Administered by:

BlueCross BlueShield of New Mexico

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New Mexico Retiree Health Care Authority

Account #: 296701
Group #: N96710

A Guide To Your Group Medicare Supplement Plan - Health Care Coverage Secondary to Medicare

296701 (July 1, 2018)

CUSTOMER ASSISTANCE

Customer Service: Medical/Surgical Claims

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:

Street address: 4373 Alexander Blvd. NE
Toll-free telephone number: 1-800-788-1792

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

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

Preauthorizations: Medical/Surgical Services—For preauthorization requests, call a Health Services representative, Monday through Friday 8 A.M. – 5 P.M., Mountain Time. Written requests should be sent to the address given above. **Note:** If you need preauthorization assistance between 5 P.M. and 8 A.M. or on weekends, call Customer Service. If you call after normal Customer Service hours, you will be asked to leave a message.

1-505-291-3585 or 1-800-325-8334

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

www.bcbsnm.com

***Exceptions to Claim Submission Procedures**—Claims for health care services received from providers that do not contract **directly** with BCBSNM, should be sent to the Blue Cross and Blue Shield Plan in the state where services were received. **Note: Do not submit drug plan claims to BCBSNM.** See *Section 6: Claim Payments and Disputes* for details on submitting claims.

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

Prescription Drugs – Prescription drug benefits are administered by a separate pharmacy benefit manager (PBM). For more information, call NMRHCA at 1-800-233-2576. Details about drug benefits are also on the NMRCHA web site www.nmrhca.org. You can also visit the PBM's web site at www.express-scripts.com. Drug claims should be sent to Express Scripts, Attn: Commercial Claims at P.O. Box 2872, Clinton, IA 52733-2872

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A message from

New Mexico Retiree Health Care Authority
Medicare Supplement

Welcome to the Medicare Supplement health care benefit plan for eligible participants of **New Mexico Retiree Health Care Authority (NMRHCA)** and their eligible family members. Blue Cross and Blue Shield of New Mexico (BCBSNM), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, and an Independent Licensee of the Blue Cross and Blue Shield Association is pleased to serve as the Claims Administrator for the **NMRHCA** self-funded health care benefit plan. These benefits are available to all retirees and their dependents who are eligible and enrolled in both Parts A and B of Medicare.

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. For a current Medicare Handbook, contact your local Social Security Administration office. The NMRHCA stresses the importance of preventive measures against illness – regular exercise, adequate rest, good nutrition, and periodic medical examinations.

Note: The Plan's benefit administrator (BCBSNM) and **NMRHCA** (your group) may change the benefits described in this benefit booklet. If that happens, BCBSNM or **NMRHCA** 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.

Visit the NMRHCA web site at www.nmrhca.org for more information about your health plan benefits, including for prescription drugs, enrollment and termination information, or to download copies of forms.

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

Sincerely,

NMRHCA

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SECTION 1: HOW TO USE THIS BENEFIT BOOKLET

This benefit booklet describes the benefits and limitations of the BCBSNM Medicare Supplement. If you have questions after reading this benefit booklet, please call a BCBSNM Customer Service Advocate at 1-800-788-1792.

This BCBSNM Medicare Supplement pays for the Medicare Part A deductible and coinsurance amounts not paid by Medicare when services are covered by Medicare. This benefit booklet is designed to make it easy for you to determine your coverage.

If you are looking for answers to a specific question, review the Table of Contents where major sections of this booklet are listed.

To know what is covered by this BCBSNM Medicare Supplement, see *Section 4: Covered Services*. Certain charges are not covered by this Plan because a limit or exclusion applies. See *Section 5: Exclusions* for more information. If you need to know how to file claims or if you have a claims problem, see *Section 6: Claims Filing, Payment, and Disputes*.

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 9: Definitions,* for an explanation of the limitations or special conditions that may apply to your benefits.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

The Summary of Benefits and Coverage is referred to as the *Summary of Benefits* throughout this benefit booklet. The *Summary of Benefits* 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. 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. 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.

Have both your BCBSNM issued ID card and your Medicare ID card handy when you call for an appointment and show them to the receptionist when you sign in for an appointment. Each member, including your spouse or other dependent received his/her own ID card from BCBSNM.

DRUG PLAN BENEFITS

NMRHCA 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: 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 6: Exclusions* lists limitations and exclusions that apply to *all* services.

CUSTOMER SERVICE

If you have any questions about your coverage, call or e-mail BCBSNM's Customer Service department. 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

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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

In addition to accepting e-mail inquiries, the BCBSNM website contains valuable information about BCBSNM provider networks, and other Plan benefits. It also has various forms you can print off that could save you time when you need to file a claim.

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

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.

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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 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 utilize the online features available to you.

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.

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SECTION 2: ENROLLMENT AND TERMINATION INFORMATION

WHO IS ELIGIBLE

Each person who becomes eligible for coverage can apply by submitting an application to the NMRHCA within 31 days of becoming eligible. Eligibility conditions are mandated by the Retiree Health Care Act and are subject to periodic changes. You may call NMHRCA at 1-800-233-2576 or check the NMRHCA website at ~~www.nmrhca.state.nm.us~~www.nmrhca.org for more information.

COVERAGE TYPES

Your coverage is one of the following types:

- Single (Individual) - Only the retiree (or his/her dependent) is covered.
- Two-Party - The retiree and one dependent (or any two dependents) are covered.
- Family - The retiree and his/her (or three or more dependents) are covered.

NOTE: Dependents are allowed to be covered under the non-Medicare NMRHCA Plan when the retiree (or surviving spouse) is covered under a NMRHCA Medicare program.

If only one member of a family is enrolled in the BCBSNM Medicare Supplement, it does not necessarily mean that the coverage type is Single.

ELIGIBLE RETIREES

You are an eligible retiree (a retiree eligible to participate in the NMRHCA) if:

- You receive a disability or normal retirement benefit from public service in New Mexico with an NMRHCA participating employer, and
- You did one of the following:
  - You retired with a pension before your employer's effective date with NMRHCA program, or
  - You and/or your employer (on your behalf) made contributions to the NMRHCA fund from your employer's NMRHCA effective date until your date of retirement, or
  - You and/or your employer (on your behalf) made contributions to the NMRHCA fund for at least five years before your date of retirement.
  - You are a former Legislator who served in the New Mexico State Legislature for at least two years.

