CHRISTUS Health Plan

2018

NEW MEXICO
Health Insurance Exchange
PROVIDER MANUAL

Effective Date: January 2018

MM349

TABLE OF CONTENTS

TITLE PAGE

IMPORTANT PHONE NUMBERS AND ADDRESSES

WELCOME LETTER/INTRODUCTION

PROVIDER PARTICIPATING REQUIREMENTS 1

PRACTITIONER PARTICIPATION CRITERIA 1
FACILITY PARTICIPATION CRITERIA 1
PROVIDER, FACILITY AND ANCILLARY CONTRACTUAL REQUIREMENTS 2
PROVIDER RIGHTS 3
PROVIDER RESPONSIBILITIES 3
APPOINTMENT WAIT TIME 3
APPOINTMENT STANDARDS 3
COVERING PHYSICIANS 4
MEDICAL RECORDS 4
- Standards 5
- Confidentiality 5
- Release of Medical Records 5
- Transfer of Medical Records 5
- Advanced Directives 6

NON-DISCRIMINATION 8
CLOSING A PCP PANEL 8
PROVIDER REQUEST TO TRANSFER A MEMBER'S CARE 8
VOLUNTARY PROVIDER TERMINATIONS 9

MEMBER ELIGIBILITY 11

ELIGIBILITY 11
MEMBER ID CARD 12
VERIFYING ELIGIBILITY WITH CHRISTUS Health Plan 13
COLLECTION OF CO-PAYMENTS AND CO-INSURANCE 13
MEMBER PAYMENT FOR NON-COVERED SERVICES 13
MEMBER RIGHTS AND RESPONSIBILITIES 14

MEMBER SUPPORT SERVICES 15

NEW MEMBER EDUCATION 15
24/7 NURSE TRIAGE LINE 15
CULTURAL COMPETENCY AND LANGUAGE ASSISTANCE 15

TABLE OF CONTENTS

TITLE	PAGE

CASE MANAGEMENT 15
DISEASE MANAGEMENT 16
Who Qualifies.. 16
Referrals to Disease Management.. 16

COVERED AND NON-COVERED SERVICES.. 17

FAMILY PLANNING 17
BEHAVIORAL HEALTH.. 17
NEW MEXICO HEALTH INSURANCE EXCHANGE PLANS 18
NEW MEXICO HEALTH INSURANCE EXCHANGE
MEDICAL BENEFITS CHART 19
NON-COVERED BENEFITS (Exclusions).. 40

QUALITY MANAGEMENT PROGRAM.. 46

QUALITY REFERRALS 46
PROCEDURE FOR UNUSUAL PROVIDER PRACTICE PATTERNS.. 48

PREVENTATIVE HEALTH GUIDELINES.. 49

PREVENTIVE HEALTH GUIDELINES 49
CLINICAL PRACTICE GUIDELINES.. 49

TABLE OF CONTENTS

TITLE	PAGE
REFERRAL/AUTHORIZATION GUIDELINES	**50**
ROLE OF PRIMARY CARE PROVIDER	50
ROLE OF SPECIALIST AS PRIMARY CARE PROVIDER	50
ROLE OF SPECIALISTS, HOSPITALS AND ANCILLARY PROVIDERS	51
ROLE OF THE MEDICAL MANAGEMENT STAFF	51
ROLE OF MEDICAL DIRECTORS	51
PEER TO PEER AVAILABILITY	52
AVAILABILITY OF MEDICAL MANAGEMENT STAFF	52
MEMBER SELF-REFERRALS	52
PCP REFERRAL TO NETWORK SPECIALISTS	53
PRIOR-AUTHORIZATION GUIDELINES	53
UTILIZATION MANAGEMENT COMPONENTS	53
UTILIZATION MANAGEMENT NOTIFICATION REQUIREMENTS	55
AUTHORIZATION PROCESS	55
REQUESTS TO OUT-OF-NETWORK PROVIDERS	55
SERVICES REQUIRING PRIOR AUTHORIZATION	56
PROVIDER OBLIGATIONS — PRECERTIFICATION	57
PROVIDER OBLIGATIONS — APPEALS (MEMBER AND PROVIDER)	57
ADMINISTRATIVE APPEALS – PROVIDER LIABILITYAPPEALS/ PROVIDER CLAIMS DISPUTES	58
PROVIDER COMPLAINTS AND APPEALS	**58**
ADMINISTRATIVE CLAIM AND UTILIZATION DISPUTES TO HMO	58
COMPETENCE OR CONDUCT DISPUTES AND APPEALS TO HMO	59
MEMBER COMPLAINTS AND APPEALS	**60**
MEMBER COMPLAINTS TO HMO	61
MEMBER COMPLAINTS TO STATE	61
MEMBER APPEALS TO HMO	61
MEMBER APPEALS TO STATE	62
PHARMACY SERVICES	**67**
PRESCRIPTION DRUGS BY MAIL ORDER	68
COVERAGE DETERMINATIONS FOR PRESCRIPTION DRUGS	68
FORMULARY EXCEPTIONS	68
TRANSITION POLICY	68

TABLE OF CONTENTS

TITLE PAGE

CLAIMS, ENCOUNTERS AND EDI TRANSACTIONS 70

CLAIMS SUBMISSIONS 70
EDI TRANSACTIONS 70
- Electronic Data Interchange (EDI) Routing 71
- Clearinghouse 71
- Electronic Claims Submissions (837) 71
- Electronic Provider Remittance Advice (835) 71
- Electronic Enrollment Status (270) 71
- Electronic Claim Status (276) 71

PAPER CLAIMS SUBMISSION 71
- Guidelines for Filing Clean Claims 71
- Claims Filing Deadlines 71
- Checking the Status of a Claim 71
- Claims Payment Explanation of Payment (EOP) 71

ENCOUNTER DATA SUBMISSION 72
OVERPAYMENTS AND WITHHOLDS 72
COORDINATION OF BENEFITS (COB)/ THIRD PARTY LIABILITY (TPL) 72

REIMBURSEMENT METHODOLOGIES 72

FEE-FOR-SERVICE 72
COPAYMENTS 72

INTEGRITY/COMPLIANCE

SAFETY 74
QUALITY CARE 74
ACCURATE RECORDING AND REPORTING 74
ACCURATE AND APPROPRIATE CLAIMS 74
PROTECTION OF PRIVACY 74
ETHICAL PRACTICES 75
FRAUD, WASTE AND ABUSE 75
IMPORTANT STATUTES 76

GLOSSARY OF TERMS 78

TABLE OF CONTENTS

TITLE	PAGE
NEW MEXICO HEALTH INSURANCE EXCHANGE PLANS	**90**

CHRISTUS HEALTH PLAN
IMPORTANT PHONE NUMBERS AND ADDRESSES
NEW MEXICO EXCHANGE

MEMBER SERVICES	1-844-282-3025 Fax: 1-469-282-3013
PROVIDER RELATIONS	1-844-282-3025 Fax: 1-469-282-3012 Fax: 210-766-8850
CLAIM RESOLUTION	1 -844-282-3025 Fax: 1-210-766-8852
UTILIZATION MANAGEMENT	1-844-282- 3025 Fax: 1-800-277-4926
PHARMACY/FORMULARY	**Express Scripts** Helpdesk: 1-844-569-2830
FAMILY PLANNING	**HealthSmart** 1-855-596-6740
BEHAVIORAL HEALTH	CHRISTUS Health: 1-800-323-0208
DENTAL	**DentaQuest** Member Services: 1-855-343-7343 Provider Services: 1-855 -343-4276
VISION	**Superior Vision** Member Services: 1-800-879-6901 Provider Services: 1-866-819-4298
24 HOUR NURSE LINE	1-844-581-3175
CLAIMS BILLING ADDRESS	P.O. Box 981636 El Paso, Texas 79998-1636
WEBSITE	http://www.christushealthplan.org

WELCOME TO CHRISTUS HEALTH PLAN

Welcome to CHRISTUS Health Plan!

We are delighted you have chosen to become a participating provider with CHRISTUS Health Plan. We view you as our partner in providing high quality, affordable healthcare to our Members.

CHRISTUS Health Plan, headquartered in Irving, Texas, is a health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. The company's strategy integrates care delivery, the member experience, and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for the people we serve across the country. CHRISTUS Health is taking its experience and success and is expanding its product services and creating a footprint in the Healthcare Insurance Exchange in the state of New Mexico. Central to its business model is the movement to population based care.

CHRISTUS Health Plan is positioned to manage the right populations in the right way while reducing the rising health care cost trends. Key to this strategy is the engagement of members and their families with a team of providers using population health tools to identify high-risk members and gaps in care for all members that transcends the continuum of care, from the community to primary care to acute care.

Our staff will work collaboratively with you to create a positive experience for you, your patients and CHRISTUS Health Plan. Any time you have a question, please feel free to call your local Provider Relations Representative or your Medical Director.

Members of CHRISTUS Health Plan receive services as part of healthcare benefits managed by their Primary Care Provider (PCP). Benefits are available only through the exclusive use of participating providers, hospitals, medical centers, pharmacies, home health agencies, and other health care providers. No benefits are provided for use of nonparticipating providers (except in the case of emergencies, and when authorized in advance for services not available from participating providers). A list of participating providers is found on the Plan's website at **http://www.christushealthplan.org,** which is updated on a regular basis.

This provider manual furnishes participating Providers and their office staff with important information concerning CHRISTUS Health Plan policies and procedures, claim submission, adjudication requirements, and guidelines used to administer CHRISTUS Health Plans. This manual replaces and supersedes any and all other previous versions and is available at **http://www.christushealthplan.org.**

Nothing in this provider manual or the CHRISTUS Health Plan Agreement is intended to, or shall be interpreted to discourage or prohibit a participating provider from discussing with a member treatment options or providing other medical advice or treatment deemed appropriate by a participating provider.

Please contact your local Provider Relations Representative for specific information in relation to your Provider Agreement, including but not limited to:

- A listing of all individuals or entities that are party to the written agreement
- Conditions for participation as a contracted provider
- Obligations and responsibilities of the organization and the participating provider, including any obligations for the participating provider to participate in the organization's management, complaint process, or other programs
- Events that may result in the reduction, suspension, or termination of network participation privileges
- The circumstances under which the network may require access to consumers' medical records as part of the organization's programs or health benefits
- Health care services to be provided and any related restrictions
- Requirements for claims submission and any restrictions on billing of consumers
- Participating provider payment methodology and fees
- Mechanisms for dispute resolution by participating providers
- Term of the contract and procedures for terminating the contract
- Requirements with respect to preserving the confidentiality of patient health information
- Prohibitions regarding discrimination against consumers

CHRISTUS Health Plan providers have agreed to follow and adhere to "Rules & Regulations," which include, but are not limited to, all quality improvement, utilization management, credentialing, peer review, grievance, and other policies and procedures established and revised by CHRISTUS Health Plan, Center for Medicare and Medicaid Services (CMS) and the CHRISTUS Health Plan Provider Manual, as amended from time to time. Further, the policies and procedures set forth herein may be altered, amended, or discontinued by CHRISTUS Health Plan at any time upon notice to the provider.

This manual and the policies and procedures contained herein do not constitute a contract and cannot be considered or relied upon as such. Further, the policies and procedures set forth herein may be altered, amended, or discontinued by CHRISTUS Health Plan at any time upon notice to the provider. The most up-to-date version of the Provider Manual is located on the Plan's website at **http://www.christushealthplan.org.** All terms and statements used in this manual will have the meaning ascribed to them by CHRISTUS Health Plan and shall be interpreted by CHRISTUS Health Plan in its sole discretion.

PROVIDER PARTICIPATING REQUIREMENTS

CHRISTUS Health Plan credentials practitioners and certain facilities (hospitals, ambulatory surgery centers, home health agencies and skilled nursing facilities) prior to participation. Practitioners and facilities are re-credentialed, at a minimum, every three (3) years. The credentialing/re-credentialing process consists of the provider application process, verification of credentials with primary sources (excludes facilities), if required, and a review by the credentialing committee.

In order to comply with the requirements of accrediting and regulatory agencies, CHRISTUS Health Plan has adopted certain rules for participating Providers that are summarized below. This is not a comprehensive, all-inclusive list.

PRACTITIONER PARTICIPATION CRITERIA

- Completed Provider Application
- Current license to practice medicine or operate facility without limitation, suspension, restriction
- Current DEA/CDS certificate (if applicable)
- Current malpractice insurance coverage, consistent with the Provider's contract/Agreement
- Board Certification or completed appropriate training in the requested specialty
- Ability to meet access and availability standards
- Must be eligible to become an approved provider
- No state, Medicare or Medicaid sanctions
- Network need

FACILITY PARTICIPATION CRITERIA

- Completed Facility/Ancillary Application
- Current operating certificate
- Current Accreditation (Joint Commission Accreditation if applicable)
- Current malpractice insurance coverage, consistent with the Provider's contract/Agreement
- Ability to meet access and availability standards
- Must be eligible to become an approved provider
- No state, Medicare or Medicaid sanctions
- Network need

PROVIDER, FACILITY AND ANCILLARY CONTRACTUAL REQUIREMENTS

At a minimum, language in the contract includes the following conditions or programs to which the provider agrees to comply:

- Provide continuous 24-hour, 7 day a week access to care
- Arrange for another provider (the "Covering Provider") to provide patient care or referral services to a member in the event that a participating provider is temporarily unavailable
- Utilize CHRISTUS Health Plan participating providers and facilities when services are available and can meet the patient's needs
- Not discriminate on the basis of age, sex, handicap, race, color, religion or national origin
- Accept patients transferring from out-of-network care to in-network facilities
- Not balance bill a member for providing services that are covered by CHRISTUS Health Plan. Providers may only bill members for applicable deductibles, co-payments, and/or cost-sharing amounts
- Not bill members for charges which exceed contractually allowed reimbursement rates. Providers may bill a member for a service or procedure that is not a covered benefit after securing written consent.
- Prepare and complete medical and other related records in a timely fashion and maintain contemporaneous clinical records that substantiate the clinical rationale for each course of treatment, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation of treatment.
- Provide clearly legible specialty care consultation or referral reports, operative reports, and discharge summaries to the member's PCP within 30 business days of the member's visit with the specialist
- Maintain medical records for ten (10) years from the last date in which service was provided to the member
- Transfer medical records within 10 business days or sooner if requested by a treating provider, after a member changes to another Provider
- Allow access to medical records for review by appropriate committees of the CHRISTUS Health Plan and, upon request, provide the medical records to representatives of the Federal Government and/or their contracted agencies
- Inform the CHRISTUS Health Plan within 24 hours, in writing, of any revocation or suspension of the provider's Drug Enforcement Agency (DEA) number, certificate or other legal credential authorizing the provider to practice in the state of New Mexico, or any other state. Failure to comply with the above could result in termination from the Plan
- Inform the CHRISTUS Health Plan immediately, in writing, of changes in licensure status, tax identification numbers, phone numbers, addresses, status at participating hospitals, loss of liability insurance, and any other change, which would affect a provider's practicing status

- Provide or assist the CHRISTUS Health Plan in obtaining Coordination of Benefits / Third Party Liability Information
- Participate in CHRISTUS Health Plan's quality improvement, utilization management, credentialing, peer review, grievance, other policies and procedures established and revised by CHRISTUS Health Plan which also includes participation in evidence-based patient safety programs
- Abide by the CHRISTUS Health Plan rules and regulations.

PROVIDER RIGHTS

Providers have certain rights as participating providers of CHRISTUS Health Plan. These rights include:

- Ask to have any adjudicated claim reconsidered if they feel it was not paid appropriately
- Appeal any action taken by CHRISTUS Health Plan that affects their status with the network and/or that is related to professional competency or conduct
- Request that the CHRISTUS Health Plan remove a member from their care if an acceptable patient-provider relationship cannot be established with a CHRISTUS Health Plan member who has selected them as his/her provider
- Request to serve on the Quality Improvement Committee or other committees that may be formed by CHRISTUS Health Plan
- Provide feedback and suggestions on how service may be improved for providers and for members through written correspondence, the Health Plan's annual Provider Satisfaction Survey or via the Physician Advisory Committee

PROVIDER RESPONSIBILITIES

APPOINTMENT WAIT TIME

Wait times in any provider's office **should not exceed 30-45 minutes** for non-emergent visits.

APPOINTMENT STANDARDS

CHRISTUS Health Plan defines appointment standards as the timeliness within which a Member can obtain available services. When a member calls to make an appointment, it must be made within the following guidelines:

NEW MEXICO
HEALTHCARE INSURANCE EXCHANGE APPOINTMENT STANDARDS

Service	Definition	Standard
Routine Primary Care	Non-urgent care for symptomatic conditions	As soon as practicable
Routine Specialty Care	Non-urgent care for symptomatic conditions	As soon as practicable
Urgent Care	Acute but not life or limb- threatening	48 hours
Emergency Care	Life or limb-threatening illness or accident potentially leading to permanent disability or seriously jeopardizing health. Symptoms requiring immediate medical attention	Immediate
Preventive Care or Periodic Health Evaluation	Health care services designed for the prevention and early detection of illness in asymptomatic people, generally including well woman exams and routine physical examinations, routine eye exams and immunizations	4 months

COVERING PROVIDERS

Covering Providers will be reimbursed according to the contracted Provider's reimbursement rates. Follow-up treatment should always occur with the member's PCP. It is the responsibility of the contracted PCP to have his/her covering Provider provide care according to the benefit and access guidelines outlined in this Provider Manual.

MEDICAL RECORDS

CHRISTUS Health Plan Provider representatives must be permitted access to the Provider's office records and operations. This access allows CHRISTUS Health Plan to monitor compliance with regulatory requirements. Each Provider office will maintain complete and accurate medical records for all CHRISTUS Health Plan Members receiving medical services in a format and for time periods as required by the following:

- Applicable federal laws
- Applicable licensing, accreditation, and reimbursement rules and regulations
- Accepted medical practices and standards

The provider's medical records must be available for utilization, risk management, peer review studies, customer service inquiries, grievance and appeal processing, claims reconsideration, and other initiatives CHRISTUS Health Plan may be required to conduct. To comply with accreditation and regulatory requirements, CHRISTUS Health Plan may periodically perform documentation audits of some Provider medical records.

Standards

Participating Providers must have a system in place for maintaining medical records that conform to regulatory standards. All medical records pertaining to CHRISTUS Health Plan members must be kept the longer of ten (10) years or as required by each state. On a periodic basis, the Plan may require access to medical records for the purpose of quality assessment, investigating grievances and appeals, credentialing, and peer review.

Confidentiality

Medical records are considered confidential and protected health information. Providers must comply with all state and federal laws concerning confidentiality of health and other information about CHRISTUS Health Plan members. Providers must maintain and adhere to policies and procedures regarding use and disclosure of health information that comply with HIPAA and other applicable laws.

Release of Medical Records

CHRISTUS Health Plan members have the right to access their medical records; therefore, each Provider must have a mechanism in place to provide this access. Appropriate communication of medical record information between treating Providers is essential to promoting continuity and coordination of care.

Transfer of Medical Records

There may be times when a member's medical record needs to be transferred from one Provider to another in the Plan. This may occur when members change Providers or if a Provider leaves the Plan. All medical records must be transferred to the new Provider within 10 business days or sooner if requested by the treating provider.

The following information must be included in every individual patient record:

- Patient identification
- Personal data
- Allergies
- Chronic/significant problem list
- Chronic/continuing medication list
- Immunization history
- Informed consent
- Provider signature/name, on each entry
- Patient's signature on file, for insurance purposes
- Growth chart (14 years of age and under)
- Initial relevant history

- Smoking status
- Alcohol or substance use/abuse
- Date of each visit
- Chief complaint
- Physical exam
- Diagnosis/impression
- Appropriate use of consultants
- Treatment/therapy plan
- Results discussed with patient
- MD Review of diagnostic studies
- Results of consultations
- Date of next visit
- Hospital records, as applicable
- Preventive health education

Advance Directives

Advance directives are written instructions that:

- Give direction to health care providers as to the provision of health care
- Provide for treatment choices when a person is incapacitated
- Are recognized under state law when signed by a competent person

There are three types of advance directives:

- A durable power of attorney for health care (durable power) allows the member to name a patient advocate to act on behalf of the member
- A living will allows the member to state his or her wishes in writing but does not name a patient advocate
- A declaration for mental health treatment gives instructions about a member's future mental health treatment if the member becomes unable to make those decisions. The instructions state whether the member agrees or refuses to have the treatments described in the declaration with or without conditions and limitations.

CHRISTUS Health Plan advance directive policies include:

- Respecting the rights of the member to control decisions relating to his or her own medical care, including the decision to have provided, withheld or withdrawn the medical or surgical means or procedures calculated to prolong his or her life. This right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession
- Adhering to the Patient Self-Determination Act and maintaining written policies and procedures regarding advance directives. Providers must adhere to this Act and to all state and federal standards as specified in SSA 1902(a)(57), 1903(m)(1)(A), 42 CFR 438.6(i) and 42 CRF 489 subpart I

Advising members of their right to self-determination regarding advance directives by:

- Encouraging members to request an advance directive form and education from their PCP at their first appointment
- Assisting members with questions about an advance directive. No CHRISTUS Health Plan associate may serve as witness to an advance directive or as a member's authorized agent or representative
- Allowing CHRISTUS Health Plan associate, a facility or a provider to conscientiously object to an advance directive within certain limited circumstances if allowed by state law
- Having Member Services, Provider Relations and/or Health Care Management Services staff review and update advance directive notices and education materials for members on a regular basis
- Producing member materials that contain information, as applicable, regarding provisions for conscience objection. Materials explain the differences between institution-wide objections based on conscience and those that may be raised by individual providers
- The Health Plan issuing a clear and precise written statement of this limitation to CMS and request a conscience protection waiver. The conscientious objection will be stated clearly and describes the following:
  - Describes the range of medical conditions or procedures affected by the conscience objection
  - Identifies the state legal authority permitting such objection
  - Notes the presence of advance directives in the medical records when conducting medical chart audits.

