

# *BlueSecure<sup>SM</sup> Member's Certificate*

*Health Care Coverage  
for Employer Group  
Members Eligible for Medicare  
(formerly called "Senior Group Advantage")*

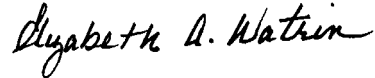
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**Blue Cross and Blue Shield  
of New Mexico**

THIS IS TO CERTIFY that the Applicant is entitled to health care benefits according to the provisions of this Certificate of Membership and any applicable Endorsements or Riders.

By:



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

**THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY AS DEFINED BY STATE AND FEDERAL LAW. If you are eligible for Medicare and are interested in a nongroup Medicare supplement policy, review the Medicare Supplement Buyers Guide available from Blue Cross and Blue Shield of New Mexico.**

This Member's Certificate combines information from the Senior Group Advantage Member's Certificate (M431; 9/92), and the "Senior Group Advantage Amendment to Coverage and Product Name Change: Blue Secure" amendment (amend\_snr adv to bsecure; 01/06).

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## ***SUGGESTIONS ON HOW TO READ THIS CERTIFICATE***

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BlueSecure helps pay for charges not paid by Medicare. As you read this Certificate, notice how BlueSecure benefits are coordinated with Medicare benefits. You will need information on both BlueSecure and Medicare to answer questions about your total health care coverage.

If you want to know what will be paid by Blue Cross and Blue Shield of New Mexico, start with the lists of services in *Section 2*. There you will find a description of what charges or amounts will be paid in addition to the Medicare payments. Certain items or amounts on your bills may not be paid because the service is not included in Medicare and your BlueSecure coverages or because a limit or exclusion applies. Read "Limitations and Controls" in *Section 2* and read *Section 3* for more information.

If you are looking for answers to a specific question, turn to the *Table of Contents* on the previous page. The major sections of this Certificate are listed there.

If you need to know how to file claims or if you have a claims problem, read *Section 4*. For questions about premium payments and what happens if your employer does not pay, see *Section 6*.

Since technical language is sometimes difficult to understand, we have used everyday English whenever possible to explain your benefits. Words that are common in the health care business are defined in the Glossary at the back of this Certificate of Membership. The definition of many terms in the Glossary determines benefits under the contract.

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## **1 ELIGIBILITY**

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To apply for coverage under this contract, a person must be eligible for Medicare by reason of age; that is, the person must be age 65 or older, and must be an employee, retiree, or dependent of an employee or retiree of an employer group with a contract with Blue Cross and Blue Shield of New Mexico.

The applicant must be enrolled in both Medicare Parts A and B. If accepted for coverage by Blue Cross and Blue Shield of New Mexico, the person must continue to pay any Medicare premiums and remain enrolled in Medicare Parts A and B.

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## **2 DESCRIPTION OF BENEFITS**

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This program compliments Medicare by paying specific benefits for Medicare eligible medical services. A Member is entitled to the benefits described below when the services are rendered by a Medicare-approved provider. The benefits are subject to the exclusions, conditions, and limitations of this contract.

### **Benefits for Medicare Part A Services**

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Benefits are provided for those services that are approved for reimbursement under Part A of Medicare. Benefits to be paid for such services will include the following services and items:

#### **1. Inpatient Hospital Services**

- a. The deductible amount the Member must pay for Medicare Part A services.
- b. The Member's portion of the Medicare Part A approved charges that are to be paid partly by Medicare and partly by the Member.
- c. 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 lifetime reserve days.)
- d. The Member's portion of Medicare Part A approved charges for care at a participating psychiatric hospital during the Member's lifetime Medicare limit. No benefits will be paid under this contract for days of hospitalization beyond the Medicare lifetime limit for days of care in a participating psychiatric hospital.
- e. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days.
  - (1) During the period when Medicare does not pay any benefits, Blue Cross and Blue Shield of New Mexico reserves the right to determine the medical necessity of all services and to decide whether benefits are available for charges. If the hospital stay is medically necessary, the following benefits will be available:
    - (a) Semiprivate room allowance for bed, board, and general nursing service; a bed in a specific care unit;
    - (b) Drugs and medicines used during hospitalization that are provided by the Hospital as prescribed by the attending Physician and that are commercially available; and
    - (c) Other Hospital services and supplies that are usually provided by the Hospital and are prescribed by the attending Physician.
  - (2) The following services and items will not be benefits and are excluded: private duty nursing; drugs prescribed for the Member to take home when discharged; and personal comfort or convenience items.

#### **2. Skilled Nursing Facility Services**

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 Blue Cross and Blue Shield of New Mexico for services after the Medicare maximum number of days of coverage in any benefit period.