~~Former legislators who served in the New Mexico State Legislature for at least two years are also eligible.~~

It is your responsibility to notify the NMRHCA (who will then notify BCBSNM) of any change in your coverage status, including a name or address change. If you have any questions about your eligibility or change in status, contact the NMRHCA for details and forms. You may call NMRHCA at 1-800-233-2576 or check the NMRHCA web site at www.mnrhca.state.nm.us.

BCBSNM Medicare Supplement Eligibility - To qualify for full coverage under the BCBSNM Medicare Supplement Plan, you must be enrolled in both Parts A and B of Medicare. To continue eligibility under this Plan, you must continue to pay any Medicare premiums and remain enrolled in both Medicare Parts A and B. If you do not have Medicare Part B, you will be responsible for the portion that Medicare Part B would have covered approximately 80%.

Medicare Part B - If you have coverage through NMRHCA and elect to decline or cancel your Medicare Part B benefit (but keep Part A of Medicare), you will automatically be enrolled in the BCBSNM Medicare Supplement and you will still be responsible for the portion that Medicare Part B would have covered approximately 80%.

Medicare Part A - If you did not contribute a minimum of 40 quarters to Social Security through your employer, you may not be entitled to premium-free Medicare Part A; NMRHCA will not penalize you for not enrolling in Part A. however, if you do not choose to purchase Medicare Part A (see below), you must provide NMRHCA with written notice and communication from the Social Security Administration indicating why you are not entitled to premium-free

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Part A. If you do not have Medicare Part A, you are not eligible for coverage under the NMRHCA Medicare Plan. Your choices are:

- You do not have Part A, but you have Part B – you may enroll in one of the non-Medicare ~~PPO~~ offered plans.
- You do not have Part A and have declined Part B – you will remain on the Supplement plan and be responsible for the portion that Medicare Part B would have covered approximately 80%.

Please note: You do have the option of purchasing Medicare Part A through the Social Security Administration, which would make you eligible for coverage under a NMRHCA Medicare plan. The monthly premium amount for Part A, which is based on the number of quarters during which you contributed to Social Security, can be obtained from the Social Security Administration. If you elect to pay for Part A, you must have Part B coverage in order to be eligible for any NMRHCA Medicare plan, as explained prior.

ELIGIBLE FAMILY MEMBERS

Covered family member, covered spouse, covered child – An eligible spouse 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 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 within 31 days of the child's attainment of the limiting age and subsequently, as may be required by BCBSNM,but not more frequently than annually after the two-year period following the Child's attainment of the limiting age of 26.
- the subscriber's **domestic partner** ~~(NOTE: Not all governing bodies of the entities have approved allowing a participant's domestic partner and his/her children to be eligible for insurance coverage. Check with your benefits administrator for more information.)~~

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

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:

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

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A **domestic partner** is a person of the same or opposite sex who meets all of the following criteria:

- shares your permanent residence and has resided with you for no less than one year;
- is not less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by BCBSNM to be sufficient to establish financial interdependency under the circumstances of your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit which can be made available to BCBSNM on request.

NMRHCA 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."

Information for Noncustodial Parents

When a child is covered by the Plan through the child's noncustodial parent, then **NMRHCA** 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 with 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.

Dependents Who Are Not Eligible – Your spouse or children are not eligible while on active duty in the armed forces of any country or covered under NMRHCA as a retiree or a dependent of another retiree.

It is your responsibility to notify the NMRHCA (who will then notify BCBSNM) of any change in your coverage status, including a name or address change or any additions or removals of a dependent (spouse or child). If you have any questions about a dependent's eligibility, contact the NMRHCA at 1-800-233-2576 for details. Forms are posted on the NMRHCA web site at ~~www.nmrhca.state.nm.us~~www.nmrhca.org.

RIGHT TO SURVIVORSHIP

An eligible dependent of a decease eligible retiree/vested-active employee may be covered under the health plan in the same terms and conditions as would apply if the retiree were still living. The surviving dependent is enrolled (or re-enrolled) under his/her own identification number and is assessed the appropriate dependent rate for medical plan premium contributions. This is called right of survivorship, and it will continue to be offered to the eligible spouse until his/her death or the eligible dependent until his/her death, marriage, or ineligibility. Eligible dependents of the surviving spouse or child are not eligible for this program unless they are related to the deceased retiree as described under Eligible Dependents, in this section of the booklet. For example, if a surviving spouse remarries, his/her new spouse is not eligible for this program.

APPLYING FOR COVERAGE

An eligible person can apply for coverage, including for his/her eligible family members, by submitting an enrollment/change form to **NMRHCA within 31 days** after becoming eligible according to the terms of the ~~Administrative Services Agreement~~**Contract Agreement**. **Note: NMRHCA** cannot use genetic information or require genetic testing in order to determine, limit or deny coverage ~~or to limit or deny coverage~~.

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WHEN COVERAGE BEGINS

NMRHCA will determine your effective date of coverage according to the provisions of the ~~Administrative Services Agreement.~~Contract Agreement

This Plan does not cover any service received before your effective date of coverage (which, for eligible family members, may be later than the subscriber's effective date). Also, if your prior coverage has an extension of benefits provision, this Plan will not cover those charges incurred after your effective date that are covered under the prior benefit plan.

CHANGES TO COVERAGE

After initial enrollment, you may need to add eligible family members to, or remove them from your coverage, update your address, or switch from Individual to Family coverage, or vice versa.

Your ability to change coverage types (e.g., from Family to Individual coverage, etc.) will depend on the rules and regulations set forth by NMRHCA. Please contact NMRHCA to find out when you can change your coverage type or remove a person from your coverage.

ADDING A FAMILY MEMBER TO COVERAGE

You may apply for coverage of your eligible dependents, which may mean changing from Single ~~(individual)~~ to Two-Party or Family coverage.

