available under the Plan.

If you are admitted to a nonparticipating facility or a facility outside the Medicare territorial limits, any such inpatient admissions to an acute care hospital, skilled nursing facility, or any other facility, any transfers from one facility to another, and any readmissions require prior approval.

If you are admitted to a participating facility, you will also need prior approval if you were told prior to being admitted that the admission would not be covered by Medicare.
For all members, prior approval is required for the services listed below in the following cases:

- services from providers that do not have Medicare ID numbers
- services from providers outside the United States

The services needing prior approval in the above cases are:

- air ambulance
- cardiac rehabilitation
- 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); treatment of accidental injuries to teeth (except initial treatment); oral surgery
- dialysis
- durable medical equipment, orthotics, medical supplies, orthopedic appliances, and prosthetics
- home health care and home I.V. services
- hospice care
- mental health, alcoholism, and drug abuse services
- physical, occupational, or speech therapy
- reconstructive surgery, breast reduction, cosmetic breast surgery following a mastectomy (this is the only cosmetic procedure covered under this Plan), orthotripsy, orthognathic surgery
- radiation therapy
- diagnosis and medical evaluation of autism
- prescription drugs, diabetic drugs and supplies, special medical foods, nebulization products, enteral nutritional products

Generally, you should request prior approval any time you receive a service not covered by Medicare, except that you do not need prior approval for:

- routine or preventive services
- acupuncture services (including any service rendered by a doctor of oriental medicine)
- chiropractic services
- services of a massage therapist or rofleer
- Veteran’s Administration or Department of Defense facility services
- incontinence undergarments
- diagnostic lab and x-ray
- services from providers with whom you have privately contracted
Covered Services

When Medicare does not cover a medically necessary service, the following services are covered by the NMSU Carveout Plan, according to the provisions described earlier in this Section 5:

Acupuncture and 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. Benefit payments for acupuncture, including office calls, treatment, and acupuncture when used as an anesthetic or in the treatment of acute, severe pain are limited to $1,500 per calendar year.

**Spinal manipulation services** administered by a chiropractor acting within the scope of his/her licensure and according to the standards of chiropractic medicine in New Mexico (or the state in which services are rendered) for the treatment of an illness or injury are covered. Benefit payments are limited to $1,500 per calendar year, which includes all payments made by the Plan for spinal manipulation services, including Plan payments made for Medicare-covered spinal manipulation services.

To receive benefits under this provision for services normally covered by Medicare, you must submit an **Explanation of Medicare Benefits (EOMB) form.** **Note:** If the Medicare reason for a spinal manipulation service denial is unclear, additional information may be required in order to determine benefits.

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

- acupuncture used for the purpose of smoking cessation
- herbs, homeopathic preparations, or nutritional supplements
- any therapeutic exercise equipment prescribed for home use

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.

*See “Emergency and Urgent Care” for details on obtaining emergency care.*

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

**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. 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. You will need prior approval for these services if the air ambulance service and/or provider is not eligible for coverage by Medicare.

**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

**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.

**Impacted teeth** — Teeth that are prevented from erupting into normal positions in the dental arch by soft tissue, bone, or positional relationship to other teeth, except that permanent teeth that are prevented from eruption by baby teeth are not impacted.

**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.”)
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. If these services are not covered by Medicare, you will need prior approval from BCBSNM.

**Dental and Facial Accidents** — Benefits for covered services for the treatment of accidental injuries to the jaw, mouth, face, or sound natural teeth are 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).

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.

Dental accident benefits include the placement of necessary dental prostheses within 12 months of the date of accident.

**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, 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 in an emergency, you are responsible for obtaining prior approval in order to receive maximum benefits. (See “Prior Approvals” earlier in this Section 5.)

**Call BCBSNM for Approval:**
(505) 291-3585 or (800) 325-8334
This Plan does **not** cover:
- surgeon’s or dentist’s charges for the 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.)

**Reminder:** If hospital services are recommended, you are responsible for obtaining **prior approval** for inpatient or outpatient services to receive benefits. (See “Prior Approvals,” earlier in this Section 5.)

**Oral Surgery** — Covered services include surgeon’s charges for the following oral surgical procedures only:
- removal of impacted teeth
- 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 TMJ or CMJ.

**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)
- removal of tori or exostoses
- 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 preparing the mouth for dentures
- 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”
- duplicate or “spare” appliances
- personalized restorations, cosmetic replacement of serviceable restorations, or materials (such as precious metals) that are more expensive than necessary to restore damaged teeth
- artificial devices and/or bone grafts for denture wear

**Emergency and Urgent Care**

*Emergency* — An accidental injury or a condition that occurs suddenly and unexpectedly and is life threatening or could result in permanent damage if not treated immediately.

*Urgent care* — Services received when prompt medical attention is required for situations that are not life threatening. Examples of urgent care are sprains, high fever, and cuts requiring stitches.

Treatment for a medical emergency or urgent care in the emergency room of a hospital, an urgent care facility, a physician’s office, or ambulatory surgical facility is covered.

**Reminder:** 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.) If the hospital does not participate with Medicare, benefits may not be available.

**Home Health Care and Home I.V. Services**

If you are homebound (unable to receive medical care on an outpatient basis), benefits for home health care and home I.V. services are available for up to 120 additional visits each calendar year for services from a home health agency. This benefit provides skilled nursing services when ordered by a physician and administered in the home on an intermittent basis. A visit is one period of home health service of up to four hours.

If your home health care is not covered by Medicare, you, your attending physician, or the home health agency must obtain prior approval from BCBSNM or benefits will be denied.
Section 5: Other Plan-Covered Services

This Plan covers the following home health care services:
- skilled nursing care by a registered nurse (R.N.) or licensed practical nurse (L.P.N.)
- physical or occupational therapy, by licensed or certified therapists, and speech therapy provided by an American Speech and Hearing Association certified therapist
- skilled services by a qualified aide to do such things as change dressings and check blood pressure, pulse, and temperature
- oxygen and its administration
- medical supplies, and laboratory services that would have been provided by a hospital had you been hospitalized
- physician home visits
- 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 your Medicare Part D prescription drug plan benefits and “Prescription Drugs and Other Items.”)
- parenteral and enteral nutritional products that can only be legally dispensed by the written prescription of a physician and are labeled as such on the packages (If not provided by the home health care agency, see your Medicare Part D prescription drug plan benefits and “Prescription Drugs and Other Items.”)

This Plan does not cover home health care that:
- is provided primarily for the convenience of the member or the member’s family
- is custodial, or consists mostly of bathing, feeding, exercising, preparing meals, homemaking, moving the patient, giving medications, or acting as a sitter (See the “Custodial Care” exclusion in Section 6.)
- is provided by a nurse who ordinarily resides in your home or is a member of your immediate family
- for nonprescription enteral nutritional products (These products may be covered under your Medicare Part D prescription drug plan or under “Prescription Drugs and Other Items.”)
- does not have prior approval from BCBSNM

Hospice Care

Hospice — A licensed program providing care and support to terminally ill patients and their families. An approved hospice must be licensed when required, or Medicare-certified as a hospice, or accredited by the Joint Commission on Accreditation of Healthcare Organizations (J CAHO) 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 benefit period must begin while the member is covered for these benefits, 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.

