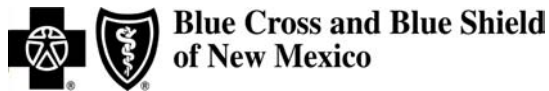


HMO Blue[®] OPTIONS Rider: Out-of-Network Coverage



Your *HMO Blue Benefit Booklet (H340)* is hereby amended in accordance with the Group Master Contract between Blue Cross and Blue Shield of New Mexico (BCBSNM) and your employer to include this HMO Blue “OPTIONS Rider,” which adds out-of-network coverage for certain services covered under your HMO Blue health care plan. The benefits of this are subject to all provisions of the *HMO Blue Benefit Booklet* unless otherwise stated.

This rider is effective on the date it is incorporated into your employer’s Group Master Contract or your effective date of coverage, whichever is later. If you have a question about these changes, please call your Customer Service Unit representative at the phone number printed on the bottom of the page or on the back of your identification card.

BY:

A handwritten signature in black ink that reads "Elizabeth A. Watrin".

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

This HMO Blue “OPTIONS Rider” is designed to give you the choice of receiving covered services outside of regular HMO Blue plan requirements. For services covered under this rider (referred to as “Out-of-Network Option” benefits), you may choose to receive covered services from a provider who is **not** in the HMO-participating provider network. You choose the level of coverage when you need medical care.

Nonemergency services that are provided by a provider that does not have an HMO-participating provider agreement with BCBSNM may be eligible for coverage as “Out-of-Network Option” benefits under this rider. Covered services under this rider are subject to a calendar year deductible and you must pay a specified percentage of the covered charges for covered services (coinsurance).

Not all covered services that are described in the *HMO Blue Benefit Booklet* are covered under this rider when received outside the HMO-participating provider network. See “OPTIONS Rider Exclusions” for a list of services that are not covered outside the network.

All services covered under this rider are subject to the provisions and limitations of your *HMO Blue Benefit Booklet* unless specifically addressed in this rider. You will receive the most comprehensive level of coverage and pay lower out-of-pocket expenses by following the “HMO Option” plan procedures described in your *HMO Blue Benefit Booklet*.

Certain words used in this rider are either not defined in the *Glossary* of your *HMO Blue Benefit Booklet* or are used in a different way in your *HMO Blue Benefit Booklet*. Please see the *Glossary* of your *HMO Blue Benefit Booklet* for additional definitions:

BCBSNM-participating provider — Health care professionals and facilities that, for the service being provided, have directly contracted with BCBSNM (or indirectly as a contractor or subcontractor), another BCBS Plan, or the Administrator's national transplant network as "participating" providers. These providers belong to the "BCBSNM-Participating Provider Network."

The BCBSNM-participating provider agrees to provide health care services to members with an expectation of receiving payment (other than copayments, coinsurance, or deductibles) directly or indirectly from BCBSNM (or other entity with whom the provider has contracted). A network provider agrees to bill BCBSNM (or other contracting entity) directly and to accept this 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. However, if there is other coverage for your services (for example, auto insurance, workers' compensation insurance, or other health plans), the BCBSNM-participating provider under the contract with BCBSNM may be able to collect the billed charge amounts not covered by the BCBSNM payment. BCBSNM (or other contracting entity) will pay the participating provider directly.

Benefit period — Some benefits under this rider are limited to a specific dollar amount or number of days or visits allowed during a "benefit period." The benefit period is the calendar year: January 1 through December 31 of the same year. The initial benefit period is from a member's effective date through December 31 of the same year, so the initial benefit period may be less than 12 months. See your *Summary of Benefits and Copayments* for benefit details.

Coinsurance — An arrangement by which a member pays a certain percentage of covered charges for covered services, after the deductible is satisfied.

Covered charges — The amount determined by BCBSNM to be a reasonable and adequate allowance for a covered service. BCBSNM's determination of a maximum allowable fee is the maximum amount BCBSNM will approve for any particular service. BCBSNM-participating provider agreements include various reimbursement arrangements, which help to control health care costs. With all of these arrangements, the calculation of the member's share (deductible and coinsurance) is based on the BCBSNM maximum allowable fee, also referred to as the "covered charge."