For eligible dependents who are newly eligible due to an event such as marriage, newborn child, or adopted child, you need to apply for dependent coverage before or within 31 days of the event. If you do not apply within ~~the~~ 31 days, you will be able to enroll under the next open enrollment period designated by the NMRHCA.~~a health statement is also required; your application for additional dependent(s) may be denied~~ (see "Late Applicants" in this section for more information.)

LATE APPLICANT

~~A late applicant (including a re-enrolling dependent or retiree) must submit a health statement with his/her application and is subject to medical underwriting. Coverage may be totally denied based upon unacceptable medical conditions of the applicant.~~A late applicant may enroll during the open enrollment period as designated by the NMRHCA.

Exception: When an eligible retiree, spouse, or dependent was receiving group health coverage through a third party and involuntarily loses the coverage due to a change in eligibility status, the eligible retiree, spouse, or dependent may enroll in the NMRHCA Plan for which he/she is eligible within 31 days of the event ~~without submitting a health statement~~. In such cases, if the loss of coverage was not caused by any neglect or wrong doing by the eligible retiree, spouse, or dependent, he/she may enroll within 31 days of the change of status without being considered a late applicant.

An involuntary loss of coverage includes the following circumstances: loss of other coverage due to legal separation, divorce, death, reaching a dependent child age limit, moving out of a qualified service area, termination of employment, reduction in hours, or termination of employer contributions (even if the affected member continues such coverage by paying the amount previously paid by the employer.) A loss of coverage may also occur if your employer ceased offering coverage to the particular class of workers or similarly situated individuals to which you belonged or terminated your benefit package option, and no substitute plan was offered. If the member is covered under a state or federal continuation policy due to prior employment, involuntary loss of coverage includes exhaustion of the maximum continuation time period. Involuntary loss of coverage does not include a loss of coverage due to the failure of the individual or member to pay premiums on a timely basis or termination of coverage for cause. You are also considered to have experienced a loss in coverage if you reach a lifetime benefit maximum under another employer's health care plan.

Late applicants may not enroll until the next Open Enrollment period.

SWITCH ENROLLMENT

Application for special enrollment must be made within 31 days of losing other coverage or experiencing a change in family status in order to qualify you and/or your eligible family member for a special enrollment or special switch

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enrollment right (switch enrollment by be available to members who are offered more than one benefit plan option). A Qualifying change in family status may occur when a retiree acquires a new dependent through marriage, birth, adoption, or placement for adoption. Please contact NMRHCA for details about special enrollment privileges that apply to you and your eligible family members.

NOTIFICATION OF ELIGIBILITY AND ADDRESS CHANGES

The subscriber must notify **NMRHCA within 31 days** following any changes that may affect his/her or a family member's eligibility, including a change to a covered family member's name or address, by indicating such changes on an enrollment/change form and submitting it to **NMRHCA.** (Members covered under federal continuation must submit enrollment/change forms directly to the COBRA administrator.)

REMOVING DEPENDENTS

When you lose a covered dependent through marriage, death, divorce, annulment, or legal separation, coverage ceases at the end of the month following the date of the event that caused the covered dependent to lose eligibility. If a covered dependent becomes ineligible because of age or recovery from mental or physical disability, coverage ceases at the end of the month.

The retiree is responsible for submitting an application to remove the dependent from coverage. Call NMRHCA at 1-800-233-2576 for the necessary form or download a copy from NMRHCA web site at ~~www.nmrhca.state.nm.us~~~~www.nmrhca.org~~www.nmrhca.org.

COVERAGE TERMINATION

Coverage under a NMRHCA Plan terminates when:

- the retiree or covered dependent ceases to be eligible; or
- the NMRHCA ceases to provide health care benefits; or
- the retiree or surviving dependent fails to make any required premium payment for coverage when due; or
- there is a material failure by the retiree or covered dependent to abide by the rules and/or policies and procedures of the NMRHCA and/or the Plan in which the member is enrolled; or
- a retiree requests cancellation of any or all plans (the effective date of cancellation will depend on the date NMRHCA received the written request); or
- the retiree dies (right of survivorship will continue to be offered to the retiree's eligible dependents spouse until his/her death, and to the retiree' eligible dependents until their death, marriage, or ineligibility).

Contact NMRHCA at 1-800-233-2576 or check the NMRHCA web site at ~~www.nmrhca.state.nm.us~~~~www.nmrhca.org~~www.nmrhca.org for more information.

~~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 date:~~

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.

Continuation Coverage

Your group may be subject to the provisions for continuation of plan coverage under federal law (COBRA or USERRA). If so, retirees and their covered family members excluding domestic partners 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 by purchasing the continuation coverage described below. You must pay premiums from the date of loss of group coverage.

You are not eligible to enroll for continuation coverage if:

- the employer stops offering this coverage to its retirees, *or*

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- you do not elect continuation coverage in a timely fashion.

Refer to *Appendix A: Continuation Coverage Rights under COBRA* or contact your benefits administrator for details about enrolling in continuation coverage.

Continuation Benefits

Continuation coverage is identical to the coverage a similarly situated regular member has. If the coverage for regular members changes, your continuation coverage will reflect the same change. For example, if the Plan's deductible or other cost-sharing amounts change for regular members, yours will change by the same amount.

Federal Continuation (COBRA)

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

Continuation coverage under federal law ends on the **earliest** of the following dates or any of the applicable dates listed under "Coverage Termination" earlier in this section:

- the first of the month when you become entitled to Medicare
- when the employer discontinues offering this Plan to retirees (If this Plan is replaced by another health care plan, continuation coverage will also be replaced by the new Plan.)
- when you become covered under another group health care plan
- when the continuation period expires (If this employer's Plan is still being administered by BCBSNM, you will have the option of changing to the conversion coverage provided by BCBSNM and described under "Conversion to Individual Coverage.")

Premium Payments

Subscribers under federal COBRA continuation coverage must pay premiums to the COBRA administrator. Contact your benefits administrator for an application for coverage and details.