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.

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.

You, your attending physician, or hospice agency, must request prior approval from BCBSNM. Prior approval requires a treatment program approved by the attending physician. Services are not covered without prior approval if not covered by Medicare.

Hospice care benefits are limited to a lifetime maximum payment of $10,000 for covered expenses per member. (Plan payments will be in addition to Medicare’s payment.)

This Plan covers the following services under the hospice care benefit:

- inpatient hospice care
- hospice care physician visits
- skilled nursing care by a registered nurse (R.N.) or licensed practical nurse (L.P.N.)
- home health care by a home health aide
- physical therapy, speech therapy, or occupational therapy
- medical supplies
- drugs and medications for the terminally ill patient (If drugs are not provided by the hospice agency, see your Medicare Part D prescription drug plan benefits.)
Section 5: Other Plan-Covered Services

- 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.)
- respite care for a period not to exceed five days for every 60 days of hospice care — no more than two respite care stays are available during a hospice benefit period (Respite care provides a brief break from total care giving by the family.)
- nutritional guidance and support, such as intravenous feeding and hyperalimentation

This Plan does not cover:
- food, housing, or delivered meals
- volunteer services or private duty nursing
- medical transportation
- homemaker and housekeeping services; comfort items
- 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

The following services are not hospice benefits but may be covered elsewhere under the NMSU Carveout Plan: acute inpatient hospital care; durable medical equipment; physician visits unrelated to hospice care; and ambulance services.

Hospital/Other Facility Services

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

**Physical rehabilitation, inpatient** — Inpatient services that are medically necessary to restore and improve lost functions following accidental injury or illness.

**Skilled nursing facility** — An institution that provides room and board and skilled nursing services for medical care and has one or more licensed nurses on duty at all times, supervised on a 24-hour basis by a registered nurse (R.N.) or a physician. The services of the physician are available at all times by an established agreement. The facility must comply with the legal requirements that apply to its operation and keep daily medical records on all patients. A skilled nursing facility is not an institution, or part of one, used mainly for care of chemical dependency, rest care, care of the aged, custodial care, or educational care.

See other subheadings in this section for limitations that apply to the specific type of service required, such as “Surgery and Related Services” or “Therapy, Outpatient or Office.”

For emergency services, see “Emergency and Urgent Care.”
For inpatient treatments related to hospice care, see “Hospice Care.”

For benefits and limitations for services related to the treatment of mental illness or chemical dependency, also see “Mental Health and Chemical Dependency.”

Remember: Medicare will not cover any services received at a facility that does not have a participating agreement with Medicare. Therefore, if you are planning to receive any services from a nonparticipating facility, if you have exhausted your Medicare benefit for inpatient services, you must obtain prior approval from BCBSNM or the services will not be covered by the Plan. (For emergency services, you must call a BCBSNM Health Services within 48 hours of receiving the service.)

Blood Services — This Plan covers:
- blood transfusions, blood plasma, and blood plasma expanders
- charges for directed donor or autologous blood storage fees if the blood is to be used during a procedure that has been scheduled for that member
- charges for processing, transporting, handling, and administration of blood

Inpatient Medical/Surgical Acute Care Admissions — For admissions to facilities that do not participate with Medicare and for any other admission not covered by Medicare (such as when lifetime reserve days have been exceeded), you are responsible for obtaining prior approval. If prior approval is not obtained, benefits may be reduced or denied. (Services received in a nonparticipating facility will be denied by the Plan if no prior approval was received.)

If an admission is due to an emergency, you must notify BCBSNM within 48 hours of the admission (or as soon as reasonably possible). See “Prior Approvals,” earlier in this Section 5.

Covered Inpatient Hospital Services: For acute 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, up to maximum benefit limits. (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. See “Prior Approvals,” earlier in this Section 5.)

Medicare Lifetime Reserve Days Exceeded: After you use all of your Medicare hospital inpatient coverage (including the Medicare lifetime reserve days), the Plan will cover eligible expenses for hospitalization not covered by Medicare, up to a lifetime maximum benefit of an additional 365 days. During this period, BCBSNM will determine the
Section 5: Other Plan-Covered Services

NMSU Carveout Plan

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

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

medical necessity of all services and whether benefits are available for services received.

Inpatient Physical Rehabilitation — This Plan covers inpatient physical rehabilitation services provided in a BCBSNM-authorized facility. (Call BCBSNM for a list of authorized facilities.) For inpatient physical rehabilitation services not covered by Medicare, you are responsible for obtaining prior approval from BCBSNM at least one week before admission or services may not be covered. See “Prior Approvals,” earlier in this Section 5, for more information.

Hospitalization for physical rehabilitation must begin within one year after the onset of the condition and while the member is covered under this NMSU health care Plan.

This Plan does not cover care that is:
- provided by a facility that has not been authorized by BCBSNM
- for personal convenience
- for maintenance therapy or care provided after a member has reached his/her rehabilitative potential (See the “Long-Term or Maintenance Therapy” exclusion in Section 6.)

Skilled Nursing Facility Services — Benefits are available for covered expenses incurred during a skilled nursing facility confinement after a hospital stay of at least three consecutive days. The confinement must begin within 15 days of discharge from the hospital and be recommended by the attending physician for the condition causing the hospitalization. Covered expenses include daily nonprivate room expenses and ancillary services. This benefit is limited to a maximum of 60 days per calendar year and subject to continued stay review for medical necessity. (These Plan benefits will be in addition to Medicare’s payment for 100 days of confinement in a skilled nursing facility.) Prior approval from BCBSNM is required when services are not covered by Medicare. See “Prior Approvals,” earlier in this Section 5.

Outpatient Facility Services — Coverage for outpatient services depends on the type of service received (for example, see “Lab, X-Ray, and Other Diagnostic Services”) or on special circumstances (for example, see “Emergency and Urgent Care”).

Exclusions — This Plan does not cover:
- additional charges made for private room expenses unless the patient’s medical condition requires that he/she be isolated to protect him/herself or other patients from exposure to dangerous bacteria or diseases (Conditions that qualify for isolation include severe burns and conditions that require isolation according to public health laws.)
If you have a private room for any reason other than isolation, covered room expenses are limited to the hospital’s standard semi-private room rate, whether or not a semi-private room is available.

- admissions related to noncovered services or procedures (See “Dental-Related/TMJ Services and Oral Surgery” for exceptions.)
- admissions to extended care facilities or to similar institutions
- transplant-related services that are not covered by Medicare
- services received in a facility that does not participate with Medicare if prior approval was not received from BCBSNM

Lab, X-Ray, and 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 invasive diagnostic procedures such as biopsies and endoscopies or any procedure that requires the use of an operating or recovery room, see “Surgery and Related Services.”

