



Summary of Benefits: 07/01/10

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

Benefit Highlights		Services Covered by Medicare		Services Not Covered By Medicare
		When provider accepts Medicare assignment or facility is Medicare-participating, you pay:	When provider does not accept Medicare assignment or facility is not Medicare-participating, you pay:	When you receive additional services covered by Plan, but not by Medicare, you pay:
Highlights of Cost-Sharing Features	Calendar year deductible	None	\$100 Per Individual	
	Calendar year out-of-pocket limit ¹	Not applicable All Medicare deductible & coinsurance amounts are paid in full; there is no out-of-pocket amount.	\$1,500 Per Individual Includes the annual Plan deductible of \$100 and the 20% coinsurance amounts paid by you under this level of coverage; does not include amounts over the covered charge or noncovered services.	
	Your copayment/coinsurance after the calendar year deductible	None	20% of Medicare's limiting charge (115% of Medicare allowable)	20% of BCBSNM's covered charge; you pay excess amounts
	Lifetime Maximum	Unlimited (Certain services are subject to calendar year and/or lifetime maximums.)		
Type of Service	Description of Service and Limitations	When Assignment is Accepted, You Pay:	Your Share After Deductible ¹	
			Assignment Not Accepted	Services Not Covered by Medicare
PHYSICIAN SERVICES				
Outpatient and Office Medical/Surgical	Office visits, including allergy testing and treatment, surgery, radiologist, pathology	-0-	20%	20%
	Preventive services, including gynecological exam and flu shots	-0-	20%	20% (additional \$200 per calendar year maximum)
	Chemotherapy, radiation therapy, other therapeutic services	-0-	20%	20% ²
	Laboratory & x-ray (including routine Pap tests and mammograms if preventive services benefit is exhausted)	-0-	20%	20%
	Emergency room visit	-0-	20%	20%
Inpatient Medical/Surgical	Medical visits, consultations, surgeon, assistant, radiology, anesthesiologist, pathologist	-0-	20%	20% ²
HOSPITAL/TREATMENT FACILITY SERVICES				
Inpatient Hospital/SNF Services	Hospitalization (includes semi-private room, board, drugs, medications, and ancillaries)	-0-	N/A - Medicare will not pay nonparticipating hospitals or other treatment facilities	After Medicare reserve days have been used, 20% of BCBSNM's covered charge for up to 365 more days ²
	Skilled nursing facility/inpatient rehabilitation services	-0-		After Medicare benefit used up, 20% (limited to an additional 60 days per calendar year) ²
Emergency Room and Outpatient Facility	Emergency room, including lab, x-ray, treatment room, ancillaries	-0-		
	Outpatient treatment room, lab, x-ray, operating room	-0-		20%

Type of Service	Description of Service and Limitations	When Assignment is Accepted, You Pay:	Your Share After Deductible ¹	
			Assignment Not Accepted	Services Not Covered by Medicare
Home Health Care	Physician and skilled nursing services	-0-	N/A - Medicare will not pay nonparticipating home health care or hospice agencies	After Medicare benefit used up, 20% (limited to an additional 120 days per calendar year) ²
Hospice Care	Home/inpatient care	-0-		20% (limited to \$7500 in additional coverage) ²
MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES				
	Outpatient services	-0-	20%	20% ²
	Inpatient services	-0-	20%	20% ²
OTHER SERVICES				
Urgent Care	Urgent care center	-0-	20%	20%
Ambulance	Ambulance	-0-	20%	20% ²
Chiropractic	Chiropractic care (up to \$1500 per calendar year for all payments made for chiropractic services)	-0-	20%	20%
DME/Supplies	Durable medical equipment, prosthetics, appliances	-0-	20%	20% ²
Therapy	Physical, occupational, and speech therapy services	-0-	20%	20% ²
Services Not Covered by Medicare	Rolfing and massage therapy			20% (each limited to \$750/calendar year)
	Acupuncture			20% (limited to \$1500 per calendar year)
	Dental-related and TMJ/CMJ services			20% ²
	Out-of-country covered services (resident or traveling)			20% ² (excluding covered nutritional products and special medical foods, which are subject to 50% coinsurance after Plan deductible)
	Nonparticipating facility			20% ²
	Smoking/tobacco use cessation counseling (Choice of two group sessions or 90 minutes of counseling/calendar year)			20%
	VA facility, Inpatient			-0-
	VA facility, Outpatient			Plan deductible only

Footnotes:

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

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