USERRA Continuation Coverage

Retirees and their covered family members who lose group coverage because the retiree is absent from work due to military service may be able to continue coverage for **up to 24 months** after the absence begins. Contact your benefits administrator for details about the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

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SECTION 3: COVERED SERVICES

The BCBSNM Medicare Supplement complements Medicare by paying specific benefits of Medicare-eligible medical services. The benefits are subject to the exclusions, conditions, and limitations .

BENEFITS FOR MEDICARE PART A SERVICES

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

Doctors and supplies 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 hospitalizing 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 are at 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 form 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.

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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 Enrolled in part A Only or 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 arrangements, 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.

If you are not enrolled in Medicare Part B, benefit payments for services that would have otherwise been covered by Medicare Part B will be calculated as if Medicare had paid 80 percent of the billed charge for a covered service (this amount is your responsibility).

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 paid.
- 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 deducible, 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.

Clinical Laboratory Services – This Plan includes coverage for blood tests for diagnostic services which is paid at 100 percent by Medicare.

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.

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SERVICES COVERED UNDER PART A AND B

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.

ADDITIONAL BENEFITS NOT COVERED BY MEDICARE

Covered Charges – All benefits payable under this provision of the Plan are based on a covered charge amount (sometimes referred to as the allowable charge). The covered charge is the greatest amount BCBSNM can use to calculate Plan benefits and your Plan coinsurance, when applicable.

The covered charges for services not covered by Medicare are based on BCBSNM's maximum allowable fee (a fair and reasonable charge for covered services as determined by BCBSNM or total billed charges, whichever is less). The provider can charge you more than the covered charge, and you are responsible for paying the difference. (If a service is covered by Medicare, see "Medicare–Covered Services" earlier in this section, for information about covered charges.)

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.

Acupuncture and Rolfing – You will pay 20 percent of the BCBSNM maximum allowable fee for covered acupuncture and rolfing services. Benefits for acupuncture and for rolfing are limited to a combined maximum calendar year benefit of $1,500 per member.

Preventive Services – This Plan pays, to the extent not covered by Medicare, 100 percent of the BCBSNM maximum allowable fee for covered routine/preventive services. You are responsible for amounts above the BCBSNM maximum allowable fee.

SERVICES NOT COVERED BY MEDICARE

Unless listed above, the following services are the only services covered under the Medicare Supplement when not covered by Medicare:

Prescription Drugs (Inpatient) – Prescription drugs are not covered under this BCBSNM Medicare Supplement, 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 (Outpatient) – NMRHCA has contracted with a pharmacy benefit manager (PBM) for claims administration of your outpatient prescription drug benefits. (This program is not affiliated with BCBSNM.) For more information about your prescription drug coverage, please review the summary of prescription drug benefits, call NMRHCA at 1–800–233–2576 or call the PBM directly at 1–800–551–1866 (TTY/TDD phone number is 1–800–716–3231.) Details about drug benefits are also on the NMRHCA web site at www.nmrhca.org. You can also visit the PBM's web site at www.express–scripts.com. Drug claims should be sent to Express Scripts.

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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).
- The Medicare program's determination of whether particular health care services will be covered under its program will be final and binding on BCBSNM's determination of the benefit payments are liability under this Plan.
- 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 BCBSNM Medicare Supplement. 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 BCBSNM Medicare Supplement 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 and their determination will be final.

  In addition, whether or not the member is enrolled in Medicare Parts A and B, the Plan will not pay amounts that would have been paid by Medicare had the member been so entitled and enrolled (see the eligibility requirements in Section 2.)
- When a member received nonemergency services in the United States from a hospital or other facility 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.
- There is no general lifetime maximum payment under the BCBSNM Medicare Supplement. Certain benefits have maximum limits per calendar year, specified benefit period, or lifetime (e.g., hospice care), and are described earlier in this section.

SERVICES RECEIVED OUTSIDE THE MEDICARE TERRITORIAL LIMITS

Only medically necessary emergency care services beginning during the first 60 days of each trip outside the Medicare territorial limits are covered under this Plan. The Medicare territorial limits are defined by Medicare as the United States, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Keep copies of your receipts. Submit the receipts as described in *Section 6: Claims Filing, Payment, and Disputes*.

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SECTION 4: 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,~~. then all services performed in conjunction with it are not covered.~~

In addition to the exclusions of Limitations and Controls in Section 3, 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 for daily living (such as sitters or home-maker's services), or services not requiring the continuous attention of skilled medical or paramedical personnel, regardless of where they are furnished and by whom they were recommended.

— 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 covered by Medicare and not accepted as *standard medical practice* (as defined) or those considered experimental, investigational, or unproven, unless for acupuncture rendered by a licensed doctor of oriental medicine or unless specifically listed as covered under "Cancer Clinical Trials" in *Section 4: Covered Services*. 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.

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- 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

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- 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
  - — private sanitarium
  - — dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group
  - — extended care facility
  - — residential treatment center (facility where the primary services are the provision of room and board and constant supervision or a structured daily routine for a person who is impaired but whose condition does not require acute care hospitalization)

— 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: NMRHCA has contracted with a pharmacy benefit manager for claim administration of your outpatient prescription drug benefits. (This program is not affiliated with BCBSNM.)

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— 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 Duty Nursing

This Plan does not cover private duty nursing.

— 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
- any procedure to correct refractive defects such as farsightedness, presbyopia, or astigmatism

— War-Related Conditions

This Plan does not cover any illness or injury suffered after the member's effective date as a result of any act 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.

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SECTION 5: CLAIMS FILING, PAYMENT 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. The steps for filing claims are described below.

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.

Hospital 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 cards issued to a member by both Medicare and BCBSNM. A notice of payment will be sent to you. It 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. 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.

Physician and other Medical Services

A claims for these medical services must be filed first 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 you to file a claim for services that were covered by Medicare, you will have to file a copy for services that were covered by Medicare, you will have to file a copy of the EOMB (Explanation of Medicare Benefits)and all other required claim information with BCBSNM. On the EOMB (Explanation of Medicare Benefits) 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 (Explanation of Medicare Benefits) 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 Services Advocate for instructions on filing a claim under this Plan. (if you receive covered emergency services while outside the Medicare territorial limits, call the BlueCard Worldwide 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.