This Plan covers diagnostic services to detect a known or suspected illness or accidental injury if ordered by a physician, including:

- radiology, ultrasound, mammography, and nuclear medicine
- laboratory and pathology
- EKG, EEG, and other electronic diagnostic medical procedures
- eye and/or audiometric (hearing) tests only for the treatment of an accidental injury or illness
- hospital outpatient services for preadmission testing

Nonroutine Pap tests and mammograms are also covered. If your preventive services benefit maximum has been reached, routine Pap tests and mammograms will continue to be covered under this provision of the Plan. (See “Physician Visits/Medical Care: Preventive Exams/ Routine Tests” for additional routine testing that is covered.)

Massage Therapy

Benefits for massage therapy, when medically necessary and administered by a licensed massage therapist who is appropriately trained and acts within the scope of licensure, are limited to a maximum payment of $750 per member each calendar year.

Pregnancy-Related/Maternity Services

This Plan covers complete prenatal care; pregnancy-related diagnostic tests; visits to an obstetrician, certified nurse-midwife, or registered lay midwife; childbirth in a hospital or in a licensed birthing center staffed by a certified nurse-midwife or physician; and delivery at home by a certified nurse-midwife or a registered lay midwife. This Plan also covers deliveries by cesarean section, ectopic pregnancies, other pregnancy
complications (such as miscarriage), and miscarriage or medically necessary terminations of pregnancy prior to full-term.

**Reminder:** If an admission is for a pregnancy-related condition, you are responsible for notifying BCBSNM within **48 hours** of the admission (within **96 hours** for a C-section) or services may not be covered.

If maternity benefits change during a pregnancy, you receive the benefits in effect on the day the service is received.

A covered, Medicare-eligible dependent daughter is eligible for pregnancy-related benefits. No benefits are available for a dependent’s baby. (If you are adopting the grandchild or becoming the grandchild’s legal guardian, please contact NMSU to obtain NMSU PPO 250 health plan coverage for the newborn.)

**Infertility-Related Services** — This Plan covers testing only to **diagnose** the cause of infertility and for the following medical/surgical treatments (such treatments are considered useful to correct an organic dysfunction but may result in fertility secondarily):

- surgical treatments such as opening an obstructed fallopian tube, epididymis, or vas deferens 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

Once the cause of infertility has been established and the treatment determined to be noncovered, no further infertility testing is covered.

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

- surgical sterilization reversal for males or females
- artificial conception, including fertilization and/or growth of a fetus outside the mother’s body in an artificial environment, such as artificial insemination, in-vitro (“test tube”) fertilization, or embryo transfer
- elective termination of pregnancy, unless medically necessary to protect the life of the mother

**Mental Health and Chemical Dependency**

**Mental illness** — A clinically significant behavioral or psychological syndrome or condition that causes distress and disability and for which improvement can be expected with relatively short-term treatment.

**Chemical dependency** — Conditions that are defined by patterns of usage of alcohol, drugs, or other substances that continue despite occupational, marital, social, or physical problems that are related to the compulsive use of alcohol, drugs, or other substance. These conditions may also be defined by significant risk of severe withdrawal symptoms if the use of
alcohol, drug, or other substance is discontinued. Chemical dependency does not include nicotine addiction.

Partial hospitalization — A nonresidential program of treatment that is no less than three and no more than twelve hours of continuous psychiatric care in a hospital. Two partial hospitalization days equal one inpatient day.

Other provider — 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.).

This Plan does not cover:
- marital or sexual counseling
- services performed or billed by a school, halfway house, or residential treatment center or members of its staff
- services that are not covered by Medicare, unless prior approval is received for such services from BCBSNM

Note: Services for the diagnosis and medical evaluation of autism are covered under the “Physician Visits/Medical Care” portion of the NMSU Carveout Plan.

Inpatient Mental Illness and Chemical Dependency — Inpatient mental illness and chemical dependency (alcoholism and drug/substance abuse) treatment is covered.

For any inpatient services not covered by Medicare, prior approval must be obtained from BCBSNM before you are admitted. See “Prior Approvals,” earlier in this Section 5. No benefits will be available for inpatient mental illness, alcoholism, or drug abuse services not covered by Medicare that are not approved by BCBSNM.

This Plan covers these inpatient services provided by a physician or other licensed provider:
- individual psychotherapy
- group psychotherapy
- psychological testing
- family counseling, or counseling with family members to assist in the patient’s diagnosis and treatment

These inpatient services are not eligible for any additional benefits on an outpatient basis.
Outpatient Mental Health and Chemical Dependency — Benefits are available for outpatient mental health services and the treatment of chemical dependency (alcoholism and/or drug abuse) when the treatment is administered according to an individual treatment plan and provided by a physician, a psychiatrist, a psychologist with a doctoral degree who is certified according to appropriate state law, or an alcoholism treatment program that complies with the Alcohol and Drug Abuse Program standards required by the State of New Mexico. Other professional providers who are properly licensed or certified to engage in the independent practice of psychotherapy (such as licensed clinical psychiatric social workers and licensed psychiatric nurses) must be acting under the direct supervision of a psychiatric physician or a licensed clinical psychologist and acting within the scope of their respective licenses. Treatment provided by anyone else (such as marriage counselors or clergy) is not covered.

All services require prior approval from BCBSNM in order to be covered.

Minimum Coverage for Alcoholism Rehabilitation — If you exhaust your maximum benefits when receiving services that are not related to alcoholism, you are still entitled to up to 30 inpatient days and 30 outpatient/office visits for medically necessary alcoholism rehabilitation during each of two 12-month benefit periods. However, if you exhaust an annual maximum for psychotherapy services while receiving alcoholism treatment, benefits for mental illness and drug abuse will not renew until the following 12-month benefit period. Likewise, if you are receiving alcoholism treatment and use up the two benefit periods, no further drug abuse rehabilitation benefits are available.

Covered services, when prior-approved by BCBSNM, include:
- short-term evaluative and therapeutic individual and group psychotherapy
- evaluation of attention deficit disorders (ADD) or attention deficit with hyperactivity disorders (ADHD)
- psychological testing

Physician Visits/Medical Care

For acupuncture services, see “Acupuncture and Spinal Manipulation.”

For services related to the treatment of mental illness or chemical dependency, see “Mental Health and Chemical Dependency.”

For services related to dental care or other conditions of the mouth, jaw, or teeth, see “Dental-Related/TMJ Services and Oral Surgery.”

For emergency or urgent care services, see “Emergency and Urgent Care.”
Benefits for services received in a physician’s office are based on the type of service received while in the office. This section describes benefits for therapeutic injections, allergy care and testing, and other nonsurgical medical visits to a health care provider for evaluating your condition and planning a course of treatment. Specified routine and preventive services are also covered.

