BlueCross BlueShield of New Mexico

New Mexico State University

Account #: 265001

A Guide To Your Medigap Plan G

CUSTOMER ASSISTANCE

Customer Service: —The 24/7 Nurseline can help when you have a **health** problem or concern. The 24/7 Nurseline is staffed by registered nurses who are available 24 hours a day, 7 days a week.

24/7 Nurseline toll-free telephone number: 1-800-973-6329

When you have a **non-medical** benefit question or concern, 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 BCBSNM Customer Service department in Albuquerque. (If you need assistance outside normal business hours, you may call the Customer Service telephone number and leave a message. A Customer Service Advocate will return your call by 5 P.M. the next business day.) You may either call toll-free or visit the BCBSNM office in Albuquerque at:

NMSU Designated Service Unit (DSU)
1-866-369-NMSU (6678)
Street address: 4373 Alexander Blvd. NE

Website—For provider network information, BCBSNM Drug List, claim forms, and other information, or to e-mail your question to BCBSNM, visit the BCBSNM website at:

www.bcbsnm.com

Be sure to read this benefit booklet carefully and refer to the *Summary of Benefits*.

A message from

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO

Welcome to the New Mexico State University (NMSU) Medigap Plan G for eligible retirees. This Plan is underwritten by Blue Cross and Blue Shield of New Mexico (BCBSNM), your partner in health care. Like most people, you probably have many questions about your coverage. This benefit booklet contains a great deal of information about the services and supplies for which benefits will be provided under your Plan. Please read your entire benefit booklet very carefully. We hope that most of the questions you have about your coverage will be answered.

We refer to our company as ''BCBSNM'' in this benefit booklet, and we refer to the company (or as a retiree of NMSU) as the ''group.'' *Section 8: Definitions* will explain the meaning of many of the terms used in this benefit booklet. Whenever the term ''you'' or ''your'' is used, we also mean all eligible family members who are covered under this Plan.

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

BCBSNM and your group may change the benefits described in this benefit booklet. If that happens, BCBSNM or your group will notify you of those mutually agreed upon changes.

If you have any questions once you have read this benefit booklet, talk to your benefits administrator or call us at the number listed on the back of your ID card, or as listed in *Customer Assistance* on the inside front cover. It is important to all of us that you understand the protection this coverage gives you.

Welcome to Blue Cross and Blue Shield of New Mexico! We are very happy to have you as a member and pledge you our best service.

Sincerely,

Janice Torrez, President
Blue Cross and Blue Shield of New Mexico

New Mexico State 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. All enrollment information comes from NMSU to BCBSNM. Please contact NMSU Benefits Services with any enrollment changes such as changes to contact information or termination.

Feel free to contact Benefits Services at (575) 646- 8000 with any questions you may have regarding benefits.

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SECTION 1: HOW TO USE THIS BENEFIT BOOKLET

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

DEFINITIONS

Throughout this benefit booklet, many words are used that have a specific meaning when applied to your health care coverage. When you come across these terms while reading this benefit booklet, please refer to *Section 8: Definitions,* for an explanation of the limitations or special conditions that may apply to your benefits.

SUMMARY OF BENEFITS

Throughout this benefit booklet, you are asked to refer to a separately issued *Summary of Benefits* that shows specific member cost-sharing amounts and coverage limitations of your Plan. If you do not have a *Summary of Benefits*, please contact a BCBSNM Customer Service Advocate (the phone number is at the bottom of each page of this benefit booklet). You will receive a new *Summary of Benefits* if changes are made to your health care plan.

IDENTIFICATION (ID) CARD

You will receive a BCBSNM identification (ID) card. Your health insurance ID card indicates the subscriber's name under this Plan. The ID card contains your "group" number and your identification number (including an alpha prefix) and tells providers that you are entitled to benefits under this health care plan with BCBSNM.

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 prescriptions. Do not let anyone who is not named in your coverage use your card to receive benefits. If you need an additional card or need to replace a lost card, contact a BCBSNM Customer Service Advocate.

BCBSNM has contracted with a separate pharmacy benefit manager to administer your outpatient drug plan benefits. In addition to your benefit booklet, you will be sent important information about your drug plan benefits.

LIMITATIONS AND EXCLUSIONS

Each provision in *Section 4: Medicare- Covered Services* not only describes what is covered, but may list some limitations and exclusions that specifically relate to a particular type of service. *Section 5: Limitations and Exclusions* lists limitations and exclusions that apply to *all* services.

DESIGNATED CUSTOMER SERVICE

If you have any questions about your coverage, call or e- mail BCBSNM's dedicated New Mexico State University Designated Customer Service Unit (DSU). Customer Service Advocates are available Monday through Friday from 6 A.M. - 8 P.M. and 8 A.M. - 5 P.M., Mountain Standard Time on Saturdays and most holidays. If you need assistance outside normal business hours, you may call the Customer Service telephone number and leave a message. A Customer Service Advocate will return your call by 5 P.M. the next business day.

Customer Service representatives can help with the following:

- answer questions about your benefits
- assist with preauthorization requests
- check on a claim's status
- order a replacement ID card, provider directory, benefit booklet, or forms

For your convenience, the toll- free customer service number is printed at the bottom of every page in this benefit booklet. Refer to Customer Assistance on the inside cover of this booklet for important phone numbers, website, and mailing information. You can also e- mail the Customer Service unit via the BCBSNM website noted below:

Website: www.bcbsnm.com

Deaf and Speech Disabled Assistance

Deaf, hard-of-hearing, and speech disabled callers may use the New Mexico Relay Network. Dialing **711** connects the caller to the state transfer relay service for TTY and voice calls.

Translation Assistance

If you need help communicating with BCBSNM, BCBSNM offers Spanish bilingual interpreters for members who call Customer Service. If you need multi-lingual services, call the Customer Service phone number on the back of your ID card.

After Hours Help

If you need or want help to file a complaint outside normal business hours, you may call Customer Service. Your call will be answered by an automatic phone system. You can use the system to:

- leave a message for BCBSNM to call you back on the next business day
- leave a message saying you have a complaint or appeal
- talk to a nurse at the 24/7 Nurseline right away if you have a health problem

ENROLLMENT ASSISTANCE

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

New Mexico State University
Attn: Benefit Services
Off-site: P.O. Box 30001, MSC 3HRS, Las Cruces, NM 88003-8001
Telephone: (575) 646-8000
E-mail: benefits@nmsu.edu

HEALTH CARE FRAUD INFORMATION

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

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

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

BLUE ACCESS FOR MEMBERS SM

To help members track claim payments, make health care choices, and reduce health care costs, BCBSNM maintains a flexible array of online programs and tools for health care plan members. The online "Blue Access for Members" (BAM) tool provides convenient and secure access to claim information and account management features and the Cost Estimator tool. While online, members can also access a wide range of health and wellness programs and tools, including a health assessment and personalized health updates. To access these online programs, go to www.bcbsnm.com, log into Blue Access for Members and create a user ID and password for instant and secure access.

If you need help accessing the BAM site, call:

BAM Help Desk (toll-free): 1-888-706-0583
Help Desk Hours: Monday through Friday 6 A.M. - 9 P.M., Mountain Standard Time
Saturday 6 A.M. - 2:30 P.M. Mountain Standard Time.

Note: Depending on your group's coverage, you may not have access to all online features. Check with your benefits administrator or call Customer Service at the number on the back of your ID card. BCBSNM uses data about program usage and member feedback to make changes to online tools as needed. Therefore, programs and their rules are updated, added, or terminated, and may change without notice as new programs are designed and/or as our members' needs change. We encourage you to enroll in BAM and check the online features available to you - and check back in as frequently as you like. BCBSNM is always looking for ways to add value to your health care plan and hope you will find the website helpful.

SECTION 2: ENROLLMENT AND TERMINATION INFORMATION

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 both Parts A and B of Medicare (regardless of age).

