

# Benefit Program Material

TRIAD National Security, LLC

National Medicare Supplement

*Medical Program Coverage Secondary to Medicare for Retirees and  
Their Covered Dependents with Both Parts of Medicare*

Administered by:



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



# Customer Assistance

**Customer Service** – When you have questions or concerns, call the BCBSNM Customer Service department toll-free Monday through Friday from 6 A.M. – 8 P.M. and 8 A.M. – 5 P.M., Mountain Time, on Saturdays and most holidays or visit the BCBSNM office in Albuquerque, Monday through Friday from 8 A.M. – 5 P.M. (If you need assistance outside normal business hours, you may call the Customer Service telephone number and leave a message. A Customer Service Advocate will return your call by 5 P.M. the next business day.)

Street address: 4373 Alexander Blvd. NE  
Toll-free telephone number: 1-877-878-LANL (5265)

Mail all **inquiries** and submit **claims\*** to:

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

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**Web Site** – For BCBSNM provider network information, copy of Drug List, claim forms, and other information, or to e-mail your question to BCBSNM, visit the BCBSNM Web site at:

[www.bcbsnm.com](http://www.bcbsnm.com)

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**Eligibility and Enrollment Questions** – For questions about eligibility, enrollment, termination, and continuation of Medical Program coverage, for information about switching Medical Programs or for adding or cancelling dependent coverage, contact:

<b>TRIAD Customer Service</b>	Empyrean Care Center
	Phone Number (844) 805-0002
	Fax Number (866) 754-1396
	PO Box 3128
	Ballaire, TX 77402

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**Web Site**

<https://ess5.emyreanbenefitsolutions.com/lans>



# TRIAD Medicare Supplement

This *TRIAD Medicare Supplement Medical Program Material* (or “benefit booklet”) is a summary of the coverage offered by TRIAD National Security, LLC (TRIAD) to eligible retirees of TRIAD or TRIAD National Laboratory (LANL), and their eligible dependents effective January 1, 2019, who are entitled to both Parts A and B of Medicare as their primary coverage.

This Medical Program is “self-insured” by TRIAD. This means TRIAD is responsible for the design of the Medical Program and the setting of contributions. TRIAD sets the retiree contribution rates to be adequate to pay for the claims all TRIAD Medical Program members incur. When claim costs exceed the contributions, the contribution rates have to go up. A small percentage of your contributions go toward the Medical Program administration costs (claims adjudication, customer service, provider networking, ID cards, booklet printing, etc.). The balance pays for the cost of your medical care.

In addition to this document, the *TRIAD Health Benefit Plan for Retirees Summary Plan Description (“TRIAD SPD”)* contains important information about your TRIAD Medical Program. If any conflict should arise between this benefit booklet and the procedures of the Claims Administrator (BCBSNM), or if any provision is not explained or only partially explained in this document, the terms of the *TRIAD SPD* (described in *Section 1*) will govern in all cases.

Every effort has been made to make this benefit booklet as accurate and easy-to-understand as possible. It is your responsibility to read and understand the terms and conditions in this booklet. We urge you to read it carefully and use it to make well-informed benefit decisions for you and your family.

Blue Cross and Blue Shield of New Mexico (BCBSNM) is pleased to serve as Claims Administrator for the TRIAD self-funded National Medicare Supplement Medical Program.

Visit the TRIAD Web site at [www.lanl.gov](http://www.lanl.gov) for more information about your Medical Program benefits, including for prescription drugs, enrollment and termination information, or to download copies of forms.