**Inpatient Physician Visits** — With the exception of dental-related services (see “Dental-Related/TMJ Services and Oral Surgery”), the following services, when required for a general condition and received on a covered inpatient hospital day, are eligible for benefits:

- visits that are not related to hospice care (see “Hospice Care” for benefits) and that are for a condition requiring only medical care
- consultations (including second opinions) and, if surgery is performed, inpatient visits by a provider who is not the surgeon and who provides medical care not related to the surgery
- medical care requiring two or more physicians at the same time because of multiple illnesses

This Plan does **not** cover:

- consultations or visits related to any noncovered services
- inpatient services received on a day when facility charges were denied

**Office, Outpatient, and Home Visits** — Medical care for the treatment of accidental injury or other general condition is covered. (Prenatal care, when billed as part of a covered delivery or pregnancy-related service, is paid in the same manner as the actual delivery or completion of pregnancy. See “Maternity Services.”) Specified routine and preventive services are also covered. Covered services include:

- office, urgent care center, home, and hospital emergency room visits and examinations — when not related to hospice care or payable as part of a surgical procedure (See “Hospice Care” and “Surgery and Related Services.”)
- consultations and second surgical opinions
- FDA-approved therapeutic and allergy injections administered in a provider’s office or in a facility
- influenza vaccinations
- direct skin (percutaneous and intradermal) and patch allergy tests and RAST (radioallergosorbent testing), including appropriate injections
- when medically necessary, diabetes self-management education programs designed for members with diabetes
- when prior-approved by BCBSNM, services for the diagnosis and medical evaluation of autism

**Preventive Exams/Routine Tests** — Benefits for physical exams and routine tests that are not covered by Medicare are subject to the Plan deductible, coinsurance, and out-of-pocket provisions, and are limited to a maximum payment of $200 per member each calendar year.

(Medicare-covered preventive services are payable under the “Medicare-Covered Services” provision of the Plan and are not subject to the maximum benefit limitation.)

You must include the EOMB from Medicare that clearly shows that the exam and/or tests were for preventive care and that the services were denied by Medicare.

Once the $200 maximum has been reached, there are no additional benefits for preventive care or routine tests for the rest of the calendar year. **Exception:** Charges for a routine mammogram or Pap test will process first under this $200 maximum benefit. If the maximum benefit under this provision has been reached, charges for a routine mammogram or Pap test will be payable under the “Lab, X-Ray, and Other Diagnostic Services” provision.

This Plan does **not** cover:
- employment physicals, insurance examinations, or examinations at the request of a third party (the requesting party may be responsible for payment)
- routine hearing or eye examinations, hearing aids, any related service or supply, or eye refractions
- exams for nonpreventive purposes such as premarital examinations; sports, camp, or school physicals
- immunizations or medications required for international travel
- hepatitis B immunizations when required due to possible exposure during the member’s work

**Rolfing**

*Rolfing* — A method of body work which releases tension stored in connective tissue of the body. Rolfing is a system of physical manipulation to improve posture and flexibility through structural integration.

Benefits received from a certified roffer will be covered up to a calendar year maximum of $750 (in combination with massage therapy) per member subject to deductible and coinsurance.
Smoking/Tobacco Use Cessation

This Plan covers smoking and tobacco use cessation treatment, limited to the following counseling services received from providers that are approved by BCBSNM 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 your Medicare Part D prescription drug plan or “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:

- drug therapy that has not received prior approval
- acupuncture, biofeedback, or hypnotherapy for smoking/tobacco use cessation
- over-the-counter tobacco cessation products, including but not limited to items such as nicotine patches or nicotine gum

Supplies, Equipment, and Prosthetics

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

Benefits are available for these durable medical equipment, supplies, and prosthetics when prior approval has been received from BCBSNM:
**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 podiatric 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), refer to your Medicare Part D drug plan benefits or see “Prescription Drugs and Other Items.”

**Durable Medical Equipment and Appliances** — The following items are covered when prior approval is received:

- orthopedic appliances
- replacement of items only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- oxygen and oxygen equipment, wheelchairs, hospital beds, crutches, and other necessary durable medical equipment
- lens implants for aphakic patients (those with no lens in the eye) and soft lenses or sclera shells (white supporting tissue of eyeball)
- either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) when necessary to replace lenses absent at birth or lost through cataract or other intraocular surgery or ocular injury, to treat conditions related to genetic inborn errors of metabolism, or prescribed by a physician as the only treatment available for keratoconus (Duplicate glasses/lenses are not covered. Replacement is covered only if a physician or optometrist recommends a change in prescription due to a change in your medical condition. Also, maintenance supplies, such as contact lens solutions, are not covered.)
- FDA-approved contraceptive devices (IUDs, cervical caps, diaphragms)
- incontinence undergarments (pants and/or diapers) when a member is diagnosed with incontinence due to an illness or injury (Although prior approval is not required, a statement from the physician will be
necessary, indicating the expected time frame these supplies will be required and the treatment plan that has been proposed.)

- cardiac pacemakers
- stethoscopes and blood pressure monitors
- 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

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

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

**Orthotics and Prosthetic Devices** — Functional orthotics are covered only for patients having a locomotive problem or gait difficulty resulting from mechanical problems of the foot, ankle, or leg and only when prescribed by a physician or podiatrist. (A functional orthotic is used to control the function of the joints.)

The following items are also covered:

- surgically implanted prosthetics or devices, including penile implants required as a result of illness or injury
- externally attached prosthesis to replace a limb or other body part lost after accidental injury or surgical removal; their fitting, adjustment, repairs, and replacement
- replacement of prosthetics only when required because of wear (and the item cannot be repaired) or because of a change in your condition
- breast prosthetics when required as the result of a mastectomy 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.

**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
- dental appliances (See “Dental-Related/TMJ Services and Oral Surgery” for exceptions.)
- contraceptive devices that do not require a prescription, including over-the-counter contraceptive products such as condoms and spermicide
- nonstandard or deluxe equipment, such as motor-driven wheelchairs, chairlifts, or beds; external prosthetics that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing
- repairs to 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
- 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 BCBSNM Health Services 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 and contact lenses and the costs related to prescribing or fitting of glasses or contact lenses, unless listed as covered; sunglasses, special tints, and other extra features for eyeglasses or contact lenses
- hearing aids or ear molds, fitting of hearing aids or ear molds, or related services or supplies (For surgically implanted devices for the profoundly hearing impaired, see “Surgery and Related Services.”)
- syringes or needles for self-administering drugs (other than insulin)
- items that can be purchased over-the-counter, including but not limited to dressings for bed sores or burns, gauze, and bandages
- items not listed as covered
- bed pans and similar supplies related to incontinence if not specifically listed as covered
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.

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

See also: *If you undergo surgery in a hospital (inpatient or outpatient) or other facility, see “Hospital/Other Facility Services” for more information.*

**Surgeon’s Services** — Covered services include surgeon’s charges for a covered surgical procedure.

**Remember:** In addition to specific procedures listed as requiring prior approval when Medicare benefits are not available, if you are hospitalized for surgery, you are responsible for obtaining prior approval or the services may be denied. See “Prior Approvals,” earlier in this Section 5.

**Surgical Sterilization** — This Plan covers surgical sterilization, such as a tubal ligation or a vasectomy. However, this Plan does not cover procedures to reverse sterilization.