Providers must:

- Comply with the Patient Self-Determination Act requirements
- Make sure the first point of contact in the Provider's office asks the member if he or she has executed an advance directive
- Document in the member's medical record his or her response to an offer to execute any advance directive in a prominent place, including a do-not-resuscitate directive or the Provider and member's discussion and action regarding the execution or non-execution of an advance directive
- Ask members who have executed an advance directive to bring a copy of the advance directive(s) to the PCP/Provider at the first point of contact
- Make an advance directive part of the member's medical record and put in a prominent place
- Discuss potential medical emergencies with the member and/or family/significant other and with the referring provider, if applicable
- Ask the member if he or she would like advance directive information. If the member desires further information, provide member advance directive education
- Not discriminate or retaliate against a member based on whether he or she has executed an advance directive.

NON-DISCRIMINATION

CHRISTUS Health Plan participating providers have agreed to provide care to plan members in the same manner and in accordance with the same standards they follow in providing care to patients who are not CHRISTUS Health Plan members. Providers cannot differentiate or discriminate against any CHRISTUS Health Plan member in the delivery of health care services consistent with covered benefits on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, such as ESRD, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

CLOSING A PCP PANEL

CHRISTUS Health Plan and participating providers share the common goal of making medical care available and accessible to members in a timely manner. PCPs whose practices are nearing capacity typically close their panels to all new patients regardless of payer. This allows them to handle urgent care for their existing patients in a timely manner and to maintain reasonable appointment lead times. PCPs interested in closing their panel should contact their Provider Relations Representative.

PROVIDER REQUEST TO TRANSFER A MEMBER'S CARE

Members have a right to voluntarily change providers. Likewise, providers have a right to request that a member be transferred to the care of another provider when the provider feels the doctor-patient relationship has been compromised due to:

- Unruly or abusive behavior
- Failure to follow the provider's recommended treatment plan
- Breakdown in patient/provider relationship
- A pattern of missed appointments
- Fraud
- Failure to pay co-payments

In such situations, the provider is required to resolve the issue through written communication to the member which includes the following:

- Refers to the specific incident (date)
- Refers to the specific behavior
- Expresses commitment to work with the member – carbon copy (CC) the CHRISTUS Health Plan Member Service Manager at the following address:

  CHRISTUS Health Plan
  P.O. Box 169016
  Irving, Texas 75016

If the behavior persists, the provider should write a formal letter to the member and carbon copy (CC) to the CHRISTUS Health Plan Member Services Manager to advise of the situation and initiate transfer of the member to another PCP. The Member Services Department will contact the member to facilitate the transfer.

Please Note: Some instances require immediate termination of the provider-member relationship. Providers are encouraged to consult with their Provider Relations Representative for additional assistance as needed.

VOLUNTARY PROVIDER TERMINATIONS

Providers may terminate their contract with CHRISTUS Health Plan according to the terms of their provider agreement. Termination of a provider agreement does not release the provider from the obligation to arrange for the provision of services and transition of member care. Providers must continue to provide medical care to assigned members until the effective date of termination. Please refer to the termination section of the provider Agreement for termination instructions, continuity of care and notification address.

MEMBER ELIGIBILITY

ELIGIBILITY

The Federal Exchange (Exchange) will make eligibility decisions based upon the Application submitted by the Member. The Member is responsible for notifying the Exchange about changes to their family circumstances that could affect eligibility such as an adoption, a birth, addition of another dependent, or a divorce. To be eligible for Covered Benefits in accordance with CHRISTUS Health Plan Policy, Members must be enrolled. In this context, the Member is the individual who has applied for coverage on behalf of his/herself and his/her Dependents, and to whom the Policy was issued.

To enroll in CHRISTUS Health Plan, a Member must be a Qualified Individual eligible for coverage through the Exchange, under the age of 65 and not be eligible for coverage under Medicare due to age, illness or disability, and must reside, live, or work in the CHRISTUS Health Plan Service Area, and the legal residence of any enrolled Dependents must be the same as the subscriber, or the subscriber must reside, live or work in the Service Area and the residence of any enrolled dependents must be in the:

- Service Area with the person having temporary or permanent conservatorship or guardianship of the Dependents, including adoptees or children who have become the subject of a suit for adoption by the enrollee, where the subscriber has legal responsibility for the for the health care of such Dependents;
- Service Area under other circumstances where the subscriber is legally responsible for the health care of the Dependents;
- Service area with the subscriber's spouse; or
- Anywhere in the United States for a child whose coverage under a plan is required by a medical support order.

Members may add newborn and other Dependents to the Plan by completing an enrollment form for the Dependent and submitting it to the Federal Exchange. Members must notify CHRISTUS Health Plan within 31 days after the birth of a child they wish to add as a Dependent and pay any premium required to continue the coverage. In addition, grandchildren living with and in the household of the subscriber may also qualify as a Dependent. Unless special circumstances apply, coverage of such Dependents is limited to those under the age of twenty-six (26). Dependent children, age 26 or older, may qualify for continued dependent coverage while the child is incapable of self-sustaining employment due to a mental retardation or physical disability, which existed prior to attaining and chiefly dependent upon the subscriber for support and maintenance.

To be eligible as a Dependent, the Dependent must:

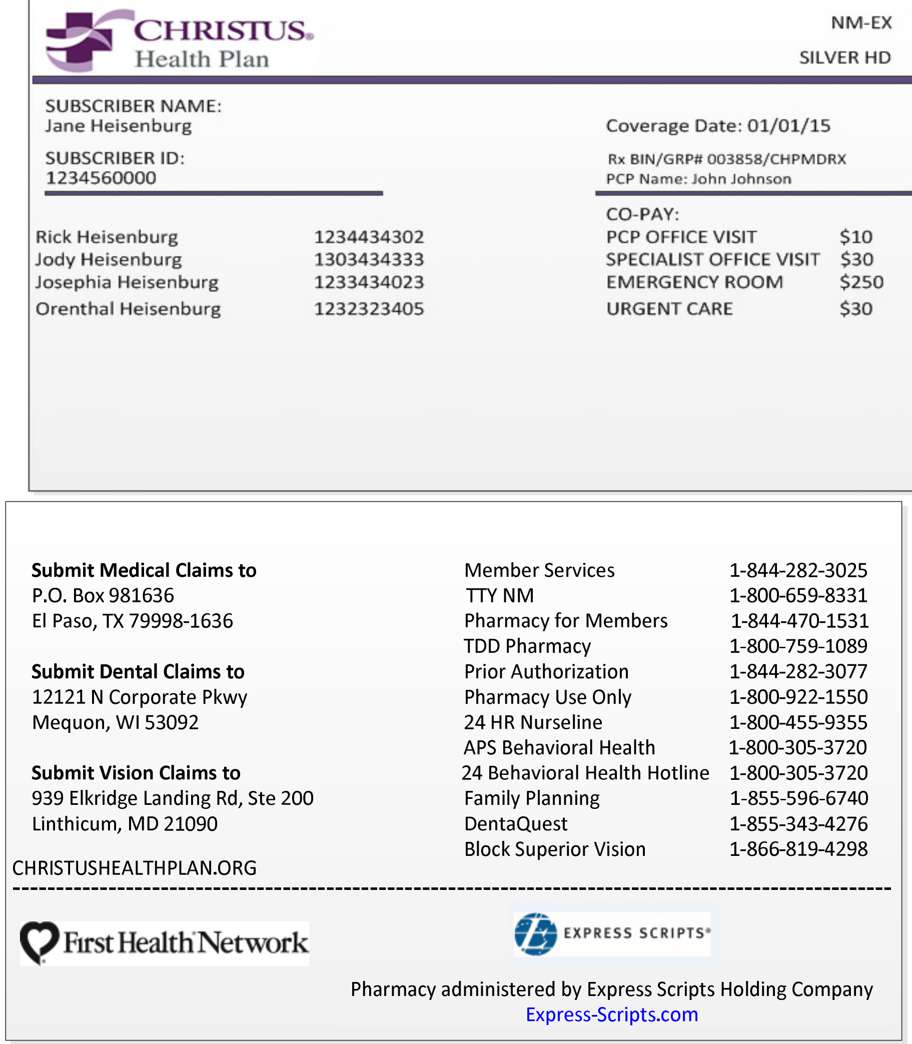
- Be enrolled at the same time as the Member;
- Be a Dependent of a Qualified Individual eligible for coverage through the Exchange under New Mexico law;
- Be enrolled within 31 days of a Qualifying Event as described under the Special Enrollment Period for Dependents.

MEMBER ID CARD

The Member identification (ID) card is issued to Members upon enrollment and contains information regarding benefit coverage, copayments, and telephone numbers for questions regarding those benefits. Each member receives an ID card when they enroll with CHRISTUS Health Plan. Most providers ask to see the ID card each time the member comes to the office. The ID card displays information such as:

- Member Name
- Member ID #
- Co-payment Amounts

Below is a sample of the Health Insurance Exchange CHRISTUS Health Plan Member ID Card:



CHRISTUS. Health Plan

NM-EX
SILVER HD

SUBSCRIBER NAME:
Jane Heisenburg

Coverage Date: 01/01/15

SUBSCRIBER ID:
1234560000

Rx BIN/GRP# 003858/CHPMDRX
PCP Name: John Johnson

Rick Heisenburg	1234434302
Jody Heisenburg	1303434333
Josephia Heisenburg	1233434023
Orenthal Heisenburg	1232323405

CO-PAY:

PCP OFFICE VISIT	$10
SPECIALIST OFFICE VISIT	$30
EMERGENCY ROOM	$250
URGENT CARE	$30

Submit Medical Claims to
P.O. Box 981636
El Paso, TX 79998-1636

Submit Dental Claims to
12121 N Corporate Pkwy
Mequon, WI 53092

Submit Vision Claims to
939 Elkridge Landing Rd, Ste 200
Linthicum, MD 21090

CHRISTUSHEALTHPLAN.ORG

Member Services	1-844-282-3025
TTY NM	1-800-659-8331
Pharmacy for Members	1-844-470-1531
TDD Pharmacy	1-800-759-1089
Prior Authorization	1-844-282-3077
Pharmacy Use Only	1-800-922-1550
24 HR Nurseline	1-800-455-9355
APS Behavioral Health	1-800-305-3720
24 Behavioral Health Hotline	1-800-305-3720
Family Planning	1-855-596-6740
DentaQuest	1-855-343-4276
Block Superior Vision	1-866-819-4298

First Health Network

EXPRESS SCRIPTS®

Pharmacy administered by Express Scripts Holding Company
Express-Scripts.com

Please Note: A member's eligibility status can change. **The member ID card does not guarantee eligibility**. Provider office staff must verify eligibility each time a member presents for service. New members may present a copy of an enrollment form or a copy of the confirmation of enrollment letter from the health plan as proof of eligibility.

VERIFYING ELIGIBILITY

A provider may confirm member eligibility directly with CHRISTUS Health Plan. Call Member Services at 1-844-282-3025.

COLLECTION OF CO-PAYMENTS AND CO-INSURANCE

It is the provider's responsibility to collect co-payments and co-insurance directly from the member at the time services are rendered. Co-payments are required for professional services and cannot be waived by the provider. Providers must not bill or collect any amount in excess of the CHRISTUS Health Plan payment except for the applicable co-payments and co-insurance.

MEMBER PAYMENT FOR NON-COVERED SERVICES

Providers may charge CHRISTUS Health Plan members for non-covered services. However, such charges must be the usual and customary fee the provider would charge all other patients. The CHRISTUS Health Plan member must agree in writing to accept payment responsibility for the non-covered service prior to receiving that service.

MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS

Plan Members have the right to:

- Available and accessible services for Medically Necessary and Covered Services, including 24 hours per day, 7 days per week for Urgent or Emergency Services, and for other Health Care Services as defined in the *Summary of Benefits and Coverage*
- Be treated in a prompt, courteous and responsible manner that respects their dignity and privacy
- Receive detailed information about their coverage, benefits and services offered under their Policy. This includes any Exclusions of specific Conditions, ailments or disorders, including restricted prescription benefits; the Plan's policies and procedures regarding products, services, Providers appeal procedures and other information about the Plan and the benefits provided to Members. This also includes access to a current list of Participating Providers in the Plan's network; information about a particular Participating Provider's education, training, and practice; and the Member Rights and Responsibilities, as well as the right to make recommendations regarding the Plan's Member Rights and Responsibilities policies
- Receive affordable health care including information regarding out-of-pocket expenses; limitations; the right to seek care from a Non-Participating Provider; and an explanation of their financial responsibility when services are provided by a Non-Participating Provider or without Prior Authorization
- Choose a Primary Care Provider within the limits of the Covered Services, the Plan's network, and as provided by the Policy, including the right to refuse care of specific Health Care Professionals. In addition, Members have the right to participate with Providers in making decisions about their health care
- Be given an explanation of their medical Condition, recommended treatment, risks of the treatment, expected results, and reasonable medical alternatives by their Participating Provider in terms that they understand. If they are unable to understand the information, an explanation must be given to their next of kin, guardian or another authorized person. This information shall be documented in their medical records
- All rights afforded by law, rule, or regulation as a patient in a licensed Health Care Facility, including the right to be informed about their treatment by their Participating Provider in terms that they understand; to request their consent (agreement) to the treatment; to refuse treatment, including medication; and to be told of possible consequences of refusing such treatment. This right exists even if treatment is not a Covered Benefit or Medically Necessary under the Plan. The right to consent or agree to treatment by them or their next of kin, guardian, or another authorized person may not be possible in an emergency where their life and health are in serious danger
- Voice Complaints, Grievances or Appeals with the Plan or the Superintendent of Insurance (Superintendent) about the Plan or the coverage the Plan provides. Members also have the right to receive an answer within a reasonable time and in accordance with existing law and without fear of retaliation
- Be promptly notified of termination or changes in benefits, services or the Provider Network

- Confidential handling of all communications, including medical and financial information maintained by the Plan. Privacy of their medical and financial records will be maintained by the Plan and Participating Providers in accordance with existing law
- A complete explanation of why a benefit is denied, the opportunity to appeal the denial decision, to our internal review and the right to request help from the Superintendent.
- Know, upon request, of any financial arrangements or provisions between the Plan and Participating Providers, which may restrict referrals or treatment options or limit the services offered to Members
- Seek from qualified Health Care Professionals services and treatments that are Covered Benefits near where they live or work within the Plan's Service Area
- Receive information about how benefits are authorized or denied. Members have the right to know how new technology for Covered Benefits are evaluated. They can also request and receive information about the Plan's quality assurance plan and Utilization Review methodology
- Receive detailed information about all requirements that must be followed for Prior Authorization and Utilization Review

MEMBER RESPONSIBILITIES

As a Member of the Plan, they have the responsibility to:

- Provide honest and complete information to those providing the care
- Review and fully understand the information they receive about the Plan
- Know the proper use of the services covered by the Plan
- Present their Plan ID card before they receive care
- Consult their Provider before receiving medical care, unless their Condition is life threatening
- Promptly notify their Provider if they will be delayed or unable to keep an appointment
- Pay all charges or Copay/Coinsurance amounts, including those for missed appointments This also applies to Deductibles and any charges for non-Covered Benefits and Services
- Express their opinions, Complaints or Concerns in a constructive way to CHRISTUS Health Plan Member Services or to their Provider
- Inform the Plan of any changes in family size, address, phone number or Membership status within thirty (30) calendar days of the change
- Make Premium payments on time
- Notify the Plan of other insurance coverage
- Follow the Plan's Grievance and Appeal process when displeased with the Plan or a Providers' actions or decisions
- Understand their health problems and participate in developing treatment goals that they agree to with their Providers
- Follow plans and instructions for care that they have agreed to with their Provider

All Members are responsible for understanding how the Plan works. They should carefully read and refer to their Policy and their *Summary of Benefits and Coverage.*

MEMBER SUPPORT SERVICES

NEW MEMBER EDUCATION

When a member joins CHRISTUS Health Plan, Member Services Representatives will call to welcome the new members and answer any questions they have. Members are encouraged to see their Primary Care Provider (PCP) within the first 90 days of eligibility and to rely on the PCP to guide them through the health care delivery system.

PCPs may send a welcome letter to their new members with information such as hours and days of operation, phone numbers, and appointment scheduling.

24/7 NURSE LINE

CHRISTUS Health Plan has a 24/7 Nurse Line. Members can access this service toll free for medical guidance/triage 24 hours a day, 7 days per week. Members are instructed based on nationally recognized triage protocols. This service does not replace the provider's after-hours coverage commitment. To reach the Nurse Line, members should call 1-844-581-3175.

CULTURAL COMPETENCY AND LANGUAGE ASSISTANCE

CHRISTUS Health Plan strives to provide services in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds by providing a culturally diverse provider network. The Plan gathers information from providers concerning languages, other than English, that are spoken in each office. CHRISTUS Health Plan's Member Services works with members to help them choose providers who can speak the member's primary language. In addition, Member Services retains a telephonic interpreter service for assistance with non-English speaking and hearing-impaired members.

Providers are encouraged to deliver care in a manner that is sensitive to the cultural background and language of the patient. It is the responsibility of the provider to obtain and pay for interpreters for language interpretation other than English, as well as for visually impaired, hearing/vision impaired, hard of hearing and speech disabled patients.

CASE MANAGEMENT

The Case Management program plans and manages the care of members with catastrophic, chronic needs and those whose needs are acute, episodic or short term in nature. The goals of case management are the provision of quality care, enhancement of member's quality of life and management of health care costs for short term and long term. Disease management is case management for members with specific chronic diseases.

Potential participants for case management may be identified by the following:

- Provider referral
- Facility admission/ Concurrent review process
- Retrospective analysis
- Member request
- Case Management criteria per policy.

Providers can refer members for a case management evaluation by calling 1-844-282-3025 or faxing information to 1-800-277-4926.

DISEASE MANAGEMENT

CHRISTUS Health Plan encourages the use of the Disease Management Program to assist provider, patients, and family members in managing members with chronic conditions. The program incorporates a unique personal and collaborative effort between nursing staff, Primary Care Providers (PCPs), and members.

The purpose of Disease Management is to:

- Identify patients with chronic conditions
- Manage chronic conditions more effectively through education, self-management and care Management
- Prevent or slow the progression of chronic conditions

Who Qualifies

All members with the following diagnoses are eligible for Disease Management:

- Chronic Obstructive Pulmonary Disease (COPD) / Asthma
- Congestive Heart Failure (CHF)
- Diabetes Mellitus (DM)

Referrals to Disease Management

Provider may refer potential candidates to Disease Management by calling 1-844-282-3025 or faxing information to 1-800-277-4926.

Referrals to the Disease Management Program are also received and accepted from the following sources:

- Case management program referral
- Referrals from PCP / Provider, Clinic staff
- UM Referrals
- Member Self-Referral
- Other (examples include referrals from mental health benefits coordinator, home health agencies, community resources)

Upon referral, members will be contacted for enrollment and will be administered a telephonic health assessment. The Disease Management team members will work with the PCPs to develop a Plan of Care.

COVERED AND NON-COVERED SERVICES

CHRISTUS Health Plan provides covered medical benefits to its members. Included below and in the following pages is a list of covered and non-covered services, although it is not all inclusive. A copayment may be required for an office visit, hospital admissions, prescribed medications, emergency room visit if not admitted, purchase or lease of durable medical equipment and other services as indicated. Members are responsible for payment for all services determined not to be medically necessary and not authorized by the provider.

FAMILY PLANNING

Family planning services are covered as a part of the CHRISTUS Health Plan package of benefits. However, since this benefit is inconsistent with the Ethical and Religious Directives for Catholic Health Care, it is not provided by CHRISTUS Health owned entities. HealthSmart administers the family planning benefit for CHRISTUS Health Plan members**.** HealthSmart is not affiliated with CHRISTUS Health.

Family Planning services provided are paid directly through HealthSmart. Providers who have questions should contact HealthSmart directly at (855) 596-6740.

BEHAVIORAL HEALTH

CHRISTUS Health Plan is directly responsible for BH member services, provider contracting, credentialing, and claims payment to behavioral health providers. CHRISTUS Health can be reached at 1-844-282-3025.

NEW MEXICO HEALTH INSURANCE EXCHANGE PLANS

CHRISTUS Health Plan offers 21 different plan types within the New Mexico Health Insurance Exchange. The following table depicts the Gold, Silver,, Catastrophic and American Indian plans.

NEW MEXICO PLANS
HD = High deductible
LD = Low deductible
S = Statewide

PLAN	TYPE	TYPE	TYPE
Gold	Gold		Gold S
Silver	Silver HD Silver HD 73% Silver HD 87% Silver HD 94%	Silver LD Silver LD 73% Silver LD 87% Silver LD 94%	Silver SLD Silver SLD 73% Silver SLD 87% Silver SLD 94%
Catastrophic	Catastrophic		Catastrophic Statewide
American Indian	American Indian		

NOTE: All New Mexico Plans are subject to an overall deductible and an out-of-pocket limit on expenses, with the exception of the American Indian Plan, as described below:

Overall deductible	Members must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services. Copays do not count towards the deductible.
Out–of–pocket limit on expenses	The **out-of-pocket limit** is the most a Member could pay during a coverage period (usually one year) for their share of the cost of covered services.