If you are over age 65 and do not have both Parts of Medicare, no coverage is available through the NMSU Medigap Plan G 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 - NMSU 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 questions regarding eligibility in the group plan or your premiums for group coverage, contact:

New Mexico State University
Attn: Benefit Services
Off-site: P.O. 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:

HCSC
P.O. Box 655082
Dallas, TX 75265-5082
Telephone (888) 541-7107

COBRA Hours: 8am - 4:30pm
Cobra Fax #: 618-998-2847
E-mail: benefits@nmsu.edu

Premiums for federal continuation coverage should be mailed to:

Health Care Service Corporation
P.O. Box 21806
Tulsa, OK 74121-1026

WHO IS ELIGIBLE

Retiree - An employee who officially retires from the New Mexico State University and received a benefit from the Education Retirement Board (ERB) or Alternative Retirement Plan (ARP) immediately upon termination of employment may receive health insurance benefits after retirement if the retiree was enrolled in the NMSU employee health plan for ten consecutive years in regular status just prior to retirement. (Persons eligible under the Alternative Retirement Plan must immediately begin receiving a benefit, and have been enrolled in the NMSU employee health plan for ten consecutive years in regular status just prior to retirement.) The ten years of coverage must, at a minimum, be satisfied as of the month in which the employee retires from the university. Time enrolled as a regular employee (or as the spouse/qualified domestic partner of an active, regular employee if both you and your spouse/qualified domestic partner are 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 becomes re-employed by NMSU in a benefit eligible employment status, the retiree may maintain coverage through the NMSU employee health insurance during the re-employment period. The retiree/employee will meet the eligibility requirements under this Plan to re-enroll on the retiree health plan upon leaving employment 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, if benefits were suspended upon hire.

Spouses or Domestic Partners - Spouses or qualified 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 qualified domestic partners acquired after retirement. See "Adding Eligible Family Members" for more information.

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

Coverage After Retirement - Employees hired after July 1, 2016 are not eligible for the retiree health insurance benefit. An employee who was hired before July 1, 2016 and who officially retires from the university and receives a monthly benefit from the Educational Retirement Board immediately upon termination of employment (those eligible under the Alternative Retirement Plan must meet eligibility rules and immediately begin receiving a benefit) may elect to continue medical insurance after retirement, providing the employee had been covered under the plan for the prior 10 consecutive years and worked in a regular employment status. Time while enrolled as an employee or as a spouse/qualified domestic partner of an active employee will be counted toward the 10 years, provided there is no gap in coverage during the 10 year period. Coverage as the spouse/qualified domestic partner of a retiree will not be credited toward the 10 years. The university continues to pay a percentage of the premium. When a retiree or dependent becomes age 65 and/or eligible for Medicare, all medical coverage will be moved to the Medigap Plan G, which includes a Medicare Part D prescription plan. If the retiree or dependent enrolls in a Medigap Plan G prescription plan outside the university retiree plan, they will no longer be eligible to access prescription or medical coverage through the retiree medical plan. Details regarding coverage, eligibility and restrictions are available through the Office of Human Resources.

ELIGIBLE FAMILY MEMBERS

Covered family members - An eligible spouse, qualified domestic partner or eligible child (as defined below) who has applied for and been granted coverage under the subscriber's policy based on his/her family relationship to the subscriber.

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

- the subscriber's legal **spouse**
- the subscriber's eligible **child** through the end of the month in which the child reaches **age 26** (Once a covered child reaches age 26, the child is automatically removed from coverage and rates adjusted accordingly - unless the child is an eligible family member under this Plan due to a disability as described below.)
- the subscriber's **unmarried** child age 26 or older who was enrolled as the subscriber's covered child in this health plan at the time of reaching the age limit, and who is medically certified as **disabled,** chiefly dependent upon the subscriber for support and maintenance, and incapable of self- sustaining employment by reason of his/her disability (Such condition must be certified by a physician and BCBSNM. Also, a child may continue to be eligible for coverage beyond age 26 only if the condition began before or during the month in which the child would lose coverage due to his/her age. BCBSNM must receive written notice of the disabling condition before the end of the month during which the child's coverage would otherwise end.)
- the subscriber's **qualified domestic partner**

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

- natural or legally adopted child of the subscriber
- child placed in the subscriber's home for purposes of adoption (including a child for whom the subscriber is a party in a suit in which the adoption of the child by the subscriber is being sought)
- stepchild of the subscriber (or otherwise eligible child of a domestic partner, if domestic partners are covered under your benefit plan)

- child for whom the subscriber must provide coverage because of a court order or administrative order pursuant to state law
- child of a domestic partner (1) if either of the domestic partners is the biological parent of the child or (2) if either or both parents are adoptive parents of the child or (3) if the child has been placed in the domestic partner's household as part of an adoptive placement

A child meeting the criteria above is an eligible child whether or not the subscriber is the custodial or noncustodial parent, and whether or not the eligible child is claimed on income tax, employed, married, attending school, or residing in the subscriber's home, except that:

- A child age 19 or older who has other group coverage available to him/her whether through the child's own employer or through the child's spouse's employer - is not eligible under this health plan. The child need not be enrolled in such available group coverage in order to be excluded as an eligible family member.
- Once the subscriber is no longer a legal guardian of a child or there is no longer a court order to provide coverage to a child, the child must be eligible as a natural child, legally adopted child, or stepchild of the subscriber in order to retain eligibility as a family member under this plan.

A **domestic partner** is a person of the same or opposite sex who meets all of the requirements by NMSU.

In addition, you and your domestic partner will meet the terms of this definition as long as neither of you nor your domestic partner:

- has signed a domestic partner affidavit or declaration with any other person within 12 months prior to designating each other as domestic partners hereunder;
- is currently legally married to another person; or
- has any other domestic partner, spouse, or spouse equivalent of the same or opposite sex.

You and your domestic partner must have registered as domestic partners if you reside in a state that provides for such registration. In any case, if your employer allows coverage for domestic partners and their children, BCBSNM will require a notarized *Affidavit of Domestic Partnership* and any other supporting documentation required by the employer.

Employees wanting to change benefit elections involving a domestic partner must adhere to the same rules regarding qualifying events.

BCBSNM may require acceptable proof (such as copies of income tax forms, legal adoption or legal guardianship papers, or court orders) that an individual qualifies as an eligible family member under this coverage. Unless listed as an eligible family member, no other family member, relative or person is eligible for coverage as a family member. Common-law spouses are **not** considered legal spouses; in order to be considered eligible for coverage, a common-law spouse must meet the definition of "domestic partner."

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

Eligible family members cannot participate in the NMSU program unless the eligible retiree participates (although 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 Medigap Plan G, the unqualified member(s) will be enrolled in the NMSU PPO Plan if not enrolled in Medicare.

Family Members Who are Not Eligible - A retiree's spouse, qualified domestic partner, or child is not an eligible family member while:

- on active duty in the armed forces of any country (unless eligible for continued coverage for a limited period of time under federal law); or
- covered under this Plan or another plan of benefits provided through NMSU for health care expenses as an employee or retiree or an eligible family member of another employee or retiree.

Information for Noncustodial Parents - When a child is covered by the Plan through the child's non-custodial parent, then the Plan will:

- provide such information to the custodial parent as may be necessary for the child to obtain benefits through the Plan:
- permit the custodial parent or the provider (with the custodial parent's approval) to submit claims for covered services without the approval of the noncustodial parent; and
- make payments on claims submitted in accordance with the above provision directly to the custodial parent, the provider or the state Medicaid agency, as applicable.

APPLYING FOR COVERAGE

An eligible person can apply for coverage, including for his/her eligible family members, by contacting NMSU Benefit Services prior to the effective date of their Medicare eligibility.

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 Medigap Plan G. 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.

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, provided the enrollment process has been completed with NMSU Benefits Services. (The subscriber may be the retiree/and or the eligible family member of the retiree who is eligible for Medicare or who is over age 65 and covered under the Medigap Plan G. In such cases, separate ID cards and benefit material are issued.)

PREMIUM PAYMENTS

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

NMSU is solely responsible for premium deductions and premium collections.

Premium Increases/Decreases - When a retiree experiences a change in status (including but not limited to: marriage, divorce, childbirth, adoption, Medicaid, family member no longer meeting insurance eligibility rules), the retiree has 31 days from the date of the status change to contact Benefit Services to make coverage changes. All status changes resulting in insurance coverage and/or premium change will be effective the first day of the month following the date of the change in status, except in the case of a newborn or the placement of child(ren) through adoption. For a newborn or placement of child(ren) through adoption, coverage becomes effective the date of birth or date of placement. The addition of a child through birth or placement will result in a full premium being charged if effective the 1st through the 15th of the month.

