

Endorsement:

Out-of-Network Pricing: Insured Health Care Plans



Blue Cross and Blue Shield
of New Mexico

This *Out-of-Network Pricing* endorsement for fully insured group and individual health plans is made a part of your Blue Cross and Blue Shield of New Mexico (BCBSNM) health care plan benefit booklet. It explains the way that BCBSNM will price out-of-network claims for **covered services** beginning on the applicable effective date below. If you have a question about these changes, please call your Customer Service Advocate at the phone number printed on the back of your ID card.

Beginning on the dates indicated below, claims for covered noncontracted provider services will be priced using the method described in this document. Please add this “Pricing of Noncontracted Provider Claims” to the information about claims payments in your benefit booklet. These changes do **not** apply to charges for which Medicare is primary, such as under Medicare Supplements and BlueSecure although these pricing methods will be used when Medicare does not cover a service that is covered under your health plan (such as under Medicare Carveout plans).

EFFECTIVE DATE – Individual (Nongroup) Plan Members: The changes below apply to services received on or after **January 1, 2011**.

EFFECTIVE DATE – Group Plan Members: The changes below apply to services received on or after your group’s **annual renewal date** that follows **October 31, 2010**. If your group renews, for example, every January, these changes will not be made to your health plan until January 2011 and will affect only those services received on or after January 1, 2011. Please speak to your employer if you are not sure when these changes go into effect for your health plan.

BY:

A handwritten signature in cursive script that reads "Elizabeth A. Watrin".

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

Pricing of Noncontracted Provider Claims

The BCBSNM covered charge for some covered services received from noncontracted providers is the lesser of the provider’s billed charges or the BCBSNM “noncontracting allowable amount.” The BCBSNM noncontracting allowable amount is based on the **Medicare Allowable** amount for a particular service, which is determined by the Centers for Medicaid and Medicare Services (CMS). The Medicare Allowable is determined for a service covered under your BCBSNM health plan using information on each specific claim and, based on place of treatment and date of service, is multiplied by an “adjustment factor” to calculate the BCBSNM noncontracting allowable amount. The adjustment factors for nonemergency services are:

- 100% of the base Medicare Allowable for inpatient facility claims
- 300% of the base Medicare Allowable for outpatient facility claims
- 200% of the base Medicare Allowable for freestanding ambulatory surgical center claims
- 100% of the base Medicare Allowable for physician, other professional provider claims, and other ancillary providers of covered health care services and supplies

Certain categories of claims for **covered services** from noncontracted providers are excluded from this noncontracted provider pricing method. These include:

- services for which a Medicare Allowable cannot be determined based on the information submitted on the claim (in such cases, the covered charge is 50 percent of the billed charge)
- home health claims (the covered charge is 50 percent of the billed charge)
- services administered and priced by any subcontractor of BCBSNM or by the Blue Cross Blue Shield Association
- claims paid by Medicare as primary coverage and submitted to your health plan for secondary payment
- New Mexico ground ambulance claims (for which the state's Public Regulatory Commission sets fares)
- covered claims priced by another BCBS Plan through BlueCard using local pricing methods

NOTE: Nonemergency services are generally **not covered** under HMO or EPO plans when received out-of-network from noncontracted providers. The pricing methods above apply **only** when the claim for out-of-network services has been authorized for payment and does not satisfy any of the conditions below:

Pricing for the following categories of claims for **covered services** from noncontracted providers will be priced at billed charges or at an amount negotiated by BCBSNM with the provider, whichever is less:

- covered services required during an emergency and received in a hospital, trauma center, or ambulance
- for HMO, EPO, and PPO health plans, services from noncontracted providers that satisfy at least one of the three conditions below and, as a result, are: a) eligible for coverage under HMO or EPO health plans, OR b) eligible for the Preferred Provider benefit level of coverage under PPO health plans:
 - covered services from noncontracted providers within the United States that are classified as "unsolicited" as explained in your benefit booklet and as determined by the member's Host Plan while outside the service area of BCBSNM
 - **preauthorized** transition of care services received from noncontracted providers
 - covered services received from a noncontracted anesthesiologist, pathologist, or radiologist while you are a patient at a **contracted** facility receiving covered services or procedures that have been preauthorized, if needed

BCBSNM will use essentially the same claims processing rules and/or edits for noncontracted providers' claims that are used for contracted providers' claims, which may change the covered charge for a particular service. If BCBSNM does not have any claim edits or rules for a particular covered service, BCBSNM may use the rules or edits used by Medicare in processing the claims. Changes made by CMS to the way services or claims are priced for Medicare will be applied by BCBSNM within 90-145 days of the date that such change is implemented by CMS or its successor.

