2 How Your Plan Works

Provider Choices

Your choice of health care provider can make a difference in the amount you pay for covered services and the benefits you receive.

You have a choice between selecting a **Participating Provider** (one that contracts with BCBSNM to provide services at a potentially reduced rates) or a **Nonparticipating Provider** (one that does not contract with BCBSNM).

The amount the Pool pays for a covered service is always based on the "covered charge" for that service. The covered charge is always less than or equal to the provider's billed amount. You may have to pay the difference between the billed amount and the covered charge.

The advantages of choosing a **Participating Provider** is that:

- the provider will file your claim for you, and
- you will **not** have to pay the difference between the amount billed by the provider and the covered charge for that service.

Example 1: Participating Provider Claim Payment (80% Plan; deductible is met):	
Provider's billed charge	$2000.00
Covered charge (maximum amount that can be considered for benefit payment)	$1800.00
The Pool's payment to provider (80% of $1800)	$1440.00
Member's coinsurance: (20% of $1800) applied to out-of-pocket limit	- $ 360.00
Amount in excess of covered charge ($2000 - $1800) NOT applied to out-of-pocket limit, but participating provider will not bill member for this amount.	- $ 0.00
Total amount due from policyholder: Member coinsurance ($360)	**$360.00**

When you choose a **Nonparticipating Provider**, the provider:

- does not have to file your claim for you, and
- you may have to pay the difference between the amount billed by the provider and the covered charge for that service (it is up to the provider).

Example 2: Nonparticipating Claim Payment (80% Plan; deductible is met):	
Provider's billed charge	$2000.00
Covered charge (maximum amount that can be considered for benefit payment)	$1800.00
The Pool's payment to member/provider (80% of $1800)	$1440.00
Member's coinsurance: (20% of $1800) applied to out-of-pocket limit	- $ 360.00
Amount in excess of covered charge ($2000 - $1800) NOT applied to out-of-pocket limit and member may be billed by provider for this amount.	- $ 200.00
Total amount due from policyholder: Member coinsurance ($360) PLUS amount in excess of covered charge ($200)	**$560.00**

Selecting a Provider — When you need medical care in New Mexico (or along the border of neighboring states), use your *Participating Provider Network Directory* to choose a participating provider.

To verify a provider's current status or if you have any questions about how to use the directory, contact a Customer Service representative or visit the BCBSNM Web site at **www.bcbsnm.com.**

Note: Although provider directories are current as of the dates shown at the bottom of each page, they can change without notice. If you do not have a current directory, ask a Customer Service representative to send you one or visit the BCBSNM Web site.

When you receive treatment or schedule a surgery or admission, ask each of your providers if he/she is a participating provider. (A physician's or other provider's contract may be separate from the facility's contract.)

Outside New Mexico — For a list of contracting providers outside New Mexico, call the BlueCard Doctor and Hospital Information Line at 1-800-810-BLUE (2583) or visit the BCBSNM Web site at **www.bcbsnm.com.** If you call, a BlueCard representative will give you the name and telephone number of a local provider who will be able to call Customer Service for eligibility information and will submit a claim to the Administrator's local, affiliated Blue Cross Blue Shield Plan office.

Deductibles, Coinsurance, Out-of-Pocket

The Individual deductible you chose is indicated on your ID card. The table below lists the deductible and the out-of-pocket limits that apply to your Policy — based on the Individual deductible amount selected by you and printed on your ID card.

While the Pool does not offer a "Family" Policy, if you have three or more qualified family members on Pool Policies with the same deductible you may receive reduced deductible and out-of-pocket limits as indicated on the table below.

Plan Variable (printed on ID card)	Individual Deductible Choice and Family Amount	Out-of-Pocket Limit (annual deductible plus coinsurance)
500	Individual = $500 Family = $1,000	Individual = $2,500 Family = $5,000
1,000	Individual = $1,000 Family = $2,000	Individual = $3,500 Family = $7,000
2,000	Individual = $2,000 Family = $4,000	Individual = $5,000 Family = $10,000
5,000	Individual = $5,000 Family = $10,000	NA - The Pool pays 100% after deductible is met
7,500	Individual = $7,500 Family = $15,000	NA - The Pool pays 100% after deductible is met
10,000	Individual = $10,000 Family = $20,000	NA - The Pool pays 100% after deductible is met

Note: Amounts applied to the annual deductible and to member coinsurance are not used to calculate benefit limitations that are based on a dollar amount (e.g., $1,500 per calendar year). Such limits are based on amounts actually paid out by the Pool. However, when a limitation is based on a maximum number of days, visits, or benefit periods (e.g., 30 days per calendar year), the maximum benefit may be reached even if all covered charges were applied to the deductible.

