

Certificate

**Medicare
Supplemental
Coverage**

Benefit Plan B



Underwritten by:



**BlueCross BlueShield
of New Mexico**

An Independent Licensee of the Blue Cross and Blue Shield Association.

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:

A handwritten signature in black ink, appearing to read "Norman P. Becker". The signature is written in a cursive style with a prominent initial "N" and a long horizontal stroke at the end.

Norman P. Becker
President and C.E.O.
Blue Cross and Blue Shield of New Mexico

Welcome

We are pleased to welcome you as a Member of a Blue Cross and Blue Shield of New Mexico Medicare Supplemental Plan. This Membership Certificate is a guide to your coverage. Keep it in a convenient place for quick reference.

Refundable Policy. You, the Member, will have the right to read this Certificate and if you are not satisfied for any reason, you may return it to us within 30 days from the date of receipt. We will refund all membership Premiums you paid for that 30-day period. However, we will recover any Benefit payments we have made for claims during that 30-day period.

When Coverage Cannot End. Your coverage will be guaranteed renewable. You will not have your coverage canceled because of poor or failing health.

Notice to the Member. This Certificate may not cover all of your medical expenses.

Customer Service. Our Customer Service Department can be reached at **1-800-307-8144 or (505) 237-5400 in Albuquerque.** (The Customer Service phone numbers are listed at the bottom of each page.)

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Section 1: Introduction

This Membership Certificate (hereinafter referred to as the “Certificate”) is part of the legal agreement between you (a Member) and us (Blue Cross and Blue Shield of New Mexico, or BCBSNM). As a Member, you are bound by all of the terms of this Certificate. In exchange for your Premium payment, we agree to pay for all or part of certain Covered Services as described in this Certificate. Our provision of Benefits to you is conditional on timely receipt of Premiums.

The legal agreement between you and us includes the following documents:

- This Certificate and any amendments made to it.
- Your application and any later applications you may make.
- Your health statement, when necessary.
- Your Identification Card.

The above documents contain all of the terms of the legal agreement between you and BCBSNM, and supersede all other statements and contracts, oral or in writing, with respect to the subject matter of this Certificate. No change or modification to your agreement with us will be valid unless it is in writing and signed by an authorized representative of BCBSNM. Further, no course of action, usage, or custom or internal policy of BCBSNM may amend or become part of our agreement with you.

We record the coverage you have in our membership records.

Term of This Certificate. This Certificate will become effective on the Member’s Effective Date of Membership. The Benefits, limitations, and exclusions of this Certificate are based on the provisions of Medicare Parts A and B.

If the Medicare Parts A and/or B provisions change, or for any other purpose we consider necessary, we reserve the right to change the terms of this Certificate by an amendment sent to you no less than 30 days in advance of the effective date of the change.

You can renew this coverage by making timely payment of membership Premiums, and your coverage can be canceled if your Premiums are not paid on time, as stated in **Section 3: Membership Premiums**.

If you need to change or end your coverage, **Section 4: Your Membership and Who Can Change or End Coverage** tells you how. Your coverage can also be canceled as stated in **Section 4**.

How to Read This Certificate. This Certificate is designed to make it easy for you to determine your Benefits, what your coverage pays, and how to receive payment from us when you send us a claim. The **Table of Contents** can help you find a definition of a word used in this Certificate or a specific provision of your coverage.

Section 2: Definitions

This section defines certain words used throughout the Certificate. The first letter of each of these words will be capitalized whenever it is used as defined below in this text. Reading this section will help you understand the rest of the agreement. You may also want to refer to this section to find out exactly how — for the purposes of this Certificate — a word is used.

Applicant. In the case of an individual Medicare Supplemental Policy, the person who seeks to contract for insurance benefits. In the case of a group Medicare Supplemental Policy, the proposed Certificate holder.

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. Each year, the carrier reviews the actual charges made by Providers in your area during the previous year. Based on this review, new Approved Amounts are put into effect each year.

Assignment. Assignment authorizes 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 is used 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.

BCBSNM. Blue Cross and Blue Shield of New Mexico.

Benefit Period. The method for measuring your 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). A non-profit health service corporation organized under the laws of New Mexico.

NOTE: “We,” “our,” and “us” refer to Blue Cross and Blue Shield of New Mexico.