The services covered by the Plan, as well as a description of the services, can be found in the following pages and Health Insurance Exchange Medical Benefits Chart. In addition, a detailed explanation of each of the 21 plans offered with applicable co-payments, deductibles and/or co-insurance requirements is found **at the end of this Provider Manual.**

NEW MEXICO HEALTH INSURANCE EXCHANGE
MEDICAL BENEFITS CHART

<table>
<tr><th colspan="2">Accidental Injury (Trauma), Urgent Care, Emergency Care Services and Observation Services</th></tr>
<tr><td>Urgent Care</td><td>Urgent Care is Medically Necessary medical or surgical procedures, treatments, or Health Care Services. Urgent Conditions require prompt medical attention to prevent a serious deterioration in health but do not have to be life threatening.</td></tr>
<tr><td>Emergency Care Services</td><td>CHRISTUS Health Plan (CHP) provides coverage for Emergency Care Services 24 hours per day, 7 days per week, when needed immediately to prevent jeopardy to health.
• Whether an Emergency Service is appropriate at a Non-Participating Provider will be determined by reasonable and prudent layperson standards.
• If a Member cannot reasonably access a Participating Provider, the Plan will arrange to cover the care at a Non-Participating Provider without additional cost.
o Coverage for trauma services and all other Emergency Services will continue at least until the Member is medically stable, does not require critical care, and can be safely transferred to a Participating Provider. This is based on the judgment of the attending provider in consultation with the Plan and in accordance with state or federal law.
• The Plan will provide reimbursement when the Member, acting in good faith, obtains Emergency Services, acting as a Reasonable and Prudent Layperson, even if the Member’s Condition is later determined to not be an emergency.
• Prior Authorization is not required for Emergency Services.
• If the Member is admitted as an Inpatient to a Hospital, the Member or the Practitioner needs to notify the Plan as soon as possible to review the Hospital stay.
• We will not deny a claim for medically necessary Emergency Services when the Member is referred to the emergency room by their PCP or by the Plan.
• If the Member’s Emergency Services results in a hospitalization directly from the emergency room, the Member is responsible for paying the Inpatient Hospital Cost Sharing amounts (Deductible, Coinsurance and/or Copayment). In this situation, the Member does not have to pay the emergency room visit Copayment.
• Refer to the Summary of Benefits and Coverage for the Cost Sharing amount.
• For Emergency Services received from a Non-Participating Provider and/or outside of New Mexico, the Member may seek Emergency Services from the nearest appropriate facility where Emergency Services can be rendered. Non-emergent follow-up care received outside of New Mexico is not a Covered Benefit for the Member’s convenience or preference. Follow-up care from a Non-Participating Provider requires the Plan’s Prior Authorization.</td></tr>
<tr><td>Observation Services</td><td>Observation Services are defined as Outpatient services furnished by a hospital and a Practitioner/Provider on the hospital’s premises. These services may include the use of a bed and periodic monitoring by a hospital’s nursing staff that are reasonable and necessary to evaluate an outpatient’s Condition, determine the need for a possible admission to the hospital, or when rapid improvement of the patient’s Condition is anticipated or occurs.

• When a hospital places a patient under Outpatient Observation, it is based upon the Practitioner’s/Provider’s written order. To transition from Observation to an Inpatient admission, the Plan’s level of care criteria must be met. The length of time spent in the hospital is not the sole factor determining Observation versus Inpatient stays. Medical criteria will also be considered.

• Observation Services for more than 24 hours will require Prior Authorization. It is</td></tr>
</table>

	the responsibility of the facility offering Observation Services to notify the Plan. • All Accidental Injury (trauma), Urgent Care, Emergency Services, and Observation Services whether provided within or outside of the Plan's Service Area are subject to the Limitations listed in the Limitations Section and the Exclusions listed in the Exclusions Section.
Ambulance Services	The Plan covers the following types of Ambulance Services: (1) Emergency Ambulance Services, (2) High-Risk Ambulance Services, and (3) Inter-facility Transfer services.
Emergency Ambulance Services	Emergency Ambulance Services are defined as ground or air Ambulance Services delivered to a Member who requires Emergency Care Services under circumstances that would lead a Reasonable and Prudent Layperson acting in good faith to believe that transportation in any other vehicle would endanger their health. Emergency Ambulance Services are Covered only under the following circumstances: • Within New Mexico, to the nearest In-network facility where Emergency Care Services and treatment can be rendered, or to an Out-of-network facility if an In-network facility is not reasonably accessible. Such services must be provided by a licensed Ambulance Service in a vehicle that is equipped and staffed with life-sustaining equipment and personnel. • Outside of New Mexico, to the nearest appropriate facility where Emergency Care Services and treatment can be rendered. Such services must be provided by a licensed Ambulance Service in a vehicle that is equipped and staffed with life-sustaining equipment and personnel. The Plan will not pay more for air Ambulance Services than it would have paid for ground Ambulance services over the same distance unless the Member's Condition renders the utilization of such ground transportation services medically inappropriate. In determining whether the Member acted in good faith as a Reasonable and Prudent Layperson when obtaining Emergency Ambulance Services, the Plan will take the following factors into consideration: • Whether the Member required Emergency Services, as defined above • The presenting symptoms • Whether a Reasonable and Prudent Layperson who possesses average knowledge of health and medicine would have believed that transportation in any other vehicle would have endangered their health • Whether the Member was advised to seek an Ambulance service by their Practitioner/Provider or by our staff. Any such advice will result in reimbursement for all Medically Necessary services rendered, unless otherwise limited or excluded under this Policy. • Ground or air Ambulance Services to any Level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols. Ambulance Services (ground or air) to the coroner's office or to a mortuary is not Covered. The exception is if the Ambulance had been dispatched prior to the pronouncement of death by an individual authorized under state law to make such pronouncement.
High-Risk Ambulance Services	High-Risk Ambulance Services are defined as non-emergency Ambulance Services prescribed by the Practitioner/Provider that are Medically Necessary for transporting a high-risk patient. Coverage for High-Risk Ambulance Services is limited to: • Air Ambulance Services when Medically Necessary. However, the Plan will not pay more for air Ambulance Services than it would have paid for transportation

	over the same distance by ground Ambulance Service, unless the Condition renders the utilization of such ground Ambulance Services medically inappropriate. • Neonatal Ambulance Services, including ground or air Ambulance Service to the nearest Tertiary Care Facility when necessary to protect the life of a newborn. • Ground or air Ambulance Services to any Level I or II or other appropriately designated trauma/burn center according to established emergency medical services triage and treatment protocols.
Inter-facility Transfer Ambulance	Inter-facility Transfer Ambulance Services are defined as ground or air Ambulance Service between hospitals, Skilled Nursing Facilities or diagnostic facilities. Inter-facility transfer services are Covered only if they are: • Medically Necessary • Prescribed by the Practitioner/Provider • Provided by a licensed Ambulance Service in a vehicle which is equipped and staffed with life-sustaining equipment and personnel.
Bariatric Surgery	Surgical treatment of morbid obesity (bariatric surgery) is Covered only if it is Medically Necessary. Bariatric Surgery is Covered for patients with a Body Mass Index (BMI) of 35 kg/m2 or greater who are at high risk for increased morbidity due to specific obesity related co-morbid medical Conditions. It is a Covered Benefit only if a Member meets these criteria and all other requirements of the Policy. Prior Authorization is required and services must be performed at a Participating Health Care Facility.
Clinical Trials	The Plan provides coverage for Medically Necessary routine patient care at a New Mexico facility, incurred as a result of the Member's participation in a clinical trial if: • The clinical trial is undertaken for the purpose of prevention, early detection or treatment of cancer or other life threatening Illnesses or Condition for which no standard treatment exists or more effective standard treatment exists; • The clinical trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology; • The clinical trial is being provided in this state as part of a scientific study of a new therapy or intervention that is being conducted at an institution in this state and is for the treatment, palliation or prevention of cancer or disease in humans with: specific goals; a rationale and back ground for the study; criteria for patient selection; specific direction for administering the therapy or intervention and for monitoring patients; a definition of quantitative measures for determining treatment response; methods for documenting and treating adverse reactions; and a reasonable expectation that the treatment will be at least as efficacious as standard cancer treatment. • The clinical trial is being provided as part of a clinical trial being conducted in accordance with a clinical trial approved or funded by at least one of the following: (a) One of the federal National Institutes of Health, including The Centers for Disease Control and Prevention, The Agency for Health Care Research and Quality, or The Centers for Medicare & Medicaid Services; (b) A federal National Institute of Health Cooperative Group or center; (c) The United States Food and Drug Administration in the form of an investigational new drug application; (d) The United States Department of Veteran Affairs, The United States Department of Defense, or the United States Department of Energy, if for a study or investigation conducted by the respective Department that has been reviewed and approved through a system of peer review that the respective Secretary determines to (A) be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and (B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; (f) A qualified research entity that meets the criteria established by the federal National Institutes

	of Health for grant eligibility; • The clinical trial or study has been reviewed and approved by an Institutional Review Board by the Office of Protection from Research Risks of the NIH • The personnel providing the clinical trial or conducting the study (a) Are providing the clinical trial or conducting the study within their scope of practice, experience and training and are capable of providing the clinical trial because of their experience, training and volume of patients treated to maintain their expertise; and (b) Agree to accept reimbursement as payment in full from the Plan and that is not more than the level of reimbursement applicable to other similar services provided by the Participating Providers within the Plan's network; (c) agree to provide written notification to the health plan when a patient enters or leaves a clinical trial • There is no non-investigational treatment equivalent to the clinical trial; and the available clinical or preclinical data provide a reasonable expectation that the clinical trial will be at least as efficacious as any non-investigational alternative; and there is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial will be at least as effective as any other medical treatment • Pursuant to the patient informed consent document, no third party is liable for damages associated with the treatment provided during a phase of a clinical trial; provided during a phase of a clinical trial o If a Member is denied coverage of a cost and contends that the denial is in violation of New Mexico law, the Member may appeal the decision to deny the coverage of a cost to the New Mexico Superintendent. In no event shall the Plan be responsible for out-of-state or out-of-network costs unless the Plan pays for standard treatment out-of-state or out-of-network. For the purposes of this specific Covered Benefit and Service, the following terms have the following meaning: • Routine Patient Care Cost" – means (a) A medical service or treatment that is a benefit under the Plan that would be covered if the patient were receiving standard cancer or life-threatening Illness treatment; or (b) A drug provided to a patient during a clinical trial if the drug has been approved by the United States Food and Drug Administration, whether or not that organization has approved the drug for use in treating the patient's particular Condition, but only to the extent that the drug is not paid for by the manufacturer, distributor or Provider of the drug. • Routine Patient Care Cost does not include: a) The cost of an investigational drug, device or procedure; (b)The cost of a non-Health Care Service that the patient is required to receive as a result of participation in the clinical trial; (c) Costs associated with managing the research that is associated with the clinical trial; (d) Costs that would not be covered by the patient if non-investigational treatments were provided; or (e) Costs paid or not charged for by the clinical trial Providers.
Certified Hospice Care	This Plan covers Hospice Care Program Services. To be covered, these services must be provided due to terminal illness. These services are limited as stated in the Member's *Summary of Benefits and Coverage*. The services must be given under a Hospice Care Program and provided by a licensed and qualified Provider. Hospice care services include Inpatient care and outpatient services. Also included are the professional services of a Physician. Other Covered Services include those of a psychologist, social worker or family counselor. The following services are not covered by the Plan: • Services provided by a family member or someone who usually lives in the Member's home or their Dependent's home • Services or supplies not listed in the Hospice Care Program • Curative or life prolonging procedures

	• Services for which any other benefits are payable under the Plan • Services or supplies that are primarily to aid in daily living • Nutritional supplements, non-Prescription Drugs or substances, medical supplies, vitamins or minerals; or • Respite care
Preventative Care Services	The Plan covers Primary Care and Specialist services for preventative care and periodic health exams. Although Preventative Care is covered at no charge, an office visit Copay may apply for other Covered Services provided during the same visit.
Preventative Services for Adult Members	• Abdominal Aortic Aneurysm screening for male Members of specific ages • Alcohol Misuse screening and counseling • Aspirin use for Members of certain ages • Blood Pressure screening • Cholesterol screening for Members of certain ages or at higher risk • Colorectal Cancer screening for Members over 50, including Colonoscopies • Depression screening • Type 2 Diabetes screening for Members with high blood pressure • Diet counseling for Members at higher risk for chronic disease • HIV screening for all Members at higher risk • Immunization vaccines – doses, recommended ages and recommended populations can vary • Obesity screening and counseling • Sexually Transmitted Infection (STI) prevention counseling for Members at higher risk • Tobacco Use screening for all Members and cessation interventions for tobacco users, including expanded counseling for pregnant tobacco users • Syphilis screening for all adults at higher risk Additional Preventative Services include but are not limited to: • Annual physical examinations, one per Calendar Year • Educational materials or consultations from Providers to promote healthy living • Periodic Glaucoma eye tests for all Members thirty-five (35) years of age or older • Periodic laboratory screening tests, including tests that determine metabolic, blood hemoglobin, blood glucose level, and blood cholesterol level • Periodic radiological screening tests

Preventative Services Specifically for Women	• Routine Anemia screening • Bacteriuria urinary tract or other infection screening • Breastfeeding comprehensive support, supplies and counseling • Folic Acid supplements for Members who may become pregnant • Hepatitis B screening for pregnant Members at their first prenatal visit • RH Incompatibility screening and follow-up testing for Members at higher risk
Preventative Services for Children	• Well baby and well childcare from birth in accordance with recommendations of the American Academy of Pediatrics • Alcohol and Drug Use assessments for adolescents • Autism screening for children at 18 and 24 months • Behavioral assessments for children of all ages • Blood Pressure screening • Cervical Dysplasia screening for sexually active females • Congenital Hypothyroidism screening for newborns • Depression screening for adolescents • Developmental screening for children under age 3 and surveillance throughout childhood • Dyslipidemia screening for children at higher risk of lipid disorders • Fluoride Chemoprevention supplements for children without fluoride in their water source • Gonorrhea preventive medication for the eyes of all newborns • Hearing screening for all newborns up to Members age 17 • Height, Weight and Body Mass Index measurements for children • Hematocrit or Hemoglobin screening for children • Hemoglobinopathies or sickle cell screening for newborns • HIV screening for adolescents at higher risk • Immunization vaccines for children from birth to age 18 – doses, recommended ages and recommended populations vary • Iron supplements for children ages 6 to 12 months at risk for anemia • Lead screening for children at risk of exposure • Medical History for all children throughout development • Obesity screening and counseling • Oral Health risk assessment for young children (newborns to children age 10) • Phenylketonuria (PKU) screening for this genetic disorder in newborns • Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk • Tuberculin testing for children at higher risk of tuberculosis • Vision screening for all children • Educational materials or consultations from Providers to promote a healthy lifestyle
Complementary Therapies	
Acupuncture	Acupuncture is treatment by means of inserting needles into the body to reduce pain or to induce anesthesia. It may also be used for other diagnoses as determined appropriate by the Practitioner/Provider. It is recommended that Acupuncture be part of a coordinated plan of care approved by the Practitioner/Provider.
Chiropractic Services	Chiropractic Services require prior authorization and are available for specific medical Conditions and are not available for maintenance therapy such as routine adjustments.

	Chiropractic Services are subject to the following: • The Practitioner/Provider determines in advance that Chiropractic treatment can be expected to result in Significant Improvement in the Condition within a period of two months. • Chiropractic treatment is specifically limited to treatment by means of manual manipulation; • Subluxation must be documented by Chiropractic examination and documented in the chiropractic record. The Plan does not require Radiologic (X-ray) demonstration of Subluxation for Chiropractic treatment. Biofeedback is only Covered for treatment of Raynaud's disease or phenomenon and urinary or fecal incontinence.
Cranionmandibular (CMJ) and Temproromandibular Joint Disorder (TMJ)	CMJ and TMJ surgical and non-surgical services are Covered Services. These services are subject to the same conditions, limitations, and Prior Authorization requirements as other surgical procedures. Orthodontic appliances and treatments, crowns, bridges, and dentures are subject to the same limitations outlined in Dental Services, unless the disorder is trauma related.
Dental Services (Limited)	Dental Services may include, as set forth in the *Summary of Benefits*: • Diagnostic and Preventive Services to diagnose or to prevent tooth decay and other forms of oral disease. • Restorative Services and Other Basic Services to treat oral disease including: (a) restore decayed or fractured teeth; (b) repair dentures or bridges; (c) rebase or reline dentures; (d) repair or re-cement bridges, crowns and onlays; and (e) remove diseased or damaged natural teeth. • Complex Dental Services to treat oral disease including: replace missing natural teeth with artificial ones; remove diseased or damaged natural teeth; and restore severely decayed or fractured teeth. • Medically Necessary Orthodontics for Dependent children There is no dental coverage for members on catastrophic plans. In addition, subject to the terms of the member's evidence of coverage, the Plan covers Hospital Services and general anesthesia provided in the hospital or ambulatory surgery center setting for dental surgery for (1) Members exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results; (2) Members for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy; (3) Member children or adolescents who are extremely uncooperative, fearful, anxious or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity;(4) Members with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; and (5) other dental surgery procedures for which hospitalization or general anesthesia in a hospital or ambulatory surgical center is Medically Necessary.
Diabetes Services	When used to treat insulin dependent diabetes, non-insulin dependent diabetes, or high blood glucose levels induced by pregnancy, the Plan will cover the following Medically Necessary services and supplies: • Blood glucose monitors, including those for the legally blind, and test strips • Glucagon emergency kits • Insulin • Prescriptive oral agents

	• Injection aids, including those adaptable to meet the needs of the legally blind • Lancet and lancet devices • Podiatric appliances for the prevention of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment • Physician visits and post-diagnosis follow-up care • Self-management training, including medical nutritional therapy related to diabetes management; Medically Necessary visits upon diagnosis of diabetes; visits following a Physician diagnosis that represents a significant change in patient; and visits for re-education • Syringes; and Visual reading Urine and Ketone strips.