**Cataract Surgery** — This Plan covers cataract surgery and the initial placement of lenses (eyeglass lenses and conventional frames or contact lenses) after surgery.

**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,” on the previous page.)
- a functional congenital defect (any condition, present from birth, that is significantly different from the common form; for example, a cleft palate or certain heart defects)

You or your physician must obtain prior approval, requested in writing, from BCBSNM before the reconstructive service is provided. If surgery (including orthognathic surgery 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.

**Transplant Surgery** — Benefits are available only for transplant procedures and related services covered by Medicare. Transplant procedures and related services not covered by Medicare are not covered by the NMSU Carveout Plan.

**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. Acupuncture services are subject to the calendar year maximum benefit described in “Acupuncture and Spinal Manipulation.”
Section 5: Other Plan-Covered Services

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:

- 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”); procedures to correct cosmetically unsatisfactory surgical results or surgically induced scars
- cochlear implants
- elective termination of pregnancy, unless medically necessary to protect the life of the mother
- refractive keratoplasty, including radial keratotomy, or any procedure to correct visual refractive defect
- trimming of corns, calluses, toenails, or bunions (except surgical treatment such as capsular or bone surgery or medically necessary services required due to diabetes)
- 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)
- obesity treatment, including the surgical treatment of morbid obesity
- any reconstructive procedure, orthognathic surgery, breast reduction, orthotripsy, or cosmetic breast surgery that has not received prior approval from BCBSNM (requested in writing)
- the insertion of artificial organs, or services related to transplants not covered by Medicare
- standby services unless the procedure is identified by BCBSNM as requiring the services of an assistant surgeon and the standby physician actually assists
- 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
Therapy, Outpatient or Office
All of the following therapeutic services are covered when performed in the outpatient department of a hospital, freestanding treatment facility or clinic, provider’s office, or patient’s home.

When received during a covered admission and billed as part of the facility service, therapy charges will be covered in the same manner as other ancillary services (see “Hospital/Other Facility Services”).

For services not covered by Medicare, you are responsible for obtaining prior approval for all of the therapeutic services listed below. Ask your physician to call BCBSNM Health Services for the necessary prior approval. If you do not obtain prior approval, benefits for covered services may be reduced or denied.

Cardiac Rehabilitation — This Plan covers up to 36 outpatient cardiac rehabilitation visits if provided within six months of a cardiac incident. If not covered by Medicare, prior approval must be obtained from BCBSNM or no benefits are available.

Chemotherapy, Dialysis, Radiation Therapy — This Plan covers the following inpatient or outpatient therapeutic services:
- treatment of malignant disease by standard chemotherapy
- treatment for removal of waste materials from the body, including renal dialysis, hemodialysis, or peritoneal dialysis, and the cost of equipment rentals and supplies
- treatment of disease by x-ray, radium, or radioactive isotopes

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. The trial must be conducted as part of a scientific study of a new therapy or intervention for the prevention of reoccurrence, early detection, or treatment or palliation of cancer. 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.

If not covered by Medicare, prior approval must be obtained from BCBSNM or no benefits are available.
Physical, Occupational, and Speech Therapy — This Plan covers outpatient rehabilitation services, including prior-approved physical therapy from a licensed physical therapist, and occupational or speech therapy from a licensed or certified occupational or speech therapist.

Covered services may include treatment using hydrotherapy, heat, or similar modalities to relieve pain, restore maximum function, and prevent disability following illness, injury, or loss of a body part.

Exclusions — This Plan does not cover:

- maintenance therapy or care provided after you have reached your rehabilitative potential (Even if you have not reached your rehabilitative potential, this Plan does not cover services that exceed maximum benefit limits. See the “Long-Term or Maintenance Therapy” exclusion in Section 6.)
- therapy for the treatment of chronic conditions such as, but not limited to, cerebral palsy or developmental delay
- diagnostic, therapeutic, rehabilitative, or health maintenance services provided at or by a health spa or fitness center, even if the service is provided by a licensed or registered provider
- therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights)
- 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 (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 Section 6.)
- services received without prior approval

Prescription Drugs and Other Items

Genetic inborn errors 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.

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.

**Covered Medications and Other Items**

For members whose Medicare coverage is primary (such as Medicare-eligible retirees and Medicare-eligible dependents of retirees and certain end-stage renal disease patients), coverage for outpatient prescription drugs and other items is under the Medicare Part D plan (BlueMedicare Rx at 1-877-838-3875).

**For members with Medicare Part D prescription drug coverage, Medicare is the primary payer.** Medicare pays first. However, if a service is not covered by Medicare Part B and/or Part D, this health plan will cover the items listed below as the primary payer, subject to Plan deductible and coinsurance:

- insulin, insulin needles, syringes, insulin delivery devices, and diabetic supplies (e.g. glucagon emergency kits, lancets, lancet devices, alcohol swabs), blood glucose and visual reading urine and ketone test strips (A drug plan claim form must be submitted.)

- 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 persons with genetic inborn errors of metabolism in order to maintain their adequate nutritional status (Benefits are limited to the purchase of a 30-day supply during any 30-day period. These products must have prior approval from BCBSNM in order to be covered and are subject to a 50 percent copayment.)

- two 90-day courses of prior-approved treatment with FDA-approved prescription drugs to assist you with quitting tobacco use or smoking (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. A drug plan claim form must be submitted.)

- nebulization products, subject to the Plan deductible and 20 percent coinsurance

Benefits for all drugs and other items covered under this provision are limited to the purchase of a 30-day supply during any 30-day period. In addition, there are no benefits for prescriptions for barbiturates or benzodiazepines. **Note:** Prescription contraceptive devices are payable under the “Family Planning” provision.
General Limitations and Exclusions

Many health care expenses are covered. However, some services and supplies are not covered. Also, benefits never exceed the expenses for covered services. This section lists some conditions, items, and services that, unless covered by Medicare, are not covered or are partially covered. Read this section carefully. (See also Sections 4 and 5 for specific benefit limitations and exclusions.)

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.

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

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

Before Effective Date of Coverage — This 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.

Cochlear Implants — This Plan does not cover cochlear implants and related care.

Complications of Noncovered Services — This Plan does not cover services and supplies that were not covered by Medicare and were received because of complications resulting from services not covered by the Plan, including complications from noncovered transplants, from cosmetic, experimental, investigational, or unproven procedures, from sterilization reversal, or from sex change procedures.
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, 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 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 5 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 6, see “Dental-Related/TMJ Services and Oral Surgery” in Section 5 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. (See “Coordination of Benefits” in Section 3.) Note: If a member is eligible for Medicare but does not choose to enroll, benefits will not be available and coverage under this Plan will be discontinued.

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 below), or those considered experimental, investigational, or unproven. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted when services were administered, the service is experimental and will not be covered. To be considered experimental, investigational, or unproven, one or more of the following conditions must be met:

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

Reliable evidence means only published reports and articles in authoritative peer-reviewed medical and scientific literature; the written protocol or protocols used by the treating facility, or the protocol(s) of another facility studying substantially the same medical treatment, procedure, device, or drug; or the written informed consent used by the treating facility or by another facility studying substantially the same medical treatment, procedure, device, or drug. Experimental, 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 BCBSNM Reconsideration” in Section 7.