See "Coverage Termination" for termination dates that apply to specific circumstances.

Premiums for Retirees - Retiree coverage begins on the date of retirement from NMSU. NMSU continues to pay a portion of the Plan's premium (except as listed under "Adding a New Spouse/Domestic Partner").

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

Premiums for Continuation Members - See "How to Continue Coverage" for details.

Notification - If the Group Master Contract is terminated or premiums are not submitted, coverage will terminate for all affected members as of the end of the last-paid billing period. BCBSNM will not notify the affected members of

such termination. (If NMSU fails to submit premium payments to BCBSNM, it is NMSU's responsibility to advise members of BCBSNM Plan termination.)

The required premiums are determined and established by BCBSNM. The percentage of the total premium that you pay is established by NMSU. BCBSNM may change premium amounts according to any of the following:

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

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

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

ADDING A FAMILY MEMBER TO COVERAGE

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

Adding a New Spouse or a Domestic Partner

New spouses and qualified domestic partners acquired by a retiree after retirement may be added to either the NMSU PPO or the NMSU Medigap Plan G, as applicable, under certain circumstances. The new spouse or qualified domestic partner will not be added until one year following the date of marriage or creation of partnership.

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

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

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

New Spouses/Qualified Domestic Partners of Continuation Subscribers - Federal continuation subscribers may add new spouses or qualified 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/qualified 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 an Eligible Child

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

Newborn Children

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

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

Adopted Children

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

Disabled Children

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

Legal Guardianship

Application for coverage must be made for a child for whom the retiree or the retiree's spouse becomes the legal guardian **within 31 days** of the court or administrative order granting guardianship. If not specified in the court order, the eligible child's effective date of coverage will be the date the order has been filed as public record with the State, or the effective date of Family or Retiree/Child(ren) coverage, whichever is later. If the 31-day deadline is not met, there will not be an option to add the child at a later date.

LATE APPLICANT

Unless eligible for a special enrollment, applications from the following enrollees will be considered late:

- anyone not enrolled **within 31 days** of becoming eligible for coverage. For example, a newborn child added to coverage more than 31 days after birth when, for example, Family coverage (or Employee/Children coverage, if available) is not already in effect, a child added more than 31 days after legal adoption, a domestic partner and/or his/her eligible children added to coverage more than 31 days after becoming eligible, or a new spouse or stepchild added more than 31 days after marriage is considered a late applicant. Note: Even if you have Family coverage, you should submit an enrollment/change form to add a newborn to coverage within 31 days of birth. This will ensure that the newborn is added to your membership records as an eligible family member in a timely manner and that claims payments will not be delayed unnecessarily.
- anyone who voluntarily terminates his/her coverage and applies for reinstatement of such coverage at a later date (except as a provider under USERRA of 1994)

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

COVERAGE TERMINATION

Unless stated otherwise, if you do not elect or do not qualify for continuation coverage (see "How to Continue Coverage"), coverage ends at the end of the month following the earliest of the termination event or request listed below:

- The date the member loses eligibility for coverage according to NMSU's rules and regulations. If NMSU fails to notify BCBSNM or the subscriber fails to notify NMSU to remove an ineligible person from coverage by

submitting a completed enrollment/change form to NMSU, BCBSNM may recover any benefit payments from the subscriber/provider who received such payments that were made on the ineligible person's behalf. It is the subscriber's responsibility to notify Benefit Services when a member loses eligibly status. If the member rescinds his/her retirement through NMERB or NMARP, he/she will be dropped from the NMSU retiree plan.

- When a discontinuance form is signed and received by Benefit Services.
- When NMSU does not receive the premium payment for coverage from the subscriber on time. (Coverage will be suspended if premium is not paid when it is due. If premium is not received within 31 days after its due date, the affected member(s) will be terminated at the end of the last-paid billing period. Any claims received and paid for during the 31-day grace period will be billed to the subscriber.)
- When BCBSNM does not receive the applicable payment from NMSU, according to the agreement set forth in the Group Master contract, on time. (Coverage will be suspended if amounts are not paid when due. If not received within 60 days after its due date, NMSU or the affected members(s) will be terminated at the end of the last-paid billing period. Any claims received and paid for during the 60-day grace period will be billed both to the subscriber and to NMSU.)
- When the member materially fails to abide by the rules, misrepresents information affecting coverage. If a member knowingly gave false material information in connection with the eligibility or enrollment of the subscriber or any of his/her covered family members, BCBSNM and NMSU may terminate the coverage of the subscriber and his/her covered family members retroactively to the date of initial enrollment. The subscriber is liable for any benefit payments made as a result of such improper actions.
- When the subscriber dies. (Surviving eligible spouses, qualified domestic partners, and eligible children may remain covered under the NMSU health care plan under certain circumstances. Contact Benefit Services for details. If the surviving family members are not eligible for continued coverage, coverage ends on the last day of the month following the retiree's death.)
- On the day when the member acts in a disruptive manner that prevents the orderly business operations of any participating provider or dishonestly attempts to gain a financial or material advantage.
- On the day when group coverage is discontinued for the entire group or for the retiree's/surviving eligible participating provider or dishonestly attempts to gain a financial or material advantage.
- When NMSU gives BCBSNM a minimum 30 days advance written notice of Group contract termination, or BCBSNM gives NMSU minimum 90 days advance written notice of group contract termination.

If Blue Cross and Blue Shield of New Mexico terminates your coverage under this Certificate for any reason, Blue Cross and Blue Shield of New Mexico will provide you with a notice of termination of coverage that includes the termination Effective Date and the reason for termination at least 30 days prior to the last day of coverage, except as otherwise provided in this Certificate. You and your eligible spouse, Domestic Partner and/or Dependents' coverage will be terminated due to the following events and will end on the dates specified below:

1. The termination date specified by you, if you provide reasonable notice.
2. When Blue Cross and Blue Shield of New Mexico does not receive the full amount of the premium payment or other charge or amount on time or when there is a bank draft failure of premiums for your and/or your eligible spouse, Domestic Partner and/or Dependents' coverage and the grace period, if any has been exhausted.
3. Your coverage has been rescinded.
4. If you no longer meet the previously stated description of an eligible Person.
5. If the entire coverage of your Group terminates.

   Termination of the Group Contract automatically terminates your coverage under this Certificate. It is the responsibility of your Group to notify you of the termination of the Group Contract, but your coverage will automatically terminate as of the Effective Date of termination of the Group Contract regardless of whether such notice is given.

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

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

Additional Family Member Termination Reasons

In addition, coverage will end for any family member on the earliest of the above dates or the earliest of the following dates:

- at the end of the month when a child **no longer qualifies as an eligible child** under the Plan (e.g., a child is removed from placement in the home or reaches the eligible child age limit);
- at the end of the month following the date of a final **divorce decree or legal separation** for a spouse;
- at the end of the month when the subscriber gives notice in writing to end coverage for a covered family member(s), according to the rules of your Plan as established by your employer.
- At the end of the month following the dissolution of a domestic partnership.
- At the end of the month when an eligible family members enters the armed forces for more than 30 days (or as provided by law).

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

If an eligible family member is being removed from coverage because of losing his/her eligibility under the Plan, NMSU Benefit Services will automatically cancel the dependent and provide the member with a notice of change in premium cost. If such notice is not received by the member prior to the end of the month in which the dependent reaches the qualifying age, the member should contact NMSU Benefit Services. If an eligible family member loses eligibility due to divorce or dissolution of domestic partnership, the member must complete an enrollment/change form within 31 days and submit to the NMSU Benefit Services. If claims payments are made for an ineligible member (for example, due to late notification), BCBSNM and the providers of care may recover benefits erroneously paid on behalf of the ineligible person.

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

Cancellation Appeals

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

Office of the Superintendent of Insurance
1120 Paseo de Peralta #4
Santa Fe, NM 87501

You may also call the Insurance Division toll-free at 855-427-5674.

Voluntary Termination of Coverage

To remove a family member from coverage before loss of eligibility or to voluntarily terminate his/her own coverage, you must submit a completed enrollment/change and signed Discontinuance form to NMSU (or to the state or federal continuation plan administrator, if applicable.) Voluntarily terminated members may not re-enroll under the Plan. Also, these members are **not** eligible for any extension of benefits or federal or state continuation or conversion coverage.