#### **3. Hospice**

The Member's coinsurance amounts will be paid for hospice services received during a period when the Member has elected hospice care.

**4. Blood**

The deductible amount the Member must pay under Medicare Part A, equal to the costs for the first three pints of whole blood or units of packed red cells in each calendar year. The Part A blood deductible would be reduced to the extent that a blood deductible had been paid under Medicare Part B.

**5. Home Health Services**

The Member's portion, if any, of the Medicare Part A or Part B approved amount. No benefits will be paid under this contract for home health care charges that are not covered by Medicare Part A or B.

## **Benefits for Medicare Part B Services**

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

**1. Physicians' Services**

- a. The annual deductible amount the Member must pay for Medicare Part B services.
- b. The Member's portion of Medicare Part B service charges that are to be paid partially by Medicare and partially by the Member, according to these terms:
  - (1) If the provider has accepted Medicare assignment, benefits will be limited to 20 percent of the Medicare approved amount less 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.
  - (2) If the provider has not accepted Medicare assignment, benefits also will be limited to 20 percent of the Medicare allowed amount less the deductible, if any. The Member will be responsible for amounts in excess of the Medicare approved amount for unassigned claims.

**2. Outpatient Hospital Services**

- a. The annual deductible amount the Member must pay for Medicare Part B services.
- b. The Member's portion of the Medicare Part B approved amount.

**3. Outpatient Physical Therapy and Speech Pathology Services**

- a. The annual deductible amount the Member must pay for Medicare Part B services.
- b. The Member's portion of the Medicare Part B approved amount.

**4. Other Services and Supplies**

The following services and supplies are benefits when approved for coverage by Medicare Part B: independent laboratory radiology and pathology services, ambulance services, prosthetic devices, and durable medical equipment. The benefits are:

- a. The annual deductible amount the Member must pay for Medicare Part B.
- b. The Member's portion of the Medicare Part B approved amount.

**5. Blood**

- a. The deductible amount the Member must pay under Medicare Part B, equal to the cost for the first three pints of whole blood or units of packed red cells in each calendar year.
- b. The Member's portion of the Medicare Part B approved amount.

**6. Prescription Drugs**

No benefits for prescription drugs will be paid under this contract except those supplied and used during a hospital admission, skilled nursing facility stay, or hospice election that qualifies for Medicare coverage.

**7. Home Health Services**

No benefits will be paid under this contract for home health care charges that are not covered by Medicare Part A or B.

## Additional Benefits

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In addition to the benefits previously described in this *Section 2*, benefits are also available for the following services and items, which usually are **not** covered by Medicare. These benefits are subject to the exclusions, conditions, and limitations of this BlueSecure contract. (In some instances, benefit payments may be made directly to the Subscriber; Blue Cross and Blue Shield of New Mexico reserves the right in all cases to pay the Subscriber directly.)

### 1. Routine Physical Exam

Benefits are available for one routine physical examination per calendar year on the following basis:

- a. Benefits for one examination are limited to a maximum benefit payment of \$150 per calendar year; and
- b. Benefits apply to the charges for the office visit, related diagnostic services such as laboratory and x-ray tests (but excluding routine mammograms that are covered by Medicare and payable as a Part B service), and routine influenza and pneumococcal immunizations not covered by Medicare; and
- c. Benefit payments are limited to Blue Cross and Blue Shield of New Mexico's Maximum Allowable Fee. (You may be responsible for paying amounts in excess of the Maximum Allowable Fee, in addition to amounts in excess of the maximum \$150 benefit per exam, per calendar year, and for noncovered services.)

### 2. Routine Hearing Exam

Benefits are available for one routine hearing examination per calendar year on the following basis:

- a. Benefits for one routine hearing examination are limited to audiometric screening test, pure tone-air only.
- b. Benefit payments are limited to Blue Cross and Blue Shield of New Mexico's Maximum Allowable Fee. (You may be responsible for paying amounts in excess of the Maximum Allowable Fee, in addition to noncovered services.)

### 3. Routine Vision Exam

Benefits are available for one routine vision examination per calendar year on the following basis:

- a. Benefits for one routine vision examination are limited to one eye examination, including history, visual acuity determination, external examination of the eye, binocular measurement, ophthalmoscopy, and tonometry.
- b. Benefit payments are limited to Blue Cross and Blue Shield of New Mexico's Maximum Allowable Fee. (You may be responsible for paying amounts in excess of the maximum allowable fee, in addition to noncovered services.)

### 4. Medically Necessary Emergency Care Outside Territorial Limits

Benefits are available for Emergency Care not covered by Medicare while outside the Medicare Territorial Limits. To the extent not covered by Medicare, this plan will pay up to 80 percent of the billed charges for Medically Necessary emergency Hospital, Physician, and medical care received outside the Medicare Territorial Limits, if that 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 onset. **Territorial Limits** means 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.