Plan Deductible

See your ID card for your individual deductible amount.

Deductible — The deductible you chose is indicated on your ID card (see table, above). You must pay your deductible amount before the Pool will begin paying its share of your covered charges. Only covered charges are applied toward the deductible. Covered charges may be less than the billed amount. If you receive services from a nonparticipating provider, you will be responsible for paying the provider any amounts over the covered charge, in addition to your deductible.

Family Deductible — An entire family meets an annual deductible when the total deductible amount for all family members reaches two times the Individual deductible amount chosen (see table, above). **Note:** If a member's Individual deductible is met, no more charges incurred by that member may be used to satisfy the Family deductible.

Change in Deductible Plan — Pool members can change from a lower to a higher deductible plan at any time upon written notice to the Administrator. The effective date of the change is the next premium due date following the request date.

If you increase your deductible amount, the new deductible amount must be met for all services received as of the change effective date. This means that if you had met your lower deductible and then change to a higher deductible, for services received as of the change effective date, you do not receive benefit payments until the increase in deductible is met.

Pool members can change from a higher to a lower deductible plan on or before October 1 each year. The effective date will be January 1 the following year. Requests for such changes must be made in writing to the Administrator. If you decrease your deductible amount, you do not receive a refund for any deductible amounts applied for services before the change effective date.

Coinsurance and Out-of-Pocket Limit

Note for members with the $5000, $7500 or $10,000 deductible options: This section does not apply to your plan. No member coinsurance is required. Once you meet your deductible, the Pool pays 100 percent of covered charges (except that you pay a percentage of covered charges for items covered under the prescription drug plan, not subject to the deductible.) **Remember:** If you receive services from a nonparticipating provider, you will be responsible for paying the provider any amounts over the covered charge. See the examples on page 3.

See your ID card for your individual deductible amount (which determines your out-of-pocket limit) and the Summary of Benefits and Plan Options for your coinsurance percentages.

Coinsurance — If you selected the $500, $1000, or $2000 deductible: For most covered services, you pay a percentage of covered charges as "coinsurance" after the annual deductible has been met. Covered charges may be less than the billed amount. If you receive services from a nonparticipating provider, you will be responsible for paying the provider any amounts over the covered charge (see the

examples on page 3), in addition to your deductible and your percentage of the covered charge (coinsurance).

Out-of-Pocket Limit — The total amount of **deductible** and **coinsurance** you must pay each calendar year is called the out-of-pocket limit (see table on page 4) After the limit is met, the Pool pays 100 percent of your **covered charges** for the rest of the calendar year. **Remember:** If you receive services from a nonparticipating provider, you will be responsible for paying the provider any amounts over the covered charge, even if your out-of-pocket limit is met. See the examples on page 3.

Admission review penalty amounts, amounts over the covered charge, noncovered expenses, and prescription drug plan copayments are **not** applied to the out-of-pocket limit and are not eligible for 100 percent payment under this provision.

Family Limit — An entire family meets the out-of-pocket limit when the total deductible and coinsurance amounts for all family members reaches the amount specified on the *Summary of Benefits and Plan Options*. (When a member meets the out-of-pocket limit, no more charges incurred by that member may be used to satisfy the family out-of-pocket limit.)

Out-of-Pocket Limit Changes — Changing your deductible plan also affects your out-of-pocket limit provisions. This means that if you had met your lower out-of-pocket limit and then you change to a higher out-of-pocket limit, for services received as of the change effective date, you do not receive the 100 percent payment until the increase in out-of-pocket is met.

Admission Review & Other Prior Approvals

In order to receive benefits, services must be listed as covered and medically necessary, services must not be excluded, and the procedures described in this section must be followed regardless of where services are rendered or by whom.