Retirees can voluntarily drop themselves or covered dependents/spouses on the Medigap Plan G plan as follows:

- Anytime, year round, with proof of coverage from another medical plan - coverage ends the end of the month in which Benefit Services receive the discontinuance form and proof of coverage.
- During the Medicare open enrollment period in October, November or December but coverage will remain in effect through December 31st. No proof of other coverage is needed, only the discontinuance form.
- Coverage will automatically cancel if you enroll in another Prescription Part D drug plan. BCBSNM will notify Benefit Services of enrollment into another Prescription Part D drugs plan and the coverage end date (usually retro-active.)

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

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

RE-ENROLLMENT

A retiree who returns to work full-time and later re-retires may only continue coverage for eligible family members who were covered under the health plan at the time of re-retirement except as defined in the "Adding an Eligible

Family Member to Coverage" section. If coverage is voluntarily discontinued after retirement by a retiree or surviving eligible family member contract holder for self or for any covered family member, the retiree and/or the eligible family member may not re-enroll at any time.

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

If coverage is voluntarily discontinued by a COBRA member, the terminated member may not re-enroll at any time.

NOTIFICATION OF ELIGIBILITY AND ADDRESS CHANGES

The subscriber must notify NMSU Benefits Services of any changes that may affect his/her or a family member's eligibility (such as a change in Medicare eligibility status, marital status, or age), including a change to a covered family member's name or address. (Members covered under COBRA continuation obtain forms from an NMSU Designated Service Unit (DSU) representative at BCBSNM and do not submit enrollment/change forms to NMSU; see *How to Continue Coverage* for applicable address.)

HOW TO CONTINUE COVERAGE

If you lose coverage under this Plan, you may be able to continue coverage for a limited period of time. **Note:** There is no special enrollment under these provisions. You must enroll timely to qualify for continued coverage.

Federal Continuation (COBRA)

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

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

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

Contact Benefit Services for details about enrolling in continuation coverage.

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

Qualifying Events and Qualified Beneficiaries - anyone who voluntarily terminated coverage while still eligible or whose coverage was terminated for good cause (as defined in the Definitions section) is not eligible for continued coverage under this provision.

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

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

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

would be eligible for continuation plan coverage if he/she subsequently loses group plan coverage due to a qualifying event.)

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

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

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

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

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

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

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

When HCSC 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 HCSC.

Maximum Continuation Periods - This law requires that eligible family members of retiree be afforded the opportunity to maintain continuation coverage for 36 months.

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

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

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

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

- The premium for your continuation coverage is not paid on time.
- You become covered by another group plan that begins coverage after your COBRA election.
- The continuation period expires.
- You enroll in and become covered by Medicare. (Eligible family members who were covered under the continuation plan when you enrolled in Medicare will then be eligible to remain on COBRA continuation for up to 36 months of coverage, starting from the initial qualifying event.)

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

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

Health Care Service Corporation
P.O. Box 21026
Tulsa, OK 74121-1026

Premiums for coverage may change annually or on any date that the Plan is amended. Written notice of any such change will be given to NMSU at least 60 days before the effective date of the premium change. There is a grace period of at least 30 days for payment of the regularly scheduled premium (45 days for the initial payment for continuation coverage).

Customer Service - The COBRA administrator is Health Care Service Corporation. This corporation collects premium and administers eligibility only. Questions about your billing, premiums, or eligibility under COBRA should be directed to:

HCSC
P.O. BOX 655082
Dallas, TX 75265-5082
Toll-Free Telephone Number: (888) 541-7107
COBRA Hours: 8am - 4:30pm CT
COBRA Fax Number: (618) 998-2747

Reminder: Do not send claims related questions to the above address.

SECTION 3: HOW YOUR PLAN WORKS

The NMSU Medigap Plan G pays for the Medicare Part A deductible and coinsurance amounts not paid by Medicare when services are covered by Medicare. You are responsible for the annual Part B deductible.

When you receive Medicare-covered health care services from a provider that accepts Medicare assignment, you have no out-of-pocket expenses for Part A services and Part B services after you have met the annual Part B deductible.

SECTION 4: MEDICARE- COVERED SERVICES

This section describes the services and supplied covered by Medicare. Covered services and supplies are also subject to the limitations and exclusions in *Section* 5.

BENEFITS FOR MEDICARE PART A SERVICES

What is a Medicare- participating doctor provider? What does "accept assignment" mean?

Doctors and suppliers may sign agreements to become Medicare participating. Medicare- participating doctors and suppliers have agreed in advance to accept assignment on all Medicare claims. Under the assignment method, your doctor or supplier agrees to accept the amount approved by the Medicare carrier as total payment for covered services (which includes Medicare's payment, the deductible, and coinsurance).

Hospitals, skilled nursing facilities, home health agencies, hospices, comprehensive outpatient rehabilitation facilities, and providers of outpatient physical and occupational therapy and speech pathology services can be participating providers under Medicare. Participating providers must submit their claims to Medicare and must accept the Medicare- approved amount as payment in full for covered services (which includes Medicare's payment, the deductible, and coinsurance).

This Plan provides benefits for that portion of the approved charges not paid by Part A of Medicare. Benefits include the following services and items:

Inpatient Hospital Services - This Plan pays:

- The deductible amount the member must pay for Medicare Part A services.
- The member's portion of the Medicare Part A approved charges that are to be paid partly by Medicare and partly by the member during the 61th to 90th day of hospitalization.
- The member's portion of Medicare Part A approved charges during the period when the member is using his or her lifetime reserve days. (No benefits are payable for the 91st through the 150th days if the member chooses not to use Medicare lifetime reserve days.)
- Once you have exhausted all your Medicare inpatient benefits, including lifetime reserve days, BCBSNM, with preauthorization, will pay the Part A Medicare eligible expenses not covered by Medicare for each additional day of hospitalization up to a lifetime maximum of 365 additional days.
- The member's portion of Medicare Part A approved charges for care at a Medicare participating psychiatric hospital during the member's lifetime Medicare limit. No benefits will be paid under this Plan for hospitalization beyond the Medicare lifetime limit for days of care, or for care rendered at a non-participating psychiatric hospital.
- The member's portion of Medicare Part A approved charges for an inpatient hospice facility.

Note: The following services and items are not benefits and are excluded - The difference between private and semiprivate room rates; private duty nursing; drugs prescribed for the member to take home when discharged; and personal comfort or convenience items.

Skilled Nursing Facility Services - The Plan pays the member's portion of the Medicare part A approved amount at a skilled nursing facility during the days when charges for covered services are to be paid partly by Medicare and partly by the member. No payment will be made by this Plan for services received beyond the Medicare maximum number of days of coverage in any benefit period.

Veterans' Administration/Department of Defense Facilities - For non- service connected disabilities, this Plan pays the amount that would have been due from the member had services been received in a non- government facility and covered by Medicare. This means that the Plan will pay an amount equal to the Medicare inpatient deductible for covered inpatient services, and an amount equal to 20 percent of billed charges for covered outpatient services.

Hospice - This Plan includes coverage for hospice care and inpatient respite care if you are getting Medicare approved hospice care. Medicare will pay all of your costs for eligible hospice services except for a limited coinsurance/copayment amount for outpatient prescription drugs and inpatient respite care.

Blood - This Plan pays the reasonable costs for the first three pints of whole blood (or equivalent quantities of packed red blood cells) unless already paid under Medicare Part B.

BENEFITS FOR MEDICARE PART B SERVICES

Benefits are provided for those services that are approved for reimbursement under Part B of Medicare. Benefits include the following services and items:

Note: member Privately Contracting With a Provider - Federal legislation allows physicians or other providers to opt out of Medicare. If you wish to continue obtaining their services (that would otherwise be covered under Medicare), you and the provider will need to enter into written private contracts that make you responsible for all payments to these providers. If you enter into a private contract arrangement, you have in effect opted out of Medicare for services from these providers. Services provided under private contracts are not covered by Medicare and are not covered by this Plan.

Also, the Medicare limit on excess charges does not apply. You are fully liable for payment for services rendered.

However, even if you sign a private contract, you may still receive services from other providers who have not opted out of Medicare and continue to receive benefits from Medicare and this plan.