## Limitations and Controls

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Benefits under this contract are subject to the following **limitations and controls**, in addition to the **exclusions** listed in *Section 3*.

1. **Where Medicare imposes any maximum benefit of dollars, number of visits or days, or other limits, Blue Cross and Blue Shield of New Mexico under this contract will not reimburse beyond the Medicare maximums.**
2. The Medicare program's determination of whether particular health care services will be benefits under its program will be final and binding on Blue Cross and Blue Shield of New Mexico's determination of its own benefit payments and liability under this contract.

In those instances where the Medicare program does not make a determination as to whether particular services are or are not benefits under its program, Blue Cross and Blue Shield of New Mexico reserves the right to determine what services will be covered and what the approved amount will be.

In addition, whether or not the Member is entitled to receive Medicare benefits by enrollment in Parts A and B of the Medicare program, Blue Cross and Blue Shield of New Mexico will not pay amounts that would have been paid by Medicare had the Member been so entitled and enrolled.

3. When a Member receives non-emergency 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 contract.
4. The Medicare deductible and the Member's portion of charges will be those applicable to Medicare benefits on the date when charges are incurred.
5. Where the furnishing of equipment is a benefit under the Medicare program and the Member has an option either to rent or purchase the equipment, Blue Cross and Blue Shield of New Mexico retains the right to decide whether the equipment will be purchased or rented by the Member as a condition of applying any benefits.
6. Payment of benefits for services provided by a Blue Cross and Blue Shield of New Mexico non-Member hospital will be made directly to the Member.

### Special Enrollment for Active Employees and Their Dependents

Involuntary loss of coverage is a loss of other coverage due to legal separation, divorce, death, moving out of an HMO 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.

There are two instances ("qualifying events") in which an eligible person can obtain a "special enrollment" right and enroll in this group plan more than 31 days after becoming eligible without being considered a late applicant under the "Pre-Existing Conditions Limitation." You have a limited amount of time during which you may request a special enrollment. If you do not request special enrollment within the time frames described below, you will be considered a late applicant. **Note:** There are no "special enrollments" for persons applying for any extension of benefits or continuation or conversion coverage offered under this group plan. You must enroll in these coverages timely.

Applying for Special 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 dependent for a special enrollment right (switch enrollment may

be available to members who are offered more than one benefit plan option). Please contact your benefits administrator for details about special enrollment privileges that apply to you and your eligible family members.

**Waiver of Coverage** — If you or an otherwise eligible member (or members) of your family decline to enroll in this group health care plan when initially eligible to do so, you (the employee) must sign a waiver of coverage for yourself and/or the affected dependent(s) and submit it to your employer. **It is very important that you indicate the reason for declining coverage.** If the eligible person(s) declined coverage due to having other health care coverage and later involuntarily loses the other coverage, you and your eligible dependent(s) may be eligible to enroll in your employer's group plan as "special enrollees." Waivers of coverage must be submitted to your employer **within 31 days** of becoming eligible for coverage under your employer's health care plan. (If the person declining coverage later requests a special enrollment, but no such written statement was provided, or if the reason for declining coverage was not due to having other coverage, he/she will be ineligible for special enrollment. If enrolled, the person will be considered a late applicant.)

**Coverage Effective Date** — If a member is granted a special enrollment due to involuntary loss of coverage or due to marriage, coverage will begin no later than the first day of the month after BCBSNM (or the employer) received the request for special enrollment. For a change in family status due to birth of an eligible newborn or adoption of a child, coverage begins on the date of birth or adoption.

**Qualifying Events** — The qualifying events for special enrollment are:

- ▣ **Change in Family Status:** An employee who acquires a new eligible dependent due to marriage, birth, adoption, or placement for adoption may apply for coverage in any of the employer health care plans for which the family is eligible. Application for special enrollment of the employee and his/her dependents will not be considered late if submitted **within 31 days** of the day the employee acquired the new dependent. If submitted more than 31 days following the change in family status, special enrollment is not available.
- ▣ **Loss of Prior Coverage:** An eligible employee (and/or his/her dependent) who declined coverage when initially eligible because of having other comprehensive medical coverage and who later *involuntarily* loses the other coverage or who reaches a lifetime maximum under another employer's health plan, may apply for coverage for himself/herself and eligible dependents. If application is made **within 31 days** of losing the other coverage or **within 31 days** of receiving the first denial notice informing the applicant that he/she had reached a lifetime limit, the applicant(s) will **not** be considered late. If application is **not** made within 31 days, the employee and his/her dependents will be considered late applicants and no special enrollment right will be available. BCBSNM reserves the right to verify the applicant's eligibility for coverage by requesting proof of loss of coverage or proof of the date of the event.