Please file all claims with 12 months after the date of service. You may obtain a copy of a Member Claim Form from the BCBSNM web site or call a Customer Service Advocate and request that one be mailed to you. Please see *Section 7: Coordination of Benefits.*

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.

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- 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 ~~form~~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 covered services are received from a provider outside New Mexico that does not participate with the local Blue Cross and Blue Shield Plan, BCBSNM will make claims payments 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, any 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.

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 recover or an emergency while out of the United States) that BCBSNM has denied totally or partially. (See your Summary of Benefits for BCBSNM Plan coverage.) However, before filing such a request, you agree to ask BCBSNM the denial and to supply whether additional documentation or information may be available in support of your claim. If request for reconsideration on a special form available from BCBSNM. You waive any right to reconsideration if you do not file the formal request for reconsideration within 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 provide in writing all of the reasons for denying the claim.

BCBSNM Contacts – For more information contact:

NMRHCA Dedicated Service Unit, Grievance Coordinator
Mailing Address: P.O. Box 27630
Albuquerque, New Mexico 87125-7630
Toll-Free Telephone: 1-800-788-1792
Email: nmrhcadsu@bcbsnm.com
Fax: (505) 837-8586

Retaliatory Action

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

NMRHCA Grievance Procedures

If you are not satisfied with BCBSNM's decision, you may appeal the decision by filing a formal complaint to the Authority within 30 days of the day the BCBSNM decision was made. (Note: you may contact NMRHCA at any time during the reconsideration process.) ~~Upon receipt of the grievance request, the Authority's Benefit Review Committee will review the case and respond to the parties involved within 30 days. If the grievance is due to an emergency situation, a response will be given within 48 hours of receipt of the formal grievance request.~~

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Executive Director, NMRHCA
4308 Carlisle Blvd. NE, Suite 104
Albuquerque, New Mexico 87107
1-800-233-2576
Fax: 505-983-8667

Additional Payment Information

If an incorrect payment is made under this Plan for any reason, an adjustment will be made. BCBSNM will make a supplemental payment when a member is entitled to an additional amount. BCBSNM will take appropriate steps to recover any excess payment. If a member is billed for an overpayment, the excess amount is due and payable to BCBSNM immediately. Any subsequent benefits will not be paid until BCBSNM receives the amount due.

Disclosure and Release of Information

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

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SECTION 6: COORDINATION OF BENEFITS

By state law, this BCBSNM Medicare Supplement is secondary to all other coverage, including Medicare and other Medicare complementary or supplemental policies, both group and non group, except CHAMPUS, TriCare, Medicaid, and Indian Health Services benefits, which are secondary to this Plan.

Medicare benefits and benefits from any other coverages that you may have are applied first, and benefits available from this Plan will be reduced accordingly as allowed by federal law.

Also, if a member is eligible for benefits under any other coverage, the combined benefit payment for all coverages cannot exceed 100 percent of the covered charges.

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SECTION 7: TERMINATION OF COVERAGE

Membership under this Plan will end without notice on the premium due date if the premium or other contribution for coverage has not been received by the NMRHCA or when the NMRHCA terminates coverage.

If membership under this Plan ends while the member is a bed patient in a hospital or skilled nursing facility, coverage will continue until benefits applicable to the admission are exhausted or until the member is discharged from where confirmed, wherever comes first.

The use of fraudulent or false means to obtain benefits or to aid or attempt to aid any ineligible person in obtaining any benefit under this Plan will terminate coverage. BCBSNM may recover benefits paid or may treat such benefits as properly paid. BCBSNM may make reasonable adjustments in any refund or premium or other contribution for coverage that may result from the above circumstances.

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SECTION 9: 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 approved amount for covered services and supplies in your area under a procedure prescribed in the Medicare law.

Assignment — Assignment authorized the payment of Medicare benefits directly to Medicare-participating providers. Under assignment, your participating provider agrees to 1) accept the approved amount as the total payment for covered services (which includes Medicare's payment, the deductible, and coinsurance), and 2) to 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 NMRHCA. 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 Retiree Health Care Authority (NMRHCA).

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.*

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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 4.~~

Experimental, Investigational or Unproven — Any treatment, procedure, facility, equipment, drug, device, or supply that is not accepted as standard medical practice in the state where services are provided. In addition, if a federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is experimental. To be considered standard medical practice and not experimental or investigational, treatment must meet all five of the following criteria:

- a technology must have final approval from the appropriate regulatory government bodies; however, approval by a governmental or regulatory agency will be taken into consideration by BCBSNM in assessing Experimental/Investigational status of a drug, device, biological product, supply and equipment for medical treatment or procedure but will not be determinative;
- the scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes;
- the technology must improve the net health outcome;
- the technology must be as beneficial as any established alternatives; and
- the improvement must be attainable outside the investigational settings.

Explanation of Medicare Benefits form (EOMB) — the Medicare notice of what medical services or supplies were covered, whet 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.

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Medically necessary, medical necessity — Services or supplies provided by a hospital, physician, or other provider that are determined to be appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease, or injury that are the most appropriate supply or level of service that can be safely provided to the member in accordance with standards of good medical practices in new Mexico. Such services or supplies cannot be primarily for the convenience of the member or the member's providers. When applied to hospital admission, medical necessity further means that the member requires acute care as a bed patient because of the nature of the services rendered or the member's condition, and the member cannot receive safe or adequate care as an outpatient. In those instances where Medicare does not determine the medical necessity of a service, BCBSNM will determined medical necessity.

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 for 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 — See Doctor of medicine (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (D.P.M.) who is duly licensed and provides services within the scope of license.

Plan — The New Mexico Retiree Health Care Authority's BCBSNM Medicare Supplement.

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.

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

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Summary of Health Insurance Grievance Procedures

This is a summary of the process you must follow when you request a review of a decision by BCBSNM. You will be provided with detailed information and complaint forms by BCBSNM at each step. In addition, you can review the complete New Mexico regulations that control the process under the **Managed Health Care Bureau** page found under the **Departments** tab on the Office of Superintendent of Insurance (OSI) website, located at www.osi.state.nm.us. You may also request a copy from BCBSNM at:

NMRHCA Designated Service Unit, Grievance Coordinator
Mailing Address: P.O. Box 27630
Albuquerque, New Mexico 871255-7630
Telephone: 1-888-966-7742
Email: nmpstadsu@bcbsnm.com
Fax: (505) 837-8509

or from OSI by calling 1-505 827-4601 or toll free at 1-855-427-5674.