**Food or Lodging Expenses — This Plan does not cover** food or lodging expenses.

**Foot Care — This Plan does not cover** foot care, including all routine services such as the treatment of flat foot conditions, supportive devices, accommodative orthotics (for functional orthotics benefit, see “Supplies, Equipment, and Prosthetics” in Section 5), orthopedic shoes (unless joined to braces), treatment of partial dislocations, bunions (except capsular or bone surgery), fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet, and the trimming of corns, calluses, or toenails except in the case of diabetics. (Diabetic members may be eligible to receive benefits for certain routine foot care services. Call a BCBSNM Health Services representative for more information.)

**Government Facility Services — This Plan does not cover** services or supplies that the member is eligible to have provided without charge, or that are paid directly or indirectly by a local, state, or federal government agency (except Medicaid or a Department of Defense or Veterans Administration facility in connection with a nonservice-connected condition), or while in active military service. Also see “Coordination of Benefits” in Section 3.

**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 required for the diagnosis and/or treatment of an accidental injury or an illness. **This Plan does not cover** hearing aids or ear molds, fitting of hearing aids or ear molds, or any related service or supply.

**Hypnotherapy — This Plan does not cover** hypnosis or services related to hypnosis, whether for medical or anesthesia 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” in Section 5.)

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. If a claim is returned for further information, resubmit it within 45 days.

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.

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.

Note: Some benefits specifically limited by the Plan may be covered by Medicare but not covered by the Plan.

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 management.
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).

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 “Physician Visits/Medical Care: Preventive Exams/Routine Tests” in Section 5).

For services not covered by Medicare, 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.

Medicare-Denied Services — This Plan does not cover any service denied by Medicare as being medically unnecessary, experimental, investigational, or unproven, cosmetic, custodial, domiciliary, for maintenance therapy, nonmedical, for personal convenience, related to a sex change, war-related, or work-related.

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: This exclusion 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
- facility that does not participate with Medicare (unless prior approval is received from BCBSNM)
- 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
  - 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

**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
- educational programs such as behavior modification and arthritis classes (Some diabetic services and other educational programs may be covered; see “Physician Visits/Medical Care” in Section 5 for details.)
- vocational or training services and supplies
- mailing and/or shipping and handling
- missed appointments; “get-acquainted” visits without physical assessment or medical care; telephone consultations; provision of medical information for 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
- directed donor or autologous blood storage fees when the blood is used during a nonscheduled surgical procedure

**Nonparticipating Facility Services — This Plan does not cover** services received at facilities that do not contract with Medicare unless such services are approved in advance by BCBSNM.

**Obesity Treatment — This Plan does not cover** weight-loss or other weight-management programs, dietary control, or medical obesity treatment. This Plan does not cover any and all surgical treatments of obesity including, without limitation, gastric bypass or other type of bariatric surgery, under any circumstance. This is true regardless of the presence or absence of other medical conditions that can be either directly or indirectly attributed to obesity. Obesity means any diagnosis of obesity including morbid obesity.

**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.

**Prescription Drugs and Other Items — This Plan does not cover** prescription or nonprescription drugs or certain items payable under your Medicare Part D prescription drug program except as specified in the “Prescription Drugs and Other Items” provision in Section 4.

**Prior Approval Not Obtained When Required — This Plan does not cover** certain services that are not covered by Medicare if you do not obtain prior approval from BCBSNM before those services are received. See “Prior Approvals” in Section 5.

**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.

Services Not Identified — This Plan does not cover any service or supply not specifically identified as covered in this benefit booklet, unless covered by Medicare and not in excess of applicable Plan maximums. BCBSNM will determine the services covered by the Plan for all services not covered by Medicare. (See “Medicare-Denied Services” for those services not covered by Medicare that are also not covered by the Plan.)

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 6, see “Supplies, Equipment, and Prosthetics” in Section 5 for additional exclusions.

Surgery and Related Services — In addition to services excluded by the other general limitations and exclusions listed throughout this Section 6, see “Surgery and Related Services” in Section 5 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 exclusions listed throughout this Section 6, 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
- transactional analysis, encounter groups, and transcendental meditation; moxibustion; sensitivity or assertiveness training
- smoking/tobacco use counseling programs of providers that do not meet the standards set by the NM Public Regulation Commission or that are received from providers not approved by BCBSNM
- vision therapy; orthoptics
- pastoral, spiritual, religious, or marital counseling
- supportive services provided to the family of a terminally ill patient when the patient is not a member of this Plan
therapy for chronic conditions such as, but not limited to, cerebral palsy or developmental delay
- any therapeutic exercise equipment prescribed for home use (e.g., treadmill, weights)
- 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 — This Plan does not cover** any other transplants, organ-combination transplant, or services related to any transplant that is not covered by Medicare.

**Travel or Transportation — This Plan does not cover** travel expenses, even if travel is necessary to receive covered services. **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

**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 Plan does not cover** eyeglasses, contact lenses, prescriptions associated with such procedures, and costs related to the prescribing or fitting of glasses or lenses, unless listed as covered in Section 5. **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 medical obesity treatment. **This Plan does not cover** any and all surgical treatments of obesity including, without limitation, gastric bypass or other type of bariatric surgery, under any circumstance. This is true regardless of
the presence or absence of other medical conditions that can be either directly or indirectly attributed to obesity. Obesity means any diagnosis of obesity including morbid obesity.

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 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.)
Filing Claims

Please file all claims within 12 months after the date of service. Claims submitted after the 12-month deadline are not eligible for benefit payments. Medicare also has time limits for filing claims. Contact the local Social Security Office for information on Medicare hospital and medical insurance filing deadlines. If a claim is returned for further information, resubmit it within 45 days.

When you receive care from providers, be sure to present both your Medicare and NMSU Carveout Plan identification cards.

An 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. Covered services are the same services listed as covered throughout this booklet and all services are subject to the limitations and exclusions listed throughout this booklet.

If You Have Other Non-Medicare Coverage

When you have other coverage that is “primary” over this Plan, you need to file your claim with the other coverage first. (See “Coordination of Benefits” and “Reimbursement” in Section 3.)

After your other coverage (including health care insurance, dental or vision plan, 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.

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. (If a provider does not file claims for you, attach a copy of the payment explanation to the claim that you send to BCBSNM.)
Medicare-Covered Facility Services
All New Mexico Medicare-participating providers of Part A services, including skilled nursing facilities and hospices, will submit claims directly to Medicare. To file claims, the facility must have the information from the identification cards issued to you by both Medicare and BCBSNM.

It is not necessary for you to file a claim for New Mexico facility services with BCBSNM. These claims are automatically submitted, by the Medicare Part A intermediary, to BCBSNM. An Explanation of Benefits will be sent to you by BCBSNM after Plan benefits have been determined.