Deductible — A specified amount of covered charges that each member must pay for covered services provided as "Out-of-Network Option" benefits under this rider within a calendar year before any payments will be made by BCBSNM for services received out-of-network.

Nonparticipating provider — An appropriately licensed health care provider who has not entered into an agreement with BCBSNM. The member is responsible to the nonparticipating provider for all charges, regardless of BCBSNM's covered charge or the amount of the benefit payment. The provider's charge may exceed the BCBSNM covered charge and the member will be responsible for paying the difference, in addition to deductible and coinsurance.

Out-of-network — Services received from providers that are not part of the HMO-participating provider network with BCBSNM. These providers may be "BCBSNM-participating" providers that have no agreement to provide services under the BCBSNM HMO plans and, therefore, are **not** considered "HMO-participating" under the "HMO Option" or may have no agreement with BCBSNM and be considered nonparticipating. In either case, the provider is "out-of-network" under the "HMO Option."

How the OPTIONS Rider Works

When you enroll in HMO Blue, you must choose a primary care provider (PCP) for each covered member of your family. If the PCP provides care or you visit an **HMO-participating** specialist or hospital for covered services, you receive full HMO Blue plan coverage, according to the terms of the *HMO Blue Benefit Booklet* (referred to as “HMO Option” benefits under this rider). Emergency care received from a nonparticipating provider is also covered under the “HMO Option.”

Under this rider, if you receive certain types of nonemergency care from a provider that does **not** contract with BCBSNM as an **HMO-participating provider**, you will receive “Out-of-Network Option” benefits, subject to a calendar year deductible and coinsurance.

Out-of-network health care providers may have a **BCBSNM-participating** provider agreement or **no agreement** with BCBSNM. Under this rider, those with no agreement with BCBSNM are referred to as **nonparticipating** providers.

With this HMO Blue “OPTIONS Rider,” you have the flexibility to choose providers that are either BCBSNM-participating providers or nonparticipating providers. **However, you can reduce your out-of-pocket expenses under the “Out-of-Network Option” by using BCBSNM-participating providers.**

Before choosing a provider for health care services, check your BCBSNM provider directory (or visit the BCBSNM web site at www.bcbsnm.com). Unless otherwise noted, all providers listed in the BCBSNM “Participating Provider” directory are BCBSNM-participating. If you do not have a current directory, contact customer service or your group administrator for a complete list of BCBSNM-participating providers.

BCBSNM-Participating Providers — When services are covered under this rider under the “Out-of-Network Option” and are received from a provider who participates with BCBSNM:

- The provider agrees to accept payment under this rider plus your deductible, coinsurance, and penalty amounts, if any, as payment in full for covered services. (The provider may request payment for deductible, coinsurance, and penalty amounts at the time services are delivered. The provider will not bill you for amounts over the covered charge, however.)
- You do not file claim forms; the participating provider files for you. In return, the provider will be paid directly for covered services.

Nonparticipating Providers — When services covered under this rider are received from a nonparticipating provider:

- You are responsible for paying all billed charges to the provider, which may include amounts greater than BCBSNM’s covered charge. You will always pay applicable deductibles, coinsurance, and penalty amounts. (The difference between the billed charges and the covered charge is not included in the annual out-of-pocket limit and is not eligible for reimbursement if the out-of-pocket limit is reached.)
- You may have to file your own claims. Payment for covered services is usually made directly to the subscriber.

Note: Transplants are not covered if received at nonparticipating facilities.

Your Payment Responsibilities

When you obtain most services under the “HMO Option,” you usually pay only a copayment to your HMO-participating provider. When you obtain out-of-network services covered under this rider, however, the provider may require that you pay in full for these services first, before filing your claim.

The contracts between BCBSNM and its HMO-participating providers include a “hold harmless” clause which provides that an HMO Blue member cannot be liable to the provider for monies owed by BCBSNM for HMO health care plan services covered under the *HMO Blue Benefit Booklet* “HMO Option.” However, “Out-of-Network Option” services covered under this rider are **not** subject to this clause and the provider may seek payment directly from you.