What types of decisions can be reviewed?

You may request a review of two different types of decisions:

Adverse determination: You may request a review if BCBSNM has denied pre-authorization (certification) for a proposed procedure, has denied full or partial payment for a procedure you have already received, or is denying or reducing further payment for an ongoing procedure that you are already receiving and that has been previously covered. (BCBSNM must notify you *before* terminating or reducing coverage for an ongoing course of treatment, and must continue to cover the treatment during the appeal process.) This type of denial may also include a refusal to cover a service for which benefits might otherwise be provided because the service is determined to be experimental, investigational, or not medically necessary or appropriate. It may also include a denial by BCBSNM of a participant's or beneficiary's eligibility to participate in a plan. These types of denials are collectively called **"adverse determinations."**

Administrative decision: You may also request a review if you object to how BCBSNM handles other matters, such as its administrative practices that affect the availability, delivery, or quality of health care services; claims payment, handling or reimbursement for health care services; or if your coverage has been terminated.

Review of an Adverse Determination

How does pre-authorization for a health care service work?

When BCBSNM receives a request to pre-authorize (certify) payment for a healthcare service (service) or a request to reimburse your healthcare provider (provider) for a service that you have already had, it follows a two-step process.

Coverage: First, BCBSNM determines whether the requested service is covered under the terms of your health benefits plan (policy). For example, if your policy excludes payment for adult hearing aids, then BCBSNM will not agree to pay for you to have them even if you have a clear need for them.

Medical necessity: Next, if BCBSNM finds that the requested service is covered by the policy, BCBSNM determines, in consultation with a physician, whether a requested service is medically necessary. The consulting physician determines medical necessity either after consultation with specialists who are experts in the area or after application of uniform standards used by BCBSNM. For example, if you have a crippling hand injury that could be corrected by plastic surgery and you are also requesting that BCBSNM pay for cosmetic plastic surgery to give you a more attractive nose, BCBSNM might certify the first request to repair your hand and deny the second, because it is not medically necessary.

Depending on terms of your policy, BCBSNM might also deny certification if the service you are requesting is outside the scope of your policy. For example, if your policy does not pay for experimental procedures, and the service you are requesting is classified as experimental, BCBSNM may deny certification. BCBSNM might also deny certification if a procedure that your provider has requested is not recognized as a standard treatment for the condition being treated.

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IMPORTANT: If BCBSNM determines that it will not certify your request for services, you may still go forward with the treatment or procedure. **However,** you will be responsible for paying the provider yourself for the services.

How long does initial certification take?

Standard decision: BCBSNM must make an initial decision within 5 working days. However, BCBSNM may extend the review period for a maximum of 10 calendar days if it: (1) can demonstrate reasonable cause beyond its control for the delay; (2) can demonstrate that the delay will not result in increased medical risk to you; and (3) provides a written progress report and explanation for the delay to you and your provider within the original 5 working day review period.

What if I need services in a hurry?

Urgent care situation: An **urgent care situation** is a situation in which a decision from BCBSNM is needed quickly because: **(1)** delay would jeopardize your life or health; **(2)** delay would jeopardize your ability to regain maximum function; **(3)** the physician with knowledge of your medical condition reasonably requests an expedited decision; **(4)** the physician with knowledge of your medical condition, believes that delay would subject you to severe pain that cannot be adequately managed without the requested care or treatment; or **(5)** the medical demands of your case require an expedited decision.

If you are facing an urgent care situation **or** BCBSNM has notified you that payment for an ongoing course of treatment that you are already receiving is being reduced or discontinued, you or your provider may request an expedited review and BCBSNM must either certify or deny the initial request quickly. BCBSNM must make its initial decision in accordance with the medical demands of the case, but within 24 hours after receiving the request for an **expedited** decision.

If you are dissatisfied with BCBSNM's initial expedited decision in an urgent care situation, you may then request an **expedited review** of the decision by both BCBSNM and an external reviewer called an Independent Review Organization (IRO). When an **expedited** review is requested, BCBSNM must review its prior decision and respond to your request within 72 hours. If you request that an IRO perform an expedited review simultaneously with BCBSNM's review and your request is eligible for an IRO review, the IRO must also provide its expedited decision within 72 hours after receiving the necessary release of information and related records. If you are still dissatisfied after the IRO completes its review, you may request that the Superintendent review your request. This review will be completed within 72 hours after your request is complete.

The internal review, the IRO review, and the review by the Superintendent are described in greater detail in the following sections.

IMPORTANT: If you are facing an emergency, you should seek medical care immediately and then notify BCBSNM as soon as possible. BCBSNM will guide you through the claims process once the emergency has passed.

When will I be notified that my initial request has been either certified or denied?

If the initial request is approved, BCBSNM must notify you and your provider within 1 working day after the decision, unless an urgent matter requires a quicker notice. If BCBSNM denies certification, BCBSNM must notify you and the provider within 24 hours after the decision.

If my initial request is denied, how can I appeal this decision?

If your initial request for services is denied or you are dissatisfied with the way BCBSNM handles an administrative matter, you will receive a detailed written description of the grievance procedures from BCBSNM as well as forms and detailed instructions for requesting a review. You may submit the request for review either orally or in writing depending on the terms of your policy. BCBSNM provides representatives who have been trained to assist you with the process of requesting a review. This person can help you to complete the necessary forms and with gathering information that you need to submit your request. For assistance, contact BCBSNM's as follows:

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BCBSNM Appeals Unit
P.O. Box 27630 Albuquerque, NM 87125-9815
Telephone (toll-free): (800) 205-9926
E-mail: see website at www.bcbsnm.com
Fax: (505) 816-3837

You may also contact the Managed Health Care Bureau (MHCB) at OSI for assistance with preparing a request for a review at:

Telephone: 1-(505) 827-4601 or toll free at 1-(855) 427-5674
Address: Office of Superintendent of Insurance - MHCB
P.O. Box 1689, 1120 Paseo de Peralta
Santa Fe, NM 87504-1689
FAX #: (505) 827-6341, Attn: MHCB
E-mail: mhcb.grievance@state.nm.us

Who can request a review?