Certificate (Membership Certificate). This Membership Certificate is part of the legal agreement between you (a Member) and us (BCBSNM). In exchange for your Premium payment, we agree to pay for all or part of certain Covered Services that are described in this Certificate. As a Member, you are bound by all the terms of the Certificate.

Coinsurance. The percentage of the Medicare Approved Amount that a Member pays after meeting the Medicare Deductible.

Continuous Period of Creditable Coverage. The period during which an individual was covered by Creditable Coverage with no breaks in coverage greater than 63 days.

Covered Service. A service or supply for which Benefits will be available as described in this Certificate.

Creditable Coverage. Coverage of the individual provided under any of the following plans or programs:

- A group health plan.
- Health insurance coverage.
- Part A or Part B of Title XVIII of the Social Security Act (Medicare).
- Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928.
- Chapter 55 of Title 10 United States Code (CHAMPUS).
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- A health plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program).
- A public health plan as defined in federal regulation.
- A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

Deductible. A specified amount of expense for covered services that the Member must pay within each Benefit Period for services covered

under Medicare Part A, or each calendar year for services and supplies covered under Medicare Part B.

Effective Date of Membership. The date that the Member is enrolled on our membership records for coverage under this Certificate.

Excess Charges. The amount in excess of (over) the Medicare Approved Amount that a Provider can bill when not accepting Assignment.

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

Good Cause. Failure of the Member to pay the Premiums or other applicable charges for coverage; a material failure to abide by the rules, policies, or procedures of this plan; or fraud or material misrepresentation affecting coverage.

Grace Period. The 30-day period immediately following the Premium due date.

Home Health Agency. A private organization or public agency that is approved 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. A Medicare-certified program that provides care and support to terminally ill patients and their families.

Hospital. A health institution primarily and continuously engaged in operating or providing medical, diagnostic, and major surgical facilities, beds, and 24-hour nursing services. Those facilities must be accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Identification Card. The card we issue that identifies the Member and the plan numbers. This card should be presented with your Medicare card whenever you receive health care services.

Issuer. Issuer includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery Medicare Supple-

mental Policies or certificates in New Mexico. BCBSNM is the issuer of this policy.

Lifetime Reserve Days. The extra days of inpatient hospitalization coverage beyond the Medicare maximum of 90 days in any Benefit Period. Sixty (60) reserve days are available during your lifetime. You decide when to use your reserve days, but the Hospital must be notified in writing ahead of time if you do **not** want to use reserve days during a particular Hospital stay.

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 your condition, illness, disease, or injury and that are the most appropriate supply or level of service that can be safely provided to you in accordance with standards of good medical practice in the state or jurisdiction where services are provided. Such services or supplies cannot be primarily for your or your Provider's convenience. When applied to Hospital admission, Medically Necessary further means that you require acute care as a bed patient because of the nature of the services rendered or your condition, and you 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 determine Medical Necessity.

Medicare. The "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Assignment. See "Assignment."

Medicare Eligible Expenses. Health care expenses that are covered by Medicare and that Medicare determines are for reasonable and necessary care.

Medicare Supplemental Policy. A group or individual policy of accident and sickness insurance or a Member contract other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et. Seq.) or an issued policy under a demonstration project specified in 42 U.S.C. § 1395ss (g)(l), which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare.

Member. The person who has applied for and been granted coverage under this Certificate.

NOTE: “You” and “your” refer to the Member.

Non-Participating Provider. A Provider that does not participate with Medicare and does not have to accept Medicare Assignment. (At your request, a Non-Participating Provider may accept one-time Medicare Assignment for a covered service.) The Member using a Non-Participating Provider may have higher out-of-pocket costs (such as Excess Charges) and additional approval responsibilities.

Other Valid Coverage. All other group and individual or direct-pay insurance policies or health care benefit plans, including Medicare (but excluding Indian Health Service and Medicaid coverages), that provide payments for medical services.

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 us. We try to pay Participating Providers directly, but reserve the right to pay the Member.

Physician. A practitioner who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided and is approved by Medicare.

Pre-Existing Condition. A condition for which medical advice was given or treatment was recommended by or received from a Physician within six months before the Member’s Effective Date of Membership.

Premium. The amount of money charged by BCBSNM for health care coverage provided by this Certificate.

Prior Authorization. A general approval received from BCBSNM before delivery of certain types of services. For certain services to be covered, the Provider recommending the services or the Member must obtain approval from us before the Member receives the services.