# Table of Contents

**Customer Assistance . . . . . Inside front cover**

Summary of Benefits . . . . . 1

**1 How to Use This Booklet . . . . . 1**

    Looking Up Information . . . . . 1

    Other Benefit-Related Materials . . . . . 1

    ID Card (Carry At All Times) . . . . . 2

    BlueExtras . . . . . 2

**2 Customer Service . . . . . 4**

**3 Description of Benefits . . . . . 6**

    Selecting a Provider . . . . . 6

    Benefits for Medicare Part A Services . . . . . 7

    Inpatient Hospital Services . . . . . 7

    Skilled Nursing Facility Services . . . . . 7

    VA/Department of Defense Facilities . . . . . 7

    Blood . . . . . 8

    Benefits for Medicare Part B Services . . . . . 8

    Services Not Covered by Medicare . . . . . 9

    Emergencies Outside Territorial Limits . . . . . 9

    Preventive Services . . . . . 9

    Hearing/Vision Exams . . . . . 9

**4 Exclusions, Limitations, and Controls . . . . . 10**

    General Exclusions . . . . . 10

    Acupuncture and Rolfing . . . . . 10

    After Termination of Coverage . . . . . 10

    Charges Above Medicare Approved/Allowed . . . . . 10

    Custodial Care . . . . . 10

    Dental Services . . . . . 11

    Diagnostic or Therapeutic Services . . . . . 11

    Experimental, Investigational, or Unproven . . . . . 11

    Foot Care . . . . . 12

    Furnished Without Charge . . . . . 12

    Hair Loss Treatments . . . . . 12

    Hearing Aids . . . . . 12

    Intermediate Nursing Home Care . . . . . 12

    Noncovered Providers of Service . . . . . 12

    Nonmedical Services . . . . . 13

    Not Covered by Medicare . . . . . 13

    Not Reasonable and Necessary . . . . . 13

    Over-the-Counter Items . . . . . 13

    Paid by Federal, State, Local Government . . . . . 13

    Personal Convenience Items or Services . . . . . 13

    Physical Examinations . . . . . 13

    Prior to Effective Date . . . . . 13

    Private Duty Nursing . . . . . 14

    Private Hospital Room . . . . . 14

    Reimbursed Expenses . . . . . 14

    Special Foods or Diets . . . . . 14

    Vision Care . . . . . 14

    War-Related Conditions . . . . . 14

    Work-Related Conditions . . . . . 14

    Limitations and Controls . . . . . 15

    Service Received Outside the Medicare Territorial Limits . . . . . 16

**5 Claims Filing, Payment, and Disputes . . . . . 17**

    Filing Claims . . . . . 17

    Hospital and Other Facility Services . . . . . 17

    Physician and Other Medical Services . . . . . 17

    Services Not Covered by Medicare . . . . . 18

    Medicare Reconsideration . . . . . 20

    BCBSNM Reconsideration . . . . . 20

    BCBSNM Contacts . . . . . 20

    TRIAD Administrative Errors and Eligibility . . . . . 20

    Escalation Appeals Process . . . . . 21

    External Appeal . . . . . 21

    External Review Board . . . . . 21

    Additional Payment Information . . . . . 21

    Disclosure & Release of Information . . . . . 21

    Execution of Papers . . . . . 21

    Independent Contractors . . . . . 22

**6 COB and Reimbursement . . . . . 23**

    Coordination of Benefits (COB) . . . . . 23

    Responsibility for Timely Notice . . . . . 25

    Facility of Payment . . . . . 25

    Right of Recovery . . . . . 25

    Reimbursement Provision . . . . . 25

**7 When Group Coverage Ends . . . . . 27**

    Conversion to Individual Coverage . . . . . 27

**8 Glossary . . . . . 28**

# National Medicare Supplement – 2022



## Medicare (Part A) Hospital Services — Per Benefit Period\*

SERVICES	MEDICARE PAYS	THIS PLAN PAYS	YOU PAY**
<b>Hospitalization*</b>			
<b>Semiprivate room and board, general nursing, and miscellaneous services and supplies</b>			
First 60 days	All but \$1,556	\$1,556 (Part A deductible)	\$0
61st through 90th day	All but \$389 a day	\$389 a day	\$0
91st day and after:			
While using 60 lifetime reserve days	All but \$778 a day	\$778 a day	\$0
Once lifetime reserve days are used:			
Additional 365 days	\$0	100% of Medicare eligible expenses	\$0
Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$194.50 a day	Up to \$194.50 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice Care</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

<b>Medicare (Parts A and B)</b>			
SERVICES	MEDICARE PAYS	THIS PLAN PAYS	YOU PAY**
<b>Home Health Care</b>			
Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable Medical Equipment			
First \$233 of Medicare-approved amounts	\$0	\$233 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

Blue Cross and Blue Shield of New Mexico (BCBSNM) is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

## Medicare (Part B) Medical Services — Per Calendar Year\*

SERVICES	MEDICARE PAYS	THIS PLAN PAYS	YOU PAY**
<b>Medical Expenses</b>			
In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$233 of Medicare-approved amounts*	\$0	\$233 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally, 80%	Generally, 20%	\$0
Medicare-covered preventive services	Generally, 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$233 of Medicare-approved amounts*	\$0	\$233 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services</b>			
Blood tests for diagnostic services	100%	\$0	\$0
<b>Immunosuppressive Drug Therapy</b>			
	80%	20%	\$0
<b>Mammography Screening</b>			
As required by your physician	80%	20%	\$0
<b>Other Benefits — Services Not Covered by Medicare</b>			
SERVICES	THIS PLAN PAYS		YOU PAY**
<b>Preventive Services Not Covered by Medicare</b>	100% of the BCBSNM maximum allowable fee.		Amounts above the BCBSNM maximum allowable fee.
<b>Hearing/Vision Exams</b>	100% of the BCBSNM maximum allowable fee; one exam per year.		Amounts above the BCBSNM maximum allowable fee.
<b>Care Outside Medicare Territorial Limits (see "NOTE" below)</b>			
<b>Nonemergency Care</b>	\$0		All expenses
<b>Emergency Care</b>	100% of the BCBSNM maximum allowable fee		Amounts above the BCBSNM maximum allowable fee

\*Once you have been billed \$233 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\* "\$0" indicates your liability for covered charges. You are responsible for all other **non-covered** charges.

**NOTE:** The Medicare territorial limits are defined by Medicare as the United States, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

## Other Benefits — Outpatient Prescription Drug Plan

<b>Prescription Drugs, Insulin, Enteral Nutrition, Special Medical Foods, and Diabetic Supplies***</b>			
You must use a participating pharmacy (except in an emergency). You pay the copayments listed, up to a maximum calendar year out-of-pocket limit of <b>\$1000</b> per member for Tier 1, Tier 2 and Tier 3 drugs.	<b>Generic Drug Tier 1</b>	<b>Brand-Name Drug</b>	
		<b>On Drug List Tier 2****</b>	<b>Not on Drug List Tier 3</b>
<b>Retail/Specialty Pharmacy Programs:</b> up to a 30-day supply or 180 units, whichever is less; benefits include flu, pneumococcal, and Shingles vaccines, for which you pay no copayment.	\$15	\$30	\$45
<b>Mail-Order Pharmacy Program:</b> up to a 60- or 90-day supply or 540 units, whichever is less.	\$30	\$60	\$90
<b>Nonprescription Enteral Nutritional Products and Special Medical Foods:</b> up to a 30-day supply per 30-day period; requires preauthorization.	\$45 retail/\$90 mail-order		
<b>Pharmacy Benefits are administered by: Express Scripts. They can be reached at 1-800-838-4590.</b>			

\*\*\* Prescription drugs and other items covered under the drug plan must be purchased at a pharmacy that participates in the Retail Pharmacy/Specialty Pharmacy or Mail-Order Programs. Some prescription drugs require prior approval before coverage will be available.

\*\*\*\* If you require a brand-name drug for which there is a generic equivalent, you will pay the difference in cost between the brand-name drug and the generic drug, plus the generic drug copayment.

**NOTE:** You must be enrolled in both Part A and Part B of Medicare to be eligible for this National Medicare Supplement coverage, which is offered by Los Alamos National Security to eligible retirees of Los Alamos National Laboratories (and Los Alamos National Security) and to their Medicare-eligible dependents. If you or your dependent does not have both Parts A and B of Medicare, the eligible person without Medicare may enroll in the medical program being offered by LANS to retirees/dependents without Medicare. Also, if you live outside the Medicare territorial limits, you may enroll in the medical program being offered by LANS to retirees/dependents without Medicare.

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

**This is a summary only – please refer to the Summary of Benefits and Coverage (SBC) document and Benefit Booklet for more details**

**1**

# How to Use This Booklet

This benefit booklet describes the benefits and limitations of the TRIAD Medicare Supplement Medical Program. If you have questions after reading this benefit booklet, please call a BCBSNM Customer Service Advocate at 1-877-878-LANL (5265).

## ■ Looking Up Information

This TRIAD Medicare Supplement Medical Program pays for the Medicare Part A and Part B deductibles and coinsurance amounts when services are covered by Medicare. This benefit booklet is designed to make it easy for you to determine your coverage:

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

To know what is covered by this TRIAD Medicare Supplement Medical Program, see *Section 3: Description of Benefits*.

Certain charges are not covered by this Medical Program because a limit or exclusion applies. Read *Section 4: Exclusions, Limitations and Controls* for more information.

If you need to know how to file claims or if you have a claims problem, read *Section 5: Claims Filing, Payment, and Disputes*.