A review may be requested by you as the patient, your provider, or someone that you select to act on your behalf. The patient may be the actual subscriber or a dependent who receives coverage through the subscriber. The person requesting the review is called the **"grievant."**

Appealing an adverse determination – first level review

If you are dissatisfied with the initial decision by BCBSNM, you have the right to request that the decision be reviewed by its medical director. The medical director may make a decision based on the terms of your policy, may choose to contact a specialist or the provider who has requested the service on your behalf, or may rely on BCBSNM's standards or generally recognized standards.

How much time do I have to decide whether to request a review?

You must notify BCBSNM that you wish to request an internal review within **180 days** after the date you are notified that the initial request has been denied.

What do I need to provide? What else can I provide?

If you request that BCBSNM review its decision, BCBSNM will provide you with a list of the documents you need to provide and will provide to you all of your records and other information the medical director will consider when reviewing your case. You may also provide additional information that you would like to have the medical director consider, such as a statement or recommendation from your doctor, a written statement from you, or published clinical studies that support your request.

How long does a first level internal review take?

Expedited review. If a review request involves an urgent care situation, BCBSNM must complete an expedited internal review as required by the medical demands of the case, but in no case later than 72 hours from the time the internal review request was received.

Standard review. BCBSNM must complete both the medical director's review and (if you then request it) BCBSNM's internal panel review within 30 days after receipt of your pre-service request for review or within 60 days if you have already received the service. The medical director's review generally takes only a few days.

The medical director denied my request - now what?

If you remain dissatisfied after the medical director's review, you may either request a review by a panel that is selected by BCBSNM or you may skip this step and ask that your request be reviewed by an IRO that is appointed by the Superintendent.

- If you ask to have your request reviewed by BCBSNM's panel, then you have the right to appear before the panel in person or by telephone or have someone, (including your attorney), appear with you or on your behalf. You may

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submit information that you want the panel to consider, and ask questions of the panel members. Your health provider may also address the panel or send a written statement.

- If you decide to skip the panel review, you will have the opportunity to submit your information for review by the IRO, but you will not be able to appear in person or by telephone. OSI can assist you in getting your information to the IRO.

IMPORTANT: If you are covered under the NM State Healthcare Purchasing Act, you may NOT request an IRO review if you skip the panel review.

How long do I have to make my decision?

If you wish to have your request reviewed by BCBSNM's panel, you must inform BCBSNM within **5 days** after you receive the medical director's decision. If you wish to skip panel review and have your matter go directly to the IRO, you must inform OSI of your decision within **4 months** after you receive the medical director's decision.

What happens during a panel review?

If you request that BCBSNM provide a panel to review its decision, BCBSNM will schedule a hearing with a group of medical and other professionals to review the request. If your request was denied because BCBSNM felt the requested services were not medically necessary, were experimental or were investigational, then the panel will include at least one specialist with specific training or experience with the requested services.

BCBSNM will contact you with information about the panel's hearing date so that you may arrange to attend in person or by telephone, or arrange to have someone attend with you or on your behalf. You may review all of the information that BCBSNM will provide to the panel and submit additional information that you want the panel to consider. If you attend the hearing in person or by telephone, you may ask questions of the panel members. Your medical provider may also attend in person or by telephone, may address the panel, or send a written statement.

BCBSNM's internal panel must complete its review within 30 days following your original request for an internal review of a request for pre-certification or within 60 days following your original request if you have already received the services. You will be notified within 1 day after the panel decision. If you fail to provide records or other information that BCBSNM needs to complete the review, you will be given an opportunity to provide the missing items, *but the review process may take much longer and you will be forced to wait for a decision.*

Hint: If you need extra time to prepare for the panel's review, then you may request that the panel be delayed for a maximum of 30 days.

If I choose to have my request reviewed by the BCBSNM's panel, can I still request the IRO review?

Yes. If your request has been reviewed by the BCBSNM's panel and you are still dissatisfied with the decision, you will have **4 months** to request a review by an IRO.

What's an IRO and what does it do?

An IRO is a certified organization appointed by OSI to review requests that have been denied by an insurer. The IRO employs various medical and other professionals from around the country to perform reviews. Once OSI selects and appoints an IRO, the IRO will assign one or more professionals who have specific credentials that qualify them to understand and evaluate the issues that are particular to a request. Depending on the type of issue, the IRO may assign a single reviewer to consider your request, or it may assign a panel of reviewers. The IRO must assign reviewers who have no prior knowledge of the case and who have no close association with BCBSNM or with you. The reviewer will consider all of the information that is provided by BCBSNM and by you. (OSI can assist you in getting your information to the IRO.) In making a decision, the reviewer may also rely on other published materials, such as clinical studies.

The IRO will report the final decision to you, your provider, BCBSNM, and to OSI. BCBSNM must comply with the decision of the IRO. If the IRO finds that the requested services should be provided, then BCBSNM must provide them.

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The IRO's fees are billed directly to BCBSNM – there is no charge to you for this service.

How long does an IRO review take?

The IRO must complete the review and report back within 20 days after it receives the information necessary for the review. (However, if the IRO has been asked to provide an expedited review regarding an urgent care matter, the IRO must report back within 72 hours after receiving all of the information it needs to review the matter.)

Review by the Superintendent of Insurance

If you remain dissatisfied after the IRO's review, you may still be able to have the matter reviewed by the Superintendent. You may submit your request directly to OSI, and if your case meets certain requirements, a hearing will be scheduled. You will then have the right to submit additional information to support your request and you may choose to attend the hearing and speak. You may also ask other persons to testify at the hearing. The Superintendent may appoint independent co-hearing officers to hear the matter and to provide a recommendation.

The co-hearing officers will provide a recommendation to the Superintendent within 30 days after the hearing is complete. The Superintendent will then issue a final order.