### **Pre-Existing Conditions Limitation**

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

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

**Initial enrollment eligibility date** — A member's effective date of coverage or the first day of any probationary period imposed on the member by the employer, whichever is earlier. For a late applicant or for a person applying under a special enrollment provision, the initial enrollment eligibility date is his/her effective date of coverage.

**Late applicant** — Unless eligible for a "special enrollment" (defined earlier in this section), applications from the following enrollees will be considered late:

- anyone not enrolled **within 31 days** of becoming eligible for coverage under this group health care plan (e.g., a newborn child added to coverage more than 31 days after birth when Family or Employee/Children coverage is not already in effect, a child added more than 31 days after legal adoption, or a new spouse or stepchild added more than 31 days after marriage)
- anyone enrolling on the group's initial BCBSNM enrollment date who was not covered under the group's prior plan (but who was eligible for such coverage)
- anyone eligible but not enrolled during the group's initial enrollment
- anyone who voluntarily terminates his/her coverage and applies for reinstatement of such coverage at a later date (except as provided under the USERRA of 1994)

**Pre-existing condition** — A physical or mental condition for which medical advice, medication, diagnosis, care, or treatment was recommended for or received by an applicant — including a condition for which the member is taking medication — within the **six-month** period before his/her initial enrollment eligibility date. Pregnancy and pregnancy-related diagnoses are **not** considered pre-existing conditions.

**Probationary period** — The amount of time an employee must work before becoming eligible for any health care coverage offered by the employer sponsoring this plan. Your employer determines the length of the probationary period.

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

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**Timely Applicants and Special Enrollees** — No benefits are available for any pre-existing condition for **six months** after the member's initial enrollment eligibility date.

**Late Applicants** — For a late applicant, no benefits are available for any pre-existing condition for **18 months** after his/her effective date of coverage.

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

- newborn child (when Family or Employee/Children coverage is in effect on the date of birth)
- newborn child added to coverage within 31 days of birth (when Family or Employee/Children coverage is **not** in effect on the date of birth)
- adopted child under age 18 (or child under age 18 placed in the subscriber's home for the purpose of adoption) and added to coverage prior to or within 31 days of adoption
- a newborn or adopted child who was enrolled in any group health plan or other creditable coverage within 30 days of birth or adoption and who has not experienced any significant lapse of coverage (i.e., 63 or more days) prior to enrolling in this health plan

**Reduction in Waiting Period** — The pre-existing conditions waiting period will be reduced for any member who had comprehensive medical/surgical coverage that was either still in effect, or was terminated within 63 days of, his/her initial enrollment eligibility date under this plan. The waiting period will be reduced by at least the length of time he/she was continuously covered under the prior plan(s).

You can add up any creditable coverage you had prior to enrollment in this plan, but if you went for 63 days or more without any creditable coverage (excluding any excepted time periods outlined below), the coverage you had before the break will not be counted. Proof

of such prior creditable coverage (e.g., Certificate of Creditable Coverage) is required before credit will be given.

**What is Not Considered a Break in Coverage —** For purposes of determining any significant break in coverage (i.e., 63 or more days), lapses in coverage due to any of the following situations will not be considered as part of a break:

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

For any employee who lost coverage due to military service (and his/her eligible dependents), was re-employed under the provisions of the USERRA of 1994, and applied for reinstatement of coverage according to the timeliness limitations of the USERRA of 1994, the pre-existing conditions waiting period will continue to be credited during the time the employee is in military service.

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## 3 EXCLUSIONS

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### **No benefits will be provided for services, supplies, or charges:**

1. furnished prior to the effective date of Member's coverage or during an admission that began prior to such date;
2. furnished after termination of coverage under this contract, except for hospital admissions and related services beginning prior to such termination;
3. not covered by Medicare, except for care received outside the Medicare territorial limits;
4. for 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 applies whether or not the Member claims the benefits or compensation;
5. for charges above the Medicare approved or allowed amounts;
6. that would be furnished without charge in the absence of this contract, 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;
7. for 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;
8. for 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;
9. furnished or paid for by federal, state, or local governments;
10. that are not prescribed by or performed by or upon the direction of a physician or professional provider, or which are rendered by any person or entity other than hospitals, physicians, and other Medicare participating providers;
11. that are experimental or investigative in nature (NOTE: To be considered standard or accepted medical practice, and NOT experimental or investigative, all five of the following criteria must be met:
  - A technology must have final approval from the appropriate government regulatory bodies.
  - The scientific evidence 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.
  - The improvement must be attainable outside the investigational settings.)
12. 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;
13. for cosmetic or plastic surgery, except that reconstructive surgery that is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved body part or that is necessary to improve the functioning of a malformed body member will be covered under this contract;
14. for palliative or cosmetic foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;
15. for routine eye refractions, eye glasses, or contact lenses, or for the vision examinations for prescribing or fitting eye glasses or contact lens (NOTE: Lenses for aphakic patients (those with no lens in the eye) and soft lenses or sclera (white supporting tissue of eye ball) shells intended for use in the treatment of disease and injury are benefits.)
16. for hearing aids or examinations for the prescription or fitting of hearing aids;
17. for dental services for the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth;
18. for insurance or employment examinations, examinations at the request of a third party, and any diagnostic tests directly related to such examinations;
19. for custodial care whether provided in any facility or at a Member's home;
20. for intermediate nursing home care;