Terms that are used to describe this Medical Program are defined in the *Glossary* at the back of this booklet.

## ■ Other Benefit-Related Materials

In addition to this booklet you may have the following benefit-related documents:



Summary Plan Description (SPD) – You have on-line access to a *Summary Plan Description* (or “SPD”) through the TRIAD, L.L.C. Web site. The *TRIAD SPD* provides a summary of the principal features of the entire *TRIAD Health Benefit Plan for Retirees, ERISA Plan 502* (called a “Plan”). The *TRIAD SPD* provides a summary of all retiree benefits such as, but not limited to, life insurance, short-term disability, survivor benefits, etc. This benefit booklet is only one component of the *TRIAD SPD* and is referenced in “Appendix C” of the *TRIAD SPD* as “Benefit Program Material” of the medical/surgical health plan. This document provides a summary only of your Medical Program benefits and exclusions, basic eligibility and enrollment requirements, cost-sharing features (such as deductible and copayments), and administrative provisions of the Claims Administrator (such as coordination of benefits rules, appeal procedures, etc.). The *TRIAD SPD* for your Benefit Program is available from the TRIAD Benefits Office at:

(877) 667-1806 or (505) 667-1806

## ID Card (Carry At All Times)

Your BCBSNM identification (ID) card provides the information needed when you require health care services, or when you are contacting a Customer Service Advocate. Carry it with you. Have **both** your BCBSNM-issued ID card and your Medicare ID card handy when you call for an appointment and show them to the receptionist when you sign in for an appointment. Each member covered under the TRIAD Medicare Supplement Medical Program, including your spouse or other dependent, receives his/her own ID card from BCBSNM.

Your ID card is part of your TRIAD Medicare Supplement Medical Program coverage. Do not let anyone who is not named in your coverage use your card to receive benefits. If you want additional cards or need to replace a lost card, contact a Customer Service Advocate.

## ■ BlueExtras<sup>SM</sup>

Certain local and national retailers, outlets, and businesses offer BCBSNM health plan members an opportunity to save money on services that are not covered under the Medical Program. These discount offers and other services are not part of the TRIAD Medical Program benefits described in this benefit booklet and the entities making the offers and the providers of the services may not be affiliated or associated with BCBSNM, TRIAD, or your Medical Program. However, from time to time, BCBSNM will be announcing such offers by sending manufacturer or retail discount coupons to member households, inserting information into *Member Newsletters*, or mailing descriptions of various programs being offered to Medical Program members by businesses

such as health clubs, pharmacies, vision care providers, hearing aid retailers, dentists, etc. These mailings may contain coupons or offers that enable you, at your discretion, to purchase the described product or enroll in a certain program at a discount or at no charge. The retailer, provider, or manufacturer may pay for and/or provide the content for this information. The discounts and services available to members may change at any time and BCBSNM does not guarantee that a particular discount or service will be available at a given time. For details of current discounts available, please contact a Customer Service Advocate by calling the phone number on the back of your ID card or by visiting BCBSNM offices in Albuquerque at 4373 Alexander Boulevard NE.

**2**

## Customer Service

### ■ Dedicated Customer Service

If you have any questions about your coverage, call or e-mail BCBSNM's TRIAD Dedicated Customer Service department. Customer Service Advocates, dedicated to serving the members of TRIAD Medical Programs, are available Monday through Friday from 6 A.M.– 8 P.M. and 8 A.M.– 5 P.M. on Saturdays and most holidays. If you need assistance outside normal business hours, you may call the Customer Service telephone number and leave a message. A Customer Service Advocate will return your call by 5 p.m. the next business day.

Whether you call, write, or visit BCBSNM, Customer Service Advocates can help with the following:

- any questions about what is covered and what is not covered under the Medical Program
- checking on a claim's status
- ordering a replacement ID card, benefit booklet, or forms

The inside front cover of this benefit booklet lists the most common telephone numbers and addresses that you will need. Also, for your convenience, the toll-free Customer Service number is printed at the bottom of every page in this booklet.

Web Site: [www.bcbsnm.com](http://www.bcbsnm.com)  
Street Address: 4373 Alexander Blvd. NE  
Mailing Address: P.O. Box 27630  
Albuquerque, NM 87125-7630

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

**After Hours Help** – If you need help or want to file a complaint outside normal business hours, you may call Customer Service. Your call will be answered by our automatic phone system. You can use this system to:

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

**24/7 Nurseline** – If you can't reach your doctor, the free 24/7 Nurseline will connect you with a nurse who can help you decide if you need to go to the emergency room or urgent care center, or if you should make an appointment with your doctor. The Nurseline will also give you advice if you call your doctor and he or she can't see you right away when you think you might have an urgent problem. To learn more, call:

**Toll-free: 1-800-973-6329**

BCBSNM also has a phone library of more than 1000 health topics available through the Nurseline, including over 600 topics available in Spanish.

**Other Member Services** – To help you track claims payments, make health care choices, and reduce health care costs, BCBSNM maintains a flexible array of online programs and tools for Medical Program members. The online "Blue Access for Members" tool provides convenient and secure access to claims information and account management features and to various cost comparison tools. While online, you can also access a wide range of health and wellness programs and tools, including a health risk assessment and personalized health updates, and a program in which you can earn merchandise and gift cards for making healthy lifestyle choices and participating in various activities.

To access these online programs, go to [www.bcbsnm.com](http://www.bcbsnm.com), log into Blue Access for Members (BAM), and create a user ID and password for instant and secure access. If you need help accessing the site, call the Blue Access Help Desk toll-free at 888-706-0583, Monday through Friday 7 A.M. to 9 P.M. MT; Saturday 6 A.M. to 2:30 P.M. MT. **Note:** Depending on your group's coverage, you may not have access to all online features. Check with your benefits administrator or call Customer Service at the number on the back of your ID card. BCBSNM uses data about program usage and member feedback to make changes to online tools as needed. Therefore, programs and their rules are updated, added, or terminated and may change without notice as new programs are designed and/or as our members' needs change. We encourage you to enroll in Blue Access for Members and check the online features available to you – and check back in as frequently as you like. We are always looking for ways to add value to your TRIAD Medical Program and hope you will find the Web site helpful.

## 3

## Description of Benefits

This TRIAD Medicare Supplement Medical Program complements Medicare by paying specific benefits for Medicare-eligible medical services. The benefits are subject to the exclusions, conditions, and limitations of this Medical Program.

What is a Medicare-Participating Doctor or Provider? What does “accept assignment” mean?