Provider. A general term for a person, practitioner, institution, or facility that is licensed by the state or jurisdiction where the treatment is given and is recognized by Medicare.

Service Date. The date from which a Member’s membership is billed (the first of any month).

Skilled Nursing Facility. A facility licensed in the state or jurisdiction where services are provided and defined, recognized, and approved for payment by Medicare.

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.

Section 3: Membership Premiums

How Premiums Are Established and Changed

The required membership Premiums are determined and established by us. We may change membership Premiums when rates are approved by the New Mexico Public Regulation Commission, Insurance Division and we give you 30 days' written notice.

How and When to Pay Premiums

1. You are not covered until we receive the first Premium payment.
2. After the first payment, your Premium will be payable on the same date every month.

NOTE: If you choose to receive a refund of membership Premiums during the first 30 days you have this Certificate, you must refund to us any payments we have made to you, or on your behalf, for claims submitted during that period.

Premium Payment Obligations

It is your responsibility as the Member to pay Premiums to us. Under no circumstances will Premium payments on behalf of you or any Member be accepted from a Physician, a Hospital, or any other Provider of your health care services. The receipt of a Premium payment from such a Provider may result in cancellation of your coverage.

Grace Period

If a Premium is not paid on or before its due date, the Premium may be paid during the 30-day Grace Period. If we do not receive the required Premium payment during the Grace Period, your coverage will be canceled as of the last day of the month through which you paid Premiums. If coverage is terminated, you will be billed for any claims received and paid on or after the cancellation date.

Reinstatement

Any Applicant whose previous BCBSNM contract was terminated for Good Cause is not eligible to re-enroll in this plan, unless approved in writing by BCBSNM.

When a Member's coverage ends because the Premium has not been paid, the terminated Member can apply for reinstatement of coverage, but will have to submit an application/health statement. BCBSNM may accept or deny the application for reinstatement.

If BCBSNM approves the application for reinstatement and the Member has made the necessary Premium payment, the Member's coverage will be reinstated on the next monthly Service Date after receipt of the application/health statement and Premium. If coverage is reinstated, it will not be retroactive. The Premium payment will be returned to the Member within 30 days of receipt if the application/health statement is still in process or if it has been denied.

Your Age and Your Premium

Your Premium is based on age and sex. A change in your age may place you in a different Premium category, and you may see an increase in the Premium amount on your bill.

Section 4: Your Membership and Who Can Change or End Coverage

There are a number of ways you may want to change or end your coverage. This section explains how you may make these changes. This section also explains how we may make changes to your policy.

When You Are Eligible to Enroll

You must be enrolled in both Parts A and B of Medicare to enroll for coverage under this Certificate.

Individual Membership

This Certificate is issued as an individual membership that covers only you, the Member.

When Your Coverage Becomes Effective

After we approve your application and health statement (when applicable), your coverage will be effective on the next monthly Service Date.

If You Want to Change Your Plan

- You may change to a plan with **higher Benefits** by completing an application (put a check mark in the “Change Plan” box at the top of the form) and health statement. The change will become effective the on first Service Date following the date we approve the health statement.
- You may change to a plan with **lower Benefits** by completing an application and putting a check mark in the “Change Plan” box at the top of the form. The effective date of change will be on the Service Date that follows the date we receive your application or on a future Service Date you specify.

NOTE: We reserve the right to refuse requests to increase coverage.

Contact the Customer Service Department for an application and health statement.

When We Can Change Your Coverage

We reserve the right to change coverage by amendment to the Membership Certificate, and the membership Premiums you pay, if the provisions of Medicare Parts A and/or B change, or for any other purpose we consider necessary. We will provide you 30 days' advance written

notice of the effective date of such change to the address we have on record for you.

When Coverage Under This Certificate Ends

Coverage under this Certificate ends on the earliest of any of the following dates:

- When you give us 30 days' advance written notice, this coverage ends on the date requested. If the notice is received after the requested cancellation date, your coverage will end on the next monthly Service Date.
- Upon the death of the Member.
- When you are no longer eligible for Medicare Part A and/or Part B.
- When we do not receive the Premium payment on time.
- When there is a misrepresentation or when false or incomplete information is presented on the application or health statement. You are liable for any Benefit payments made as a result of such improper actions.
- When we provide 30 days' advance written notice to you due to a change in state or federal law, regulation, or ruling of the New Mexico Regulation Commission, Insurance Division.
- If you establish permanent residence outside the United States of America, the date you left the United States.
- When we receive the premium payment from a Physician, a Hospital, or any other Provider of your health care services.
- When you establish permanent residence outside New Mexico, you may be required to transfer your membership to the out-of-state Blue Cross and Blue Shield plan serving your new address. Your coverage with us will terminate on the date you are accepted for enrollment by the other plan. (See "Transfer of Coverage," page 22.)