There is no charge to you for a review by the Superintendent of Insurance and any fees for the hearing officers are billed directly to BCBSNM. However, if you arrange to be represented by an attorney or your witnesses require a fee, you will need to pay those fees.

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Review of an Administrative Decision

How long do I have to decide if I want to appeal and how do I start the process?

If you are dissatisfied with an initial administrative decision made by BCBSNM, you have a right to request an internal review within **180 days** after the date you are notified of the decision. BCBSNM will notify you within 3 days after receiving your request for a review and will review the matter promptly. You may submit relevant information to be considered by the reviewer.

How long does an internal review of an Administrative Decision take?

BCBSNM will mail a decision to you within 30 days after receiving your request for a review of an administrative decision.

Can I appeal the decision from the internal reviewer?

Yes. You have **20 days** to request that BCBSNM form a committee to reconsider its administrative decision.

What does the reconsideration committee do? How long does it take?

When BCBSNM receives your request, it will appoint two or more members to form a committee to review the administrative decision. The committee members must be representatives of the company who were not involved in either the initial decision or the internal review. The committee will meet to review the decision within 15 days after BCBSNM receives your request. You will be notified at least 5 days prior to the committee meeting so that you may provide information, and/or attend the hearing in person or by telephone.

If you are unable to prepare for the committee hearing within the time set by BCBSNM, you may request that the committee hearing be postponed for up to 30 days.

The reconsideration committee will mail its decision to you within 7 days after the hearing.

NMRHCA Grievance Review Procedures

If you are not satisfied with BCBSNM's internal review decision, you may file a complaint with New Mexico Retiree Health Care Authority within 30 days after BCBSNM's internal review decision. (Note: You may contact NMRHCA at any time during the internal review process.) Upon receipt of your complaint, the New Mexico Retiree Health Care Authority will review the case and respond to the parties involved within 30 days. If your situation requires expedited

review, a response will be provided within 48 hours of receipt by New Mexico Retiree Health Care Authority of the complaint. Your complaint should be submitted to:

Executive Director, NMRHCA
4308 Carlisle Blvd. NE, Suite 104
Albuquerque, New Mexico 87107
1-800-233-2576
Fax: 505-983-8667

How can I request an external review?

If you are dissatisfied with the reconsideration committee's decision, you may ask the Superintendent to review the matter within **20 days** after you receive the written decision from BCBSNM or the Executive Director. You may submit the request to OSI using forms that are provided by BCBSNM. Forms are also available on the OSI website located at www.osi.state.nm.us. You may also call OSI to request the forms at (505) 827-4601 or toll free at 1-(855)-427-5674.

How does the external review work?

Upon receipt of your request, the Superintendent will request that both you and BCBSNM submit information for consideration. BCBSNM has 5 days to provide its information to the Superintendent, with a copy to you. You may also submit additional information including documents and reports for review by the Superintendent. The Superintendent will review all of the information received from both you and BCBSNM and issue a final decision within 45 days. If you need extra time to gather information, you may request an extension of up to 90 days. Any extension will cause the review process and decision to take more time.

General Information

Confidentiality

Any person who comes into contact with your personal health care records during the grievance process must protect your records in compliance with state and federal patient confidentiality laws and regulations. In fact, the provider and insurer cannot release your records, even to OSI, until you have signed a release.

Special needs and cultural and linguistic diversity

Information about the grievance procedures will be provided in accessible means or in a different language upon request in accordance with applicable state and federal laws and regulations.

Reporting requirements

Insurers are required to provide an annual report to the Superintendent with details about the number of grievances it received, how many were resolved and at what stage in the process they were resolved. You may review the results of the annual reports on the OSI website.

GENERAL INQUIRIES AND COMPLAINTS

Inquiry – A general request for information regarding claims, benefits, or membership.

Complaint – An expression of dissatisfaction by you, either orally or in writing. Issues may include, but are not limited to, claims payments or denials, quality of care, and locating a network provider.

If you have an inquiry or a concern about any preauthorization request, claims payment, claims that have been denied or only partially paid, the quality of care you receive, or any other review decisions made by BCBSNM, call the BCBSNM Customer Service at 1-800- 788-1792. Many complaints or problems can be handled informally by calling, writing, or e-mailing the BCBSNM Customer Service Unit. If you are not satisfied with the initial response, you can request internal review as described under "Summary of Health Insurance Grievance Procedures.

RETALIATORY ACTION

No retaliatory action will be taken against you for making a complaint or for requesting internal or external review under this health benefits plan.

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CATASTROPHIC EVENTS

In case of fire, flood, war, civil disturbance, court order, strike, or other cause beyond BCBSNM's control, BCBSNM may be unable to process claims or provide preauthorization for services on a timely basis. If due to circumstances not within the control of BCBSNM or a network provider (such as partial or complete destruction of facilities, war, riot, disability of a network provider, or similar case), BCBSNM and the provider will have no liability or obligation if medical services are delayed or not provided. BCBSNM and its network providers will, however, make a good-faith effort to provide services.

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

The legal agreement between **New Mexico Retiree Health Care Authority (NMRHCA)** and Blue Cross and Blue Shield of New Mexico (BCBSNM) includes the following documents:

- this benefit booklet and any amendments, riders, or endorsements;
- the enrollment/change form(s) for the subscriber and his/her dependents;
- the members' identification cards; and
- the *Summary of Benefits*

In addition, your employer (or association) has important documents that are part of the legal agreement:

- the Benefit Program Application from the employer; and
- the Contract Agreement between BCBSNM and **NMRHCA**.

The above documents constitute the entire legal agreement between BCBSNM and **NMRHCA**. No agent or employee of BCBSNM has authority to change this benefit booklet or waive any of its provisions. You will be notified of any changes to this benefit booklet at least 30 days before the changes become effective.

NMRHCA reserves the right to amend, modify, or discontinue coverage provided for employees and their dependents. This benefit booklet is not an implied contract and does not guarantee benefits or employment.

BCBSNM provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims, except as may be specified in the Contract Agreement.

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BlueCross BlueShield of New Mexico

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www.bcbsnm.com

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