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

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

### Selecting a Provider

Before obtaining health care services, check the *Medicare-Participating Provider / Supplier Directory*. If you do not have a current *Medicare-Participating Provider / Supplier Directory*, you can obtain one free of charge from your local Medicare carrier or you can ask your local Medicare carrier for names of some Medicare-participating providers in your area. (Call your local Social Security Administration office for more information.) You may also want to ask your provider if he/she accepts Medicare assignment before you receive services. **For Medicare-covered services, your choice of a participating or nonparticipating provider may make a difference in the amount you pay.** (See “Assignment” in the glossary for more information.)

You receive maximum benefits when you obtain your services from providers that accept Medicare assignment (which means the provider is either participating with Medicare or they are nonparticipating but have accepted a **one-time** assignment).

## ■ Benefits for Medicare Part A Services

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

### Inpatient Hospital Services

This Medical Program pays:

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

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

### Skilled Nursing Facility Services

This Medical Program pays the member's portion of the Medicare Part A approved amount at a skilled nursing facility during the days when charges for covered services are to be paid partly by Medicare and partly by the member. No payment will be made by this Medical Program for services received beyond the Medicare maximum number of days of coverage in any benefit period.

### Veterans' Administration/Department of Defense Facilities

For non-service-connected disabilities, this Medical Program pays the amount that would have been due from the member had services been received in a non-government facility and covered by Medicare. This means that the Medical Program will pay an amount equal to the

Medicare inpatient deductible for covered inpatient services, and an amount equal to 20 percent of billed charges for covered outpatient services.

## Blood

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

## ■ Benefits for Medicare Part B Services

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

**Member Privately Contracting With a Provider** – Federal legislation allows physicians or other providers to opt out of Medicare. If you wish to continue obtaining their services (that would otherwise be covered under Medicare), you and the provider will need to enter into written “private contracts” that make you responsible for all payments to these providers.

If you enter into a “private contract” arrangement, you have in effect “opted out” of Medicare for services from these providers. Services provided under “private contracts” are not covered by Medicare and are not covered by this Medical Program. 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 Medical Program.

## Medical Expenses

This Medical Program pays:

- The Medicare Part B deductible amount.
- The remainder of Medicare-approved amounts (e.g., generally 20 percent) under Part B after the Part B deductible is paid.
- 100 percent of Medicare Part B excess charges (above Medicare-approved amounts) according to these terms:
  - If the provider accepts Medicare assignment, your benefits under this Medical Program will be limited to 20 percent of the Medicare-approved amount after the deductible, if any. The doctor or supplier will accept Medicare’s approved amount as full payment, and there will be no excess amount due from the member.
  - If the provider does not accept Medicare assignment, this Medical Program will also pay 20 percent of the Medicare-approved amount after the deductible, if any. In addition, the Medical Program will pay 100 percent of the amount in excess of the Medicare-approved amount, not to exceed the Medicare limiting factor.



**Blood** – This Medical Program pays:

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

**Medicare-Covered Preventive Care** – This Medical Program pays:

- The Medicare Part B deductible, if any, and coinsurance (i.e., 20 percent of most Medicare-approved amounts) for routine checkups and screening tests, including flu shots and any other preventive services covered by Medicare.

**Home Health Care Services** – This Medical Program pays the Medicare Part B deductible, if any, and Medicare coinsurance for Medicare-approved charges for durable medical equipment after the Part B deductible has been met.

## ■ Services Not Covered by Medicare

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

**Emergency Care Outside Territorial Limits** – This Medical Program pays, to the extent not covered by Medicare, 100 percent of the billed charges for medically necessary emergency hospital, physician, and medical care received outside the Medicare territorial limits, if such care would have been covered by Medicare when provided in the United States. The care must begin during the first 60 consecutive days of a trip outside the territorial limits. For purposes of this benefit, “emergency care” means care needed immediately because of an injury or an illness of sudden an unexpected outset. **Nonemergency** care outside the Medicare territorial limits is **not** covered.

**Preventive Services** – This Medical Program pays, to the extent not covered by Medicare, 100 percent of the billed charges for flu, pneumococcal, and Zostavax vaccines, when received at a retail pharmacy that is participating in the BCBSNM vaccination program. This Medical Program pays other preventive services not covered by Medicare at 100 percent of the BCBSNM maximum allowable fee. You are responsible for amounts above the BCBSNM maximum allowable fee.

**Hearing/Vision Exams** – This Medical Program pays, to the extent not covered by Medicare, 100 percent of the BCBSNM maximum allowable fee for one vision exam per year and one hearing exam per year. You are responsible for amounts above the BCBSNM maximum allowable fee.



## 4

## Exclusions, Limitations, and Controls

Many health care expenses are covered. However, some services and supplies are not covered. Also, benefits never exceed the expenses for covered services. Read this section carefully.

**This Medical Program does not cover any service or supply not specifically listed as a covered service in this benefit booklet. If a service is not covered, then all services performed in conjunction with it are not covered.**

### ■ General Exclusions

In addition to the exclusions of “Limitations and Controls” later in this *Section 4*, this Medical Program will not cover any of the following services, supplies, situations, or related expense:

**Acupuncture and Rolwing – This Medical Program does not cover** any acupuncture or rolwing services that are not covered under Medicare.

**After Termination of Coverage – This Medical Program does not cover** services furnished after termination of coverage under this Medical Program, except for hospital admissions and related services beginning prior to such termination. Generally, benefits are determined based upon the coverage in effect on the day a service is received, an item purchased, or a health care expense incurred. For inpatient services, benefits are based upon the coverage in effect on the date of admission, except that if you are inpatient at the time your coverage either begins or ends, benefits for the admission will be available only for those covered services received on and after your effective date of coverage or those received before your termination date. Benefits for such services may be coordinated with any additional health care coverage that applies after your termination date under this Medical Program.

**Charges Above the Medicare Approved or Allowed Amounts – This Medical Program does not cover** charges above the Medicare approved or allowed amounts.

**Custodial Care – This Medical Program does not cover** custodial care or care in a place that serves the patient primarily as a residence when the member does not require skilled nursing, except for at home recovery as listed under “Benefits for Medicare Part B Services” in *Section 3: Description of Benefits*. **This Medical Program does not**

**cover** services to assist the member in activities of daily living (such as sitters or homemaker’s services), or services not requiring the continuous attention of skilled medical or paramedical personnel, regardless of where they are furnished and by whom they were recommended.

**Dental Services – This Medical Program does not cover** dental services that Medicare does not cover, such as the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth.

**Diagnostic or Therapeutic Services – This Medical Program does not cover** any diagnostic or therapeutic services that are not covered benefits under Medicare.