When Coverage Cannot End

Your coverage will be guaranteed renewable. You will not have your coverage canceled because of poor or failing health.

What We Will Pay After Your Coverage Ends — Extension of Benefits

We are liable for payment of covered health care expenses provided only during the period in which this Certificate is in effect. We will have no liability for those expenses incurred either after this Certificate is terminated or following any amendment(s) that may affect a change in such payment.

However, we will continue to pay an allowance under the terms of this Certificate for covered inpatient Hospital and Physician services directly related to an inpatient Hospital stay only if you meet **all three** of these conditions:

- You are an inpatient in a Hospital when the coverage is ended.
- Your inpatient stay **remains uninterrupted**, excluding any leave of absence.
- Your inpatient stay is approved by Medicare.

Our liability will be limited to the duration of your inpatient stay, or payment of the maximum Benefits available under this benefit plan, whichever is less. We will not pay for any other services that do not meet the conditions above after your coverage ends.

Suspension of Coverage Upon Eligibility for Medicaid

If you become entitled to medical assistance under Title XIX of the Social Security Act, you may request that coverage under this Certificate be suspended. We must be notified within 90 days of the date you become entitled to such assistance. If we receive timely notice, we will suspend your Benefits and Premiums under the Certificate for up to 24 months. We will return to you the Premium that applies to the period of Medicaid eligibility.

If you lose the right to Medicaid while coverage is suspended, we will — if we are notified — reinstate your coverage. The effective date of the reinstatement of coverage will be the date you lost the right to Medicaid, if we are notified within 90 days of that date. You must also pay the Premium due from the effective date of the reinstatement of coverage. Your Premium will be determined as if your coverage had not been suspended.

Section 5: What We Will Pay — Benefits

The Benefits of this Certificate are provided as a supplement to the services and supplies covered under Medicare. When Medicare provides a benefit for a service, we also provide a Benefit if the service is covered by this plan. If Medicare first pays and then retracts a benefit for a service, we will do the same. If the benefits, limitations, or exclusions of Medicare change, or for any other purpose we consider necessary, we reserve the right to change the terms of this Certificate by amendment upon 30 days' advance notice to you.

We pay only Medicare Eligible Expenses and those otherwise specified in this Certificate. All payments are based on the Approved Amount as determined by Medicare. If you use a Non-Participating Provider, you also may pay up to an additional 15 percent of the Approved Amount (the Excess Charges); we will not pay Excess Charges.

If you submit a claim for a service or supply not listed as a Benefit or exclusion, we will review your claim to determine whether the service or supply qualifies as a Benefit.

Pre-Existing Conditions Limitation

The Pre-Existing Conditions waiting period below applies to Members 65 years of age or older who are enrolled under this Certificate more than six months after their effective date under Medicare Part B, and who have had no prior coverage under a Medicare Supplemental Policy immediately preceding enrollment under this Certificate:

Surgical, medical, or other health care services provided within the first **six months** after the Member's Effective Date of Membership are **not** covered if these services are related to any condition for which medical advice was given or treatment was recommended by, or received from a Physician within six months before the Member's Effective Date of Membership. We will not pay for services related to such conditions during this time period even if these services are covered by Medicare Part A or Part B.

The Pre-Existing Conditions limitation will be waived for a Member with a Continuous Period of Creditable Coverage of at least six months. If this Period is less than six months, BCBSNM will reduce the period of the Pre-Existing Conditions limitation by the length of the Member's Continuous Period of Creditable Coverage. To qualify, a Member must have had Creditable Coverage that was either still in effect on his/her Effective Date of Membership under this plan, or that

was terminated at any time within the last 63 days prior to his/her Effective Date of Membership. (In such a case, a certificate of medical coverage from the prior carrier, including Medicaid, must be provided as supportive documentation.)