21. for private duty nursing;
22. for any diagnostic or therapeutic services furnished by a chiropractor that are not covered benefits under Medicare;
23. for special foods or diets, or dietary supplements or vitamins;
24. for personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment;
25. related to a pre-existing condition that meets the criteria described under "Limitations and Controls" in Section 2;
26. for telephone consultations, charges for failure to keep a scheduled visit, charges for completion of a claim form, interest charges, or charges for medical records.

When Medicare imposes any maximum, including dollars, number of visits, or number of service units, benefits will not be available beyond such limits, except as specifically provided as benefits under this contract.

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## 4 CLAIMS FILING, PAYMENT, AND DISPUTES

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1. Because payment for health care expenses will be made by both Medicare and Blue Cross and Blue Shield of New Mexico, claims must be filed with both. The steps for filing claims are described below.

**a. HOSPITAL SERVICES:** Medicare Part A Hospital Insurance and Blue Cross and Blue Shield of New Mexico 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 Blue Cross and Blue Shield of New Mexico. A notice of payment will be sent to the Member. It is not necessary for the Member to file a claim for New Mexico hospital services with Blue Cross and Blue Shield of New Mexico.

All New Mexico Medicare participating providers of Part A services, including skilled nursing facilities and hospices, will submit claims directly.

If the hospital or provider is not in New Mexico, the Member must file the claims with Blue Cross and Blue Shield of New Mexico after Medicare has made its payment on the out-of-state services.

**b. PHYSICIAN AND OTHER MEDICAL SERVICES:** A claim for these medical services must be filed FIRST with Medicare Part B Medical Insurance.

If the physician or other provider does not file the claim, it is the Member's responsibility to file the Medicare Part B Claim and to provide the necessary information. After Medicare has made its payment and sent an Explanation of Medicare Benefits form (E.O.M.B.) to the Member, the Member must then file a copy of the E.O.M.B. and all other billing information necessary to process the claim with Blue Cross and Blue Shield of New Mexico. On the E.O.M.B. you receive from Medicare, **print your Blue Cross and Blue Shield of New Mexico certificate number and your correct mailing address and zip code.** Then make a copy of the E.O.M.B. form for your records.

In circumstances when these procedures do not apply, for example, claims for services received from providers outside the United States, you should contact a Social Security Office for instructions on filing with Medicare and also contact a Blue Cross and Blue Shield of New Mexico Customer Service Representative for instructions on filing a claim under this contract.

2. The filing of claims for benefits is the sole responsibility of the Member, even though claims may be filed on behalf of the Member by hospitals, physicians, or other providers.

**To be entitled to benefits, claims must be filed with Blue Cross and Blue Shield of New Mexico within 18 months following the date the claimed services were rendered.** Blue Cross and Blue Shield of New Mexico will refuse to honor any claim after this time period, whether such claim is filed by the provider of services or the Member.

Medicare also has time limits for filing claims. A Member can contact a local Social Security Office for information on Medicare hospital and medical insurance filing deadlines.

3. As a condition for processing claims under this contract, a Member specifically authorizes Blue Cross and Blue Shield of New Mexico to obtain from attending or examining physicians or from hospitals providing services or from other providers the information and records of attendance, examination, or treatment that may be required by Blue Cross and Blue Shield of New Mexico to administer such claims.

4. Blue Cross and Blue Shield of New Mexico reserves the right in all cases to pay the Member directly, and to prohibit assignment of benefits 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. The Member agrees as a condition for Membership under this contract to execute no power of attorney, either limited or general, to avoid this assignment provision.
5. You may file a formal request for reconsideration of claims that Blue Cross and Blue Shield of New Mexico has denied totally or partially. However, before filing such a request, you agree to ask Blue Cross and Blue Shield of New Mexico about the denial and supply whatever additional documentation or information may be available in support of your claim. If still dissatisfied with Blue Cross and Blue Shield of New Mexico's decision, you may file a formal request for reconsideration on a special form available from Blue Cross and Blue Shield of New Mexico. **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.**