**Experimental, Investigational, or Unproven Services – This Medical Program does not cover** any treatment, procedure, facility, equipment, drug, device, or supply not covered by Medicare and not accepted as *standard medical practice* as defined on the next page, and thus considered experimental, investigational, or unproven. In addition, if federal or other government agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is experimental and will not be covered. To be considered experimental, investigational, or unproven, one or more of the following conditions must be met:

- The device, drug, or medicine cannot be marketed lawfully without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the device, drug, or medicine is furnished.
- Reliable evidence shows that the treatment, device, drug, or medicine does not include trials designed to test toxicity, or disease pathophysiology, but must have therapeutic intent and be provided as part of a study being conducted in a cancer clinical trial in New Mexico.
- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug, or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in authoritative peer-reviewed medical and scientific literature; the written protocol or protocols used by the treating facility, or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug, or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug, or medicine. Also, the service must be medically necessary and not excluded by any other contract exclusion.

*Definition*

*Standard medical practice* means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in standard medical textbooks published in the United States and/or peer-reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the hospital or other facility provider in which they were performed; and
- the physician or other professional provider has had the appropriate training and experience to provide the treatment or procedure.

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

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

**Hair Loss Treatments – This Medical Program does not cover** wigs, artificial hairpieces, hair transplants or implants, or medication used to promote hair growth or control hair loss, even if there is a medical reason for hair loss.

**Hearing Aids – This Medical Program does not cover** hearing aids or exams for fitting hearing aids.

**Intermediate Nursing Home Care – This Medical Program does not cover** intermediate nursing home care.

**Noncovered Providers of Service – This Medical Program does not cover** services prescribed or administered by a:

- member of the patient's immediate family or a person normally residing in the patient's home
- physician, other person, supplier, or facility not specifically listed as covered in this benefit booklet, such as a:
  - health spa or health fitness center (whether or not services are provided by a licensed or registered provider)
  - school infirmary
  - halfway house
  - private sanitarium
  - extended care facility
  - residential treatment center (facility where the primary services are the provision of room and board and constant supervision or a structured daily routine for a person who is impaired but whose condition does not require acute care hospitalization)

- dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group

**Nonmedical Services – This Medical Program does not cover** non-medical services, such as telephone consultations, charges for failure to keep a scheduled visit, charges for completion of a claim form, interest charges, or charges for medical records.

**Not Covered by Medicare – This Medical Program does not cover** services that are not covered by Medicare (unless specifically listed as covered in *Section 3*), including services received from any provider with whom the member has privately contracted (as set forth in Section 4507 of the Balanced Budget Act of 1997).

**Not Reasonable and Necessary – This Medical Program does not cover** services that Medicare determines are not reasonable and necessary to diagnose or treat an illness or injury, or to improve the functioning of a malformed body part.

**Over-the-Counter Items – This Medical Program does not cover** over-the-counter items, including charges for any dressing, brace, medical supply, or medication than can be purchased without a prescription from a physician or professional provider, unless otherwise specified in this benefit booklet.

**Paid for by Federal, State, Local Government – This Medical Program does not cover** services furnished or paid for by federal, state, or local governments.

**Personal Convenience Items or Services – This Medical Program does not cover** items or services such as air conditioners, humidifiers, or physical fitness exercise equipment or personal services such as haircuts, shampoos and sets, guest meals, and radio or television rentals.

**Physical Examinations – This Medical Program does not cover** insurance or employment examinations, examinations at the request of a third party, and any diagnostic tests directly related to such examinations.

**Prior to Effective Date – This Medical Program does not cover** services received prior to the effective date of the member's coverage or during an admission that began prior to such date.

Private Duty Nursing – **This Medical Program does not cover** private duty nursing.

Private Hospital Room – **This Medical Program does not cover** the difference between the private and semiprivate room rates.

Reimbursed Expenses – **This Medical Program does not cover** any condition, ailment, or injury for which the member is reimbursed or is eligible to be reimbursed by a person or organization responsible for causing the harm.

Special Foods or Diets – **This Medical Program does not cover** special foods or diets, or dietary supplements or vitamins.

Vision Care – **This Medical Program does not cover** vision care services such as:

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

War-Related Conditions – **This Medical Program does not cover** any illness or injury suffered after the member's effective date as a result of any act of war, whether declared or undeclared, or while a member of the armed forces or auxiliary units.

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

## ■ Limitations and Controls

Benefits under this Medical Program are subject to the following **limitations and controls**, in addition to the general **exclusions** listed in this *Section 4*.

- **Where Medicare imposes any maximum benefit of dollars, number of visits or days, or other limits, the Medical Program will not reimburse beyond the Medicare maximums, *except as specifically outlined in this section of the booklet (e.g., for inpatient care after Medicare lifetime reserve days are exhausted), and emergency services rendered outside the Medicare territorial limits (see “Services Received Outside the Medicare Territorial Limits,” on the next page).***
- The Medicare program’s determination of whether particular health care services will be benefits under its program will be final and binding on BCBSNM’s determination of the benefit payments and liability under this Medical Program.
- If Medicare allows a service as medically necessary, BCBSNM will also consider it medically necessary. When Medicare determines that a service was not medically necessary, that service will also be found not medically necessary under this TRIAD Medicare Supplement Medical Program. The fact that a physician has prescribed, ordered, recommended, or approved a service or supply does not make it medically necessary or make the expense a covered service under this Medical Program, even though it is not specifically listed as an exclusion.
- This Medical Program pays Medicare Part A and Part B deductible and member coinsurance amounts for services that are covered by Medicare and limited amounts for services specifically listed as being covered in this booklet (e.g., emergency services while traveling or residing outside the United States, Medicare Part B excess charges, preventive services and immunizations not covered by Medicare, and hearing/vision exams). These are the only services covered under the Medical Program that may be considered for TRIAD Medicare Supplement Medical Program coverage when Medicare makes no determination as to their medical necessity or benefit status. If Medicare does not make a benefit determination because no claim was filed to Medicare, you may be asked to file the claim first to Medicare and their determination will be final.
- When a member receives nonemergency services in the United States from a hospital or other facility provider that is not participating in the Medicare program, no benefits will be available for those services under this Medical Program, except as specified for Veterans’ Administration and Department of Defense facilities.
- The Medicare deductible and the member’s portion of charges will be those applicable to Medicare benefits on the date when charges are incurred.

- When the furnishing of equipment is a benefit under the Medicare program and the member has an option to rent or purchase the equipment, Medicare will decide whether the equipment will be purchased or rented by the member as a condition of applying any benefits.
- There is no general lifetime maximum payment under the TRIAD Medicare Supplement Medical Program. Certain benefits may have maximum limits per calendar year, specified benefit period, or lifetime, and are described in *Section 3*.