Medical Expense - This Plan pays:

- The remainder of Medicare- approved amounts (e.g., generally 20 percent) under Part B after the Part B deductible is met.
- 80 percent of Medicare Part B excess charges (above Medicare- approved amounts) according to these terms:
  - If the provider accepts Medicare assignment, your benefits under this Plan will be limited to 20 percent of the Medicare approved amount after the deductible, if any. The doctor or supplier will accept Medicare's approved amount as full payment, and there will be no excess amount due from the member.
  - If the provider does not accept Medicare assignment, benefits under this Plan also will be limited to 20 percent of the Medicare approved amount after the deductible, if any.

Diabetic Supplies and Specified Pharmacy Charges - If one of the items listed below is covered by Medicare Part B, this Plan pays 100 percent of your share after the Medicare Part B deductible has been met. In order to obtain this coverage, you must either order these supplies/drugs through a Medicare Part B provider or from a Medicare Part B participating retail pharmacy. Please make sure you use both your Medicare card and your BCBSNM member ID card when purchasing these items; otherwise, you will be responsible for the full cost of the supply or drug covered under this provision:

- diabetic supplies (test strips, meters)
- specific medication used to aid tissue acceptance following organ transplants
- certain oral medications used to treat cancer
- ostomy supplies

Blood - This Plan pays:

- The reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells as defined under federal regulations), unless already paid under Part A.
- The coinsurance (e.g., 20 percent for the remainder of most Medicare- approved amounts) under Part B.

Medicare- Covered Preventive Care - This Plan pays the coinsurance (e.g., 20 percent for the remainder of most Medicare- approved amounts) for routine checkups and screening test.

Home Health Care Services - This Plan pays:

- The coinsurance (e.g., 20 percent for the remainder of Medicare- approved amounts) under Part A and Part B.
- Medicare- approved charges for durable medical equipment after the Part B deductible has been met.

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.

Unless listed under "Additional benefits not covered by Medicare", services that Medicare does not cover are not covered under the Medigap Plan G.

Prescription Drugs (Inpatient) - Prescription drugs are not covered under Medigap Plan G, except those supplied and used during a hospital admission, skilled nursing facility stay, or hospice election that qualified for Medicare coverage. Self- administered drugs billed in an inpatient setting are not covered.

Prescription Drugs (Retail Pharmacy) **– Blue Cross MedicareRx Enhanced Plus (PDP)**

Blue Cross Group MedicareRxSM Please refer to your MedicareRx Summary of Benefits and Evidence of Coverage. Toll Free 1-877-838-3833

ADDITIONAL BENEFITS NOT COVERED BY MEDICARE

Calendar Year Benefit Period - Some benefits are limited to a specific dollar amount or number of days or visits allowed during a calendar year benefit period. The initial calendar year benefit period is from your effective date through the next following December 31, which may be less than 12 months. Generally, benefits are determined based upon the coverage in effect on the day a service is received, an item purchased, or a health care expense incurred.

Medically Necessary Emergency Care Outside Territorial Limits - This Plan pays, to the extend not covered by Medicare, 80 percent of the billed charges for medically necessary emergency hospital, physician, and Medicare care received outside the Medicare territorial limits, if such care would have been covered by Medicare when provided in the United States. The care must begin during the first 60 consecutive days of a trip outside the territorial limits. This benefit is subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, emergency care means care needed immediately because of an injury or an illness of sudden and unexpected outset.

Home Health Care/At Home Recovery - This Plan pays up to $40 per visit (up to an annual maximum of $1,600) to assist you with activities of daily living during recovery from all illness, injury, or surgery.

DRUGS COVERED BY MEDICARE AND THIS PLAN

This Supplemental Coverage Plan does not provide coverage for Medicare Part D Prescription. Please contact your Group Benefits Administrator for additional information on options if you need coverage for Medicare Part D Prescription Drugs. Prescription Drug coverage under this Supplemental Coverage Plan is limited to those supplied and used during a covered Hospital admission, Skilled Nursing Facility stay, or hospice election under Medicare Part A, or administered in a covered outpatient setting or doctor's office under Medicare Part B.

MEDICAL NECESSITY

The NMSU Medigap Plan G 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.

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 specially listed as an exclusion.

YOUR PARTICIPATING PROVIDER NETWORK

For this Supplemental Coverage Plan, Medicare is primary, and this plan provides secondary coverage to Medicare. Your Supplemental Coverage Plan does not include a network requirement, but you may wish to confirm that your provider accepts Medicare reimbursement. Find Providers who do, at www.medicare.gov/physiciancompare. This website is run by the federal government, which keeps track of all providers accepting Medicare patients.

For questions about your medical or Hospital coverage under this Supplemental Coverage Plan call the Customer Service number on the back of your ID Card.

What is a Medicare-participating provider? What does "accept Assignment" mean?

Doctors and suppliers may sign agreements to become Medicare participating. Medicare-participating doctors and suppliers have agreed in advance to accept Assignment on all Medicare claims. Under the Assignment method, your doctor or supplier agrees to accept the amount approved by the Medicare carrier as total payment for Covered Services (which includes Medicare's payment, the Deductible, and coinsurance).

Hospitals, Skilled Nursing Facilities, home health agencies, hospices, comprehensive outpatient rehabilitation facilities, and providers of outpatient physical and occupational therapy and speech pathology services can be participating providers under Medicare. Participating Providers must submit their claims to Medicare and must accept the Medicare-Approved Amount as payment in full for Covered Services (which includes Medicare's payment, the Deductible, and coinsurance).

It is important to ask any Provider you see whether he or she accepts "Assignment" before you receive care because this can have an impact on what you pay.

"Non-Participating Providers" accept Medicare but do not agree to take Medicare Assignment in all cases (they may on a case-by-case basis). This means that while Non-Participating Providers have signed up to accept Medicare, they do not accept Medicare's Approved Amount for health care services as full payment.

"Opt-Out Providers" do not accept Medicare at all and have signed an agreement to be excluded from the Medicare program. This means they can charge whatever they want for services but must follow certain rules to do so. Medicare will not pay for care you receive from an Opt-Out Provider (except in emergencies). You are responsible for the entire cost of your care. Opt-Out Providers must give you a private contract describing their charges and confirming that you understand you are responsible for the full cost of your care and that Medicare will not reimburse you.

ASSIGNED VS. NON-ASSIGNED

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).

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, non-participating 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.

WHAT IS COVERED AND NOT COVERED

Benefits are available under this "Medicare-Covered Services" provision for all services approved by Medicare.

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.)	
Provider's billed charge	$200.00
Covered charge = Medicare-approved amount	$175.00
Medicare deductible: ($175 - $100 = $75 balance)	- $100.00
Medicare's payment (80% of $75)	- $60.00

Plan's payment = 100% of Medicare-approved amount less Medicare's payment ($175 - $60)	$115.00
Balance due from member (Provider cannot charge more than the Medicare-approved amount)	$0.00

Provider Does Not Accept Medicare Assignment

When a physician or other professional provider does not accept Medicare assignment, the covered charge is calculated using the method described below:

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.

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.)	
Provider's billed charge	$300.00
Medicare-approved amount	$200.00
Medicare limiting charge (115% of Medicare-approved amount. Provider cannot bill you for more than this amount.)	$230.00
Plan's calculation = 80% of the limiting charge of $230	$184.00
Medicare's payment (80% of $200)	- $160.00
Plan's payment = $184 less Medicare's payment ($160)	$24.00
Balance due from member - your plan picks up the Part B excess charges (above Medicare-approved amounts). Please call Customer Service so that the Part B excess charges can be processed by the Plan.	$0.00

LIMITATIONS AND CONTROLS

Benefits under this Plan are subject to the following limitations and controls, in addition to the exclusions section of the booklet:

- Where Medicare imposes any maximum benefit of dollars, numbers of visits or days, or other limits, the Plan will not reimburse beyond the Medicare maximums, except as specifically outlined in this section of the booklet (e.g., for inpatient care after Medicare lifetime reserve days are exhausted), and emergency services rendered outside the Medicare territorial limits (see Services Received Outside the Medicare Territorial Limits later in this section).
- If Medicare allows a service as medically necessary, BCBSNM will also consider its medically necessary. When Medicare determines that a service was not medically necessary, that service will also be found not medically necessary under this NMSU Medigap Plan G. The fact that a physician has prescribed, ordered, recommended, or approved a service or supply does not make it medically necessary or make the expense a covered service under this Plan, even though it is not specifically listed as an exclusion.
- This Plan pays Medicare Part A deductible and member coinsurance amounts for services that are covered by Medicare and limited amounts for services specifically listed as being covered in this booklet (e.g., emergency services while traveling or residing outside the United States). These are the only services covered under the Plan which may be considered for NMSU Medigap Plan G coverage when Medicare makes no determination as to their medical necessity or benefit status. If Medicare does not make a benefit determination because no claim was filed to Medicare, you may be asked to file the claim first to Medicare.
- When a member received nonemergency services in the United States from a provider that is not participating in the Medicare program, no benefits will be available for those services under this Plan, except as specified for Veteran's Administration and Department of Defense facilities.
- The Medicare deductible and the member's portion of charges will be those applicable to Medicare benefits on the date when charges are incurred.
- When the furnishing of equipment is a benefit under the Medicare program and the member has an option to rent or purchase the equipment, Medicare will decide whether the equipment will be purchased or rented by the member as a condition of applying any benefits.