Calendar Year Deductible — Each member must pay a deductible each calendar year before payment for covered “Out-of-Network Option” services begins under this rider. Your group’s *Summary of Benefits and Copayments* indicates the amount of your deductible. The deductible requirements must be met before a member begins paying coinsurance for “Out-of-Network Option” benefits. (Copayments for “HMO Option” services do not count toward the calendar year deductible.)

Individual Deductible — Each member’s calendar year deductible is the amount specified on the group’s *Summary of Benefits and Copayments*.

Family Deductible — All covered family members meet the deductible when the combined deductible amounts for three or more family members reach the amount specified as the family deductible on your group’s *Summary of Benefits and Copayments*. **Note:** If a member’s individual deductible is met, no more charges incurred by that member may be used to satisfy the family deductible.

Coinsurance — Under this rider, you are responsible for paying a percentage of “Out-of-Network Option” covered charges, called “coinsurance,” after the calendar year deductible is met. Please refer to your *Summary of Benefits and Copayments* for coinsurance percentages you pay.

Out-of-Pocket Limit — This rider also includes an out-of-pocket limit designed to protect you from catastrophic health care expenses. After the out-of-pocket limit is reached, the plan pays 100 percent of the “Out-of-Network Option” covered charges for the remainder of that calendar year, up to the maximum benefit amounts.

The out-of-pocket limit includes only the “Out-of-Network Option” coinsurance paid by you. It does **not** include copayments for prescription drugs or regular “HMO Option” benefits, penalty amounts (see “Prior Authorization” on the next page), deductible amounts, expenses in excess of covered charges, or expenses for noncovered services.

Each member meets his/her annual out-of-pocket limit after coinsurance amounts for his/her covered services equal the individual “Out-of-Network Option” out-of-pocket limit shown on your *Summary of Benefits and Copayments*. There is no family out-of-pocket limit amount.

Maximum Lifetime Benefit — If your group is subject to this provision, the maximum amount that will be paid for all services covered under this rider is **\$1,000,000** per member per lifetime. The maximum lifetime benefit includes all “Out-of-Network Option” covered charges less deductible, coinsurance, and penalty amounts, if any, under this “OPTIONS Rider.” Any payments made by BCBSNM for “HMO Option” services under the *HMO Blue Benefit Booklet* do **not** contribute to the \$1,000,000 “OPTIONS Rider” maximum lifetime benefit. Check your *Summary of Benefits and Copayments* to find out if this maximum lifetime benefit is applicable to your plan.

Prior Authorization

You **must** obtain prior authorization **before** certain services are received, or payment for covered services will be reduced as explained below. **There is no coverage or payment for any service, procedure, admission, or portion of an admission that is not medically necessary.**

Nonemergency Admissions — You are responsible for obtaining prior authorization **before** being admitted as an inpatient to a hospital or other treatment facility in these nonemergency situations:

- a provider recommends that you be admitted as an inpatient
- you are transferred from one inpatient facility to another
- you are readmitted as an inpatient for any reason (other than an emergency)

Routine newborn care admissions do **not** require prior authorization if the newborn is discharged before or on the same date as the mother. If the newborn remains in the hospital after the mother is discharged, you must call BCBSNM **within 48 hours** of the mother's discharge to notify BCBSNM of the newborn's continued inpatient stay.

Outpatient Services and Surgical Procedures — You must also obtain prior authorization *before* treatment begins for the services and procedures listed in *Section 2* of your *HMO Blue Benefit Booklet*, or payment will be reduced or denied as explained below.

Obtaining Prior Authorization

To obtain prior authorization, you or your provider or hospital **must** call the BCBSNM health services department (1-800-325-8334 or 505-291-3585, Monday through Friday, 8 A.M. to 5 P.M, Mountain Time) **before** you receive the service or are admitted. The health services representative will explain prior authorization requirements and ask for information about your provider and the proposed services or admission. If the provider has not already requested authorization for the proposed services, a representative will call his/her office for more information. You or your provider will be notified of authorization decisions. Your treatment may be reviewed at periodic intervals to ensure services continue to be covered.

Penalty for Not Obtaining Prior Authorization — If authorization is **not** obtained **in advance**, but you choose to receive the services anyway, payment may be reduced:

- If the services would have been authorized if a request had been received, there will be a penalty amount of **20 percent** of total covered charges related to the procedure. This penalty amount is in addition to all deductible and coinsurance requirements. If your out-of-pocket limit is reached, the penalty amount for covered services received without prior authorization will be 20 percent of covered charges.
- If prior authorization is denied or if the services would **not** have been authorized if a request had been received, all related claims will be denied.