<table>
<tr><td>Diagnostic Services</td><td>Laboratory, x-ray and other diagnostic tests are a Covered Service when Medically Necessary and provided under the direction of the Provider.
Some Diagnostic Services require Pre-authorization.</td></tr>
<tr><td colspan="2">Durable Medical Equipment, Orthotic Appliances, Prosthetic Devices, Repair and Replacement of Durable Medical Equipment, Prosthetics and Orthotic Devices and Hearing Aids</td></tr>
<tr><td>Durable Medical Equipment</td><td>DME is a Covered Service when it is Medically Necessary and Pre-authorized by the Plan. Equipment must be necessary for a person’s care or health status. Equipment must be necessary for a person’s care or health status. DME includes:
Durable medical equipment
Orthotic appliances
Prosthetic devices
Repair and replacement of durable medical equipment
Prosthetics and orthotic devices
Hearing aids
Coverage includes the rental or purchase of DME, at CHP’s option. Examples of DME include, but are not limited to:
Crutches
Hospital beds
Oxygen equipment
Wheelchairs
Walkers
In addition to being Medically Necessary and Preauthorized by the Plan, Durable Medical Equipment should meet the following criteria:
Be able to withstand repeated use
Be reusable by other people
Be used to serve a medical purpose; and
The equipment is generally not useful to a person who is not ill or injured.
There are some Exclusions and limitations to DME coverage:
DME coverage is for medically appropriate equipment only, and does not include special features, upgrades or equipment accessories unless Medically Necessary
The Plan will cover the rental or purchase of Medically Necessary DME, including repair and adjustment of DME. The Plan will not cover repairs that exceed the purchase price
Repair or replacement of DME is covered if it is Medically Necessary, as determined by CHP, or due to a change in the Member’s physical or medical Condition. Repair of DME or prosthetic or orthotic devices which were previously owned by the Member and not supplied to them through the Plan may be covered, except as defined under Diabetes Supplies and Treatment. Coverage for repairs shall be at the discretion of CHP
The Plan follows guidelines established by Medicare for the lifetime of DME. Equipment is expected to last at least 5 years
Replacement due to loss, theft, misuse, abuse, or destruction is not covered. The Plan also will not cover replacement in cases where the patient improperly sells or gives away the equipment
The Plan does not cover replacement of DME solely for warranty expiration, or new improved equipment becoming available. The Plan does not cover duplicate or extra DME for the purpose of Member comfort, convenience or travel.</td></tr>
<tr><td>Orthotic Appliances</td><td>Orthotic Appliances are a Covered Services when Medically Necessary. Orthotic Appliances include braces and other external devices used to correct a body function including clubfoot deformity. Orthotic Appliances are subject to the following limitations:</td></tr>
</table>

	• Foot Orthotics or shoe appliances are not covered, except for Members with diabetic neuropathy or other significant neuropathy. • Custom fabricated knee-ankle-foot orthoses (KAFO) and ankle-foot orthoses (AFO) are Covered in accordance with nationally recognized guidelines.
Prosthetic Devices	Internal prosthetics and/or medical appliances are covered when ordered by a Physician and Preauthorized by the Plan. An External Prosthetic Appliance (EPA) is covered with Pre-authorization by the Plan and Medically Necessary for a person's care or health status. External Prosthetic Appliances are artificial substitutes worn on, or attached to the outside of the body; are used to replace a missing part (such as the leg, arm, or hand); or are needed to alleviate or correct an illness, injury, or congenital defect. The Plan covers EPA that is necessary to accomplish ordinary activities of daily living. Braces are considered EPA. (This does not include orthodontic braces.) There are some Exclusions and limitations that apply to coverage for EPA: • The Plan covers EPA for K1-3 ambulators. EPA for Level 0 or Level 4 ambulators are not covered. • This Plan will cover replacement of EPA if it is needed due to normal body growth or for changes due to illness or injury. • The Plan follows Medicare guidelines to determine the lifetime of EPA. • The Plan covers pre-fabricated EPA unless there is clinical documentation supporting that custom EPA is Medically Necessary. • EPA for the purpose of being able to participate in recreational or leisure activities or for the purposed of being able to play a sport are not covered. • Repair or replacement of EPA is covered if Medically Necessary as determined by the Plan. • Repair or replacement of EPA is not covered if due to loss, theft or destruction. • The Plan does not cover duplicate or extra EPA for the Member convenience or comfort.
Implanted Medical Devices	The Plan covers Implanted medical devices when Medically Necessary and ordered by a Participating Provider. These devices include but are not limited to pacemakers, artificial hip joints, cochlear implants and cardiac stents. Coverage consists of permanent or temporary internal aids and supports for defective body parts. The Plan will also cover the cost for repairs or maintenance of covered appliances. Services require Pre-authorization.
Hearing Aids	The Plan covers Hearing aids and certain related services for Dependent children under eighteen (18) years of age (or under age twenty-one (21) if still attending high school). Services include fitting and dispensing fees; and ear molds, as necessary, to maintain optimal fit of the hearing aids. Hearing aid means durable medical equipment that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children. Services must be provided by an audiologist, hearing aid dispenser or Physician/Provider.
Family, Infant and Toddler (FIT) Program	Members from birth through three (3) years of age that are covered under this Plan may qualify for up to $3,500 of annual coverage for services through the FIT Program. Providers must be certified and licensed as defined by New Mexico regulations and must work in early intervention programs approved by the New Mexico Department of Health. The program provides intervention services for children who have or are at risk for early developmental delays and/or disabilities. Children must be enrolled in the FIT Program

	with the New Mexico State Department of Health and must receive services from designated FIT Program Providers as defined in 7.30.8. of the New Mexico Administrative Code. More information can be obtained from the New Mexico State Department of Health.
Genetic Inborn Errors of Metabolism Disorders (IEM)	A genetic inborn error of metabolism is a rare, inherited, disorder that is present at birth and can result in death if untreated. Inherited or genetic errors of metabolism are genetic Conditions that result in metabolism problems. Most people with inherited metabolic disorders have a defective gene that results in an enzyme deficiency. There are many different metabolic disorders, but each disorder is usually rare in the general population. Inherited metabolic disorders are present at birth. • Covered Services for Genetic Inborn Errors of Metabolism include the treatment of genetic inborn errors of metabolism that involve amino acids, carbohydrate and fat metabolism for which medically standard methods of diagnosis, treatment, and monitoring exist. Such treatments include special diets that eliminate or replace certain nutrients, taking enzyme replacements or other supplements to support metabolism, treating the blood to remove toxic products of metabolism, clinical services, biochemical analysis, medical supplies, Prescription drugs, and corrective lenses for Conditions related to the genetic inborn error of metabolism. • An inborn error of metabolism is not just allergy or intolerance to certain foods, such as lactose intolerance or gluten sensitivity. Covered Services under this section must be performed by Providers with specific training in managing patients diagnosed with genetic inborn errors of metabolism diagnosing, monitoring, and controlling disorders by nutritional and medical assessment.
Special Medical Foods For Generic Inborn Errors of Metabolism	The Plan covers Special medical foods to treat inborn errors of metabolism. Special medical foods include nutritional substances that: • Are intended for the medical and nutritional management of a patient with limited capacity to metabolize ordinary food • Are specifically processed or formulated to be distinct in one or more nutrients that is present in natural foods • Are formulated to be consumed or administered internally; and • Are essential for optimal growth, health and metabolic homeostasis • Special medical foods must be obtained from a Plan Participating vendor or Provider, and must be prescribed by a Physician for the treatment of an inborn error of metabolism.
Habilitative Services	Habilitative Services help a person keep, learn or improve the skills and functions required for daily living. Such functions may include eating and bathing. The Plan covers Habilitative Services such as Physical and Occupational Therapy; speech-language pathology; and other services for people with disabilities.
Autism Spectrum Disorder	Coverage for the diagnosis and treatment of Autism Spectrum Disorder is covered for Members nineteen years (19) of age or younger; or for Members twenty-two (22) years of age or younger if they are enrolled in high school. Coverage includes well-baby and well-child screenings for diagnosing the presence of Autism Spectrum Disorder as well as treatment of Autism Spectrum Disorder through Speech, Occupational, and Physical Therapy and applied behavioral analysis. Providers of these services must be certified, registered or licensed to provide these services. Coverage is limited to treatment plan as prescribed by the Member's provider. Some services may need to be Pre-authorized.
Home Health Care Services	Medically Necessary home health services are covered for a Member under certain conditions. The Member must be confined to the home, require Skilled Care and be unable to receive medical care on an Ambulatory outpatient basis. The Member does not need to be confined in a hospital or other Health Care Facility. Home health services must be provided by a licensed and qualified Provider.

	Physical; Occupational; Respiratory; and Speech Therapy provided in the home will be covered by the Plan. These are limited to services provided on the written order of a Provider provided the order is renewed at least every sixty (60) days.
Inpatient Hospital Services	The Plan covers Inpatient Hospital services when Medically Necessary. Services include the treatment and evaluation of Conditions for which outpatient care would not be appropriate. Inpatient Acute Care Hospital Services require Pre-authorization.
Inpatient Long Term Acute Care	The Plan covers Long Term Acute Care (LTAC) hospitalizations when Medically Necessary. LTAC hospitals provide care for Members that require longer-term Inpatient care due to complex Conditions that cannot be treated at a facility with a lower level of care. LTAC may include pulmonary care, advanced wound care, and critical care services. Inpatient LTAC Hospital Services require Pre-authorization.
Inpatient Physician Care Services	The Plan covers Inpatient services provided by Provider or other health professionals. These services must be Medically Necessary. Inpatient provider Care Services include services performed, prescribed, or supervised by Provider or other health professionals.
Inpatient Rehabilitation Services	The Plan covers Inpatient services at an acute Rehabilitation facility. These services must be Medically Necessary. Services must be rendered by a licensed and qualified Provider. Inpatient Rehabilitation Services require Pre-authorization.
Hyperbaric Oxygen Therapy	Hyperbaric Oxygen Therapy is a covered benefit only if the therapy is proposed for a Condition recognized as one of the accepted indications as defined by the Hyperbaric Oxygen Therapy Committee of the Undersea and Hyperbaric Medical Society (UHMS). Hyperbaric Oxygen Therapy is Excluded for any other Condition. Hyperbaric Oxygen Therapy requires Pre-authorization and services must be provided by a Participating Provider in order to be Covered.
Alcohol and Substance Abuse Services	The Plan will cover the diagnosis and treatment of Substance Abuse, which includes alcohol and drug abuse disorders in an Inpatient and outpatient setting. • Inpatient services include hospitalization for alcohol and drug abuse detoxification, Rehabilitation partial hospitalization. Rehabilitation does not include a Residential Treatment Center or other facility using a social model to provide Rehabilitation. Inpatient services require Pre-authorization by Health Integrated. • Outpatient services include assessment, outpatient detoxification, individual, family or couple therapy and counseling, intensive outpatient program (IOP), group therapy, as well as medication management by a qualified Provider.
Behavioral Health Treatment	The Plan will cover the diagnosis and treatment of Behavioral Disorders or Mental Illness disorders in an Inpatient and outpatient setting. Prior Authorization is not required for in network outpatient behavioral health services. Inpatient mental health services may require Prior Authorization. Please contact Member Services at 1-844-282-3025 for more information. • Inpatient services include hospitalization, partial hospitalization, and electroconvulsive therapy (ECT). Inpatient and ECT services require Pre-authorization and must be furnished by a licensed and qualified Provider. Continued stay must meet medical necessity criteria and any applicable state law requirements • Outpatient services include assessment, individual, group, family or couple therapy and counseling, intensive outpatient program (IOP), electroconvulsive therapy (ECT) and medication management.
Nutritional Support and Supplements	This Plan will cover the following Nutritional Supplements that are prescribed by a licensed and qualified Provider: • Nutritional Supplements for prenatal care for a pregnant Member

	• Nutritional Supplements when Medically Necessary to replace a specific documented deficiency • Nutritional Supplements when Medically Necessary and administered by injection at the Provider's office • Enteral formulas or products, as Nutritional support, when administered by enteral tube feedings • Total Parental Nutrition (TPN) through intravenous catheters via central or peripheral veins • Special Medical Foods as listed in the IEM Benefit section Some Nutritional Support and Supplements require Pre-authorization; please refer to the Pre-authorization Section for more information.
Nutritional Evaluation	The Plan covers dietary evaluations and counseling for the medical management of a documented disease. This includes coverage for obesity. These services must be obtained from a licensed and qualified Provider or a registered dietician. Exclusions apply.
Outpatient Medical Services	The Plan covers Outpatient Hospital and/or ambulatory surgical procedures. These services must be Medically Necessary and prescribed by the Primary Care Provider or attending Health Care Professional. Services may be provided at a Hospital; a Physician's office; or any other appropriately licensed facility. • The Provider delivering services must be licensed to practice; and must be practicing under authority of the health care plan, a medical group, an independent practice association or other authority as applicable by New Mexico law. • Outpatient Hospital or Ambulatory Surgical Procedures may include: o Operating, recovery and other treatment rooms; o Physician and surgeon services; o Diagnostic laboratory tests, x-rays and pathology services; o Pre-surgical testing; o Administration of blood, blood plasma and other Biologicals; o Dressings, casts and sterile tray services; o Medical supplies; and o Anesthetics and/or anesthesia services • Some Outpatient Hospital or Ambulatory Services require Pre-authorization; please refer to the Pre-authorization Section for more information.
Practitioner/Provider Services	Practitioner/Provider services are those services that are reasonably required to maintain good health. These services include, but are not limited to, periodic examinations and office visits.
Medical Office Visits	The Plan will cover Primary Care and Specialist services for the diagnosis and treatment of an Illness or injury.
Allergy Treatment	Coverage is provided for allergy consultation, testing, treatment and injections by an allergy Specialist or Immunologist.
Second Opinions	Second Opinions can be obtained from In-Network Participating Providers without need for Pre-authorization. If CHP determines, in consultation with a Participating Provider, that a Second Opinion is not available in network, coverage is limited to one out of network consultation per diagnosis. An out of network Second Opinion requires Pre-authorization by CHP.
Prescription Drugs/Medications	The Plan will provide coverage for drugs, supplies, supplements and administration of a drug (if such services would not otherwise be excluded from coverage) when prescribed by a licensed and qualified Provider and obtained at a Pharmacy or through the Plan's Mail Order program. • Coverage for Prescription Drugs includes generic, brand name or non-preferred drugs. • CHP uses a Formulary, which is a list of Prescription Drugs that are covered by the Plan. The *Formulary* includes drugs for a variety of disease states and

	Conditions. Periodically, the *Formulary* is reviewed and updated to assure that the most current and clinically appropriate drug therapies are being used. Sometimes it is Medically Necessary for a Member to use a drug that is not on the *Formulary*. When this occurs, the prescribing provider may request an exception for coverage. In addition, some of the *Formulary* drugs may require a Pre-authorization, a Step Therapy requirement, or may have quantity limits before coverage. See the Exclusions Section for more information on Prescription Drugs that are not covered. • Some Prescription Drugs may be limited to a Specialty Pharmacy or a specific pharmacy based upon FDA approval. These drugs will be designated in the *Formulary* with such limitations. • If the Member received out-of-area Emergency Care and had a prescription filled, the Plan requires that the Claim be submitted for reimbursement no later than 1 year (365 days) following the date of service. The Claim must contain itemized statement of expenses. • There are certain medications that are not required to be covered by law. These drugs are related to the treatment of cancer, diabetes and smoking cessation.
Reconstructive Surgery	The Plan will cover Medically Necessary services for surgery from which an improvement in physiologic function can reasonably be expected and performed for the correction of functional disorders resulting from accidental injury or from congenital defects or disease.
Rehabilitation Therapy	Rehabilitation Therapy includes Physical; Speech; Occupational; and cardiac and pulmonary Therapy. These therapies are covered by the Plan when it has been determined that they can be expected to result in significant improvement of a Member's physical Condition. These services may be needed as a result of an injury; surgery or an acute medical Condition. Related Occupational Therapy is provided for the purpose of training Members to perform the activities of daily living.
Skilled Nursing Facility Care	Inpatient services at a Skilled Nursing Facility are covered under the Plan. These services must be Medically Necessary, Pre-authorized, and be furnished by a licensed and qualified Provider. Covered Services are limited.
Smoking Cessation Counseling Program	The Plan covers smoking cessation and counseling, as set forth below, and certain smoking cessation Drugs as set forth on the *Formulary*. • Group counseling, including classes or a telephone Quit Line, are covered through a Participating Provider. No Cost Sharing applies and there are no dollar limits or visit maximums.
Transplant Services	The Plan also covers organ procurement needed for human-to-human organ or tissue transplant. The types of transplants covered include, but are not limited to, kidney, kidney/pancreas, cornea, bone marrow, some stem cell, heart, heart/lung, liver and pancreas. Transplant services include medical, surgical and Hospital services for the recipient. • The Plan will cover human organ and tissue transplant services when Pre-authorized; and services are received from Plan-approved facilities within the United States. • Transplant services must be Pre-authorized by the Plan. Pre-authorization is based on an evaluation conducted by a Plan-approved transplant facility and on the relevant evidence-based medical guidelines. • A Member may seek authorization from the health plan for dual transplant listing. The second listing must be within a separate or different Organ Procurement Organization. While dual listing is authorized, payment will be made to only one facility for the actual transplant event.

	• See limitations on stem cell transplants on non-covered benefits
Organ Procurement Costs	• The Plan will cover costs directly related to the procurement of an organ from a cadaver or from a live donor. Surgery needed for organ removal; organ transit and the transportation; hospitalization and surgery of a live donor are also covered by the Plan. Compatibility testing that is done prior to procurement is covered if it is determined to be Medically Necessary.
Transplant Travel	• Travel expenses incurred in connection with a pre-approved transplant are covered up to $10,000 per lifetime. Benefits for transportation, lodging and food are available to Members only if they are the recipient of a pre-approved organ/tissue transplant from a Plan approved Provider. Transplant Travel must be Pre-authorized by the Plan. • The Plan will also cover travel expenses for one companion to accompany the patient as described above. Patients that are minors are allowed travel benefits for themselves, one or both parents, or a parent and a designated companion. A companion may be a spouse; a family member; a legal guardian; or any person not related to the Member but actively involved in the Member's care. The following travel expenses are excluded from coverage: • travel costs incurred due to travel within sixty (60) miles of the Member's home; • laundry bills; • telephone bills; • alcohol or tobacco products; and • charges for transportation that exceed coach rates.
Immunosuppressive Drugs for Organ Transplants	The Plan will cover Inpatient immunosuppressive drugs for organ transplants. Prescription Drugs may be covered. *Refer to the Summary of Benefits and Coverage* for further information.

Vision Care (Limited)	Refer to the *Summary of Benefits and Coverage* for Cost Sharing amounts, limitations, and maximums. Vision services may include:
	• One wellness eye exam per year for children Members, one wellness eye exam every 24 months for adult Members.
	• One pair of glasses per year for children, one every 24 months for adults, with a limit of
	• $100 allowance for frames and lenses or $150 for contact lenses.
	• Vision services for Dependent children that are Essential Health Benefits. These services include:
	  o 1 routine eye exam for children per year.
	  o 1 pair of eye glasses for children every 12 months.
	  o Minor repairs to eyeglasses.
	  o Lens tinting only if certain Conditions are present such as diseases, injuries,
	  o Syndromes, or anomalies which are documented on the exam record and the prescription meets the dioptic correction purchase criteria.
	  o Lenses to prevent double vision.

Please refer to the SPECIAL NOTICE ABOUT REPRODUCTIVE & FAMILY PLANNING SERVICES section*	
	The Plan covers certain services related to women's health care. Some Covered Services

	are: • Prenatal care, including nutritional supplements that are Medically Necessary and prescribed by a provider • Mammograms for screening and diagnosis. These services include but are not limited to low-dose mammography screenings performed at a designated imaging facility; and mammograms for screening and diagnostic purposes, including but not limited to low-dose mammography screenings performed at designated and approved imaging facility. At a minimum, the Plan shall cover one baseline mammogram to persons age thirty-five (35) through thirty-nine (39); one mammogram biennially to persons age forty (40) through forty-nine (49); and one mammogram annually to persons age fifty (50) and over • Breast Cancer Chemoprevention counseling for women at higher risk • Cytologic Screenings (Pap tests) including a screening for papillomavirus to determine the presence of precancerous or cancerous Conditions and other health problems. These tests are available for women age thirteen (13) or older; and for women who are at risk of cancer, or at risk of other health Conditions that can be identified through a Cytological Screening • Human papillomavirus vaccine available to female Members age nine (9) to fourteen (14) years of age • Breast and ovarian cancer genetic testing and genetic counseling based on family history • Screening for gestational diabetes • Counseling and screening for HIV and other sexually transmitted diseases • Screening and counseling for interpersonal and domestic violence and abuse • Forty-eight (48) hours of Inpatient care following a mastectomy; and twenty-four (24) hours of Inpatient care following lymph node dissection for the treatment of breast cancer • Mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts; prostheses; and complications resulting from a mastectomy, including lymphedema; Direct access to qualified obstetric and gynecological care for female Members age thirteen (13) or older
Maternity Care	Maternity Care is a covered benefit. Some Covered Services may require Pre-authorization by the Plan before services are provided.
Prenatal Maternity Care	Coverage for Prenatal Care includes: • a minimum of one prenatal office visit per month during the first two trimesters of pregnancy • a minimum of two office visits per month during the seventh and eighth months • a minimum of one office visit per week during the ninth month and until term by a Participating Provider. Each office visit shall also include; prenatal counseling and education, necessary and appropriate screening, including history, physical examination and the laboratory and diagnostic procedures deemed appropriate by the Participating Provider/Practitioner. This is based upon recognized medical criteria for the Member's risk group.
Obstetrical Care	Maternity Care includes coverage for Obstetrical care, including Participating Physician's, Participating Licensed Certified Nurse Midwife's, and Participating delivery room and other Medically Necessary services directly associated with delivery.
Services Provided by a Licensed Certified Nurse	The services of a Licensed Certified Nurse Midwife are covered, subject to the following Limitations: • The Licensed Certified Nurse Midwife is a Participating Provider.