These approval requirements will provide you with assurance that you are being treated in the most efficient and appropriate health care setting and can help manage the rising costs of health are. **Failure to obtain a required approval may result in a reduction or denial of benefits.** Please note:

Prior Approval Does Not Guarantee Payment or Validate Eligibility

Prior approval determines only the medical necessity of a specific service and/or an admission and an allowable length of stay. Prior approval does not guarantee payment or eligibility for coverage. Eligibility and benefits available are based on the date you receive the services. If you lose coverage under this Policy, benefits are not allowed for any service received after coverage ends, even if prior approval was obtained from BCBSNM.

When You Have Other Coverage

Even when this Policy is not your primary coverage, these approval procedures must be followed.

Retroactive Approvals Not Given

Retroactive approvals will not be given and you may be responsible for the charges if approval is not obtained **before** the service is received.

Call BCBSNM for Approval:
(505) 291-3585 or (800) 325-8334

If a provider recommends an admission or a service that requires prior approval, the provider is not obligated to obtain the approval for you. The provider may call on your behalf, but it is **your responsibility** to ensure that the Administrator is called:

Call Monday through Friday, 8 A.M. to 5 P.M., Mountain Time
(505) 291-3585
(800) 325-8334

Note: Prior approvals are not processed after 5 P.M. If you need prior approval assistance between 5 P.M. and 8 A.M. or on weekends, call Customer Service.

Admission Review Approval

Admission review is required for most admissions **before** you are admitted, transferred, or re-admitted to the hospital, physical rehabilitation facility, or other treatment facility. If you do not obtain admission review approval for admissions within the time limits indicated in the chart below, benefits for covered facility services will be **denied or reduced by 20 percent** as explained on the next page.

Type of inpatient admission, readmission, or transfer	When to obtain admission review approval:
Nonemergency	**Before the patient is admitted.**
Emergency, nonmaternity	**Within 48 hours of the inpatient admission.** If the patient's condition makes it impossible to call within 48 hours, call as soon as possible. (No approval is required for emergency room services that do not result in an inpatient admission.)
Maternity-related (including eligible newborns for whom the mother will not be covered)	**Before the mother's maternity due date,** usually about one or two months before delivery. However, make sure you or your hospital calls within 48 hours of the admission for routine deliveries (96 hours for C-sections). If the mother's condition makes it impossible to call within 48 (or 96) hours, call as soon as possible.
Extended stay, newborn (an eligible newborn stays in the hospital longer than the mother)	**Before the newborn's mother is discharged.**

How the Approval Procedure Works — When you or your provider call, the Administrator's Health Services staff will ask for information about your medical condition, the proposed treatment plan, and the estimated length of stay. The Health Services staff will evaluate the information and notify the attending physician and the facility (usually at the time of the call) if benefits for the proposed hospitalization are approved. If the admission is not approved, you may appeal the decision as explained in *Section 7.*

Penalty for Not Obtaining Admission Approval — If you or your provider do not call, or if you call and do not receive approval for inpatient benefits, but you choose to be hospitalized anyway, no benefits may be paid or partial payment may be made as specified in the table on the next page:

If you do not obtain admission approval and based on a review of the claim:	Then:
The admission was **not for a covered service.**	Benefits for the facility and all related services will be **denied.***
The admission was for an item listed under **"Other Prior Approvals,"** below (e.g., high-dose chemotherapy).	Benefits for the facility and all related services will be **denied.***
The admission was for any other covered service but hospitalization was **not medically necessary.**	Benefits will be **denied** for **room, board, and other charges** that are not medically necessary.*
The admission was for **a medically necessary covered service.**	Benefits for the facility's covered services will be **reduced by 20 percent.***

* The 20 percent admission review penalty and charges for noncovered and denied services are **not** applied to any deductible or out-of-pocket limit.

Admission review requirements may affect the amounts that the Pool pays for inpatient services, but they do not deny your right to be admitted to any facility and to choose your services. If an admission is not approved by the Administrator, you may always choose to receive the services and pay the full amount billed by the facility and other health care providers for the admission.