Benefits for Medicare Part A Services

This plan provides Benefits for that portion of Medicare Eligible Expenses not paid by Plan A of Medicare. Benefits include the following services and items:

Inpatient Hospital Services

The payment of Covered Services and supplies is based on the number of inpatient days remaining in either the Benefit Period or your Lifetime Reserve Days under Medicare and this Certificate.

- We pay the Deductible each Benefit Period for inpatient Hospital care.
- We pay the daily Coinsurance for the 61st to the 90th day of inpatient care each Benefit Period.

If you have been continuously hospitalized longer than 90 days, you may choose to use all or part of your 60 Lifetime Reserve Days under Medicare. While using your Lifetime Reserve Days, we pay your daily Coinsurance for the 91st through the 150th days. (No Benefits are payable for the 91st through the 150th days if you do not choose to use your Lifetime Reserve Days.)

- Once you have exhausted all your Medicare inpatient benefits, including Lifetime Reserve Days, we pay all 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. You will need to obtain Prior Authorization from BCBSNM for additional Hospital days after Medicare Lifetime Reserve Days have been exhausted.

During the period that Medicare does not pay any benefits, we will determine the Medical Necessity of all services and decide whether Benefits are available for charges. If the Hospital stay is Medically Necessary, the following Benefits will be available:

- Semiprivate room allowance for bed, board, and general nursing service (including special care units);
- Drugs and medicines used during hospitalization that are provided by the Hospital as prescribed by the attending Physician and that are commercially available; and
- Other Hospital services and supplies that are usually provided by the Hospital and are prescribed by the attending Physician.

Blood

We pay for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells as defined under federal regulations), unless replaced in accordance with federal regulations or already paid under Part B.

What We Pay After Benefits for Medicare Part B Services

This plan provides Benefits for that portion of Medicare Eligible Expenses not paid by Plan B of Medicare. Benefits include the following services and items:

Medical Expenses

- **You** pay the Medicare Part B Deductible.
- We pay the Coinsurance (20 percent of Medicare Approved Amounts) under Part B after you meet the Deductible.

Blood

- We pay for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells as defined under federal regulations), unless replaced in accordance with federal regulations or already paid under Part A.
- We pay the Member's portion of the Medicare Part B Approved Amount (excluding the Medicare Deductible).

Exclusions

The following services and items are not Benefits and are excluded:

- Medicare Part B Deductible
- Excess Charges
- The difference between private and semiprivate room rates
- Private duty nursing
- Drugs prescribed for the Member to take home when discharged
- Personal comfort or convenience items
- Hospice care and Skilled Nursing Facility services
- Services outside Territorial Limits
- Any service not covered by Medicare

Section 6: General Provisions

The following general provisions apply to **all** Benefits described in this Certificate.

Applicable Law

All interpretations of both your and our rights and obligations under this Certificate shall be governed by the laws of the United States and the state of New Mexico.

Assignment of Benefits

We will normally pay Medicare Participating Provider directly for all Benefits in this Certificate, but we reserve the right to pay the Member. We will pay a Non-Participating Provider directly only if we receive an “assignment of benefits.” An “assignment of benefits” is a signed statement from the Member requesting that his/her Benefits be paid directly to the Provider of service. You or the Provider must send us this written verification of the assignment. If we have not received an assignment of benefits, we will pay you directly.

Availability of Provider Services

We make no guarantee as to the kind of room or the services that will be available at the Hospital or facility you choose. Neither do we guarantee that the services of a Provider will be available.

Catastrophic Events

In case of fire, flood, war, civil disturbance, court order, strike, or other cause beyond our control, we may be unable to process your claims on a timely basis. No suit or action in law or equity may be taken against us because of a delay caused by any of these events.

Coordination of Benefits

This plan contains a coordination of benefits (COB) provision that prevents duplication of payments. When you are eligible for benefits under any Other Valid Coverage, the combined benefit payments from all coverages cannot exceed 100 percent of the Medicare Approved Amount.

The following rules determine which coverage pays first:

No COB Provision

If the Other Valid Coverage does not include a COB provision, that coverage pays first and this health care plan pays secondary benefits.

Subscriber/Dependent

If the Member who received care is covered as an employee, retiree, or other policyholder (i.e., as the subscriber) under one coverage and as a dependent under another, the subscriber's coverage pays first.