SECTION 5: 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. Read this section carefully.

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:

— After Termination of Coverage

This Plan does not cover services furnished after termination of coverage under this Plan, except for hospital admissions and related services beginning prior to such termination. Generally, benefits are determined based upon the coverage in effect on the day a service is received, an item purchased, or a health care expense incurred. For inpatient services, benefits are based upon the coverage in effect on the date of admission, except that if you are 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. Benefits for such services may be coordinated with any additional health care coverage that applied after your termination date under this Plan.

— Charges Above the Medicare Approved or Allowed Amounts

This Plan does not cover charges above the Medicare approved or allowed amounts.

— Custodial Care

This Plan does not cover custodial care or care in a place that services the patient primarily as a residence when the member does not require skilled nursing, except for a home recovery as listed under ”Benefits for Medicare Part B” services in Section 4. **This Plan does not cover** services to assist the member in activities of daily living (such as sitter’s or homemaker’s services), or services not requiring the continuous attention of skilled medical or paramedical personnel, regardless of where they are furnished or by whom they were recommended.

— Dental Services

This Plan does not cover dental services that Medicare does not cover, such as the care, treatment, filing, removal, or replacement of teeth or structures directly supporting the teeth.

— Diagnostic or therapeutic Services

This Plan does not cover any diagnostic or therapeutic services that are not covered benefits under Medicare.

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

- The device, drug, or medicine cannot be marketed lawfully without approval of the U.S. Food and Drug Administration (FDA), 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, 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, its safety, or its efficacy as compared with the standard means of treatment or diagnosis.

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

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

— Foot Care

This Plan does not cover palliative or cosmetic foot care that Medicare does not cover, such as corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet.

— Furnished Without Charge

This Plan does not cover services that would be furnished without charge in the absence of this Plan, or that the member has no legal obligation to pay for, or that are billed by a provider who is a member of the member's immediate family or household.

— 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 Aids

This Plan does not cover hearing aids or exams for fitting hearing aids.

— Intermediate Nursing Home Care

This Plan does not cover intermediate nursing home care.

— Noncovered Providers of Service

This Plan does not cover services prescribed or administered by a:

- member of your immediate family or a person normally residing in your home
- physician, other person, supplier, or facility (including staff members) that are not specifically listed as covered in this benefit booklet, such as a:
  - — health spa or health fitness center (whether or not services are provided by a licensed or registered provider)
  - — school infirmary

- halfway house
- massage therapist
- private sanitarium
- extended care facility or similar institution
- residential treatment center (A residential treatment center is a 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.)

— Nonmedical Services

This Plan does not cover nonmedical services, such as telephone consultations, charges for failure to keep a scheduled visit, charges for completion of a claim form, interest charges, or charges for medical records.

— Not Covered by Medicare

This Plan does not cover services that are not covered by Medicare (unless specifically listed as covered in Section 4), including services received from any provider with whom the member has privately contracted (as set forth in section 4507 of the Balanced Budget Act of 1997).

— Not Reasonable and Necessary

This Plan does not cover services that Medicare determines are not reasonable and necessary to diagnose or treat an illness or injury, or to improve the functioning of a malformed body part.

— Over-the-Counter Items

This Plan does not cover over-the-counter items, including charges for any dressing, brace, medical supply, or medication that can be purchased without a prescription from a physician or professional provider, unless otherwise specified in this benefit booklet.

— Paid for by Federal, State, Local Government

This Plan does not cover services furnished or paid for by federal, state, or local governments.

— Personal Convenience Items or Services

This Plan does not cover items or services such as air conditioners, humidifiers, or physical fitness exercise equipment or personal services such as haircuts, shampoos and sets, guest meals, and radio or television rentals.

— Physical Examinations

This Plan does not cover insurance or employment examinations, examinations at the request of a third party, and any diagnostic tests directly related to such examinations.

— Prescription Drugs, Outpatient

This Plan does not cover prescription drugs obtained on an outpatient basis: NMSU offers a Medicare Part D Rx for your outpatient prescription drug benefits.

— Prior to Effective Date

This Plan does not cover services received prior to the effective date of the member's coverage or during and admission that began prior to such date.

— Private Hospital Room

This Plan does not cover the difference between the private and semiprivate room rates.

— Reimbursement Expenses

This Plan does not cover any condition, ailment, or injury for which the member is reimbursed or is eligible to be reimbursed by a person or organization responsible for causing the harm.

— Special Foods or Diets

This Plan does not cover special foods or diets, or dietary supplements or vitamins.

— Vision Services

This Plan does not cover vision care services such as:

- eye glasses or contact lenses (exception: one pair of eyeglasses with standard frames or one set of contact lenses after cataract surgery that implants an intraocular lens.)
- examinations needed to prescribe and fit either the glasses or contact lenses, and routine eye refractions, except that lenses for aphakic patients (those with no lens in the eye) and soft lenses or sclera shells (white supporting tissue of eyeball) intended for use in the treatment of illness or accidental injury are benefits.
- any surgical or medical service or supply provided in connection with refractive keratoplasty (surgery to correct myopia or nearsightedness), including radial keratotomy (surgical incision of the cornea) to correct myopia or nearsightedness.

— War-Related Conditions

This Plan does not cover any illness or injury suffered after the member's effective date as a result of any of war, whether declared or undeclared, or while a member of the armed forces or auxiliary units.

— Work-Related Conditions

This Plan does not cover any condition, ailment, or injury arising out of or in the course of employment for which the employer or the employer's insurer is liable under any law dealing with Workers' Compensation or occupational disease, or similar laws; this exclusion applied whether or not the member claims the benefits or compensation.

SECTION 6: CLAIMS FILING, PAYMENTS, APPEALS, AND DISPUTES

FILING CLAIMS

Because payment for health care expenses will be made by both Medicare and the Plan, claims must be filed with both. You must submit claims **within 12 months** after the date or supplies were received. **A claim submitted more than 12 months after the service was received will not be accepted under any circumstance.** If a claim is returned for further information, resubmit it **within 45 days.**

When you receive care from providers, be sure to present both your Medicare and your BCBSNM issued Medicare Supplement identification cards. Medicare is your primary insurance. Always present your Medicare ID card to your health care providers so that they will bill Medicare first.

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.

HOSPITAL, MEDICARE-COVERED, AND OTHER FACILITY SERVICES

Medicare Part A Hospital Insurance and the Plan pay the hospital directly. To file claims, the hospital must have the information from the identification care issued to a member by both Medicare and BCBSNM. A notice of payment will be sent to you. If is not necessary for you to file a claim for hospital, skilled nursing facility, or hospice services with BCBSNM. These claims are automatically submitted to BCBSNM by Medicare. An Explanation of Benefits will be sent to you by BCBSM after Plan benefits have been determined. If you find that your claims are not being sent automatically to BCBSNM, please call a Customer Services Advocate to verify that the correct Medicare HIC number is on file for you.

PHYSICIAN, MEDICARE-COVERED FACILITY SERVICES, AND OTHER MEDICAL SERVICES

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

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 covered by Medicare with BCBSNM.

If you find that your claims are not being sent automatically to BCBSNM, please call a Customer Service Advocate to verify that the correct Medicare HIC number is on file for you.