	• The Licensed Certified Nurse Midwife's services must be provided under the supervision of a Participating licensed Obstetrician or a licensed Family Practice Provider. • The services must be provided in preparation for, or in connection with, the delivery of a newborn infant at a site that is covered under this Maternity benefit. • The only allowable sites of delivery are a Participating hospital or a licensed birthing center. The combined fees of the Licensed Certified Nurse Midwife and any attending or supervising Physician(s), for all services provided before, during and after the birth, may not exceed the allowable fee(s) that would have been payable to the Physician had he/she been the sole Provider.
Delivery Services	• Medical, surgical and hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy are covered. Coverage for a mother shall be available for a minimum of forty-eight (48) hours of Inpatient care following a vaginal delivery and a minimum of ninety-six (96) hours of Inpatient care following a Cesarean section. Any decision to shorten the period of Inpatient care for the mother or the newborn must be made by the attending Physician or Provider in consultation with the mother. • Transportation, including air transport to the nearest available contracted appropriately licensed Health Care Facility, is available for medically high-risk pregnant women with an impending delivery of a potentially viable infant. When necessary to protect the life of the infant, transportation, including air transport, to the nearest available tertiary care Health Care Facility, is covered.
Postpartum Care	• Maternity Care includes postpartum visits. Postpartum care in the home is covered in accordance with accepted maternal and neonatal Physician assessments, by a person with appropriate licensure, training and experience to provide postpartum care. Services provided by such person shall include, but not be limited to, parent education, assistance and training in breast and bottle feeding, and the performance of any necessary and appropriate clinical tests. • Coverage for postpartum care in the home includes a minimum of three home visits, unless one or two home visits are determined to be sufficient by the attending Physician or person with appropriate licensure, training and experience to provide postpartum care, and the mother. The home visits shall be conducted within the time period ordered by the attending Physician or person with appropriate licensure, training and experience to provide postpartum care.
Breast feeding support, supplies and counseling	The following benefits and services are covered at no cost to the Member when received from a Participating Provider: • Member must have a prescription for a manual breast pump, supplies, and counseling to prove that the Member gave birth • Member will be provided with one (1) manual breast pump. One (1) replacement manual breast pump is allowed the following year and every year thereafter. A replacement set of associated supplies is allowed per Member per year. Supplies include such items as breast pump, tubing and pads

	• If it is deemed Medically Necessary for the Member to use an electric breast pump, the Member's Durable Medical Equipment benefit would apply and may include a cost share • Breastfeeding counseling services are limited to a duration of one year
Alpha-fetoprotein IV Screening	The alpha-fetoprotein IV screening test for pregnant women. The test screens for certain genetic abnormalities in the fetus. This test generally occurs between the sixteenth (16th) and twentieth (20th) week of pregnancy.
Newborn and Adopted Children Coverage	The Plan will cover Injury or Illness of a newborn child. The child can be natural or adopted or in a "placement for adoption" status. This includes circumcision for newborn males, and the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Ground or air transportation to the nearest available Tertiary Care Facility is covered when necessary to protect the life of the infant.
Nutritional Supplements	This Maternity Benefit includes coverage for Medically Necessary nutritional supplements listed on the *Formulary* (as directed by the attending Participating Provider/Practitioner).
Transition of Care	For a Member who is in the third trimester of pregnancy when her Participating Provider/Practitioner leaves the Plan's network, the transitional period will include postpartum care directly related to the delivery. Determinations for Continuity of Care are made based on established criteria. The Continuity of Care Period will be for a period of no less than thirty (30) days.
Additional Women's Health Care Benefits	
Mastectomy Care	The Plan shall offer forty-eight (48) hours of Inpatient care for a mastectomy; and twenty-four (24) hours of Inpatient care following lymph node dissection for the treatment of breast cancer. The Plan will also cover mastectomy-related services; including all stages of breast reconstruction and surgery to achieve symmetry between the breasts; prostheses; and any complications resulting from a mastectomy, including lymphedema. Requests for reconstructions after initial reconstruction post-mastectomy require Pre-authorization, and clinical information must be reviewed by a Medical Director for Medical Necessity. Requests that are not an initial reconstruction that are cosmetic in nature are not a Covered Benefit.
Osteoporosis Coverage	Services related to the diagnosis, treatment, and appropriate management of osteoporosis when Medically Necessary.
SPECIAL NOTICE ABOUT REPRODUCTIVE AND FAMILY PLANNING SERVICES	

	CHRISTUS Health Plan is an affiliate of a Catholic health care system, which is subject to the Ethical and Religious Directives for Catholic Health Care Services. Based on religious beliefs, the Plan limits performance of certain services. Certain services are designated under federal law as covered Essential Health Benefits for women with reproductive capacity. The administration of these services is performed by HealthSmart. These covered services include: • FDA-approved contraceptive methods (not including abortifacient drugs) FDA-approved sterilization procedures • Patient education and counseling Direct abortion is not a covered benefit. The termination of a pregnancy is a covered benefit only in the following circumstances: 1) as a result of treating a proportionately serious pathological condition of a pregnant woman, and 2) when the intervention cannot be safely postponed until the fetus is viable.

NEW MEXICO NON-COVERED BENEFITS (Exclusions)

The Member's Policy only covers certain Medically Necessary healthcare benefits. This EXCLUSIONS Section lists services that are specifically excluded from coverage under the Policy. All other benefits and services not specifically listed in the COVERED BENEFITS section of the Policy are also Excluded Services. **The following are specifically EXCLUDED from coverage:**

- **Abortion**
  - **Direct abortions are not a covered benefit. See Covered Benefits for more exceptions.**
- **Accident and Emergency Care Services**
  - **Use of an emergency facility for non-emergent services (including without limitation, Urgent Care or observation).**
- **Autopsies and Ambulance Services**
  - **Autopsy costs for deceased Members.**
  - **Ambulance services to the coroner's office or to a mortuary, unless the Ambulance has been dispatched prior to the pronouncement of death by an individual authorized under state law to make such pronouncements.**
- **Before or After Coverage Period**
  - **Services received, items purchased, prescriptions filled or expenses incurred before the date of coverage or after the effective date of termination of Coverage under the Policy.**
- **Cancer Clinical Trials**
  - **Any Cancer Clinical Trials provided outside of New Mexico, as well as those that do not meet the requirements of the COVERED BENEFITS section of the Policy.**
  - **Costs of Cancer Clinical Trials that are customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources.**
  - **Services from non-Participating Providers, unless services are not available from a Participating Provider. Pre-authorization is required for any Out-of-Network Services, which must be provided in New Mexico.**
  - **Costs of a non-FDA approved Investigational drug, device or procedure.**
  - **Costs associated with managing the research associate with the Cancer Clinical Trial.**
  - **Costs of tests necessary for the research of the Cancer Clinical Trial.**
  - **Costs paid for or not charged by the Cancer Clinical Trial Providers.**
- **Certified Hospital Care Benefits**
  - **Food, housing and delivered meals.**
  - **Volunteer services.**
  - **Personal or comfort items.**
  - **Homemaker or housekeeping services.**
  - **Private duty nursing.**
  - **Bereavement counseling.**
- **Clothing or Protective Devices**
  - **Clothing or other protective devices, including photo protective clothing, windshield tinting, lighting fixtures or other items or devices whether prescribed or not.**
- **Complementary Therapies**
  - **Acupuncture, except as specified in COVERED BENEFITS.**
- **Cosmetic Surgery**
  - **Cosmetic therapy, drugs or medications, or procedures for the purpose of changing appearance.**
  - **Any surgical or non-surgical procedures that are primarily for the purpose of altering appearance and not performed for the purpose of correcting functional disorders resulting from injury, congenital**

defects or disease.
  - **Reconstructive surgery following a mastectomy will be covered.**
- **Circumcisions**
  - **Performed other than for newborn stays, unless Medically Necessary.**
- **Dental Services**
  - **Dental care and dental x-rays, except as specified in COVERED BENEFITS.**
  - **There is no dental coverage for members on catastrophic plans.**
- **Durable Medical Equipment**
  - **Upgraded or deluxe Durable Medical Equipment**
  - **Convenience items, including items for comfort and ease and not primarily medical in nature, such as shower seats, bath grab bars, shades for wheelchairs, pillows, fans, special beds and chairs, and other items.**
  - **Duplicate Durable Medical Equipment items.**
  - **Repair or replacement of Durable Medical Equipment due to loss, neglect, misused, abuse to, or to improve appearance or convenience.**
  - **Repair or replacement of items under the manufacturer or supplier's warranty.**
  - **Additional wheelchairs, if the Member has a functional wheelchair.**
- **Excessive Charges**
  - **Charges or costs in excess of Usual, Customary and Reasonable Charges.**
- **Exercise Equipment and Services**
  - **Exercise equipment, videos, personal trainers, club memberships and weight reduction programs.**
- **Experimental, Investigational or Unproven Drugs, Medicines, Treatments, Procedures, Devices or Services**
- **Extracorporeal shock wave therapy**
- **Foot Care**
  - **Routine foot care, such as treatment of flat feet or other structural misalignments of the removal of corns, and calluses, unless Medically Necessary due to diabetes or other significant peripheral neuropathies.**
- **Genetic Inborn Errors of Metabolism**
  - **Food substitutes for lactose intolerance or other carbohydrate intolerances**
  - **Food substitutes that do not qualify as Special Medical Foods for the treatment of IEM.**
  - **Special Medical Foods for Conditions that are not present at birth.**
  - **Dietary supplements and items for Conditions including diabetes, hypertension, hyperlipidemia, obesity, autism spectrum disorder, celiac disease, and food allergies.**
- **Hair Loss**
  - **Hair loss or baldness treatments, medications, supplies and devices, regardless of medical cause of hair loss or baldness.**
- **Home Health Care Services**
  - **Private duty nursing.**
  - **Custodial Care needs that can be performed by non-licensed medical personnel to meet normal activities of daily living.**
  - **Respite care.**
- **Hospital Services**
  - **Acute medical detoxification in a residential treatment center.**
  - **Rehabilitation as part of acute medical detoxification.**
- **Infertility Services**

- **Prescription Drugs and injections.**
- **Reversal of voluntary sterilization.**
- **Donor sperm.**
- **In-vitro, Gamete Intra Fallopian Transfer (GIFT) and zygote intrafallopian transfer (ZIFT) fertilization.**
- **Storage or banking of sperm, ova (human eggs), embryos, zygotes, or other human tissue.**

- **Male Health Care**
  - **Contraceptive Coverage**
  - **Family planning services**
  - **Sterilization procedures**
- **Mental Health and Alcoholism and Substance Abuse**
  - **Codependency treatment.**
  - **Bereavement and sexual counseling.**
  - **Psychological testing when not Medically Necessary.**
  - **Special education, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary or behavioral problems.**
  - **Court ordered evaluation or treatment, or a treatment that is a condition of parole or probation in lieu of sentencing.**
  - **Alcohol or Substance Abuse Services**
  - **Treatment in a halfway house.**
  - **Residential Treatment Centers, unless for the treatment of Alcoholism or Substance Abuse.**
  - **Codependency treatment.**
  - **Bereavement and sexual counseling.**
  - **Court-ordered treatment, or treatment that is a condition of parole or probation in lieu of sentence.**
  - **Any treatment for Alcoholism or Substance Abuse services after the maximum episodes of treatment allowed under this Policy.**

- **Military Service Disabilities**
  - **Care for military service connected disabilities to which Members are legally entitled to and for which facilities are reasonable available.**
- **Nutritional Supports and Supplements**
  - **Baby food (including formula or breast milk) or other regular grocery products that can be used with the enteral system for oral or tube feedings.**
- **Out-of-Network Services Not Authorized**
  - **Services received out of network that require Pre-authorization, if Pre-authorization was not obtained.**
- **Orthotic Appliances**
  - **Functional foot Orthotics, including those for plantar fascitis, pes planus (flat feet), heel spurs and other Conditions, Orthopedic or corrective shoes, arch supports, shoe appliances, foot Orthotics, and custom fitted braces or splints, except for Members with diabetes or other significant peripheral neuropathies.**
  - **Custom-fitted Orthotics, except for knee-foot-ankle Orthosis (KAFO) and/or ankle-foot Orthosis (AFO) for Members who meet nationally recognized guidelines.**
- **Prescription Drugs/Medicines**
  - **Compounded Prescription Drugs/Medicines.**
  - **New Medications for which the determination of criteria for Coverage have not yet been established by the Plan.**
  - **Over the counter (OTC) medications and drugs, except as listed on the *Formulary*.**
  - **Prescription Drugs/Medicines that require a Pre-authorization if no Pre-authorization was obtained.**
  - **Prescription Drugs/Medicines purchased outside the United States.**
  - **Replacement Prescription Drugs/Medicines resulting from loss, theft or destruction.**
  - **Prescription Drugs/Medicine, medicines, treatments, or devices that the Plan determines are Experimental, Investigational or Unproven.**
  - **Disposable medical supplies, except when provided in a hospital or a Participating Provider's office.**
  - **Treatments and medications for the purpose of weight reduction or control, except as specified in COVERED BENEFITS.**
  - **Nutritional supplements as prescribed by the attending Provider or as sole source of nutrition.**
  - **Infant formula, under any circumstance.**
  - **Prescription Drugs/Medicines for the treatment of sexual dysfunction or Infertility.**
  - **Prescription Drugs/Medicines for cosmetic purposes.**
- **Provider Services**
  - **Services provided by an Excluded Provider.**
  - **Telephone visits, except as set forth in COVERED BENEFITS.**
  - **Electronic mail by a Provider or consultation by telephone for which a charge is made to the patient.**
  - **Get acquainted visits without physical assessment or diagnostic or therapeutic intervention.**
- **Prosthetic Devices**
  - **Artificial aids including speech synthesis devices, except as specified in COVERED BENEFITS.**
- **Reconstructive Surgery for Cosmetic Purposes**
  - **Cosmetic Surgery (examples include breast augmentation, dermabrasion, dermaplaning, excision of acne scarring, acne surgery, asymptomatic scar revision, microphlebectomy, sclerotherapy (except for truncal veins), and nasal rhinoplasty.**
- **Rehabilitation and Therapy**
  - **Athletic trainers or treatments by athletic trainers.**
  - **Vocational rehabilitation services.**
  - **Long-term therapy or rehabilitation services, including treatment for chronic or incurable Conditions for which rehabilitation produces minimal or temporary change or relief. If Members reached**

maximum rehabilitation potential, a point where a significant improvement is unlikely to occur, or therapy for 4 consecutive months, additional therapy is considered long-term therapy or rehabilitation.
  - **Treatment of chronic Conditions (i.e.muscular dystrophy, down syndrome, cerebral palsy).**
- **Services Covered Under Another Program**
  - **Services eligible under any governmental program (except Medicaid), to the extent determined by law.**
  - **Services for which, in the absence of any health service plan, no charge would be made to the Member or their Dependent.**
- **Services Provided Outside the United States**
  - **Any services or materials for non-Emergency Care or non-Urgent Care received outside the United States.**
- **Sex Dysfunction**
  - **Treatment for sexual dysfunction, including medication, counseling and clinics.**
- **Sex Transformation**
  - **Surgery and drugs related to sex transformation.**
- **Skilled Nursing Facility Care**
  - **Custodial or domiciliary care.**
- **Speech Therapy**
  - **Therapy for stuttering.**
  - **Hearing aids and evaluation for fitting, except for Dependents under 18 years old.**
  - **Additional benefits beyond those listed in COVERED BENEFITS.**
- **Smoking Cessation**
  - **Hypnotherapy for smoking cessation counseling.**
  - **Over the counter drugs, unless listed on the *Formulary*.**
  - **Acupuncture for smoking cessation purposes.**

- **Transplant Services**
  - **Non-human organ transplants, except for porcine (pig) heart valve.**
  - **Transportation costs for deceased Members.**
  - **Embryonic or fetal stem cell transplants**
  - **Medical and hospital Services of an organ transplant donor when the transplant recipient is not a Member or the transplant procedure is not a Covered Benefit.**
  - **Travel and lodging, except as specified in COVERED BENEFITS.**
- **Treatment While Incarcerated**
  - **Services or supplies a Member receives while in custody of any state or federal law enforcement authorities, including while in jail or prison.**
- **Vision Care**
  - **Routine vision care and eye refractions, except as specified in COVERED BENEFITS.**
  - **Corrective eyeglasses or sunglasses, frames, lenses, contact lenses, or fittings, except as specified in COVERED BENEFITS.**
  - **Eye refractive procedures, including radial keratotomy, laser procedures and other techniques.**
  - **Eye movement therapy.**
- **Women's Health Care**
  - **Abortifacient drugs.**
  - **Family planning services, excepted as specified in SPECIAL NOTICE ABOUT REPRODUCTIVE & FAMILY PLANNING SERVICES Section of the Policy.**
- **Work-Related Illnesses or Injuries, under any circumstances.**

QUALITY MANAGEMENT PROGRAM

CHRISTUS Health Plan has a comprehensive Quality Management Program. The goal of the Quality Management Program is to ensure that every member receives quality care in a timely and accessible fashion and to provide a mechanism for evaluating the appropriateness of member care. The purpose of the Quality Management Program serves to assure timely identification, assessment and resolution of known or suspected problems/trends by continuous monitoring and evaluation of care and services provided. The Quality Management Program includes, but is not limited to, the following topics:

- Access and availability of provider/services
- Accreditation and compliance
- Appeals
- Complaints and grievances
- Credentialing
- Disease management
- Improvement of member and provider satisfaction
- Medical record review at physician offices (types of medical record reviews include continuity of care and other focused reviews)
- Patient safety
- Pharmacy services effectiveness
- Preventative health services
- Timely credentialing of providers and adequacy of the provider network
- Timely resolution of complaints and appeals
- Utilization management

All participating providers are required to comply with CHRISTUS Health Plan's policies and procedures including complying with, participating in, and implementing quality management projects including patient safety programs. This includes but is not limited to implementing activities necessary and required to comply with external accreditation by the NCQA, URAC or other similar accrediting bodies selected by the Health Plan. In addition, all participating providers are required to comply with the terms of this Provider Manual as well as Medical Management and Quality Management Programs.

QUALITY REFERRALS

Any stakeholder may refer a matter for review as a potential quality of care issue (PQI). The Director of Quality Management, Quality RN or designee may refer cases to the Medical Director for review and recommendations. The Medical Director's review may determine that:

- No quality issue exists
- Potential quality concerns exist
- Actual quality concerns exist

The Medical Director will recommend any action as appropriate to the event, in keeping with CHRISTUS Health Plan Policies and Procedures, contractual requirements of the Plan and other relevant federal, state or local regulatory requirements.

HEDIS

CMS requires Medicare Advantage (MA) Managed Care Health Plans to report Health Care Effectiveness Data Information Set (HEDIS)® measures annually. HEDIS is a set of standardized Quality Indicators that compare the performance of managed care plans in areas such as preventive screenings and chronic health care which was developed by the National Committee for Quality Assurance (NCQA)®.

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate CPT, ICD-10 effective October 1, 2015) and HCPCS codes can reduce the necessity of medical record reviews

Medical Record Reviews (MRR) for HEDIS
CHRISTUS Health Plan may contract with an independent national Medical Record Review (MRR) vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, if any of your patient's medical records are selected for review, you will receive a call from a medical record review representative. Your prompt cooperation with the representative is greatly needed and appreciated. As a reminder, sharing of Protected Health Information (PHI) that is used or disclosed for purposes of treatment, payment or health care operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the Member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Superior which allows them to collect PHI on our behalf.

How can Providers improve their HEDIS scores?

- Understand the specifications established for each HEDIS measure.
- Submit claims and encounter data for each and every service rendered. All Providers must bill (or submit encounter data) for services delivered, regardless of their contract status with Superior. Claims and encounter data is the most clean and efficient way to report HEDIS.
- Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS rate calculation.
- Keep accurate chart/medical record documentation of each Member service and document conversation/services.
- Submit claims and encounter data using CPT codes related to HEDIS measures such as diabetes, eye exam, and blood pressure.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the QI Department at qualitydepartment@christushealthplan.org

In addition, CMS mandates that certain Member Satisfaction Surveys are performed annually. These surveys include the following questions:

Consumer Assessment of Health Plan Providers and Services (CAHPS)

The CAHPS survey is a Member care experience survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to Members by an NCQA certified survey vendor. The survey provides information on the experiences of Members with health plan and practitioner services and gives a general indication of how well the plan is meeting the Members' expectations. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability

The survey capture answers to questions like (but not limited to)

1. Did you get an appointment with your doctor as quickly as you thought you needed to?
2. Wait time to see provider in relation to actual appointment time?
3. Did the provider give you easy-to-understand information about your health concerns?
4. Did the provider seem to know important information about your medical history?
5. Did someone from the office follow up to give you test results?
6. Were clerks and receptionists helpful?
7. How long did it take for the doctor's office staff to return your call?
8. How often did this doctor seem informed about your care with specialists?
9. Did the office give you information about what to do if you needed care during the evenings, weekends, or holidays?
10. In the last 12 months, how often were you able to obtain care you needed during evenings, weekends, or holidays?

PROCEDURE FOR UNUSUAL PROVIDER PRACTICE PATTERNS

Whenever a concern regarding a potential quality of care and/or services arises, all available records and related correspondence are screened by the Quality Management Department. The concerns are then forwarded to the Medical Director for review and determination of any PQI's.

Individual concerns that do not represent a pattern of behavior or do not seriously jeopardize patient care/welfare may be individually addressed by the Medical Director and summarized to the Peer Review Committee (PRC) at its next regularly scheduled meeting. The PRC may accept the Medical Director's assessment and follow up actions, or it may recommend another course of action based upon the information presented. All PQI's are assigned a severity level of 1-4, with 4 being the most severe. The PRC will determine the final severity level of the PQI. When individual concerns represent a pattern of behavior, the Medical Director ensures that the matter is addressed through the Quality Improvement Committee (QIC).

Note: When a situation occurs that is deemed to pose an immediate threat to the health and safety of a member, the Medical Director may, on behalf of the PRC, QIC and Credentialing Committee act to immediately revoke, limit or suspend the privileges of a participating provider. The affected provider will be immediately notified as will other affected parties (i.e., Provider Relations, Utilization Management, Quality Management and Plan Administration). In such an event, the PRC will be assembled at the earliest possible time to discuss the situation and support or override the Medical Director's decision.

The sanctioning process will follow the Healthcare Quality Improvement Act of 1986. The CHRISTUS Health Plan has a policy and process for conducting the required due process. The provider may request a copy of the policy at any time by contacting the Medical Director or the Quality Management Department.

PREVENTATIVE HEALTH GUIDELINES

PREVENTIVE HEALTH GUIDELINES

Evidence-based treatment protocols have been shown to improve patient outcomes through clinical research. Treatment protocol values are evidence-based recommendations for care. CHRISTUS Health Plan recommends the adults and children preventive health guidelines established by U.S. Preventive Services Task Force (USPSTF) of the Agency for Healthcare Research and Quality (AHRQ). These preventive health guidelines include recommendations for screenings, testing, immunizations and counseling. Full references are available at the following website:

http://www.ahrq.gov/clinic/pocketgd1011/gcp10s1.htm

CLINICAL PRACTICE GUIDELINES

Clinical Practice Guidelines are evidence-based guidelines used to help providers make decisions about specific clinical situations. CHRISTUS Health Plan consults with participating provider practicing in the community to adopt nationally recognized guidelines and standards.