Penalty amounts do **not** contribute to your out-of-pocket limit.

Prior authorization does not guarantee benefits or validate eligibility — it determines only the medical necessity of a service or an admission and an allowable length of stay based on information provided at the time authorization was requested. If you lose coverage under this rider, no payments will be made for services received or admissions beginning after coverage ends — even if prior authorization was obtained.

OPTIONS Rider Covered Services

Benefits are available under this rider for only those services listed as covered under the *HMO Blue Benefit Booklet*. Some services listed as covered at the “HMO Option” benefit level are excluded from coverage under this rider (see “OPTIONS Rider Exclusions”). **All services are subject to *Section 4: General Limitations and Exclusions* in your *HMO Blue Benefit Booklet*.**

Combined HMO Option and Out-of-Network Option Limitations — Certain covered services have a limited number of visits and/or maximum benefit payment limit (see your *Summary of Benefits and Copayments*). A member may receive these covered services as follows:

- all under the “HMO Option,” or
- all under the “Out-of-Network Option,” or
- part under the “HMO Option” and part under the “Out-of-Network Option” – until the combined number of visits or payments reach the specified limit.

When you call BCBSNM for prior authorization, you may also ask about visit or maximum payment limitations. You are responsible for charges for services that exceed the maximum number of visits or maximum payment limitations.

OPTIONS Rider Exclusions

If you receive services that are covered under the *HMO Blue Benefit Booklet*, those services will not be covered under this rider. In addition to the exclusions and limitations listed in *Section 4: General Limitations and Exclusions* of your *HMO Blue Benefit Booklet*, the “OPTIONS Rider” excludes the following services:

Excluded Services — The following services and supplies are **not** covered under this rider, but may be covered as “HMO Option” benefits under your *HMO Blue Benefit Booklet* when provided by your HMO-participating provider:

- **home health/home I.V. care**
- **allergy injections**
- **alcoholism and drug abuse treatments**
- **mental illness treatments**
- **adult preventive care services**, with the exception of annual gynecological examinations
- **rehabilitation services** (inpatient or outpatient physical, occupational, or speech therapy, cardiac or pulmonary rehabilitation, chiropractic services, and acupuncture)

Note: Transplants and pretransplant evaluations are covered at the “Out-of-Network Option” level, but must be received from **BCBSNM-participating** facilities in order to be covered outside the HMO-participating provider network.

Prescription Drugs — This “OPTIONS Rider” does not cover prescription drugs purchased at a pharmacy that does not participate in the Retail Pharmacy Program. Prescriptions may be written by nonparticipating physicians and filled at pharmacies participating in the Retail Pharmacy Program and still be considered for coverage under the *HMO Blue Benefit Booklet*.

General Provisions

Services covered under this rider are subject to all provisions of your *HMO Blue Benefit Booklet* (except requirements for obtaining services within the HMO-participating network of providers), or unless specifically addressed in this rider.

How and Where to Send Claims — Submit claims for covered services of nonparticipating providers in accordance with the provisions of *Section 6: Claims Payment and Appeals* in your *HMO Blue Benefit Booklet* to:

Blue Cross and Blue Shield of New Mexico
P.O. Box 11968
Albuquerque, NM 87192-0968

How Payments Are Made — After a claim has been processed, the subscriber will receive an *Explanation of Benefits* (EOB) form. (When the member is a dependent child of divorced parents, the custodial parent may receive the EOB.) Payments for covered services usually are sent directly to BCBSNM-participating providers and the subscriber receives an EOB that explains the payment. If payment for covered services is sent to the subscriber, the check is attached to the EOB. The EOB indicates what services were covered and what services, if any, were not.

The benefit payment to providers is based upon provider agreements and the covered charge as determined by BCBSNM. You are responsible for paying all deductible amounts, coinsurance, penalty amounts, and expenses for noncovered services. Payments for covered services received from a non-participating provider are usually made to the subscriber, who is also responsible for paying the provider, including any amounts greater than BCBSNM's covered charge.

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

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