If you find that it is necessary for your to file a claim for services that were covered by Medicare, you will have to file a copy of the EOMB and all other required claim information with BCBSNM. On the EOMB you receive from Medicare, print your BCBSNM issued Plan ID number (on your BCBSNM ID card) and your correct mailing address and zip code. Then make a copy of the EOMB for your records.

SERVICES NOT COVERED BY MEDICARE

When these procedures do not apply, such as claims for covered services from providers outside the Medicare territorial limits or for services not covered by Medicare but listed as covered under this Plan, you should contact a BCBSNM Customer Service Advocate for instructions on filing a claim under this plan. (If you receive covered emergency service while outside the Medicare territorial limits, call the BlueCardWorldWide Service Center – collect – at (804) 673-1177 for assistance with claims filing.)

Even though claims may be filed on your behalf by hospitals, physician, or other providers, it is your responsibility to make sure that the claim is filed. 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. You may obtain a copy of a Member Claim Form from the BCBSNM website or call a Customer Service Advocate and request that one be mailed to you. (See Itemized Bills) Complete the claim for using the instructions on the form. Do not file the same service twice unless asked to do so by an NMSU DSU representative.

Medicare also has time limits for filing claims. Contact the local Social Security Office for information on Medicare hospital and medical insurance filing deadlines.

- As a condition for processing claims under this Plan, a member specifically authorized BCBSNM to obtain for physicians, hospitals, or other providers the information and records that may be required by BCBSNM to administer such claims.

The Plan reserves the right in all cases to pay the member directly, and to refuse to hone the assignment of benefit under any circumstances when not in conflict with federal laws for the administration of Medicare. Assignment means to authorize someone other than the member to receive payment.

- If Plan covered services are received from a provider in New Mexico that does not participate with BCBSNM, BCBSNM will make claims payments to the subscriber (or to the applicable alternate payee when a Qualified Child Medical Support Order or its equivalent is in effect). When payment is made to the subscriber, the subscriber is responsible for arranging payment to the provider. If Plan services are received from a provider outside New Mexico that does not participate to the provider unless the subscriber submits documentation proving that the provider has already been paid directly for covered services. In all cases, the subscriber is solely responsible for paying any amounts greater than covered charges plus copayments, deductible, coinsurance, and benefit reduction amounts, and noncovered expenses.
- Benefit payments for members eligible for Medicaid are paid to the New Mexico Human Services Department or the provider when required by law.

Note: An EOMB indicting Medicare denied the service is required on all claims except claims for services received outside the Medicare territorial limits, and at home recovery.

SERVICE OUTSIDE MEDICARE TERRITORIAL LIMITS

You have health care coverage for services received inside and outside the Medicare territorial limits. 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 to English. File claims as you would 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.)

REQUEST FOR MEDICARE RECONSIDERATION

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

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

REQUEST FOR BCBSNM RECONSIDERATION

You may file a formal request for reconsideration of claim for plan benefits (e.g., home health care at home recovered or an emergency while outside of the United States) that BCBSNM has denied totally or partially. (See your Summary of Benefits for BCBSNM Plan coverage.) You waive any right to reconsideration if you do not file the formal request for reconsideration within 6 months of the denial of the claim.

BCBSNM will acknowledge in writing the receipt of the request. Within 60 calendar days of receipts. BCBSNM will review the request for reconsideration and notify the member 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 provider in writing all of the reasons for denying the claim.

RETAILIATORY ACTION

BCBSNM shall not take any retaliatory action against you for filing a grievance under this health benefits plan.

ITEMIZED BILLS

Claims for covered service must be itemized on the provider's billing forms or letterhead stationery and must show:

- member's identification number
- member's and subscriber's name and address
- member's date of birth and relationship to the subscriber
- name, address, National Provider Identification number (NPI), and tax ID or social security number of the provider
- date of the service or purchase, diagnosis, type of service or treatment, procedure, and amount charged for each service (each service must be listed separately)
- accident or surgery date (when applicable)
- amount paid by you (if any) along with a receipt, canceled check, or other proof of payment

Correctly itemized bills are necessary for your claim to be processed. The only acceptable bills are those from health care providers. Do **not** file bills you prepared yourself, canceled checks, balance due statements, or cash register receipts. Make a copy of all itemized bills for your records before you send

them. The bills are not returned to you. All information on the claim and itemized bills must be readable. If information is missing or is not readable, BCBSNM will return it to you or to the provider.

WHERE TO SEND CLAIM FORMS

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

Blue Cross and Blue Shield of Texas
Claims Division
P.O. Box 660044
Dallas, Texas 75266-0044

Please file all claims within 12 months after the date services or supplies 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.

HOW PAYMENT ARE MADE

After your claim has been processed, you will receive an Explanation of Benefits (EOB). The EOB tells you what charges are covered and what charges, if any, were not.

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.

If payments for covered services is sent to you, the check is attached to an EOB and explains the Plan's payments. In these cases, you are responsible for arranging payment to the provider and for paying any amounts greater than covered charges plus copayments, deductible, coinsurance, and penalty amounts, and noncovered expenses.

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 judgment obtained by you when the facility has not been paid its total billed charges from all other sources.

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.

MEDICAID

Payment of benefits for members eligible for Medicaid is made to the appropriate state agency or to the provider when required by law.

OVERPAYMENTS

If BCBSNM makes an erroneous benefit payment to the subscriber of member for any reason (e.g., provider billing error, claims processing error), BCBSNM may recover overpayments from you. If you do not refund

the overpayment, BCBSNM reserves the right to withhold future benefit payments to apply to the amount that you owe the Plan, and to take legal action to correct payments made in error.

APPLICATION STATEMENT

No statement (except for 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.

DISCLOSURE AND RELEASE OF INFORMATION

BCBSNM will only disclose information as permitted or required under state and federal law.

ENTIRE CONTRACT

This benefit booklet (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.

DISCLAIMER OF LIABILITY

BCBSNM has no control over any diagnosis, treatment, care, or other service provide 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 or negligence or otherwise.

SECTION 7: DEFINITIONS

It is important for you to understand the meaning of the following terms.

Approved amount - The basis of payment for services, as determined by Medicare. The Medicare carrier for your area determines the approval amount for covered services and supplies in your area under a procedure prescribed in the Medicare law.

Assignment - Assignment authorizing the payment of Medicare benefits directly to Medicare-participating providers. Under assignment, your participating provider agrees to:

- accept the approved amount as the total payment for covered services (which includes Medicare's payment, the deductible, and coinsurance), and
- accept assignment on all Medicare claims. Assignment issued only when you and your provider agree to it. A non-participating provider may agree to accept one-time assignment for any covered service, at your request.

Benefit period or Medicare benefit period - The method for measuring use of services under Medicare hospital insurance. A benefit period begins when you enter a hospital and ends when you have been out of the hospital or other facility that primarily provides skilled nursing or rehabilitation services for 60 days in a row (including the day of discharge). There is no limit to the number of benefit periods under Medicare coverage, but there are limits on the number of days within any benefit period for which Medicare will help pay.

Benefits - Payments for health care services provided to a member according to the terms of this Plan.

Blue Cross and Blue Shield of New Mexico (BCBSNM) - The Claim Administrator of this Medicare Supplement Health Plan, as selected by the New Mexico State University. 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, January 1 through December 31 each year, during which expenses and certain Plan maximums may accrue. The initial calendar year benefit period is from your effective date through the next following December 31, which may be less than 12 months.

Claims administrator - Blue Cross and Blue Shield of New Mexico (BCBSNM) as selected for this Medicare Supplement Plan provided by the New Mexico State University.

Covered service - A service or supply for which benefits will be available as described in this booklet.

Deductible - The specified dollar amount of covered services that must be incurred by a member before Medicare will begin to make any payments. This Plan pays for Part A deductibles. The member must pay for Part B deductible amount before this Plan will pay the coinsurance percentage above Medicare's payment based on Medicare's allowable.

Durable medical equipment - Equipment that is medically necessary for treatment of an illness or injury or to prevent the patient's further deterioration. Such equipment must be:

- capable of withstanding repeat use,
- primarily and customarily used to serve a medical purpose,
- generally not useful to a person in the absence of an illness or injury, and
- appropriate for use in the home.

Durable medical equipment does not include items for personal comfort and convenience or physical fitness or climate control devices.