Refer to the National Guideline clearing house website at http://www.guideline.gov for the following specific guidelines:

- 2013 ACCF/AHA guideline for management of heart failure
- 2014 evidence-based guideline for the management of high blood pressure in adults. Report from the panel members appointed to the Eighth Joint National Committee (JNC8)
- 2012 ACCF/AHA/ACP/AATS/PCNA/SCAI/STS guideline for the diagnosis and management of patients with stable ischemic heart disease
- Diagnosis and management of stable chronic obstructive pulmonary disease :a clinical practice guideline update from the American college of Physicians, American College of Chest Physicians, American Thoracic Society, and European Respiratory Society
- American Association of Clinical Endocrinologists medical guidelines for clinical practice for developing a diabetes mellitus comprehensive care plan
- American Association of Clinical Endocrinologists medical guidelines for clinical practice for the diagnosis and treatment of postmenopausal osteoporosis
- Practice guideline for treatment of patients with major depressive disorder, third edition

Providers unable to access these guidelines via the internet may contact their local Provider Relations Representative for a paper copy.

REFERRAL/AUTHORIZATION GUIDELINES

CHRISTUS Health Plan Medical Management program is designed to assure that members receive appropriate care at the right time, in the right setting.

The Medical Management function is performed in accordance with State guidelines, Federal regulations and NCQA standards. Provider and CHRISTUS Health Plan staff have no incentives, including compensation, that are based upon the quantity of adverse determinations. Nurses and Medical Directors collaborate with Primary Care Providers, specialists and other providers to assure members get the care they need in a proactive manner.

ROLE OF PRIMARY CARE PROVIDER

The Primary Care Provider (PCP) plays a critically important role in the medical care delivery model. The PCP works collaboratively with the member and all other providers to ensure that appropriate care is delivered at the right time in the right setting. Within this provider centric model, the PCP:

- Assesses the health care needs of each member
- Delivers primary care services
- Provides patient education, health screening and prevention services
- Guides the member through the healthcare system by arranging for specialty and ancillary care as needed.

For inpatient hospital and skilled nursing facility (SNF) admissions, the PCP (or assigned hospitalist) is responsible for:

- Obtaining the member's history and physical
- Formulating the patients hospital plan of care and coordinating subspecialty consultation
- Overseeing the discharge plan and arrangements for follow-up care
- Communicating with case management, consulting provider, the patient and the patient's family
- Facilitating approval of all services for discharge and follow-up care.

ROLE OF SPECIALIST AS PRIMARY CARE PROVIDER

A specialty physician may assume the responsibilities of a primary care provider as a primary care provider under specific circumstances, such as in the case of a Member with a disability or chronic/complex condition. The Member's signature is required for a specialist to serve as the Member's PCP. By allowing a specialist to act as a primary care provider, Members are able to draw upon the most appropriate care to meet their needs. In this capacity, the specialist is required to fulfill all of the responsibilities of a primary care provider and the specialist must agree to coordinate all of the member's care. Specialists who would like to be the Primary Care Provider should contact the Medical Management Department at 1-844-282-3025 for further information and to complete the request form.

A determination will be made within 30 calendar days from the date the request is received. Member and provider requests for a specialist to be a primary care provider will be reviewed by a Medical Director and approved if the specialist meets criteria for participation as a primary care provider, and there is a medical need for the specialist to act as the Member's PCP. The effective date of the designation of the specialist as the primary care provider may not be applied retroactively.

If this request is denied, a Member may appeal the decision through the HMO's established complaint and appeal process. Please refer to the member complaint and appeal section for more information. If the request for special consideration of a non-primary care physician specialist to act as a primary care physician is approved, the HMO may not reduce the amount of compensation owed to the original primary care physician for services provider before the date of new designation.

ROLE OF SPECIALISTS, HOSPITALS AND ANCILLARY PROVIDERS

Members are encouraged to utilize their Primary Care Provider as their guide through the healthcare system. Other providers are likewise encouraged to work closely with the Primary Care Provider to coordinate the care of the member. It is expected that all other providers will report back to the Primary Care Provider about diagnosis, findings, treatment plans and treatments in a timely manner.

With the exception of medical emergencies, all providers are required to call before performing services listed on the Prior Authorization List. In addition, providers are required to work closely with Medical Management staff to coordinate the member's health care within the CHRISTUS Health Plan delivery system.

ROLE OF THE MEDICAL MANAGEMENT STAFF

Utilization Management Nurses and Case Managers collaborate with provider to:

- Utilize the CHRISTUS Health Plan network of contracted providers where appropriate
- Provide prior authorization for those procedures on the Prior Authorization List
- Conduct concurrent review of inpatient stays
- Participate in discharge planning using approved clinical guidelines to prevent readmissions
- Facilitate transfer of hospitalized patients to alternate levels of care
- Coordinate with other providers including SNF, Home Health, Durable Medical Equipment (DME), and Hospice
- Arrange for social intervention to improve care management.

ROLE OF MEDICAL DIRECTORS

Medical Directors are board certified/full time employed physicians who oversee the day-to-day health plan clinical operations. Their functions include:

- Provide clinical guidance for the Medical Management staff
- Interface directly with practicing physicians to resolve clinical issues
- Make decisions related to the authorization of medically necessary services
- Medical Directors are available for Peer to Peer discussion as needed regarding adverse determinations. Please call 1-844-282-3077 for a Peer to Peer discussion.

Providers may speak directly to a Medical Director at any time they have a question regarding an authorization or clinical issue. Providers are encouraged to contact a Medical Director to provide additional information and to directly discuss any clinical issues during the authorization/review process.

PEER TO PEER AVAILABILITY

Medical Directors conducting medical necessity reviews are available to discuss review determinations with the requesting/ordering provider or attending provider via Peer-to-Peer conversation. The peer-to-peer conversation allows the treating provider the opportunity to discuss the Utilization Management determination before the initiation of the appeals process. A Peer-to-Peer conversation is available by calling the Utilization Management department toll free number: 1-844-282-3025. Peer-to peer conversations are completed within one business day of request by a treating provider. If the Peer-to-Peer discussion does not result in authorization of the request, the process includes informing the provider and member of their appeal rights during the notification.

Providers will be notified of the availability of peer-to-peer using the following mechanisms:

- Verbal notification to treating provider
- Fax notification to treating provider
- Denial letter language

AVAILABILITY OF MEDICAL MANAGEMENT STAFF

Medical Management (MM) staff is available on normal business days Monday through Friday from 8:00am to 5:00pm. Providers can reach the Medical Management department by calling: 1-844-282-3025 or Faxing: 1- 800-277-4926. After normal business hours and on holidays, an answering service is available to provide direction.

MEMBER SELF-REFERRALS

Members have direct access to the following services provided by an in-network provider without going through their PCP:

- Annual well woman exam
- Annual mammogram
- Behavioral health outpatient services
- Disease management programs
- Hearing exam
- Optometry - annual eye exam and glasses
- Out-of-area dialysis

PCP REFERRALS TO NETWORK SPECIALISTS

The PCP does not need prior/referral authorization to refer the member to an in-network specialist. Participating providers are listed in the provider directory, CHRISTUS Health Plan website or providers may call member services to verify in-network participation.

Specialists may not refer to other specialists. If a specialist determines that a member needs to be seen by another specialist, the member's PCP is to be contacted for initiation of referral and coordination of care.

PRIOR-AUTHORIZATION GUIDELINES

The PCP must complete the CHRISTUS Health Plan Referral/Authorization Form in its entirety and either:

- Contact the Utilization Management Department at 1-844-282-3025 or an urgent or emergent request
- Fax a routine request to 1- 800-277-4926

The following information will be requested from the provider:

- Provider name, address, and telephone number
- Patient name, ID number, and date of birth
- Diagnosis/ICD-9
- Procedure(s), if applicable
- Procedure code (CPT)
- Name of facility
- Date of admission/procedure
- Indications for admission/procedure
- Requested length of stay
- Pertinent clinical information

Completed referrals containing all necessary information and supporting documentation will be processed by the Utilization Management Department.

UTILIZATION MANAGEMENT COMPONENTS

Preadmission Review: The process of authorizing non-emergency medical and surgical hospitalizations.

Admission Notification: The provider and/or hospital notifies Utilization Management when a CHRISTUS Health Plan member is admitted to the hospital.

Continued Stay Review: Concurrent Review is a process that assures the length of stay in the hospital is appropriate for the member's medical condition, whether admitted for non-emergency or emergency treatment.

Discharge Planning: CHRISTUS Health Plan's Care Manager is responsible for coordinating a member's care and will work with the patient and the provider to assist in arranging for the member's discharge needs. The Plan's Care Manager will assist in discharge planning by arranging for any home care services, skilled nursing care, or medical equipment that is required after leaving the hospital. This process helps assure that every member is provided with appropriate care, both in the hospital and post discharge.

Retrospective Review: The process of review that occurs before payment of any claims for which Precertification/Authorization did not occur. The review will consist of assessing the medical necessity of all services not previously approved. Clinical information will be reviewed for appropriateness using InterQual® Criteria, Plan Protocols, and policy coverage, as appropriate.

Ambulatory/Outpatient Review: The process of authorizing non-emergency selected diagnostic and surgical outpatient procedures.

Skilled Nursing, Long Term Acute Care and Rehabilitation Facility Authorization: Skilled Nursing Facilities (SNF), Long Term Acute Care facilities (LTAC) and Rehabilitation Facilities are specially qualified facilities or designated units in a hospital which have the staff and equipment to provide acute care, skilled nursing care or rehabilitation services and other related health services. CHRISTUS Health Plan coverage includes, as a benefit, inpatient care in a participating SNF, LTAC or Rehabilitation Facility. Prior authorization is required. Custodial care is a non-covered benefit.

Home Health Care: A home health agency is a public or private agency that specializes in providing skilled nursing services and other therapeutic services, such as physical therapy in the home. The home health Care program provides skilled professional services to members upon receiving prior orders by the attending physician and authorization by the Utilization Management department. Requests for continuation of services will be reviewed on an ongoing basis to determine medical necessity**.** Custodial care is a non-covered benefit.

Durable Medical Equipment: Durable medical equipment (DME) is used primarily and customarily for a medical purpose, rather than primarily for transportation, comfort or convenience. It can withstand repeated use and improves the function of a malformed, diseased or injured body part or retards further deterioration of the patient's physical condition. Specific DME items require prior authorization (see Services Requiring Prior Authorization). DME must be obtained through CHRISTUS Health Plan contracted providers.

UTILIZATION MANAGEMENT NOTIFICATION REQUIREMENTS

There are specific notification requirements that apply to the services evaluated in each of the review components, in order to ensure payment. The provider must call the Plan regarding proposed treatment and service.

Treatment/Service	Notification Requirement
Urgent admissions/ observations	With 1 business day of admission to the facility
Elective admissions/ observations/surgical procedures/ outpatient procedures	5 business days prior to the requested date of service
SNF/ Rehab/ Hospice	Initiation – 2 business days prior to requested date of admission Continuation – 3 days prior to requested date of service
Home health	Initiation – 2 business days prior to requested date of admission Continuation – 7 days prior to requested date of service
Diagnostic services/DME/ other procedures requiring authorization	7 business days prior to requested date of services

AUTHORIZATION PROCESS

Information received either via phone or electronic means in the Utilization Management department will be reviewed for coverage and benefits. Appropriateness and medical necessity will be reviewed using InterQual® Criteria, Plan Clinical Protocols, benefits and coverage. Upon approval of authorization, the system generated authorization sheet is faxed to the requesting provider and servicing provider. Requests that do not meet the medical necessity or coverage guidelines are forwarded for further review.

If CHRISTUS Health Plan determines that medical necessity or benefit coverage is not established, notification is made to the requesting provider that will include the physician reviewer's determination to deny authorization. A denial letter will be sent to the requesting provider within two (2) business days of the determination.

REQUESTS TO OUT-OF-NETWORK PROVIDERS

Requests for services to non-participating or out-of-network providers may only be made:

- For emergencies experienced in or out of the service area
- In urgent situations experienced outside the 48 contiguous states
- When other medically necessary services are unavailable from participating providers.

Most out-of-network requests for services will be sent to medical review and may require service negotiations, which could potentially delay the request.

SERVICES REQUIRING PRIOR AUTHORIZATION

For Eligibility and Benefits, please contact Member Services at 844-282-3025
For Family Planning Assistance, please contact HealthSmart at 855-596-6740
For Mental Health Assistance, please contact Health Integrated at 1-800-323-0208

ALL OUT-OF-NETWORK SERVICES REQUIRE AUTHORIZATION

Durable Medical Equipment
Authorization Required

- Alternating pressure pad/mattress
- Bone growth stimulator
- Compression/lymphedema sleeve and pump
- CPAP/BiPAP
- Continuous passive motion device (CPM)
- Customized splints
- Diabetic shoes/inserts
- Dialysis equipment
- Electric wheelchair/scooter (includes accessories, lifts and modifications
- Hospital Bed and Accessories
- Hoyer Lift
- Insulin Pump
- Oxygen and Equipment
- Standard Wheelchair
- Traction Equipment
- Ventilator and Supplies
- Implanted Neuromuscular Stimulator

Orthotics

Authorization not required for orthotics with a cost of $300 or less when furnished by a Network Provider, except:

- AS590 – AS513 (Diabetic Shoes, Fitting and Modification), and
- L3000 – L3649 (Orthopedic Shoes) require authorization

Prosthetics

Authorization not required for prosthetics with a cost of $300 or less when furnished by a Network Provider.

Inpatient Authorization Required

All elective and urgent admissions/ observation stays to acute care hospitals, hospice, long-term acute care, rehabilitation, skilled nursing facilities and pre-operative admissions.

Specialty Drugs Authorization Requirements (Not All Inclusive)

- Activase (Alteplese
- Aranesp (Darbepoetin)
- Botox (Botulinum Toxin Type A)
- Desferal (Deferoxamine)
- Enbrel (Etanercept)*
- Growth Hormone (Somatropin)*
- Interferon (Avonex)
- IVIG (Immune/Human Gamma Globulin)
- Lucentis (Raniblzumab)
- Maeugen (Pegaptnnib Sodium)
- Neulasta (Pegfilgrastim)
- Remicade (Infliximab)*
- Vantas (Histrelin Implant

* **Authorization required if not dispensed through the Network Pharmacy**

Authorization Required

Outpatient Office/Facility/Home

- Chemotherapy
- Dialysis
- Home Health (Physician Review Required for Aide Requests)
- Radiation Therapy
- Rehabilitation Therapy (physical, occupational, speech, cardiac)
- Hospice-Outpatient and Continuous Care
- Selected Outpatient surgical/diagnostic procedures
- Clinical Trials
- Hyperbaric Oxygen Therapy
- All out-of-network services

Diagnostic Services

- Cardiac Catheterization (scheduled)
- PET Scan
- MRI/MRA
- SPECT
- Sleep Studies
- Genetic Testing
- Nuclear Medicine
- Stress Test (must be performed in outpatient hospital setting)

PROVIDER OBLIGATIONS — PRECERTIFICATION

Providers are responsible for obtaining precertification from CHRISTUS Health Plan and for submitting the adequate required information before performing certain procedures or when referring members to non-contracted providers. CHRISTUS Health Plan will render a determination on the request within the appropriate time frame and provide notification of the decision. Requests that are denied will generate a notice that includes the denial rationale and applicable appeal rights. Members will receive a denial letter as well that includes appeal rights. Denials that are the result of contractual issues between CHRISTUS Health Plan and the provider will not generate a member denial letter.

PROVIDER OBLIGATIONS — APPEALS (BOTH MEMBER AND PROVIDER APPEALS)

Providers must cooperate with CHRISTUS Health Plan and with members in providing necessary information to resolve the appeals within the required time frames. Providers must provide the pertinent medical records and any other relevant information upon request and when initiating an appeal. In some instances, providers must provide the records and information very quickly in order to allow CHRISTUS Health Plan to make an expedited decision.

ADMINISTRATIVE APPEALS — PROVIDER LIABILITY APPEALS/PROVIDER CLAIMS DISPUTES

Appeals or claim disputes that are the result of contractual issues between the provider and CHRISTUS Health Plan carry no member liability, and the member is held harmless for any payment over and above the applicable cost share. It is important to follow the directions in the denial letter issued to ensure the proper appeals process is followed.

PROVIDER COMPLAINTS AND APPEALS

All participating providers have agreed to comply with the Plan's dispute resolution process by signing the provider agreement. The provider complaint process is available to any participating provider to resolve disputes with the Plan. The Plan distinguishes disputes by the following categories: 1) Administrative Disputes related to claims or claims payment; 2) Administrative Disputes not related to claims payment; and 3) Disputes Concerning Professional Competence and Conduct.

1) Administrative Claim Disputes- a request for review of claims denied or (underpaid) by the claims administrator or claims processing entity for technical or medical necessity issues.
2) Utilization Review Disputes- a request for review of a determination made by the CHRISTUS Health Plan Utilization Review department on request for retro-authorization.
3) Disputes Concerning Professional Competence and Conduct- a request for review of an action by the Plan that relate to a participating provider's status within the Plan's provider network *and* any action by the Plan related to a participating provider's professional competency or conduct.

ADMINISTRATIVE CLAIM AND UTILIZATION REVIEW DISPUTES TO HMO

CHRISTUS Health Plan will make every effort to resolve provider dispute inquiries using consistent procedures for reviewing and responding to inquiries.

- Dispute reviews will be completed within sixty (60) days of receipt of the request.
- A provider dispute must be sent in writing to:

CHRISTUS Health Plan Exchange
Attn: Claims Dispute
P.O. Box 981636
El Paso, Texas 79998-1636

- All requests must be submitted for review within 180 days of an action taken or decision made by CHRISTUS Health Plan.
- For any dispute involving a denied claim, the 180 day period begins on the date of the CHRISTUS Health Plan remittance reflecting the denial. For any dispute related to a claim audit, the 180 day period begins on the date of the notice to the provider.
- CHRISTUS Health Plan will forward the provider request to the appropriate area for research and resolution. When appropriate, the Medical Director will review the matter using appropriate peer input.
- Providers will receive a payment or written response generally within sixty (60) calendar days describing how their request was resolved.

COMPETENCE OR CONDUCT DISPUTES AND APPEALS TO HMO

- Providers may file a non-administrative dispute that involves actions by the Plan that relate to a participating provider's status within the Plan's provider network *and* any action by the Plan related to a participating provider's professional competency or conduct.
- A competence or conduct provider dispute or appeal with CHRISTUS Health Plan can only be requested in writing.
- Participating providers have the right to appeal their dispute to two (2) separate panels above the level of the Plan body involved in the dispute, each consisting of at least three qualified individuals, of which at least one must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider that filed the dispute. In no case will panel members be assigned who have been previously involved with the issue.
- A panel will be convened within 60 days of the request and the decision will be returned to the participating provider within 30 days of the closure of the panel. When an adverse action is taken or if the provider voluntarily relinquishes participation while undergoing investigation and/or peer review, it is noted in the Credentialing File and reported if required by law.
- The following actions are required to be reported to The Data Bank (NPDB): terminations resulting from serious quality deficiencies, providers who terminate themselves while under investigation and providers who terminate themselves with an action plan in place.

MEMBER ADMINISTRATIVE AND ADVERSE DETERMINATION GRIVEANCE

All beneficiary and their representatives will be provided with detailed information and complaint forms by the health plan at each step. In addition, beneficiary and their representatives can review the complete New Mexico regulations that control the process under the Legal tab on the Office of Superintendent of Insurance (OSI) website, located at www.osi.state.nm.us. A beneficiary and their representatives may also request a copy from the health plan at: (CHRISTUS Health Plan, 919 Hidden Ridge Irving, TX 75038. or from OSI by calling 1-505 827-4601 or toll free at 1-855-427-5674.

What types of decisions can be reviewed?

A beneficiary and their representatives may request a review of two different types of decisions:

Adverse determination: may be requested if the health plan has denied pre-authorization (certification) for a proposed procedure, has denied full or partial payment for a procedure that a beneficiary have already received, or is denying or reducing further payment for an ongoing procedure that a beneficiary is already receiving and that has been previously covered. (The health plan must notify the beneficiary *before* terminating or reducing coverage for an ongoing course of treatment, and must continue to cover the treatment during the appeal process.) This type of denial may also include a refusal to cover a service for which benefits might otherwise be provided because the service is determined to be experimental, investigational, or not medically necessary or appropriate. It may also include a denial by the health plan of a participant's or beneficiary's eligibility to participate in a plan. These types of denials are collectively called **"adverse determinations."**

Administrative decision: A beneficiary and their representatives may also request a review if the beneficiary object to how the health plan handles other matters, such as its administrative practices that affect the availability, delivery, or quality of health care services; claims payment, handling or reimbursement for health care services; or if a beneficiary coverage has been terminated.

Review of an Adverse Determination

How does pre-authorization for a health care service work?

When the health plan receives a request to pre-authorize (certify) payment for a healthcare service (service) or a request to reimburse a healthcare provider (provider) for a service that a beneficiary has already had, it follows a two-step process.

Coverage: First, the health plan determines whether the requested service is covered under the terms of the beneficiary health benefits plan (policy). For example, if the beneficiary policy excludes payment for adult hearing aids, then the health plan will not agree to pay for a beneficiary to have them even if the beneficiary has a clear need for them.