Exception to the Subscriber/Dependent rule: If Medicare is secondary to the plan covering you as a *dependent of an active employee*, then the plan of an active worker covering you as a dependent determines its benefits first, then Medicare, and last this Medicare Supplemental Policy. If you have Other Valid Coverage in addition to Medicare, contact the other carrier's customer service department to determine if the other coverage is primary or secondary to Medicare. There are many federal regulations regarding Medicare Secondary Payer provisions, and other coverage may or may not be subject to those provisions.

Active/Inactive Employee

If the Member who received care is covered as an active employee under one coverage and as an inactive employee under another, the coverage through active employment pays first. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, the next rule applies.

Longer/Shorter Length of Coverage

When none of the above applies, the plan in effect for the longest continuous period of time pays first. (The start of a new plan does not include a change in the amount or scope of a plan's benefits, a change in the entity that pays, provides, or administers the plan's benefits, or a change from one type of plan to another.)

Responsibility for Timely Notice

This plan is not responsible for coordination of benefits if timely information has not been provided by the complaining party regarding the application of this provision.

Facility of Payment

Whenever payments that should have been made under this plan have been made under any other plan, BCBSNM will have the right to pay to that other plan any amount BCBSNM determines to be warranted to satisfy the intent of this provision. Any amount so paid will be considered to be Benefits paid under this plan, and with that payment BCBSNM will fully satisfy its liability under this provision.

Right of Recovery

Whenever payments for Covered Services have been made by BCBSNM and those payments are more than the maximum payment

necessary to satisfy the intent of this provision, regardless of who was paid, BCBSNM has the right to recover the excess amount from any persons to or for whom those payments were made, or from any insurance company, service plan, or any other organizations or persons.

Disclaimer of Liability

We have no control over any diagnosis, treatment, care, or other service provided to a Member by any Provider, and we are not liable for any loss or injury caused by any Provider by reason of negligence or otherwise.

Exclusions

All Benefit exclusions applied by Medicare in effect on the date services are rendered will be applied to this Certificate.

Legal Fees

If we are required to bring legal action against you or defend ourselves in an action brought by you in regard to the provisions of this Certificate, and we prevail in that action, you will be required to pay for court costs and attorneys' fees.

Legal Payment Obligations

We will not pay for services for which legally you do not have to pay, or charges that are made only because Benefits are available under this Certificate.

Medical Information

Disclosure of Your Medical Information

Ordinarily, we cannot release your medical information without your written consent. That information is strictly confidential. We may, however, release your medical information without notice or consent when:

- Peer and utilization review boards and our medical consultants need such information to ensure that you are getting appropriate care.
- We receive a judicial or administrative subpoena for such information.
- The Insurance Division of the New Mexico Public Regulation Commission requests such information.
- The information is required for:
 - Workers' Compensation proceedings, or
 - third-party liability (subrogation) proceedings, or
 - coordination of benefits.

We cannot release to you information provided to us by a Provider without the Provider's written consent.

Examination

You may be requested to have another Physician examine you, at our expense, if there are questions about a Prior Authorization or about a particular service or supply for which you are claiming Benefits.

Release of Medically Related Information

You must provide us with whatever information is necessary to determine Benefits on your claims. We may obtain information from any insurance company, organization, or person when such information is necessary to carry out the provisions of this Certificate. Such information may be exchanged without consent of or notice to you.

- You agree to cooperate at all times (including while you are hospitalized) by allowing us access to your medical records to investigate claims and verify information provided in your application and/or health statement. If you do not cooperate with us, you forfeit your right to Benefit payments on claims subject to investigation and acknowledge our right to cancel your coverage.
- To help us determine which services and supplies qualify for Benefits, you authorize all Providers of health care services or supplies to provide us with any medically related information pertaining to your treatment.
- You waive all provisions of law that otherwise restrict or prohibit Providers of health care services or supplies from disclosing or testifying to such information.

Medicare Private Contracting Provision

Recent 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 by Medicare), you and these Providers will need to enter into written "private contracts" that make you responsible for all payments to these Providers.

If you enter into a "private contract" arrangement, you have in effect "opted out" of Medicare for services from these Providers. Services provided under "private contracts" are not covered by Medicare and are not covered by this plan. Also, the Medicare limit on Excess Charges does not apply. You are fully liable for payment of 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.

Payment in Error

If we make a payment in error, we may require the Provider of services, the Member, or the ineligible person to refund the amount paid in error. We reserve the right to correct payments in error through offset against new claims or legal action if necessary.