Effective date of coverage - 12:01 a.m. of the date on which a member's coverage under this plan begins.

Emergency - *See medical emergency*

Endorsements, addenda, and riders - Written changes to the Plan that , by their terms, are made part of the Plan.

Excess charges - The amount in excess of (over) the Medicare approved amount that a provider can bill when not accepting assignment.

Experimental, investigational, or unproven - See the "Experimental, Investigational, or Unproven Services" exclusion in Section 5.

Explanation of Medicare Benefits form (EOMB) - The Medicare notice of what medical services or supplies were covered, what charges were approved, how much was credited towards the Part A or B deductible, and the amount that Medicare paid.

Home health agency - A public agency or private organization that is approved for payment by Medicare and licensed to provide both skilled nursing services and other therapeutic services on a visiting basis in a member's home and is responsible for supervising the delivery of such services under a plan prescribed and approved by the attending physician.

Hospice or Medicare hospice program - A Medicare certified program that provides care and support to terminally ill patients and their families.

Hospital - A licensed institution that is primarily and continuously engaged in providing diagnostic, surgical, and therapeutic services for medical treatment and care of injured and sick person on an inpatient basis and is approved for payment by Medicare. These services are provided by or under the supervision of licensed physician. The institution also provides 24-hour nursing service by or under the supervision of registered nurses. Hospital does not include convalescent, rest, or nursing homes; facilities primarily furnishing custodial, educational, or rehabilitative care; facilities for the aged, drug addicts, or alcoholics; facilities primarily for treatment of mental disease or tuberculosis.

Identification card (ID card) - The card issued by BCBSNM that identified the member and the Plan numbers. This care should be presented with the Medicare card whenever health care services are received by a member.

Inpatient - A patient and resident in a hospital or skilled nursing facility for at least one full night.

Medical emergency - An accidental injury or a condition that occurs suddenly and unexpectedly and it life threatening or could result in permanent damage if not treated immediately. To be eligible for possible emergency benefits, the member must seek treatment within 48 hours of the accidental injury or onset of the condition.

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 accidental injury.

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 assignment - See "Assignment".

Medicare-approved amounts - Medicare payments are based, for the most part, on Medicare fee schedule amounts. The fee schedule of physicians and certain suppliers lists payments for each Part B service and takes into account geographic variation in the cost of practice. The fee schedule amount is often less than the actual charges billed by doctors and suppliers. Part B usually pays 80 percent of the fee schedule amount, even if it is less than the actual charge.

Medicare-eligible expense - Health care expenses that will be covered by Medicare and that Medicare determines are for reasonable and necessary care.

Medicare lifetime reserve days - The extra days of inpatient hospitalization coverage beyond the Medicare maximum of 90 days in any benefit period. The total of these reserve days cannot be exceeded 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 limiting factor - The amount over the Medicare approved amount that a provider can bill when not accepting assignment.

Medicare participating provider - A provider that the Department of Health and Human Services of the United States has approved for receiving Medicare payment.

Member - The person who has applied for and has been granted coverage under this BCBSNM Medicare Supplement.

Nonparticipating provider - A provider that does not participate with Medicare and does not have to accept Medicare assignment. (At your request, a nonparticipating provider may accept one-time Medicare assignment for a covered service.) If you use a nonparticipating provider, you may have higher out-of-pocket costs (such as excess charges) and additional approval responsibilities.

Outpatient - Care received in a hospital department or doctor's office where the person enters and leaves the same day.

Participating provider - A provider that has entered into an agreement with Medicare to accept Medicare assignment. Participating providers submit their claims to Medicare and Medicare files these claims with BCBSNM. BCBSNM tries to pay participating providers directly but reserves the right to pay the member.

Physician - A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or Doctor of Podiatric Medicine (D.P.M) who is dully licensed and providers services within the scope of license.

Plan - The New Mexico State University Medigap Plan G.

Prescription drugs - Drugs that are taken at the direction of or under the supervision of a physician and that by federal law require a physician's prescription to be dispensed.

Private contracting - Federal legislation allows physician and other providers to opt out of Medicare. If you wish to continue obtaining their services (that would otherwise be covered by Medicare), you and these providers will need to enter into written private contracts that make you responsible for all payments to these providers. (See "Benefits For Medicare Part B Services" for further information about private contracting.)

Prosthetic device - An appliance or supply that is designed to replace all or part of an absent body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances).

Provider - A person or facility that is licensed in accordance with state and/or local laws and its approved for payment by Medicare to provide covered services.

Psychiatric lifetime limit - The inpatient psychiatric hospitalization coverage is the same as any other inpatient stay.

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

Skilled nursing facility - A facility or part of a facility that:

- is licensed in accordance with state or local law; *and*
- is a Medicare-participating facility; *and*
- is primarily engaged in providing skilled nursing care to inpatients under the supervision of a duly licensed physician; *and*

- provides continuous 24- hour nursing services by or under the supervision of a registered nurse; *and*
- does **not** include any facility that is primarily a rest home, a facility for the care of the aged, or for treatment of drug abuse, mental disorder, tuberculosis, or for intermediate, custodial care or educational care.

Territorial limits - The geographic region or political jurisdiction in which you must receive health care services for Medicare benefits to be paid; the United States, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

AMENDMENTS

BENEFIT BOOKLET
NO SURPRISES ACT AMENDMENT

Amendment Effective Date: This Amendment is effective on the Employer's Contract Anniversary Date or for the Plan Year of your Employer's Group Health Plan occurring on or after January 1, 2022.

The terms of this Amendment supersede the terms of the Benefit Booklet to which this Amendment is attached and becomes a part of the Benefit Booklet. Unless otherwise required by Federal or New Mexico law, in the event of a conflict between the terms on this Amendment and the terms of the Benefit Booklet, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to You and Your mean any Member, including Subscriber and Dependents.

The Benefit Booklet is hereby amended as indicated below:

I. Continuity of Care

If You are under the care of a Participating Provider as defined in the Benefit Booklet who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), You may be able to continue coverage for that Provider's Covered Services at the Participating Provider Benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for Your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if You are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date The Plan notifies You of the Provider's termination, or any longer period provided by state law. If You are in the second or

third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the Benefit Booklet.

II. Federal No Surprises Act

1. Definitions

The definitions below apply only to this Amendment. To the extent the same terms are defined in both the Benefit Booklet and this Amendment, those terms will apply only to their use in the Benefit Booklet or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this Amendment only,

- a medical screening examination performed in the emergency department of a hospital or a Freestanding Emergency Department;
- further medical examination or treatment You receive at a Hospital, regardless of the department of the Hospital, or a Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until Your condition is stabilized; and
- Covered Services You receive from a Non-Participating Provider during the same visit after Your Emergency Medical Condition has stabilized unless:
    1. Your Non-Participating Provider determines You can travel by non-medical or non-emergency transport;
    2. Your Non-Participating Provider has provided You with a notice to consent form for balance billing of services; and
    3. You have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with Blue Cross and Blue Shield of New Mexico (BCBSNM) for furnishing such item or service under the Plan to which this Amendment is attached.

"Non-Participating Emergency Facility" means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSNM for furnishing such item or service under the Plan to which this Amendment is attached.

"Participating Provider" means, for purposes of this Amendment only, with respect to a Covered Service, a physician or other health care provider who has a contractual relationship with BCBSNM setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Participating Facility" means, for purposes of this Amendment only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSNM setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached. Whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Qualifying Payment Amount" means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

2. <u>Federal No Surprises Act Surprise Billing Protections</u>

a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.

- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless You give written consent and give up balance billing protections).
- Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

b. Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

c. Cost-Sharing

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward Your Participating Provider deductible and/or Out-of-Pocket Limit, if any.

3. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If You receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill You is Your in-network cost-share. You cannot be balance billed for these Emergency Services unless You give written consent and give up Your protections not to be balanced billed for services You receive after You are in a stable condition.

When You receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill You is Your Plan's in-network cost-share requirements. When You receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill You and may

not ask You to give up Your protections not to be balance billed. If You get other services at Participating Facilities, Non-Participating Providers can't balance bill You unless You give written consent and give up Your protections.

If Your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill You is Your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

NOTE: The revisions to Your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.

BlueCross BlueShield of New Mexico