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

6. Any controversy or claim arising out of or relating to this contract, or its breach, where the amount in dispute exceeds \$1,000 shall be settled by arbitration pursuant to Rules of the American Arbitration Association. Such decisions rendered in arbitration shall be binding on both the Member and Blue Cross and Blue Shield of New Mexico. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction. Rules governing arbitration are available from Blue Cross and Blue Shield of New Mexico to any Member upon request.
7. Benefit payments by Blue Cross and Blue Shield of New Mexico that are not claimed by Members will be established in a separate account. Blue Cross and Blue Shield of New Mexico will charge a fee of not less than \$1 each month as a service charge for the handling and bookkeeping associated with the maintenance of the account. The amount of the service charge may change from time to time without prior notice being given to the Member.
8. When Medicare under Part A or Part 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 the right to appeal Medicare claims decisions.
9. If an incorrect payment is made under this contract for any reason, an adjustment will be made. Blue Cross and Blue Shield of New Mexico will make a supplemental payment when you are entitled to an additional amount. Blue Cross and Blue Shield of New Mexico will take appropriate steps to recover any excess payment. If you are billed for an overpayment, the excess amount is due and payable to Blue Cross and Blue Shield of New Mexico immediately. Any subsequent benefits will not be paid until Blue Cross and Blue Shield of New Mexico receives the amount due.

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## 5 COB AND SUBROGATION

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### Coordination of Benefits (COB)

BlueSecure includes a Coordination of Benefits provision that prevents duplication of payments. Under this provision, if you are eligible for benefits under any other group or nongroup coverage, the combined benefit payments from all coverages, including Medicare payment, will not exceed 100 percent of the covered expenses.

If the other coverage is a nongroup policy that *does not* include a coordination of benefits provision, that coverage pays first and benefits available from Blue Cross and Blue Shield of New Mexico will be reduced. If the other coverage is a nongroup policy that *does* include a coordination of benefits provision, the coverage you have had for the longest continuous period pays first.

### Subrogation

In those situations when Blue Cross and Blue Shield of New Mexico has paid for your health care services and you have a right to recover the medical expenses from the person or organization causing the injury, Blue Cross and Blue Shield of New Mexico has a right to repayment of the amounts it has paid.

You have a legal obligation to help Blue Cross and Blue Shield of New Mexico recover the amounts paid for health care services. You must notify Blue Cross and Blue Shield of New Mexico when filing a claim, consulting an attorney, or bringing any action against the person or organization causing the injury. You will cooperate with Blue Cross and Blue Shield of New Mexico in any way that will assist in recovery of the amounts paid.

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## 6 TERMINATION OF COVERAGE

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1. **Membership under this certificate will end without notice on the premium due date if the premium has not been paid by your Employer or when your Employer terminates coverage.**
2. If Membership under this contract ends while the Member is a bed patient in a hospital or skilled nursing facility, coverage under this contract will continue until benefits applicable to the admission are exhausted or until the Member is discharged from where confined, whichever occurs first.
3. 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 the contract shall, at the option of Blue Cross and Blue Shield of New Mexico, terminate the contract, and all rights and privileges under this contract shall be forfeited. Blue Cross and Blue Shield of New Mexico may recover benefits paid or may treat such benefits as properly paid. Blue Cross and Blue Shield of New Mexico reserves the right to make reasonable adjustments in any refund of premium which may result from the above circumstances.
4. **Extension of Benefits**  
An employee's health care coverage continues for up to 12 consecutive months after the group's coverage termination if:
  - the employee was totally disabled (the employee is prevented, solely because of illness or accidental injury, from engaging in substantial gainful employment) on the date of the termination; and
  - the employee incurs an expense directly resulting from that particular disability that would have been a covered service before termination; and
  - the employee is not entitled to benefits for these expenses under any other policy or plan providing similar benefits on the date of service.

If coverage is continued under this provision, benefits are paid subject to all applicable limitations, exclusions, and maximums that applied at the time coverage terminated.

An employee claiming an extension of benefits must notify BCBSNM within 30 days of the group master contract termination date and provide evidence of total disability.

5. **Conversion to Medicare Supplement Coverage**  
When membership ends under this contract, except under paragraph 3 above, the member is entitled to convert to the Blue Cross and Blue Shield of New Mexico Medicare Supplement Program, Plan A. Application to convert must be received by BCBSNM within 31 days following termination of coverage under this contract. Contact your customer service representative for more information.

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## **7 CONTRACT CHANGE AND NOTICE**

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Blue Cross and Blue Shield of New Mexico may from time to time revise the provisions of the contract or replace the contract after such revision or alternative contract has been filed in accordance with the laws of the State of New Mexico. You will be given notice of any such revision or replacement.