If services are not received in New Mexico, you must file the claim, along with Medicare’s Explanation of Medicare Benefits form (EOMB), to BCBSNM, after Medicare has made its payment. (See the inside front cover of this booklet for the claims filing address.)

Medicare-Covered Professional Services
A claim for physician and other professional provider services must be filed first with Medicare Part B Medical Insurance. (All providers must file claims for you to Medicare.)

If the services were provided in New Mexico, the Medicare Part B carrier will send an electronic copy of the claim to BCBSNM. You do not need to file a claim for services received in New Mexico with BCBSNM.

For services provided outside New Mexico, after Medicare has made its payment and sent an EOMB to you, you must file a copy of the EOMB and all other required claim information with BCBSNM. On the EOMB you receive from Medicare, print your Plan ID number and your correct mailing address and zip code. Then make a copy of the EOMB for your records.

Even though providers may file claims on your behalf, it is your responsibility to make sure that the claim is filed to BCBSNM.

Services Not Covered by Medicare
You may have to file your claim yourself. If your provider does not file a claim for you, you must submit a separate claim form for each family member. Submit all claims as the services are received.

Sometimes providers use preprinted statements or Super Bills to list services. If this is the case, you should complete the portion of the statement asking for the subscriber’s name, patient’s name, and identification and group numbers. The diagnosis, illness, or accidental injury that required treatment must also be stated.
Attach the itemized bills or Super Bills for services or supplies to a Member Claim Form. (See “Itemized Bills.”) Complete the claim form using the instructions on the form. Do not file for the same service twice unless asked to do so by an NMSU DSU representative.

**Note:** An EOMB indicating Medicare denied the service is required on all claims except claims for services received outside the Medicare territorial limits, acupuncture, rolfing, and massage therapy.

**Services Outside Medicare Territorial Limits** — You have health care coverage for services received inside and outside the Medicare territorial limits (services outside the territorial limits of Medicare may be eligible under the “Other Plan-Covered Services” provision of this Plan). When services are received outside the Medicare territorial limits, you must pay for the services or supplies. **Keep copies of your receipts and translate the language into English.** File claims as you would for any other service not covered by Medicare. (Medicare defines Medicare territorial limits as the United States, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.)

To submit a claim for services received outside the Medicare territorial limits, you do not need an EOMB.

**Itemized Bills**

Itemized bills must be submitted on billing forms or provider’s letterhead stationery and must show:

- name and address of the physician or other health care provider, including the provider’s tax ID or social security number
- full name of the patient receiving treatment or services
- date, type of service, diagnosis, and charge for each service (each service must be listed separately)

The only acceptable bills are those from health care providers — do **not** file bills you prepared yourself, canceled checks, balance due statements, or cash register receipts. Make a copy of all itemized bills for your records before you send them. The bills are not returned to you. **Correctly itemized bills are necessary for your claim to be processed so that all benefits available under the NMSU Carveout Plan are provided.**

If your itemized bills include services previously filed, identify clearly the new charges that you are submitting.
Reminder: For Medicare-covered services received in New Mexico, you do not have to file a claim; a claim is filed for you automatically. Note: Do not send claims for prescription drugs to BCBSNM unless they are covered under “Prescription Drugs and Other Items” provision in Section 4.

Where to Send Claim Forms
If your provider does not file a claim for you, you (not the provider) are responsible for filing the claim. Member claim forms are available from an NMSU DSU representative. Mail the forms and itemized bills to:

Blue Cross and Blue Shield of New Mexico
Attention: NMSU DSU
P. O. Box 27630
Albuquerque, New Mexico 87125-7630

Please file all claims within **12 months** after the date services or supplies were received. If your provider does not file a claim for you, you (not the provider) are responsible for filing the claim. If a claim is returned for further information, please resubmit it within 45 days.

Advance Benefit Information
If you want to know what benefits will be paid before receiving a service or filing a claim, BCBSNM may require you to submit a written request for such information. In some cases, BCBSNM may require a written statement from your physician identifying the circumstances of your case and the specific services that will be provided. An advance confirmation of benefits does not guarantee benefits if the actual circumstances of your case differ from those originally described. When submitted, your claims will be reviewed in accordance with the terms of this benefit booklet or any other coverage that applies on the date of service.

How Payments Are Made
After your claim has been processed, you will receive an Explanation of Benefits (EOB). The EOB tells you 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 a dependent child of divorced parents, the custodial parent may receive the payment and the EOB.

Payments for covered services may be sent to the providers. Your EOB explains the payment. For Medicare-covered services, if Medicare pays the provider, the Plan will generally pay the provider; if Medicare does not pay the provider, the Plan will generally pay the Medicare beneficiary.
Provider payments under this Plan are based upon the Plan’s covered charge. You are responsible for paying all deductible, coinsurance, and noncovered expenses.

If payment for covered services is sent to you (or to the applicable alternate payee when a QCMSO is in effect), the check is attached to an EOB that explains the NMSU Carveout Plan’s payment. In these cases, you are responsible for arranging payment to the provider and for paying any amounts greater than covered charges plus copayments, deductibles, coinsurance, any penalty amounts, and noncovered expenses.

**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.

**Medicaid** — Payment of benefits for members eligible for Medicaid is made to the New Mexico Human Services Department 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.

**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 payments made by BCBSNM are greater than the benefits available under the Plan, you must refund the excess. If you do not, future benefits may be withheld and applied to the amount that you owe to BCBSNM.

### Request for Medicare Reconsideration

When Medicare Part A or B denies part or all of a claim, you can obtain information from a local Social Security Office on how to request reconsideration or review of denied Medicare claims and a description of your right to appeal Medicare claims decisions.
Section 7: Claims, Claims Payments, and Appeals

NMSU Carveout Plan

If Medicare makes an additional payment after reconsideration, file the new Explanation of Medicare Benefits to BCBSNM for additional reimbursement under this Carveout Plan.

[Box: Request for BCBSNM Reconsideration]

You may file a formal request for reconsideration of claims or prior approval requests that BCBSNM has denied totally or partially. However, before filing such a request, you agree to ask an NMSU DSU representative about the denial and supply whatever additional documentation or information may be available in support of your claim. If still dissatisfied with BCBSNM’s decision, then you may file a formal request for reconsideration on a special form available from BCBSNM. **You waive any right to reconsideration if you do not file the formal request for reconsideration within 180 days of the denial of the claim.**

BCBSNM will acknowledge in writing the receipt of the request. Within 60 calendar days of receipt, BCBSNM will review the request for reconsideration and notify you in writing of its decision. If BCBSNM’s decision continues to be that no benefits will be allowed or no changes will be made in the amounts paid, BCBSNM will provide in writing all of the reasons for denying the claim.

[Box: 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, 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).

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.

[Box: 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.
BlueExtras℠
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 Blvd. NE.

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.

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.
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 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.

**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.

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

**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** — A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an
Independent Licensee of the Blue Cross and Blue Shield Association; also referred to as BCBSNM.

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

**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 5, 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 prevention information 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.

**Chiropractic services** — Any service or supply administered by a chiropractor acting within the scope of his/her licensure and according to the standards of chiropractic medicine in New Mexico or the state in which services are rendered.