Research Fees

We reserve the right to charge you an administrative fee when extensive research is necessary to reconstruct information that has already been provided to you in explanations of benefits, letters, or other forms.

Reserve Funds

No Member is entitled to share in any reserve or other funds that may be accumulated or established by us, unless a right to share in such funds is granted by our board of directors.

Sending Notices

All notices to the Member are considered to be sent to and received by the Member when deposited in the United States mail with postage prepaid and addressed to the Member at the latest address appearing on our membership records.

Services and Supplies Not Allowed

You are liable for expenses for services and supplies that are not allowed as a Medicare Eligible Expense and not otherwise allowed as a Benefit under this Certificate.

Services/Inpatient Admissions Before Coverage Becomes Effective

We will not pay for services provided before your Effective Date of Membership.

Third-Party Liability — Subrogation

Third-party liability exists when someone else is or may be legally responsible for your condition or injury. If you suffer any illness or injury for which a third party may be responsible and if this plan has paid Benefits for that illness or injury, this plan will have the right to recover fully any Benefits paid, or Benefits that may become payable, for that illness or injury — regardless of the source.

When a third party is liable for the costs of any Covered Service, BCBSNM has subrogation rights. This means that BCBSNM has the right, either as co-plaintiff or by direct suit, to enforce your claim against a third party for the Benefits paid to you or on your behalf. If this plan provides Benefits, BCBSNM has a direct first-party priority

lien against any money you may recover from a third party or any other source as a result of the condition or injury. BCBSNM's lien must be satisfied regardless of the amount you recover.

If a third party is or may be liable for the cost of or charges for any Covered Services, the following actions must be taken:

- You must promptly notify BCBSNM of the claim against the third party.
- If you receive money for the claim by suit, settlement, or otherwise, you or your attorney must reimburse BCBSNM for the amount of Benefits provided under this plan or an amount agreed upon with BCBSNM. You may not exclude recovery for this plan's health care Benefits from any type of damages or settlement recovered.
- You must cooperate in every way necessary to help BCBSNM enforce its subrogation rights.

You may not take any action that might prejudice BCBSNM's subrogation rights.

When you fail to cooperate in satisfying BCBSNM's subrogation interest, and BCBSNM must file a lawsuit against you or the third party in order to enforce its rights under this provision, you will be responsible for attorneys' fees and costs incurred by BCBSNM.

Medicare also has subrogation rights and may subrogate separately from BCBSNM.

Time Limit on Defenses (Incontestability)

No statement (except a fraudulent statement) that is made by a Member in any application for coverage can be used to void the coverage or to deny a claim.

Transfer of Coverage

Members Who Enrolled Before April 1, 1997

Transfer of coverage does not apply to you. However, if you relocate outside New Mexico, you may choose to transfer your coverage (as described below) from BCBSNM to the Blue Cross and/or Blue Shield Plan serving your new address.

Members Who Enrolled On or After April 1, 1997

If you move to an area served by another Blue Cross and/or Blue Shield Plan, you will be offered a coverage transfer to that Plan. You must be offered at least the same level of standardized Medicare Supplemental Policy, if the same level is offered by the new Plan. If not, you will be offered an adjacent level available for sale by the new

BCBS Plan. If neither the same nor an adjacent level of policy is available, then the next alphabetically preceding standardized product available for sale will be offered. If you accept the offer, the new BCBS Plan will credit you for the length of enrollment in BCBSNM toward any of its waiting periods. The premium rate and benefits available from your new Plan may vary significantly from those offered by BCBSNM.

Your coverage with BCBSNM will terminate on the date you are accepted for enrollment by the other Plan.

Utilization Review

Claims for Covered Services are reviewed to establish that the services were Medically Necessary and in accordance with guidelines established by Medicare for Medicare claims.

Workers' Compensation

This section explains how Benefits may be paid on claims for services resulting from a work-related illness or injury.

Services and supplies resulting from work-related illness or injury are not a Benefit under this Certificate. This exclusion from coverage applies to expenses resulting from occupational accidents or sickness covered under:

- Occupational disease laws.
- Employer's liability.
- Municipal, state, or federal law.
- Workers' Compensation Act.

In order to recover benefits for a work-related illness or injury, you must pursue your rights under the Workers' Compensation Act or any of the above provision that may apply to your situation.