Medical necessity: Next, if the health plan finds that the requested service is covered by the policy, the health plan determines, in consultation with a physician, whether a requested service is medically necessary. The consulting physician determines medical necessity either after consultation with specialists who are experts in the area or after application of uniform standards used by the health plan. For example, if a beneficiary has a crippling hand injury that could be corrected by plastic surgery and the beneficiary is also requesting that the health plan pay for cosmetic plastic surgery to give the beneficiary a more attractive nose, the health plan might

certify the first request to repair of the beneficiary hand and deny the second, because it is not medically necessary.
Depending on terms of the beneficiary policy, the health plan might also deny certification if the service that is being requested is outside the scope of the health plan policy. For example, if a beneficiary policy does not pay for experimental procedures, and the service being requested is classified as experimental, the health plan may deny certification. The health plan might also deny certification if a procedure that a provider has requested is not recognized as a standard treatment for the condition being treated.

IMPORTANT: If the health plan determines that it will not certify a request for services, the beneficiary may still go forward with the treatment or procedure. **However,** the beneficiary will be responsible for paying the provider for the services.

How long does initial certification take?

Standard decision: The health plan must make an initial decision within 5 working days. However, the health plan may extend the review period for a maximum of 10 calendar days if it: **(1)** can demonstrate reasonable cause beyond its control for the delay; **(2)** can demonstrate that the delay will not result in increased medical risk to the beneficiary; and **(3)** provides a written progress report and explanation for the delay to the beneficiary and their provider within the original 5 working day review period.

What if a beneficiary needs services in a hurry?

Urgent care situation: An **urgent care situation** is a situation in which a decision from the health plan is needed quickly because: (1) delay would jeopardize the beneficiary life or health; (2) delay would jeopardize the beneficiary ability to regain maximum function; (3) beneficiary's provider reasonably requests an expedited decision; (4) the physician with knowledge of the beneficiary medical condition, believes that delay would subject the beneficiary to severe pain that cannot be adequately managed without the requested care or treatment; or (5) the medical demands of the beneficiary case require an expedited decision.

If the beneficiary is facing an urgent care situation or the health plan has notified the beneficiary that payment for an ongoing course of treatment that the beneficiary already receiving is being reduced or discontinued, the beneficiary or their provider may request an expedited review and the health plan must either certify or deny the initial request quickly. The health plan must make its initial decision in accordance with the medical demands of the case, but within 24 hours of the written or verbal receipt of the request for an expedited decision.

If the beneficiary is dissatisfied with the health plan's initial expedited decision in an urgent care situation, the beneficiary may then request an expedited review of the health plan's decision by both the health plan and an external reviewer called an Independent Review Organization (IRO). When an expedited review is requested, the health plan must review its prior decision and respond to the beneficiary's request within 72 hours. If the beneficiary request that an IRO also perform an expedited review simultaneously with the health plan review, the IRO must also provide its expedited decision within 72 hours of receiving the necessary release of information and related records. If the beneficiary is still dissatisfied after the IRO completes its review, the beneficiary may request that the Superintendent review their request. This review will be completed within 72 hours after the beneficiary request is complete. The internal review, the IRO review, and the review by the Superintendent are described in greater detail in the following sections.

IMPORTANT: If a beneficiary is facing an emergency, they should seek medical care immediately and then notify the health plan as soon as possible. The health plan will guide a beneficiary through the claims process once the emergency has passed.

When will a beneficiary be notified that their initial request has been either certified or denied?

If the initial request is approved, the health plan must notify the beneficiary and their provider within 2 working days after the decision, unless an urgent matter requires a quicker notice. If the health plan denies certification, the health plan must notify the beneficiary and their provider within 24 hours after the decision.

If an initial request is denied, how can a beneficiary appeal this decision?
If a beneficiary initial request for services is denied or the beneficiary is dissatisfied with the way the health plan handles an administrative matter, the beneficiary will receive a detailed written description of the grievance procedures from the health plan as well as forms and detailed instructions for requesting a review. The beneficiary must submit the request for review in writing, but assistance is available. The health plan provides representatives who have been trained to assist beneficiaries with the process of requesting a review. This person can help the beneficiary to complete the necessary forms and with gathering information that the beneficiary need to submit their request. For assistance, contact the health plan's member advocate as follows:
Telephone: 1-844-282-0380
Address: PO Box 169009 Irving, TX 75016
Fax #: 1-866-416-2840
Email: Appealsandgrievances@chhealthplans.org

The beneficiary may also contact the Managed Health Care Bureau (MHCB) at OSI for assistance with preparing the written request for a review at:

Telephone: 1-(505) 827-4601 or toll free at 1-(855) 427-5674
Address: Office of Superintendent of Insurance - MHCB
P.O. Box 1689, 1120 Paseo de Peralta
Santa Fe, NM 87504-1689
FAX #: (505) 827-4734, Attn: MHCB
E-mail: mhcb.grievance@state.nm.us

Who can request a review?

A review may be requested by the beneficiary as the patient, their provider, or someone that the beneficiary select to act on his or her behalf. The patient may be the actual subscriber or a dependent who receives coverage through the subscriber. The person requesting the review is called the **"grievant."**

Appealing an adverse determination — first level review

If the beneficiary is dissatisfied with the initial decision by the health plan, the beneficiary can request that the health plan's decision be reviewed by its medical director. The medical director may make a decision based on the terms of the beneficiary policy, may choose to contact a specialist or the provider who has requested the service for the beneficiary, or may rely on the health plan's standards or generally recognized standards.

How much time does a beneficiary have to decide whether to request a review?

The beneficiary must notify the health plan that they wish to request an internal review within **180 days** after the date the beneficiary is notified that the initial request has been denied.

What does the beneficiary need to provide? What else the beneficiary provide?

If the beneficiary request that the health plan review its decision, the health plan will provide the beneficiary with a list of the documents that the beneficiary need to provide and will provide to the beneficiary all of the beneficiary's records and other information the medical director will consider when reviewing the case. The beneficiary may also provide additional information that the beneficiary would like to have the medical director consider, such as a statement or recommendation from the beneficiary doctor, a written statement from the beneficiary, or published clinical studies that support the beneficiary's request.

How long does a first level internal review take?

Expedited review. If a review request involves an urgent care situation, the health plan must complete an expedited internal review as required by the medical demands of the case, but in no case later than 72 hours from the time the internal review request was received.

Standard internal review. The health plan must complete both the medical director's review and (if the beneficiary then request it) the health plants internal panel review within 30 days after receipt of the beneficiary request for internal panel review conducted prior to service and within 60 days after receipt of a request involving a post-service claim. The medical director's review generally takes only a few days.

The medical director denied the beneficiary's request - now what?

If the beneficiary remain dissatisfied after the medical director's review, the beneficiary may either request a review by a panel that is selected by the health plan or the beneficiary may skip this step and ask that their request be reviewed by an IRO that is appointed by the Superintendent.

If the beneficiary ask to have their request reviewed by the health plan panel, then the beneficiary have the right to appear before the panel in person or by telephone or have someone, (including your attorney), appear with the beneficiary or on their behalf. The beneficiary may submit information that they want the panel to consider, and ask questions of the panel members. The beneficiary medical provider may also address the panel or send a written statement.

If the beneficiary decide to skip the panel review, the beneficiary will have the opportunity to submit their information for review by the IRO, but the beneficiary will not be able to appear in person or by telephone. OSI can assist the beneficiary in getting their information to the IRO.

IMPORTANT: If the beneficiary is covered under the NM State Healthcare Purchasing Act, they may NOT skip the panel review.

How long does a beneficiary have to make a decision?

If the beneficiary wish to have their request reviewed by the health plan's panel, the beneficiary must inform the health plan within **5 days** after the beneficiary receive the medical director's decision. If the beneficiary wish to skip the health plan's panel review and have their matter go directly to the IRO, the beneficiary must inform OSI of their decision within **4 months** after the beneficiary receive the medical director's decision.

What happens during a panel review?

If the beneficiary request that the health plan provide a panel to review its decision, the health plan will schedule a hearing with a group of medical and other professionals to review the request. If the beneficiary request was denied because the health plan felt the requested services were not medically necessary, were experimental or were investigational, then the panel will include at least one specialist with specific training or experience with the requested services.

The health plan will contact the beneficiary with information about the panel's hearing date so that the beneficiary may arrange to attend in person or by telephone, or arrange to have someone attend with them or on their behalf. The beneficiary may review all of the information that the health plan will provide to the panel and submit additional information that the beneficiary wants the panel to consider. If the beneficiary attends the hearing in person or by telephone, the beneficiary may ask questions of the panel members. The beneficiary's medical provider may also attend and address the panel or send a written statement.

The health plan will notify the beneficiary and the provider of the internal panel's decision within 24 hours by telephone and in writing by mail or electronic communication sent within one day after the initial attempt to provide telephonic notice , unless earlier notice required by the medical exigencies of the case. If the beneficiary fails to provide records or other information that the health plan needs to complete the review, the beneficiary will be given an opportunity to provide the missing items, but the review process may take much longer and the beneficiary will be forced to wait for a decision.

Hint: If the beneficiary needs extra time to prepare for the panel's review, then the beneficiary may request that the panel be delayed for a maximum of 30 days.

If the beneficiary choose to have his or her request reviewed by the health plan's panel, can the beneficiary still request the IRO review?

Yes. If the beneficiary request has been reviewed by the health plan's panel and the beneficiary is still dissatisfied with the decision, the beneficiary will have **4 months** to decide whether he or she want to have the request reviewed by an IRO.

What's an IRO and what does it do?

An IRO is a certified organization appointed by OSI to review requests that have been denied by the health plan. The IRO employs various medical and other professionals from around the country to perform reviews. Once OSI selects and appoints an IRO, the IRO will assign one or more professionals who have specific credentials that qualify them to understand and evaluate the issues that are particular to a request. Depending

on the type of issue, the IRO may assign a single reviewer to consider the beneficiary request, or it may assign a panel of reviewers. The IRO must assign reviewers who have no prior knowledge of the case and who have no close association with the health plan or with the beneficiary. The reviewer will consider all of the information that is provided by the health plan and by the beneficiary. (OSI can assist the beneficiary in getting their information to the IRO.) In making a decision, the reviewer may also rely on other published materials, such as clinical studies. The IRO will report the final decision to the beneficiary, their provider, the health plan, and to OSI. The health plan must comply with the decision of the IRO. If the IRO finds that the requested services should be provided, then the health plan must provide them.

The IRO's fees are billed directly to the health plan— there is no charge to the beneficiary for this service.

How long does an IRO review take?

The IRO must complete the review and report back within 20 days after it receives the information necessary for the review. (However, if the IRO has been asked to provide an expedited review regarding an urgent care matter, the IRO must report back within 72 hours after receiving all of the information it needs to review the matter.)

Review by the Superintendent of Insurance

If the beneficiary remain dissatisfied after the IRO's review, the beneficiary may still be able to have the matter reviewed by the Superintendent. The beneficiary may submit their request directly to OSI, and if their case meets certain requirements, a hearing will be scheduled. The request for hearing must be submitted to OSI within 20 days from the IRO decision. If the case did not involve medical judgment, the request for hearing can be submitted within 4 months of receiving the health plan internal decision. The beneficiary will then have the right to submit additional information to support their request and the beneficiary may choose to attend the hearing and speak. The beneficiary may also ask other persons to testify at the hearing. The Superintendent may appoint independent co-hearing officers to hear the matter and to provide a recommendation.
The superintendent shall complete the review within 72 hours for expedited review and 45 days for standard reviews.
There is no charge to the beneficiary for a review by the Superintendent of Insurance and any fees for the hearing officers are billed directly to the health plan. However, if the beneficiary arranges to be represented by an attorney or their witnesses require a fee, the beneficiary will need to pay those fees.

Review of an Administrative Decision

How long does the beneficiary **have to decide if they want to appeal and how does** the beneficiary **start the process?**

If the beneficiary is dissatisfied with an initial administrative decision made by the health plan, the beneficiary have a right to request an internal review within **180 days** after the date the beneficiary is notified of the decision. The health plan will notify the beneficiary within 3 days after receiving their request for a review and will review the matter promptly. The beneficiary may submit relevant information to be considered by the reviewer.

How long does an internal review of an Administrative Decision take?

The health plan will mail a decision to the beneficiary within 30 days after receiving their request for a review of

an administrative decision.

Can the beneficiary **appeal the decision from the internal reviewer?**

Yes. The beneficiary has 20 days to request that the health plan form a committee to reconsider its administrative decision.

What does the reconsideration committee do? How long does it take?

When the health plan receives your request, it will appoint two or more members to form a committee to review the administrative decision. The committee members must be representatives of the company who were not involved in either the initial decision or the internal review. The committee will meet to review the decision within 15 days after the health plan receives the beneficiary request. The beneficiary will be notified at least 5 days prior to the committee meeting so that they may provide information, and/or attend the hearing in person or by telephone.
If the beneficiary is unable to prepare for the committee hearing within the time set by the health plan, the beneficiary may request that the committee hearing be postponed for up to 30 days. The reconsideration committee will mail its decision to the beneficiary within 7 days after the hearing.

How can the beneficiary **request an external review?**

If the beneficiary is dissatisfied with the reconsideration committee's decision, the beneficiary may ask the Superintendent to review the matter within **20 days** after the beneficiary receive the written decision from the health plan. The beneficiary may submit the request to OSI using forms that are provided by the health plan. Forms are also available on the OSI website located at www.osi.state.nm.us. The beneficiary may also call OSI to request the forms at (505) 827-4601 or toll free at 1-(855)-427-5674. The request can be mailed to the superintendent, attn.: managed health care bureau-external review request, office of superintendent of insurance, P.O. Box 1689, 1120 Paseo de Peralta, Santa Fe, NM 87504-1689; emailed to mhcb.grievance@state.nm .us, subject: external review request; faxed to the superintendent, attn.: managed health care bureau-external review request at (505) 827-4734;

How does the external review work?

Upon receipt of the beneficiary request, the Superintendent will request that both the beneficiary and the health plan submit information for consideration. The health plan has 5 days to provide its information to the Superintendent, with a copy to the beneficiary. If the beneficiary matter qualifies for external review, the beneficiary may also submit additional information including documents and reports for review by the Superintendent. The Superintendent will review all of the information received from both the beneficiary and the health plan and issue a final decision within 45 days. If the beneficiary need extra time to gather information, the beneficiary may request an extension of up to 90 days. Any extension will cause the review process and decision to take more time.

General Information

Confidentiality

Any person who comes into contact with the beneficiary personal health care records during the grievance

process must protect the beneficiary's records in compliance with state and federal patient confidentiality laws and regulations. In fact, the provider and the health plan cannot release the beneficiary records, even to OSI, until the beneficiary have signed a release.

Special needs and cultural and linguistic diversity

Information about the grievance procedures will be provided in accessible means or in a different language upon request in accordance with applicable state and federal laws and regulations.

PHARMACY SERVICES

CHRISTUS Health Plan includes coverage for prescription drugs. Pharmacy claims are processed by Express Scripts (ESI), the CHRISTUS Health Plan pharmacy benefit management vendor. The formulary includes coverage of generic drugs, as well as many brand-name drugs, non-preferred brands and specialty drugs. Formularies are reviewed by a Pharmacy & Therapeutics Committee composed of provider and pharmacists. Providers can view a copy of the formulary on the CHRISTUS Health Plan website. Some of these drugs have precertification or step-therapy requirements or quantity limits, defined as:

- Prior Authorization (PA): CHRISTUS Health Plan requires the provider to get prior authorization before the drug will be approved for coverage,

- Quantity Limits (QL): For certain drugs, CHRISTUS Health Plan limits the amount of the drug it will cover for a given duration of time (i.e. 30 pills every 30 days).

- Step Therapy (ST): In some cases, CHRISTUS Health Plan requires trial and failure of certain drugs to treat a medical condition before it will cover another drug for that condition.

The following chart depicts the pharmacy related services provided by CHRISTUS Health Plan as well as the contact information:

Pharmacy Related Service	Performed By	Notification	Contact Information
Prescription Drugs	ESI	Pharmacy Dept.: Pharmacy Helpdesk:	1-844-470-1531 1-800-922-1557
Coverage Determination-	ESI	Standard Coverage Review: Expedited Coverage Review:	1-800-935-6103 1-800-935-6103
Formulary Exceptions	ESI	Coverage Review:	1-800-935-6103

PRESCRIPTION DRUGS BY MAIL ORDER

Members can use the mail-order service to fill prescriptions for maintenance drugs (i.e., drugs taken on a regular basis for a chronic or long-term medical condition). For mail-order prescriptions, the provider must write on the maintenance drug prescription whether it is for a 31-, 62- or 93-day supply. When mailing in a prescription to the mail-order service for the first time, the member should allow up to two weeks for the prescription to be filled. For refills of the same prescription, members should allow up to 7-10 days for mailing and processing.

If a member runs out of a medication before receiving a new supply from the mail-order pharmacy, please call 1-844-470-1531.

COVERAGE DETERMINATIONS FOR PRESCRIPTION DRUG BENEFITS

A coverage determination is any decision CHRISTUS Health Plan makes regarding:

- A decision about whether to provide or pay for a drug, including a decision not to pay because the drug is not on the Plan's formulary, the drug is determined not to be medically necessary, the drug is furnished by an out-of-network pharmacy or we determine the drug is otherwise excluded, but the member believes it may be covered by the Plan
- Failure to provide a coverage determination in a timely manner, when a delay would adversely affect the member's health
- A decision concerning a formulary exception request
- A decision on the amount of cost sharing for a drug
- A decision on whether a member has satisfied a precertification or other utilization management requirement

Two decisions govern the need for prescription drugs the member has not yet received:

- A standard decision made within the standard 72-hour time frame
- An expedited decision made within 24 hours

An expedited decision can only be requested if the member or any provider believes waiting for a standard decision could jeopardize the member's life, health or ability to regain maximum function. This is called the expedited criteria. The member or a provider can request an expedited decision. If a provider requests an expedited decision or supports a member in asking for one and if the provider indicates the situation meets the expedited criteria, CHRISTUS Health Plan will automatically provide an expedited decision within 24 hours from the initial request.

FORMULARY EXCEPTIONS

If a prescription drug is not listed in the CHRISTUS Health Plan formulary, please check the updated formulary on the www.express-scripts.com website. The website formulary is updated frequently with any changes.

If the drug is not on the formulary, there are two options:

- The prescribing provider can prescribe another drug that is covered on the formulary.
- The patient or prescribing provider may ask CHRISTUS Health Plan to make an exception (a type of coverage determination) to cover the non-formulary drug. If the member pays out-of-pocket for a non-formulary drug and requests an exception CHRISTUS Health Plan approves, CHRISTUS Health Plan will reimburse the member. If the exception is not approved, the member may appeal the Plan's denial.

In some cases, CHRISTUS Health Plan will contact a member who is taking a drug that is not on the formulary. CHRISTUS Health Plan will give the member the names of covered drugs used to treat his or her condition and encourage the member to ask his or her provider if any of those drugs would be appropriate options for treatment. Also, members who recently joined CHRISTUS Health Plan may be able to get a temporary supply of a drug they are taking if the drug is not on the CHRISTUS Health Plan formulary.

TRANSITION POLICY

New members in CHRISTUS Health Plan may be taking drugs that are not on the formulary or that are subject to certain restrictions, such as precertification or step-therapy. Current members may also be affected by changes in the formulary from one year to the next. Members are encouraged to talk to their providers to decide if they should switch to a different drug CHRISTUS Health Plan covers or request a formulary exception to get coverage for the drug.

During the period of time members are talking to their providers to determine the right course of action, CHRISTUS Health Plan may provide a temporary supply of the non-formulary drug if those members need a refill for the drug during the first 90 days of new membership in CHRISTUS Health Plan. For current members affected by a formulary change from one year to the next, CHRISTUS Health Plan will provide a 30 day temporary supply of the non-formulary drug for members needing a refill for the drug during the first 90 days of the new plan year.

When a member goes to a network pharmacy and CHRISTUS Health Plan provides a temporary supply of a drug that is not on the formulary or that has coverage restrictions or limits, CHRISTUS Health Plan will cover at least a one time, 30-day supply (unless the prescription is written for fewer days). CHRISTUS Health Plan will provide the member with a written notice after it covers a temporary supply. The notice will explain the steps the member can take to request an exception and the way to work with the prescribing provider to decide if switching to an appropriate formulary drug is feasible. This policy also applies to current members who experience a change in the level of their care.

The Health Plan drug formulary is a listing of generic and brand-name prescription medications that are preferred for use by CHRISTUS Health Plan. CHRISTUS Health Plan may add or remove drugs from our formulary during the year. To inquire about the status of a drug on the formulary, visit www.express-scripts.com.

CLAIMS, ENCOUNTERS AND EDI TRANSACTIONS

CLAIM SUBMISSIONS

Providers using electronic submission must submit all claims to CHRISTUS Health Plan using the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant 837 electronic format, or a CMS-1500 and/or UB-04. Claims must include the provider's NPI and the valid taxonomy code that most accurately describes the services reported on the claim. Providers must submit all claims, encounters, and clinical data to CHRISTUS Health Plan by electronic means available and accepted as industry standard, which may include claims clearinghouses or electronic data interface companies used by CHRISTUS Health Plan, unless applicable law provides that submissions may be in a paper format.