## ■ Service Received Outside the Medicare Territorial Limits

Only medically necessary emergency care services beginning during the first 60 days of each trip outside the Medicare territorial limits are covered under this Medical Program.

The Medicare territorial limits are defined by Medicare as the United States, Puerto Rico, the U. S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Keep copies of your receipts. Submit the receipts as described in *Section 5: Claims Filing, Payment, and Disputes*



## 5

## Claims Filing, Payment, and Disputes

### ■ Filing Claims

Because payment for health care expenses will be made by both Medicare and the Medical Program, claims must be filed with both. The steps for filing claims are described below.

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

#### Hospital and Other Facility Services

Medicare Part A Hospital Insurance and the Medical Program pay the hospital directly. To file claims, the hospital must have the information from the identification cards issued to a member by both Medicare and BCBSNM. A notice of payment will be sent to you. It is **not** necessary for you to file a claim for hospital, skilled nursing facility, or hospice services with BCBSNM. These claims are automatically submitted to BCBSNM by Medicare. If you find that your claims are not being sent automatically to BCBSNM, please call a Customer Service Advocate to verify that the correct Medicare HIC number is on file for you.

#### Physician and Other Medical Services

A claim for these medical services must be filed **first** with Medicare Part B Medical Insurance. (All Medicare providers must file claims for you to Medicare.)

The Medicare Part B carrier will send an electronic copy of the claim to BCBSNM. You do **not** need to file a claim for services covered by Medicare with BCBSNM.

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

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



## Services Not Covered by Medicare

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

Even though claims may be filed on your behalf by hospitals, physicians, or other providers, it is your responsibility to make sure that the claim is filed.

Please file all claims **within 12 months** after the date of service. You may obtain a copy of a Member Claim Form from the BCBSNM Web site, or call a Customer Service Advocate and request that one be mailed to you. Please see *Section 6: COB and Reimbursement*.

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

- As a condition for processing claims under this Medical Program, a member specifically authorizes BCBSNM to obtain from physicians, hospitals, or other providers the information and records that may be required by BCBSNM to administer such claims.
- the Medical Program reserves the right in all cases to pay the member directly, and to refuse to honor the 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.
- If Medical Program-covered services are received from a provider in New Mexico that does not participate with BCBSNM, BCBSNM will make claims payments to the subscriber (or to the applicable alternate payee when a Qualified Child Medical Support Order or its equivalent is in effect). When payment is made to the subscriber, the subscriber is responsible for arranging payment to the provider. If Medical Program-covered services are received from a provider outside New Mexico that does not participate with the local Blue Cross and Blue Shield Plan, BCBSNM will make claims payments to the provider unless the subscriber submits documentation proving that the provider has already been paid directly for covered services. In all cases, the subscriber is solely responsible for paying any amounts greater than covered charges plus copayments, deductibles, coinsurance, any benefit reduction amounts, and noncovered expenses.
- Benefit payments for members eligible for Medicaid are paid to the New Mexico Human Services Department or the provider when required by law.

Outside the United States, U.S. Virgin Islands, Jamaica, Puerto Rico, or Canada – For covered **inpatient hospital** emergency services received outside the United States (including Puerto Rico, Jamaica, and the U.S. Virgin Islands) and Canada, show your Plan ID card issued by BCBSNM. BCBSNM participates in a claims payment program with the Blue Cross and Blue Shield Association. If the hospital has an agreement with the Association, the hospital files the claim for you to the appropriate Blue Cross Plan. Payment is made to the hospital by that Plan, and then BCBSNM reimburses the other Plan.

You will need to pay up front for emergency care received from a **doctor**, a **participating outpatient hospital**, and/or a **nonparticipating hospital**. Then, complete an international claim form and send it with the bill(s) to the BlueCard Worldwide Service Center (the address is on the form). The *International Claim Form* is available from BCBSNM, the BlueCard Worldwide Service Center, or on-line at:

[www.bcbs.com](http://www.bcbs.com)

The Blue Cross Blue Shield Global Core *International Claim Form* is to be used to submit institutional and professional claims for benefits for covered emergency services received outside the United States, Puerto Rico, Jamaica and the U.S. Virgin Islands. For filing instructions for other claim types (e.g., dental, etc.) contact your Blue Cross and Blue Shield Plan. The *International Claim Form* must be completed for each patient in full, and accompanied by fully itemized bills. It is not necessary for you to provide an English translation or convert currency.

Since the claim cannot be returned, please be sure to keep photocopies of all bills and supporting documentation for your personal records. The member should submit an *International Claim Form*, attach itemized bills, and mail to Blue Cross Blue Shield Global Core at the address below. Blue Cross Blue Shield Global Core will then translate the information, if necessary, and convert the charges to United States dollars. They also will contact BCBSNM for benefit information in order to process the claim. Once the claim is finalized, and *Explanation of Benefits* will be mailed to the subscriber and payment, if applicable, will be made to the subscriber via wire transfer or check. Mail international claims to:

Service Center  
P.O. Box 2048  
Southeastern, PA 19399

## ■ Medicare Reconsideration

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

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

## ■ BCBSNM Reconsideration



You may file a formal request for reconsideration of claims for Medical Program benefits (e.g., home health care at home recovery or an emergency while out of the United States) that the Medical Program has denied totally or partially. However, before filing such a request, you agree to ask BCBSNM about the denial, and to supply whatever additional documentation or information may be available in support of your claim. If still dissatisfied with the BCBSNM decision, you may file a formal request for reconsideration on a special form available from BCBSNM.

**You waive any right to reconsideration if you do not file the formal request for reconsideration within 180 days of the denial of the claim.**

BCBSNM will acknowledge in writing the receipt of the request. Within 60 calendar days of receipt, BCBSNM will review the request for reconsideration and notify the member in writing of its decision. If the BCBSNM decision continues to be that no benefits will be allowed or no changes will be made in the amounts paid, BCBSNM will provide in writing all of the reasons for denying the claim.

**Retaliatory Action** – BCBSNM and TRIAD shall not take any retaliatory action against you for filing a grievance under this Medical Program.

**BCBSNM Contacts** – For more information, contact:

BCBSNM Appeals Unit  
P.O. Box 27630  
Albuquerque, NM 87125-9815  
Telephone (toll-free): (800) 205-9926  
Fax: (505) 816-3837

## TRIAD Administrative Errors and Eligibility Escalation Appeals Process

TRIAD is responsible for determining employee eligibility for coverage. If you have an administrative appeal about your eligibility, termination, contributions for coverage, or any other issue related to eligibility, please contact TRIAD or see the *TRIAD SPD* for details.