Any notice given under this contract will be sufficient when delivered or mailed to your employer.

No change in the provisions or terms of a Member's contract will be valid until approved and signed by an executive officer of Blue Cross and Blue Shield of New Mexico and unless such approval is made a part of the contract.

No agent or employee of Blue Cross and Blue Shield of New Mexico is authorized to vary or change any terms or conditions of the contract.

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## 8 GENERAL PROVISIONS

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Nothing contained in this contract shall confer on a Member any claim, right, action, or cause of action, either at law or in equity, against Blue Cross and Blue Shield of New Mexico for any act or omission of any person, firm, or corporation who is involved directly or indirectly in furnishing any item or rendering any service to a Member.

No statement, except a fraudulent statement, that is made by a Member in any application or accompanying Health Statement for a contract and that is more than two years old shall void this contract or shall be used against the Member in any legal action or proceeding relating to this contract.

If Blue Cross and Blue Shield of New Mexico has probable cause under the terms of this contract for any benefit determination, Blue Cross and Blue Shield of New Mexico will not be liable for punitive damages to any Member, even if the benefit determination is later found to be in error.

As a condition of providing benefits under this contract, Blue Cross and Blue Shield of New Mexico retains the right at its discretion to designate a physician contracting with Blue Cross and Blue Shield of New Mexico to examine the Member for whom benefits are being provided or have been provided. Upon reasonable notification to the Member, such an examination may occur either before or after benefits have been provided for the Member.

While a Member may choose to be hospitalized in any hospital that is able to furnish the hospital services required, Blue Cross and Blue Shield of New Mexico does not guarantee either the admission of a Member to any hospital or the availability of any accommodation or services in the hospital that the Member or his/her physician requests.

**The Blue Cross and Blue Shield of New Mexico identification card must be presented when applying for any services under this contract.**

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## GLOSSARY

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**ACCIDENTAL INJURY:** injury to the body that is the direct result of an accident. Accidental injury does NOT include disease, infection, hernia, cerebral vascular accident, or medical emergencies. A medical emergency is an injury or condition that if not treated immediately could be life threatening or seriously impair one's health. No benefit payments will be made if the accidental injury would be covered by workers' compensation, employer's liability or similar law, or a motor vehicle no-fault plan.

**APPROVED OR ALLOWABLE CHARGE:** the amount that Medicare has determined is a reasonable charge for any medical insurance service. The approved charge may be less than the actual amount charged by a physician or other health care provider.

**BENEFIT PERIOD OR MEDICARE BENEFIT PERIOD:** the method by which use of services is measured. A benefit period begins when a Member enters a hospital and ends when the Member has been out of the hospital or other facility which 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.

**BENEFIT YEAR:** a period of 12 consecutive months (the calendar year). A Member may have an initial benefit year of less than 12 months.

**BENEFITS:** health care services provided to a Member that will be paid according to the terms of the contract. **The fact that a charge for a service or item is a benefit under the contract does not mean that the charge will be paid in whole or in part.**

**CONTRACT:** the total agreement between Blue Cross and Blue Shield of New Mexico and the employer for coverage of health expenses. The contract includes this document, the Group Master Contract, the accepted application, and any Endorsements, Addenda, or Riders issued by Blue Cross and Blue Shield of New Mexico.

**COVERED SERVICES:** a service or supply for which benefits will be available when rendered by a provider.

**CUSTODIAL CARE:** care wherever furnished that is primarily for the purpose of assisting a person in meeting personal needs of daily living and that does not require the continuous attention of trained medical or paramedical personnel. For example, custodial care includes help in walking and getting in or out of bed; assistance in bathing, dressing, eating, and using the toilet; preparation of special diets; and supervision over medication that can be self-administered. Despite the fact that the care is received in a participating hospital or skilled nursing facility or from a participating home health agency, **Medicare will not pay for care that is primarily custodial; neither will Blue Cross and Blue Shield of New Mexico pay for custodial care.**

**DEDUCTIBLE:** the specified dollar amount of covered services that must be incurred by a Member before Medicare will begin to make any payments. Under this contract, Blue Cross and Blue Shield of New Mexico pays for both Part A and Part B deductibles.

**DENTIST:** a Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.) who is licensed to practice prevention, diagnosis, and treatment of disease, injuries, and malformations of the teeth, jaws, and mouth.

**DIAGNOSTIC SERVICE:** a procedure ordered by a physician or other provider because of specific symptoms to determine a definite medical condition or disease.

**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 (1) capable of withstanding repeated use, (2) primarily and customarily used to serve a medical purpose, (3) generally not useful to a person in the absence of an illness or injury, and (4) 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:** 12:01 A.M. of the date on which coverage for a Member begins under this certificate.