Call BCBSNM for Approval:
(505) 291-3585 or (800) 325-8334

Other Prior Approvals

In addition to admission review for all inpatient services, prior approval is required for certain other services or **benefits will be denied** for all related services. Most prior approvals may be requested over the telephone. If a *written* request is needed and you call, a Health Services representative will give you instructions for filing a written request for prior approval:

- equipment, supplies, hearing aids, and prosthetics costing **$500** (or more) or requiring **long-term rental**
- treatment of **accidental injuries to teeth** (except initial treatment)
- **air ambulance** services (unless during a medical emergency)
- **cardiac** or **pulmonary rehabilitation**
- **cardiac CT scans**
- **chemical dependency services (alcoholism** or **drug abuse);** inpatient, outpatient, and office services
- **chemotherapy** (high-dose)
- **dental-related** hospital services (The procedure may not be covered even if benefits for the hospital stay are approved as medically necessary; see *Section 3.)*
- certain **drugs** purchased through the "Prescription Drugs and Other Items" provision (such as for smoking cessation or erectile dysfunction); prescription **refills** before the supply should have been exhausted
- **electroshock therapy** and **narcosynthesis**, outpatient
- **home dialysis**
- **home health care** and **home I.V.** services
- **home sleep studies**
- **hospice care**
- **infertility-related services** (Only limited procedures are covered.)
- certain **injections**
- **insulin pumps**
- treatment of **orthognathism**
- **orthopedic appliances**
- **orthotics**
- **PET scans**

- **private room charges**
- **prosthetics, surgically implanted**
- outpatient **psychiatric intake evaluations** and **medication checks** that are not related to chemical dependency
- **psychological testing** and **psychotherapy** that is not related to chemical dependency; outpatient (For inpatient services, you must obtain admission approval or benefits for covered services will be reduced by 20 percent.)
- **rehabilitative services** (inpatient and outpatient physical, occupational, and speech therapy)
- **routine foot care** and orthopedic shoes required due to diagnosed severe non-diabetic neuropathy of the foot
- **special medical foods** required to compensate for inborn errors of metabolism
- **specialty pharmacy drugs** (see "Prescription Drugs and Other Items.")
- certain **surgical procedures,** including:
  - **breast reduction**
  - **breast surgery following a mastectomy** (Note: This is the only cosmetic procedure covered under this Policy.)
  - **cochlear implants**
  - surgical treatment of **morbid obesity**
  - **orthotripsy**
  - **reconstructive surgical procedures**
  - **transplants,** including pretransplant evaluations

The services listed above and on the previous page may not be approved for payment (for example, due to being experimental/investigational or not medically necessary). It is strongly recommended that you request prior approval for high-cost services in order to reduce the likelihood of benefits being denied *after* charges are incurred. The complete list of services requiring prior approval is subject to review and change by the NM Medical Insurance Pool Board of Directors. Participating providers have a list of all procedures and services, including individual surgical procedures and injectable drugs, that require prior approval. If you need a copy of this list, call a Customer Service representative.

Remember: Even if you receive prior approval for an inpatient procedure, admission review approval is also required for all inpatient admissions, transfers, re-admissions, and extended stay newborn hospitalizations. See "Admission Review Approval," earlier in this section.

Advance Benefit Information

If you want to know what benefits will be paid before receiving services or filing a claim, the Administrator may require a written request. The Administrator may also require a written statement from the provider identifying the circumstances of the case and the specific services that will be provided. An advance confirmation of benefits **does not guarantee** benefits if the actual circumstances of the case differ from those originally described. When submitted, claims are reviewed according to the terms of this Policy or any other coverage that applies on the date of service.

Utilization Review/Quality Management

Medical records, claims, and requests for covered services may be reviewed to establish that the services are/were medically necessary, delivered in the appropriate setting, and consistent with the condition reported and with generally accepted standards of medical and surgical practice in the area where performed and according to the findings and opinions of the Administrator's professional consultants. Utilization management decisions are based only on appropriateness of care and service. The Administrator does not reward providers or other individuals conducting utilization review for denying coverage or services and does not offer incentives to utilization review decision-makers to encourage under-utilization.

Health Care Fraud Information

Health care and insurance fraud results in cost increases for health care plans. You can help. Always:

- Be wary of offers to waive copayments, deductibles, or coinsurance. These costs are passed on to you eventually.
- Be wary of mobile health testing labs. Ask what your health care insurance will be charged for the tests.
- Review the bills from your providers and the *Explanation of Benefits* (EOB) form you receive from the Administrator after a claim has been paid or denied. Verify that all services billed to the Administrator were received. If there are any discrepancies, call a Customer Service representative.
- Be very cautious about giving information about your health care insurance over the phone.

If you suspect fraud, contact the BCBSNM Fraud Hotline at 1-888-841-7998.