## External Appeal

Since this Medical Program is governed by the Employee Retirement Income Security Act of 1974 (ERISA), if you are still not satisfied after having completed the appeal process administered by BCBSNM and described above, or if applicable, the eligibility and enrollment appeal process administered by TRIAD and described in the *TRIAD SPD*, you may have a right to bring a civil action under ERISA Section 502(a). You may not take legal action to recover benefits under this Medical Program until 60 days after BCBSNM has received the claim or preauthorization request in question. Also, you may not take any legal action after three years from the date that the claim in question must be filed with BCBSNM.

## External Review Board

If you (a retiree or a covered family member of a retiree) are still not satisfied after having completed the appeal process administered by BCBSNM and described above, or if applicable, the eligibility and enrollment appeal process administered by TRIAD and described in the *TRIAD SPD*, you have the right to request a hearing in front of an External Review Board. If you choose to request a hearing, you will be sent details on the process.

## ■ Additional Payment Information

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

## ■ Disclosure & Release of Information

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

## ■ Execution of Papers

On behalf of yourself and your covered family members you must, upon request, execute and deliver to BCBSNM any documents and papers necessary to carry out the provisions of this Medical Program.

## ■ Independent Contractors

The relationship between BCBSNM and its network providers is that of independent contractors; physicians and other providers are not agents or employees of BCBSNM, and BCBSNM and its employees are not employees or agents of any network provider. BCBSNM will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any network provider. The relationship between BCBSNM and TRIAD is that of independent contractors; the employer is not an agent or employee of BCBSNM, and BCBSNM and its employees are not employees or agents of TRIAD.

6

# COB and Reimbursement

## Coordination of Benefits (COB)



*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.



*For a work-related injury or condition, see the “Work-Related Conditions” exclusion in Section 4.*

This Medical Program contains a coordination of benefits (COB) provision that prevents duplication of payments. When you are enrolled in any other valid coverage, the combined benefit payments from all coverages cannot exceed 100 percent of BCBSNM’s covered charges.

**NOTE:** If you have other prescription drug coverage (excluding Medicare Part D), this Medical Program will **not** coordinate benefits with the other coverage. You are responsible for paying the amounts due under primary coverage for prescription drugs. If you choose to purchase Medicare Part D, Medicare Part D is your primary drug plan.

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.

**Medicare** – If the other valid coverage is Medicare and Medicare is primary according to federal regulation, Medicare pays first. You may not elect to change this Medical Program to be primary coverage over Medicare and may not elect to bypass Medicare. If services are among those normally covered by Medicare, you or your doctor or hospital (your health care “provider”) must submit a claim for those services first to Medicare as explained in *Section 5*. Medicare will calculate its benefits and will send you an *Explanation of Medicare Benefits (EOMB)* form. This form must be attached to any claim you send to BCBSNM (however, most providers will file claims for you or a “crossover” claim should automatically be sent by the Medicare Part B carrier or Part A intermediary to BCBSNM for secondary benefit determination).

**Child/Spouse** – If a covered child under this health plan is covered as a spouse under another health plan, the covered child’s spouse’s health plan is primary over this health plan.

**Subscriber/Covered Family Member** – 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 spouse, child, or other covered family member under another, the coverage that designates the member as the employee, retiree, or other policyholder (i.e., as the subscriber) pays first. This rule includes coverage that designates a covered child under this health plan as the employee/subscriber under another health plan. If a person is covered under two health plans and one is primary over Medicare and the other is secondary to Medicare, the Medical Program that is secondary to Medicare pays last. The Medical Program that is primary over Medicare always pays first when a person is enrolled in Medicare, then Medicare pays, and then the Medical Program that is secondary to Medicare. (For example, if a retiree with retiree coverage is also covered under his/her spouse's policy, the retiree's own coverage would normally pay first since the spouse's plan covers the retiree as a family member, and not as a subscriber. But if the spouse's policy is primary over Medicare because the spouse is still actively employed, the spouse's coverage would pay first for the retiree, then Medicare, and then the retiree's own coverage last.)

**Covered Child** – For a child whose parents are not separated or divorced, the coverage of the parent whose birthday falls earlier in the calendar year pays first. If the other coverage does not follow this rule, the father's coverage pays first.

If you have other valid group coverage *and* Medicare, contact the other carrier's customer service department to find out if the other coverage is primary to Medicare. There are many federal regulations regarding Medicare Secondary Payer provisions, and other coverage may not be subject to those provisions.

**Covered Child, Parents Separated or Divorced** – For a child of divorced or separated parents, benefits are coordinated in the following order:

- *Court-Decreed Obligations*. Regardless of which parent has custody, if a court decree specifies which parent is financially responsible for the child's health care expenses, the coverage of that parent pays first.
- *Custodial/Noncustodial*. The Medical Program of the custodial parent pays first. The Medical Program of the spouse of the custodial parent pays second. The Medical Program of the noncustodial parent pays last.
- *Joint Custody*. If the parents share joint custody, and the court decree does not state which parent is responsible for the health care expenses of the child, the plans follow the rules that apply to children whose parents are not separated or divorced.

**Active/Inactive Employee** – If a member is covered as an active employee under one coverage and as an inactive employee under another, the coverage through active employment pays first. (Even if a member is covered as a family member under both coverages, the coverage through active employment pays first.) If the other plan does not have

this rule and 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 Medical Program 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 benefits, a change in the entity that pays, provides, or administers the benefits, or a change from one type of plan to another.)

### Responsibility for Timely Notice

BCBSNM is not responsible for coordination of benefits if timely information is not provided.

### Facility of Payment

Whenever any other plan makes benefit payments that should have been made under this Medical Program, BCBSNM has the right to pay the other plan any amount BCBSNM determines will satisfy the intent of this provision. Any amount so paid will be considered to be benefits paid under this Medical Program, and with that payment BCBSNM will fully satisfy the Plan’s liability under this provision.

### Right of Recovery

Regardless of who was paid, whenever benefit payments made by BCBSNM exceed the amount necessary to satisfy the intent of this provision, 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.

## ■ Reimbursement Provision

If you or one of your covered family members incur expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for covered services described in this benefit booklet, you agree:

TRIAD has the right to reimbursement for all benefits provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of that sickness or injury, in the amount of the total covered charges for covered services for which TRIAD provided benefits to you or your family members.

BCBSNM and TRIAD are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits TRIAD provided for that sickness or injury.