IMPORTANT: Regardless of the pricing method used, the BCBSNM covered charge will usually be less than the provider's billed charge and **you will be responsible** for paying to the provider the difference between the BCBSNM covered charge and the noncontracted provider's billed charge for a covered service. **This difference may be considerable.** The difference is **not** applied to any deductible or out-of-pocket limit. In the case of a noncovered service, you are responsible for paying the provider's full billed charge directly to the provider. **Reminder:** Contracted providers will **not** charge you the difference between the BCBSNM covered charge and the billed charge for a covered service.

Glossary

Add or revise the following definitions in your benefit booklet glossary:

Adjustment factor — The percentage by which the Medicare Allowable amount is multiplied in order to arrive at the "noncontracting allowable amount." (See "Covered charge," below.) Adjustment factors will be evaluated and updated no less than every two years.

Contracted provider — A provider that has a contract with BCBSNM or another BCBS Plan to bill BCBSNM (or other BCBS Plan) directly and to accept this health plan's payment (provided in accordance with the provisions of the contract) plus the member's share (coinsurance, deductibles, copayments, etc.) as payment in full for covered services. Also see "Network provider (in-network provider)," below.

Covered charge — The amount that BCBSNM allows for covered services using a variety of pricing methods and based on generally accepted claim coding rules. The covered charge for services from "contracted providers" is the amount the provider, by contract with BCBSNM (or another entity, such as another BCBS Plan), will accept as payment in full under this health plan. For information about pricing of noncontracted provider claims, see "Pricing of Noncontracted Provider Claims" in the *Claims Payment and Appeals* (or similar) section of your booklet.

Noncontracting allowable amount — The maximum amount, not to exceed billed charges, that will be allowed for a covered service received from a noncontracted provider in most cases. The BCBSNM noncontracting allowable amount is based on the **Medicare Allowable** amount for a particular service, which is determined by the Centers for Medicaid and Medicare Services (CMS).

Medicare Allowable — The amount allowed by CMS for Medicare-participating provider services, which is also used as a base for calculating noncontracted providers' claims payments for some covered services of noncontracted providers under this health plan. The Medicare Allowable amount will not include any additional payments that are not directly tied to a specific claim, for example, medical education payments. If Medicare is primary over this health plan, and has paid for a service, the covered charge under this health plan may be one of the two following amounts:

Medicare-approved amount — The Medicare fee schedule amount upon which Medicare bases its payments. When Medicare is the primary carrier, it is the amount used to calculate secondary benefits under this health plan when no "Medicare limiting charge" is available. The Medicare-approved amount may be less than the billed charge.

Medicare limiting charge — As determined by Medicare, the limit on the amount that a nonparticipating provider can charge a Medicare beneficiary for some services. When Medicare is the primary carrier and a limiting charge has been calculated by Medicare, this is the amount used to determine your secondary benefits under this health plan. **Note:** Not all Medicare-covered services from nonparticipating providers are restricted by a Medicare limiting charge.

Network provider (in-network provider) — A contracted provider that has agreed to provide services to members in your *specific* type of health plan (i.e., HMO, PPO, EPO, indemnity, etc.).

Noncontracted provider — A provider that does not have any contract with BCBSNM, either directly or indirectly (for example, through another BCBS Plan), to accept the covered charge as payment in full under your health plan.

Noncontracting allowable amount — See "Covered charge," above.

Nonpreferred provider (PPO/EPO plan types only) — A provider that does not have a **PPO** contract with BCBSNM, either directly or indirectly (for example, through another BCBS Plan). These providers may have "participating-only" provider or "HMO" provider agreements, but are **not** considered "preferred" and are **not** eligible for Preferred Provider coverage under your health plan – unless listed as an exception under "Benefit Exceptions for Nonpreferred Providers" earlier in the booklet.