**ENDORSEMENTS, ADDENDA, AND RIDERS:** written changes to the contract that, by their terms, are made part of the contract.

**EXPERIMENTAL/INVESTIGATIVE:** a treatment, procedure, facility, equipment, drug, device, or supply that is not accepted as standard medical treatment of the condition being treated. Also, if federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were rendered, the service is experimental.

**EXPLANATION OF MEDICARE BENEFITS FORM (E.O.M.B.):** the Medicare notice of what medical services or supplies were covered, what charges were approved, how much was credited toward 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 persons on an inpatient basis and is approved for payment by Medicare. These services are provided by or under the supervision of licensed physicians. 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 diseases or tuberculosis; or any military or veterans hospital or facility operated by or under contract with the federal government and providing non-emergency services without charge to members or former members of the armed services.

**IDENTIFICATION CARD:** the card issued by Blue Cross and Blue Shield of New Mexico that identifies the Member and the Blue Cross and Blue Shield numbers. This card 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.

**MAXIMUM ALLOWABLE FEE:** a fair and reasonable allowance for professional services charges, determined by Blue Cross and Blue Shield of New Mexico (also known as Maximum Fee Allowance). The Maximum Allowable Fee may be less than actual charges.

**MEDICALLY NECESSARY, MEDICAL NECESSITY:** services or supplies provided by a hospital, physician, or other provider that Blue Cross and Blue Shield of New Mexico determines are appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease, or injury and 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 practice in New Mexico. Such services or supplies cannot be primarily for the convenience of the Member or the Member's provider. 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, Blue Cross and Blue Shield of New Mexico reserves the right to determine medical necessity.

**MEDICARE:** the program for health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965 and as amended.

**MEDICARE ELIGIBLE EXPENSES:** health care expenses that will be covered by Medicare and that Medicare determines are 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. These reserve days can be used only once during anyone's lifetime. The decision of when to use the reserve days is made by the individual, but the Hospital must be notified in writing ahead of time if the individual does not want to use reserve days during a particular hospital stay.

**MEDICARE PARTICIPATING PROVIDER:** a provider that has been certified by the Department of Health and Human Services of the United States and approved for receiving Medicare payments.

**MEMBER:** the person who has applied for and has been granted coverage under this contract.

**MEMBER HOSPITAL:** a hospital with which Blue Cross and Blue Shield of New Mexico has a contract to provide hospital services to Members.

**MENTAL ILLNESS, PSYCHONEUROTIC, AND PERSONALITY DISORDERS:** means the specific psychiatric conditions as described in *Diagnostic and Statistical Manual—Mental Disorders* by the American Psychiatric Association.

**NONMEMBER HOSPITAL:** a licensed hospital in New Mexico which has no contract with Blue Cross and Blue Shield of New Mexico or other Blue Cross and Blue Shield Plans to provide hospital services to Members.

**NURSE, NURSING SERVICES:** care given by a licensed practical or vocational nurse (L.P.N. or L.V.N.) who has graduated from a formal practical or vocational nursing education program and is licensed by appropriate state authority, or care given by a registered nurse (R.N.) who has graduated from a formal program of nursing education (diploma school, associate degree, or baccalaureate program) and is licensed by appropriate state authority.

**OTHER PROVIDER:** a person or facility other than a physician or hospital which is licensed in accordance with state or local law and is approved for payment by Medicare to provide covered services.

**OUTPATIENT:** care received in a hospital department or doctor's office where the person enters and leaves the same day.

**PHYSICIAN:** a 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.

**PREMIUM:** the amount of money charged by Blue Cross and Blue Shield of New Mexico for the health care coverage provided by this contract.

**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.

**PROSTHETIC DEVICES:** an appliance or supply that is designed to replace all or part of an absent body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances).

**PROVIDER:** a general term for a person, practitioner, institution, or facility that is licensed, where required, and provides covered health care services.

**PSYCHIATRIC LIFETIME LIMIT:** the Medicare maximum of 190 days per lifetime of inpatient psychiatric hospitalization coverage.

**SICKNESS:** illness or disease of a Member that first manifests itself after the effective date of this contract and while the contract is in force.

**SKILLED NURSING FACILITY:** a facility or part of a facility that is licensed in accordance with state or local law, is approved as a Medicare participating facility, is primarily engaged in providing to inpatients skilled nursing care under the supervision of a duly licensed physician, and provides continuous 24-hour nursing service by or under the supervision of a registered nurse. Skilled nursing facility does NOT include any facility that is primarily a rest home, a facility for the care of the aged, or for care and treatment of substance abuse, mental diseases, or tuberculosis, or for intermediate, custodial, or educational care.





**Blue Cross and Blue Shield  
of New Mexico**

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Albuquerque, New Mexico 87112**

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