TRIAD shall have the right to first reimbursement out of all funds you, your covered family members or your legal representative, are or were able to obtain for the same expenses for which TRIAD has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that BCBSNM and/or TRIAD may reasonably require in order to obtain TRIAD's rights under this provision. This provision applies whether or not the third party admits liability.

7

# When Group Coverage Ends

Please refer to the *TRIAD Health Benefit Plan Summary Plan Description* for enrollment, eligibility, termination, and Plan Administration information.

## ■ Conversion to Individual Coverage



Involuntarily terminated members may change to individual (direct-pay) conversion coverage if this TRIAD group health care plan is still in effect and coverage is lost due to one of the following circumstances:

- a member no longer meets the eligibility requirements of TRIAD
- a family member loses coverage for one of the following reasons:
  - divorce or legal separation from the subscriber
  - disqualification of the member under the definition of an eligible spouse or eligible child (excluding domestic partnership dissolution)
  - death of the subscriber



The subscriber and any eligible family members *who were covered* at the time that group (or continuation) coverage was lost are eligible to apply for conversion coverage without a health statement. BCBSNM must receive your application for conversion coverage **within 31 days** after you lose eligibility under the group (or continuation) plan. **You must pay conversion coverage premiums from the date of such termination.**

Conversion coverage is **not** available in the following situations:

- when group coverage under this Medical Program was discontinued for the entire group or the employee’s enrollment classification
- when you reside outside of or move out of New Mexico (Call BCBSNM for details on transferring coverage to the Blue Cross Blue Shield Plan in the state where you are living.)

**Medicare-Eligible Members** – If you are entitled to Medicare, your conversion coverage option is limited to a Medicare Supplemental Plan administered by BCBSNM. Depending upon your age and if you request a different plan than the policy offered to you, a health statement may be required and a pre-existing conditions limitation may apply. (The options for members under age 65 are limited.) Call a Customer Service Advocate for the enrollment options available to you. The benefits and premiums for conversion coverage will be those available to terminated health care plan members on your coverage termination date. You will receive a new benefit booklet if you change to conversion coverage. (Some benefits of this Medical Program are not available under conversion coverage.) Contact a Customer Service Advocate for details.

## 8

## Glossary

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

**Assignment** — Assignment 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.

**Blue Cross and Blue Shield of New Mexico (BCBSNM)** — The Claims Administrator of this Medicare Supplement Medical Program, as selected by TRIAD. BCBSNM is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

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

**Calendar year benefit period** — The Medical Program's specified time period — January 1 through December 31 each year — during which expenses and certain Medical Program maximums may accrue. The initial calendar year benefit period is from your effective date through the next following December 31, which may be less than 12 months.

**Benefits** — Payments for health care services provided to a member according to the terms of this Medical Program.

**Claims Administrator** — Blue Cross and Blue Shield of New Mexico (BCBSNM) as selected for this Medicare Supplement Medical Program provided by TRIAD.

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

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

**Dependent** – A person entitled to apply for coverage as specified in the TRIAD SPD. See “Eligible family member,” below.

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

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

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

**Effective date** – 12:01 A.M. of the date on which coverage for a member begins under this Medical Program.

**Eligible family member** – The subscriber’s legal spouse, the subscriber’s eligible child, or the subscriber’s eligible domestic partner as defined in the *TRIAD SPD*.

**Emergency** – See “Medical emergency.”

**Endorsements, addenda, and riders** – Written changes to the Medical Program that, by their terms, are made part of the Medical Program.

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

**Experimental, investigational, or unproven** – See the “Experimental, Investigational, or Unproven Services” exclusion in *Section 4*.

**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.

**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.

**Identification card** – The card issued by BCBSNM that identifies the member and the Medical Program 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.

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

**Medically necessary, medical necessity** – Services or supplies provided by a hospital, physician, or other provider that are determined to be appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease, or injury 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, BCBSNM will 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 Assignment** – See "Assignment"

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

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

**Medicare lifetime reserve days** – The extra days of inpatient hospitalization coverage beyond the Medicare maximum of 90 days in any benefit period. The total of these reserve days cannot be exceeded during anyone's lifetime. The decision of when to use the reserve days is made by the individual, but the hospital must be notified in writing ahead of time if the individual does not want to use reserve days during a particular hospital stay.

**Medicare limiting factor** – The amount over the Medicare approved amount that a provider can bill when not accepting assignment.

**Medicare participating provider** – A provider that the Department of Health and Human Services of the United States has approved for receiving Medicare payments.

**Member** – The person who has applied for and has been granted coverage under this TRIAD Medicare Supplement Medical Program.

**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.) If you use a non-participating provider, you may have higher out-of-pocket costs (such as excess charges) and additional approval responsibilities.

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

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

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

**Plan** – The TRIAD Medicare Supplement Medical Program.

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

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

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

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

**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.

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



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

The legal agreement between TRIAD, L.L.C. (TRIAD) and Blue Cross and Blue Shield of New Mexico (BCBSNM) includes the following documents:

- this benefit booklet (or *Medical Benefit Program Material*) and any amendments, riders, or endorsements to it;
- the *TRIAD Health Benefit Plan for Employees, ERISA Plan 501* or the *TRIAD Health Benefit Plan for Retirees, ERISA Plan 502, Summary Plan Description (TRIAD SPD)* -whichever applies to you - and any *Summary of Material Modifications* to the *TRIAD SPD*;
- the enrollment/change form(s) for the subscriber and his/her dependents; and
- the members' identification cards.

In addition, TRIAD has important documents that are part of the legal agreement:

- the *Benefit Program Application* from TRIAD; and
- the *Administrative Services Agreement* between BCBSNM and TRIAD.

The above documents constitute the entire legal agreement between BCBSNM and TRIAD for these Medical Program benefits. No agent or employee of BCBSNM has authority to change this *Medical Benefit Program Material* or waive any of its provisions. Receipt of this *Medical Benefit Program Material* (or "benefit booklet") and/or your participation in a Plan and any Benefit Programs offered under the Medical Program is not an implied contract and does not guarantee your employment or any rights or benefits under a Plan or Medical Benefit Program. Each Plan and the Benefit Programs offered to you are governed by federal law (known as ERISA), which provides rights and protections to Plan participants and beneficiaries.

BCBSNM provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims, except as may be specified in the *Administrative Services Agreement*. **Note:** TRIAD reserves the right to amend, modify, or discontinue each Plan or any Benefit Program under a Plan at any time. If that happens, TRIAD will notify you of those changes.

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**BlueCross BlueShield  
of New Mexico**

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