Section 7: How to File Claims and Appeals

Filing Claims

Most Providers will file claims on your behalf with both Medicare and BCBSNM. You may never have to file a claim.

Because payment for health care expenses will be made by both Medicare and BCBSNM, claims must be filed with both. A claim is first filed with Medicare. The resulting Explanation of Medicare Benefits (EOMB) form you receive from Medicare must be filed with the claim submitted to BCBSNM. Please call Customer Service with any questions (the phone number is at the bottom of the page). Instructions for filing claims are listed below.

Hospital Services

To file claims for you, a Hospital must have the information from your Medicare identification card and your BCBSNM identification card. Medicare Part A Hospital Insurance and BCBSNM pay the Hospital directly. A notice of payment will be sent to you.

Your claims for services will be filed for you by New Mexico Hospitals, Skilled Nursing Facilities, Hospices, and all other New Mexico Medicare Participating Providers of Part A services.

If the Hospital or Provider is not in New Mexico, you may have to file the claims with BCBSNM after Medicare has made its payment for the out-of-state services.

Physician and Other Medical Services

Most Providers of Medicare Part B Medical Insurance will file claims for you with both Medicare and BCBSNM. If the services were provided in New Mexico, a copy of the Medicare Part B payment *is usually* sent to BCBSNM automatically.

If you need to file a claim, see the instructions below.

Instructions for You to File Claims

Please follow these instructions carefully. BCBSNM will return incomplete or unreadable claims to you or your provider.

The Provider will usually submit a claim to Medicare and BCBSNM on your behalf. If you, rather than the Provider, file a claim with BCBSNM, you must wait until Medicare has made its payment and sent you an EOMB form. On the EOMB form, **print your BCBSNM**

ID number, and your correct mailing address and zip code.

Then make a copy of the EOMB form for your records. *File your claim* by sending the EOMB to BCBSNM at the address listed below.

When these procedures do not apply, you should contact a Social Security Office for instructions on filing with Medicare, and also contact a BCBSNM Customer Service Representative for instructions on filing a claim under this plan.

Where to Send Your Claims

MEDICARE SUPPLEMENT PLANS
BLUE CROSS AND BLUE SHIELD OF NEW MEXICO
PO BOX 27630
ALBUQUERQUE NM 87125-7630

Time Limit for Filing Claims

Claims must be filed within **12 months** of the date of service or Medicare's payment date, whichever is later.

Other Provisions

Even though Hospitals, Physicians, or other Providers may file claims on your behalf, it is your responsibility to make sure that the claim is filed.

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

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

Benefit payments for members eligible for Medicaid are paid to the New Mexico Human Services Department or the provider when required by law.

How to Appeal the Action We Took on Your Claim

If you have questions concerning the action we took on a claim, follow these steps:

- Call our Customer Service department for an explanation: 1-800-307-8144 or (505) 237-5400.
- If you are not satisfied with the explanation given, send us a letter asking us to reconsider your claim. We must receive your letter within 60 days after we notify you of the claim denial.

- With your letter, send us any additional information that will help support your reason for appealing our decision.
- We will make a final decision on your claim within 60 days after we receive your letter. If, because of a delay beyond our control, we cannot make a final decision within 60 days, we will send you written notice of the delay. Examples of such delays are when we need to obtain medical records or refer your case to a medical consultant for further review.
- In some cases, our medical consultants may review your claim. If a Provider disagrees with our consultants, our medical director will review your claim with the help of a committee of appropriate medical authorities chosen by us. These experts will make the final decision.

Binding Arbitration

- Any controversy or claim arising out of or relating to this contract, or its breach, where the amount in dispute exceeds \$1,000 will be settled by arbitration pursuant to the Rules of the American Arbitration Association. Such decisions rendered in arbitration are final and binding on both you and BCBSNM.
- Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction.
- Rules governing arbitration are available from BCBSNM to any Member upon request.
- The Arbitration finding will be final and binding.

Legal Action

You may not take legal action to recover Benefits under this policy until 60 days after we have received a claim from you or on your behalf. Also, you may not take any legal action after 3 years from the date that the claim in question must be filed with BCBSNM under this Medicare Supplemental Policy.

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.



BlueCross BlueShield of New Mexico

Member company of the Blue Cross and Blue Shield Association

Medicare Supplemental Plan
PO Box 27630
Albuquerque NM 87125-7630

Customer Service: 1-800-307-8144
or 237-5400 in Albuquerque