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

**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 the covered charge — after the deductible has been met — that you are required to pay for most Medicare-covered services received from providers that do not accept Medicare assignment and for most other services that are covered by the Plan.

**Cosmetic** — See the “Cosmetic Services” exclusion in Section 6.

**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** — The amount that is, for Medicare-covered services, Medicare's approved amount for assigned claims, or Medicare's limiting charge (or 115 percent of the Medicare-approved amount) for non-assigned claims. For services not covered by Medicare, covered charges are BCBSNM's maximum allowable fee.

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

**Deductible** — The amount of money that you must pay in a calendar year before this Plan pays benefits for non-assigned Medicare-covered services and for most non-Medicare-covered services that are covered by the Plan.
**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 3: 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 2.

**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 coverage for a member begins under this Plan.

**Experimental, investigational, or unproven** — See “Experimental, Investigational, or Unproven Services” exclusion in Section 6.

**Explanation of Medicare Benefits form (EOMB)** — The Medicare notice explaining what medical services or supplies were covered, what charges were approved, the amount of the limiting charge, if applicable, how much was credited toward the Part A or B deductible, and the amount that Medicare paid.

**Facility** — A hospital (see “Hospital,” later in this section) 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.

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 dependents.

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

Home health care services — Covered services, as listed under “Home Health Care and Home I.V. Services” in Section 5, 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 provider that is a short-term, acute, general hospital that meets all of the following criteria:
- is a duly licensed institution;
- for compensation from its patients, is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of physicians;
- has organized departments of medicine and major surgery;
- provides 24-hour nursing service by or under the supervision of registered nurses;
- is not, other than incidentally, a skilled nursing facility, nursing home, custodial care home, health resort, spa, or sanitarium; and
- is not a place for rest, for the aged, for the treatment of mental illness, alcoholism, drug abuse, or pulmonary tuberculosis, and ordinarily does not provide hospice or rehabilitation care, and is not a residential treatment facility.

**Identification card (ID card)** — The card BCBSNM issues to 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 5, an “investigational drug or device” means a drug or device that has not been approved by the federal Food and Drug Administration.

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

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

**Maintenance therapy** — Treatment that does not significantly enhance or increase the patient’s function or productivity. See the “Long-Term or Maintenance Therapy” exclusion in Section 6.
Maternity — Any condition or service 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 C-section. See “Maternity Services” in Section 5 for more information.

Maximum allowable fee — A fair and reasonable charge as determined by BCBSNM (or total billed charges, whichever is less) for Plan-covered services that are not covered by Medicare. Also see the definition of “Covered charge.”

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

Medical detoxification — Treatment in an acute care facility for withdrawal from the physiological effects of 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 “Medical Necessity” in 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.

Medicare-covered services — Health care services that are covered by Medicare.

Medicare lifetime reserve days — The extra days of inpatient hospitalization coverage beyond the Medicare maximum of 90 days in a Medicare benefit period. These reserve days can be used only once during anyone’s lifetime. The decision of when to use the reserve days is made by the individual, but the hospital must be notified in writing ahead of time if the individual does not want to use reserve days during a particular hospital stay.
Medicare-approved amount — The Medicare fee schedule amount upon which Medicare bases its payments. This amount may be less than the actual amount charged by the provider.

Medicare limiting charge — As determined by Medicare, the limit on the amount that a nonparticipating provider can actually charge a Medicare beneficiary. Note: Not all Medicare-covered services from nonparticipating providers are restricted by a Medicare limiting charge.

Medicare territorial limits — The United States, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

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

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.

NMSU Carveout Plan — The New Mexico State University's Plan that coordinates benefits with Medicare benefit payments and provides additional medical benefits as described in this benefit booklet.

Nonparticipating provider — See “Provider,” later in this section.

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 where the patient leaves the same day and which does not involve an overnight stay.

**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.

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

**Physical therapist** — A licensed physical therapist. Where there is no licensure law, the physical therapist must be certified by the appropriate professional body. 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 Doctor of Osteopathy (D.O.) who is licensed and legally entitled to practice medicine in all of its branches, and dispense drugs.

**Plan** — The New Mexico State University Carveout Plan.

**Plan coinsurance** — The percentage of a covered charge that is your responsibility to pay for Medicare-covered services from providers that do not accept Medicare assignment and for some non-Medicare-covered services that are covered by the Plan. For covered services that are subject to coinsurance, you pay a percentage of the covered charge after the deductible has been met.

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

**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 physician must obtain approval from BCBSNM before you receive certain types of non-Medicare-covered services or procedures, or services from non-participating facilities. Without prior approval, benefits for covered services may be reduced or denied.
**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 residential treatment center, a home health care agency, a diagnostic laboratory or imaging center, and a rehabilitation or other therapeutic health setting.

- **Professional provider:** A physician or health care practitioner, including a pharmacist, who is licensed, certified, or otherwise authorized by the state to provide health care services consistent with state law.

- **Participating provider:** A health care provider or practitioner that accepts Medicare’s approved amount as payment in full by accepting Medicare assignment. These providers have been approved by the Department of Health and Human Services of the United States for receiving Medicare payments.

- **Nonparticipating provider:** A health care provider or practitioner that does not accept Medicare assignment. Also, see “Medicare limiting charge.”

**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 6.

Respiratory therapist — A person qualified for employment in the field of respiratory therapy. A respiratory therapist assists patients with breathing problems.

Routine patient care cost — For purposes of the cancer clinical trial benefit described in Section 5, 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. **Note:** A “routine patient care cost” does not include the cost of any investigational drug, device, or procedure, the cost of a non-health care service that you must receive as a result of your participation in the clinical trial, costs for managing the research, costs that would not be covered or that would not be rendered if non-investigational treatments were provided, or costs paid or not charged for by the trial providers.

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

Skilled nursing facility — A facility or part of a facility that:
- is licensed in accordance with state or local law;
- is approved as a Medicare-participating facility;
- is primarily engaged in providing to inpatients skilled nursing care under the supervision of a duly licensed physician;
- 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, for the care of the aged, or for the care and treatment of chemical dependency, mental illness, 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 employment or other status, except for family dependency, is the basis for enrollment eligibility, or in the case of a direct-pay contract, the person in whose name the contract is issued. The term “subscriber” may also encompass other persons in a nonemployee relationship with NMSU if specified in the Group Master Contract (e.g., retirees, surviving eligible spouses).

**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.

**Urgent care** — Services received when prompt medical attention is required for situations that are not life threatening. Examples of urgent care are sprains, high fever, and 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 dependent 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 dependent 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 “dependent 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 dependent 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 dependent child losing eligibility for coverage as a dependent 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 dependent child losing eligibility as a dependent 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 dependent 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 dependent 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 dependent child stops being eligible under the Plan as a dependent child — but only if the second event would have caused the spouse or dependent 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 dependents; and
- the members’ identification cards.

In addition, NMSU has important documents that are part of the legal agreement:

- the Group Master Application from NMSU; 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 or NMSU 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.