A claim is processed promptly if it is approved or denied within the time required by the Agreement or the applicable regulation of the state in which CHRISTUS Health Plan is operating. For claims to be paid promptly:

- A properly completed claim must be submitted electronically or by paper and the claim must not involve an investigation for coordination of benefits (COB), member eligibility, or subrogation
- Separate charges must be itemized on separate lines, Medical record documentation must validate the scope of the services provided and billed
- Claim must be submitted within one (1) calendar year from the date of service or date of discharge. The CHRISTUS Health Plan will bear no liability to pay claims received after the 365th day and members cannot be balanced billed for provider's failure to submit claims within this timeframe.
- Include AMA-developed procedural coding.
- Include ICD-9/10, as required by state or federal regulations or statutes, diagnosis coding to the highest specification.
- Be submitted on original red and white CMS 1500 or UB-04 forms when filing paper claims. (Black and white copies or faxes will not be accepted).
- Not be handwritten.

Note: If submitted electronically, a claim must be paid within 30 days of receipt; and
If submitted manually, a claim must be paid within 45 day of receipt.

EDI TRANSACTIONS

Electronic Data Interchange (EDI) Routing
Electronic Data Interchange (EDI) is the exchange of information using a routine business transaction in a standardized computer format; for example, data interchange between an insurance carrier and a provider. CHRISTUS Health Plan supports the electronic exchange of the Health Insurance Portability Accountability Act (HIPAA) adopted file formats.

- Eligibility Inquiry and Response (270)
- Health Care claims professional (837P)
- Health Care claims Institutional (837i)
- Healthcare electronic payment-remittance advice (835) transactions.
- Claims Inquire and Response (276/)

Providers are asked to direct all inquiries regarding electronic file exchange set up for HIPAA compliant transactions to their local assigned Provider Relations Representative, or they may call our Member Services Team at 1-844-282-3025.

Clearinghouse
The Plan's EDI transactions are performed via the clearinghouse, Emdeon. Providers should contact their clearinghouse or billing entity to ensure that they are set-up to interact with Emdeon prior to performing any EDI transactions involving CHRISTUS Health Plan.

Electronic Claims Submissions (837)
- For submission of 837s, providers are to use **Payor ID: 21062**
- The Plan is listed **as CHRISTUS Health NM HIX**
- Providers should ensure they have a valid NPI on file with the health plan.

Electronic Provider Remittance Advice (835)
- The EDI Form should be completed and sent to **EDIChristus@christushealth.org.**
  - For group providers, submit a form for each provider associated with the group.
  - For ancillary providers or facilities, submit a form for each location.
- Once set up, the provider's billing service/clearinghouse will receive email notification.

Electronic Enrollment Status (270)
Providers do not need to contact the Plan to be set up for this service. Providers only need to contact Emdeon and choose this transaction.

Electronic Claim Status (276)
Providers can obtain electronic claims status (276/277) through Emdeon. Providers should ensure that both their NPI 1 and NPI 2 (if applicable) are captured in the Plan's system.

PAPER CLAIMS SUBMISSION

Guidelines for Filing Clean Claims
CHRISTUS Health Plan recognizes that occasionally providers may need to submit claims on paper. Providers are asked to submit paper claims on the appropriate UB-04 or CMS -1500 claim form. The Plan will not accept super-bills, similar submissions, and handwritten forms as valid claims.

CHRISTUS Health Plan Exchange
Attention: Claims
P.O. Box 981636
El Paso, Texas 79998-1636

Claims Filing Deadlines
Providers are encouraged to submit claims as soon as possible after services are rendered; however, all claims must be received within 120 days of the date of service or, in accordance with the terms specified in the provider Agreement. The filing deadline is calculated from the date of service to the date the claim has been received. All claims received over the weekend or on a holiday will be stamped with the date of the following business day.

Checking the Status of a Claim
Providers can check the status of a claim by calling Member Service at 1-844-282-3025.

Claims Payment Explanation of Payment (EOP)
An EOP is a summary statement sent with the check to the provider which lists the services, amounts billed, denials, adjustments and payment for one or more claims. CHRISTUS Health Plan uses system generated message

codes to communicate with the providers on their explanation of payment (EOP). These event codes are used to further explain claim payments, adjustments or denials. Please contact Member Service or your Provider Relations Representative for assistance with interpretation.

ELECTRONIC ENCOUNTER DATA SUBMISSION

CHRISTUS Health Plan accepts encounter data electronically or via paper.

OVERPAYMENTS AND WITHHOLDS

When an overpayment is identified, the provider will receive a written request for refund with a full explanation of the determination of overpayment. The provider may then refund the requested amount, or send in a written dispute of the overpayment determination. If no correspondence is received from the provider, then the amount overpaid will be withheld from future reimbursement to the provider. The provider will receive an updated EOP which indicates the amount overpaid and any subsequent adjustments.

When the provider identifies an overpayment made by CHRISTUS Health Plan, the provider should contact the Claims Department for assistance in determining if an overpayment did indeed occur. If it is determined that an overpayment was made, the provider may request a future offset on their EOP or proceed with refunding the money back to CHRISTUS Health Plan. Refund checks can be submitted to our claims address at:

CHRISTUS Health Plan Exchange
Attn: Claims Recovery Unit
P.O. Box 981636
El Paso, Texas 79998-1636

COORDINATION OF BENEFITS (COB) AND THIRD PARTY LIABILITY (TPL)

Coordination of Benefits is a procedure to determine an insurer's liability when a person is covered by more than one insurer. CHRISTUS Health Plan is the primary payor for covered services provided to members. CHRISTUS Health Plan may become the secondary payor when services are also reimbursable under other medical insurance plans.

Other third parties may be responsible for payment under automobile, liability or worker's compensation insurance. If a primary insurance has made payment or denied a claim, the EOP from the primary carrier must be included with the claims submission to CHRISTUS Health Plan. The count for timely filing of the claim and EOP from the primary carrier starts on the date of the EOP from the primary carrier. Providers are required to identify on the claim form when other insurance is involved. Please note on the CMS 1500 claim form, Block 9 & 10 and UB -04 claim form blocks 50- 51 & 58-62.

REIMBURSEMENT METHODOLOGIES

FEE-FOR-SERVICE

CHRISTUS Health Plan reimburses Providers according to the Provider Agreement.

COPAYMENTS

It is the responsibility of the provider's office to collect the basic office visit copayment at the time of the member's visit. If the copayment or deductible is not collected from the member, the provider's office will be reimbursed by CHRISTUS Health Plan.

INTEGRITY/COMPLIANCE

INTEGRITY/COMPLIANCE

CHRISTUS Health Plan adheres to a corporate strategy that underlines its commitment to health care integrity. CHRISTUS Health Plan is responsible for ensuring that medically necessary services are provided only to eligible beneficiaries by authorized providers under existing law, regulation and CMS instructions. Furthermore, the CHRISTUS Health Plan is responsible for the evaluation of quality care and for ensuring that payment is made for care which is in keeping with generally accepted standards of medical practice.

The CHRISTUS Health Plan is dedicated to the CHRISTUS "Core Values" of Dignity, Integrity, Excellence, Compassion and Stewardship, and we hold contracted physicians and providers to the same standards. As a participating provider in CHRISTUS Health Plan, providers are expected to:

SAFETY

- Strive to provide a safe, secure and hazard-free environment consistent with national standards and established federal, state and local regulations
- Strictly follow all laws and regulations governing the disposal of hazardous waste and radioactive materials.

QUALITY CARE

- Provide quality care to all members by performing duties to the best of their abilities
- Attempt to anticipate and understand member needs while meeting their expectations
- Employ professionals with proper credentials and recognize that members and their personal representatives have the right to access information regarding the identity and licensure of their caregivers.

ACCURATE RECORDING AND REPORTING

- Prepare and maintain all member and organizational data, records and reports accurately and truthfully and adhere to applicable standards in maintaining all records
- Strive to maintain complete and accurate medical records of each member and protect this information from breach of confidentiality or loss.

ACCURATE AND APPROPRIATE CLAIMS

- Submit claims for payment or reimbursement only for services actually rendered and make sure that claims submitted for payment or reimbursement are for services that are medically necessary
- Submit claims for payment or reimbursement which are not knowingly false, fraudulent or otherwise incorrect. Establish an audit function to validate accuracy of claims submission
- Strive to make sure that all submitted claims are properly coded and documented, and filed according to all applicable laws and regulations.

PROTECTION OF PRIVACY

- Protect and maintain the confidentiality of all member records as required by applicable laws and regulations
- Maintain knowledge of information protection standards affecting job function recognizing that confidential information is valuable, sensitive, and protected by law.
- Maintain the appropriate confidentiality and privacy of all members.

ETHICAL PRACTICES

- Not mislead members or the public or cause them to request services they do not reasonably need
- Treat all members with dignity, respect, and compassion
- Respect and support the rights of all members
- Strive for excellence in quality of care and service provided to all served, regardless of race, color, religion, gender, orientation, disability, age or national origin
- Clearly explain care, treatment and services to the member and family so that informed consent can be obtained. Explanation of treatment must include:
  - Potential benefits and drawbacks
  - Potential problems related to recovery
  - Likelihood of success
  - Possible results of non-treatment; and
  - Significant alternatives.

FRAUD AND ABUSE

Fraud and abuse includes deception or misrepresentation by a provider, or any person or entity acting on behalf of a provider in relation to a CHRISTUS Health Plan claim. Examples of potential fraud (the intent to deceive or misrepresent to secure unlawful gain) include:

- Billing for items or services not rendered or not provided as claimed
- Submitting claims for equipment, medical supplies and services that are not reasonable and necessary
- Double billing resulting in duplicate payment
- Billing for non-covered services as if covered
- Unbundling (billing for each component of the service instead of billing or using an all-inclusive code)
- Failure to properly use coding modifiers
- Clustering, and
- Up-coding the level of service provided.

Examples of potential abuse (practices inconsistent with sound fiscal, business, or medical procedures and services not considered to be reasonable and necessary) include:

- A pattern of claims for services that are not medically necessary, or if necessary, not to the extent rendered
- Care of inferior quality (does not meet accepted standards of care)
- Failure to maintain adequate clinical or financial records, or
- Refusal to furnish or allow access to records.

In addition, unbundling, fragmenting or code gaming to manipulate the Provider's Current Procedural Terminology (CPT) codes as a means of increasing reimbursement is considered an improper billing practice and a misrepresentation of the services rendered. Such a practice can be considered fraudulent and abusive.

As a provider, it is important to note that it is considered a crime to knowingly and willfully execute (or attempt to execute) a scheme to defraud a health care benefit program, or to obtain money or property from a health care benefit program through false representations.

IMPORTANT STATUTES

CHRISTUS Health Plan hopes that providers find this information helpful, however, if providers would like more information regarding compliance programs, please visit OIG's web site at www.oig.hhs.gov Whistleblower – Sarbanes/Oxley Act

False Claims Act
Imposes civil liability on any person/entity submitting false claims to the US government.

Criminal Investigation of Health Care Offenses
Imposes criminal penalties for any person willfully obstructing such investigation(s), for example, withholding medical records

Mail and Wire Fraud
Imposes criminal penalties for any scheme to defraud another of money or property by using mail, private courier, telephone, fax or computer. Notably each offense is considered a separate crime.

Social Security Act
A broad statute with civil and criminal penalties that covers many fraudulent and abusive activities including:

- *Upcoding*
- *Providing services not medically necessary*
- *Unlicensed providers*
- *Offering kickbacks/bribes/rebates to influence the beneficiary to seek services from a provider excluded from participation with the Federal government*

There are a limited number of exceptions to the Social Security law known as "safe harbors," which provide immunity from criminal prosecution.

Federal Anti-Referral Law (Stark Laws)
Providers are prohibited from referring patients to health entities. In which they have an ownership relationship. Any health service receiving a "prohibited referral" is prohibited from billing for it. Health services include:

- *Lab and radiology*
- *Physical Therapy and Occupational Therapy*
- *DME equipment and supplies*
- *Intravenous and enteral (tube feeding) nutrients and supplies*
- *Orthotic and Prosthetic devices and supplies*
- *Home Health services, inpatient and outpatient hospital services*
- *Outpatient prescription drugs*

There are specific exceptions to the Stark laws, some related to Stocks and Bonds, and some related to certain physician services. The Sherman Antitrust Act-prohibits any ventures which result in a monopoly or combination of restraint of interstate trade.

Emergency Medical Treatment and Active Labor Act-(EMTALA)
Prohibits hospitals that receive Medicare funds from transferring out patients in their ERs based solely on their inability to pay for services.

Civil Rights Act of 1964
Prohibits any federally funded program from discriminating on the basis of race, creed, color, or national origin.

Rehabilitation Act of 1973
Prohibits qualified handicapped individuals from being discriminated against in any program or activity receiving federal funds. Individuals protected are those with:

- *Physical or mental impairment which substantially limits one or more major activities of daily living*

- *Has a record of such an impairment or has it currently*
- *Blind/visual impairment or deaf/hearing impairment*
- *Cerebral Palsy, epilepsy or seizure disorder*
- *Drug/Alcohol addiction*
- *Mental retardation and Psychiatric disorders*
- *Orthopedic handicap, spinal cord/traumatic brain injury*
- *Specific learning disability, and certain speech disorders*
- *Chronic diseases including AIDS, arthritis, cancer and diabetes*

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Mandates that security and confidentiality of individually identifiable protected health information (PHI) must be stored and transmitted securely, patients must be notified of their rights, and where to submit complaints, and patients must have access to their medical records.

Alcohol Drug Abuse and Mental Health Administration Reorganization Act
Specifies that alcohol and drug abuse records are kept confidential and requires certain court orders.

The Freedom of Information Act
Enacted to reach a balance between the right of the public to know, and the needs of government to keep information private. CHRISTUS Health Plan has specific procedures by which information is made available to the public that requires a written request.

GLOSSARY OF TERMS

The following terms are intended to provide a brief description of the more important concepts and provisions found in the CHRISTUS Health Plan Provider Manual They are further intended to provide a point of reference when the terms appear in this manual.

Advance Directive – A statement executed by a person while of sound mind as to that person's wishes about the use of medical interventions for him or herself in case of the loss of his or her own decision-making capacity.

Administrative Grievance-An oral or written complaint submitted by or on behalf of a Grievant regarding any aspect of a health benefits plan other than a request for Health Care Services, including but not limited to:

- administrative practices of the health care plan that affects the availability, delivery, or quality of Health Care Services;
- claims payment, handling or reimbursement for Health Care Services; and
- terminations of coverage.

Adverse Determination –Any of the following: any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time), a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payments, that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Allowable –The monetary amount a provider will receive in exchange for providing health care services, per the terms of the contract.

Annual Out-of-pocket Maximum – A specified dollar amount of Covered Services received in a Calendar Year that is the most the Member will pay (Cost Sharing responsibility) for that Calendar Year.

Appeal – The type of complaint made by a member when they want CHRISTUS Health Plan to reconsider and change a decision made about a pre-service (authorization), a post service (claim) or any other cost-sharing dispute.

Application – The forms, including required medical underwriting questionnaires, if any, that each Subscriber is required to complete when enrolling for Coverage.

Beneficiary – A recipient of insurance benefits.

Calendar Year – The period of time beginning January 1 and ending December 31 of any given year. The initial Calendar Year period is from a Member's Effective Date of coverage and ends on December 31, which may be less than 12 months.

Case Management – A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.

Centers for Medicare and Medicaid Services (CMS) – The agency within the Department of Health and Human Services which administers Medicare, Medicaid, and the State Children's Health Insurance Program. Formerly known as HCFA.

Certification – A decision by a health plan that a Health Care Service requested by a Provider or Grievant has been reviewed and, based upon the information available, meets the Plan's requirements for coverage and medical necessity, and the requested Health Care Service is therefore approved.

Claim – A notification to the insurance company that payment is due under the policy provisions; a medical bill.

Claim Turn-Around Time – Claims payment turn-around time is measured from the date received until the disposition date on the check.

Clean Claim – A claim submitted by a physician or provider for medical care or health care services rendered to a Member, with the data necessary for the Managed Care Organization (MCO) or subcontracted claims processor to adjudicate and accurately report the claim. A Clean Claim must meet all requirements for accurate and complete data as defined in the appropriate 837- (claim type) encounter guides as follows:

- 837 Professional Combined Implementation Guide;
- 837 Institutional Combined Implementation Guide;
- 837 Professional Companion Guide; and
- 837 Institutional Companion Guide.
- National Council for Prescription Drug Programs (NCPDP) Companion Guide.
- Note: If submitted electronically, a claim must be paid within 30 days of receipt; and
  If submitted manually, a claim must be paid within 45 day of receipt.

Clinical Practice Guidelines – A utilization and quality management mechanism designed to aid providers in making decisions about the most appropriate course of treatment for a specific clinical case. The development and implementation of parameters for the delivery of health care services to plan members.

Coinsurance – The percentage of allowed charges for Covered Services for which the Member is responsible for payment.

Commissioner – The New Mexico Superintendent of Insurance.
Complaint (Grievance) – Any dispute or expressed level of dissatisfaction, either verbally or in writing, by the member or the member's authorized representative with the health plan or a delegated contractor's processes other than an action associated with the disposition of a claim, i.e., adverse determination of a benefit.

Concurrent Review – Review of a procedure or hospital admission done by a health care professional (usually a nurse) other than the one providing the care, during the same time frame that the care is provided. Usually conducted during a hospital confinement to determine the appropriateness of hospital confinement and the medical necessity for continued stay.

Condition – A group of related diagnoses dealing with the same organ, system, or disease process.

Continuity of Care – Term used to describe the process that allows an individual to continue to receive medical care from his/her current health care provider if he or she is currently involved in an active, covered treatment plan that if interrupted, could seriously affect the health of the member.

Coordination of Benefits (COB) – An insurance claims review process used when a beneficiary is insured by two or more carriers. The process determines the liability of each carrier in order to eliminate duplication of payments.

Copayment – The amount that Members are required to pay to a Participating Provider or other authorized provider in connection with the provision of Health Care Services.

Cost Sharing – Any contribution Members make towards the cost of their Covered Health Care Services as

defined in their policy. This includes Deductibles and Copayments.

Coverage/Covered – Benefits extended under the Member's Policy, subject to the terms, conditions, Limitations, and Exclusions of the Policy.

Covered Benefit or **Covered Service(s)** – A benefit or service incurred by or on behalf of a Member for those services or supplies which are:

- Administered or ordered by a Physician or other qualified Provider;
- Medically Necessary to the diagnosis and treatment of an Injury or Illness;
- Not excluded by any provision of the Policy; and
- Incurred while the Member's coverage is in force under the Policy.

Credentialing – Review procedure where a potential or existing provider must meet certain standards in order to begin or continue participation in a given health care plan, on a panel, in a group or in a hospital medical staff organization.

Cultural Competence – Possession of the knowledge, skills, and attitudes needed to provide effective health care for diverse populations, taking into account the culture, language, values, and reality of the patient and patient's community.

Current Procedural Terminology (CPT) – A manual that assigns five digit codes to medical services and procedures to standardize claims processing and data analysis.

Custodial Care – Any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of a Member's Condition. Custodial Care also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine drugs, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

Denial – Refusal to approve services or payment to a provider for covered or non- covered services under a member's benefit plan.

- Denial in part of a service, i.e., has been limited, reduced, suspended, or terminated;
- Denial in whole of the service;
- Denial in whole or part of payment for a covered service;

Deductible – Part of the contribution that Members make toward the cost of their health care, also known as Cost Sharing. It means that amount the Member is required to pay each Calendar Year, directly to the Practitioner/Provider in connection with Covered Health Care Services before CHP begins to pay Covered Benefits.

Diagnosis – The nature of a disease; the identification of an illness. It is represented on a medical claim by an ICD-9/10 code.

Diagnosis Related Group (DRG) – An inpatient or hospital classification system developed and administered by CMS to pay a hospital or other provider for their services and to categorize illness by diagnosis and treatment.

Diagnostic Service means procedures ordered by a Practitioner/Provider to determine a definite condition or disease or review the medical status of an existing condition or disease.

Disenroll or **Disenrollment** – The process of ending membership in the Plan. Disenrollment may be voluntary (member's own choice) or involuntary (not their own choice).

Drug Formulary – Varying lists of prescription drugs approved by a given health plan for distribution to a covered person through specific pharmacies.

Durable Medical Equipment – Equipment or supplies prescribed by a Practitioner/Provider that is Medically Necessary for the treatment of an Illness or Accidental Injury, or to prevent the Member's further deterioration. This equipment is designed for repeated use, generally is not useful in the absence of Illness or Accidental Injury, and includes items such as oxygen equipment, wheelchairs, hospital beds, crutches, and other medical equipment.

Effective Date – 12:01 a.m. of the date on which the Member's coverage begins.

Electronic Data Interchange (EDI) – The automated exchange of data and documents in a standardized format. In health care, some common uses of this technology include claims submission and payment, eligibility, and authorization.

Eligibility Verification – Confirmation of a member's eligibility status at the time of service.

Emergency Care or **Emergency Care Services** – Covered Services that are furnished by a Provider or Practitioner who is qualified to provide Emergency Care Services. The services are needed to evaluate or stabilize an Emergency Medical Condition.

Emergency Medical Condition – A severe Injury or the sudden onset of a medical Condition. The Injury or medical Condition must be one which manifests itself by acute symptoms that in the absence of immediate medical attention a prudent layperson with an average knowledge of health and medicines would expect that: (a) such person's life or health would be in serious jeopardy; (b) bodily functions would be seriously impaired; (c) a bodily organ or part would be seriously damaged; or (e) or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another hospital for delivery or that a transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollee – A person that is enrolled in the health plan (insured, member, subscriber).

Enrollment – Initial process whereby new individuals apply and are accepted as members of a prepayment plan. The total number of covered persons in a health plan. Also refers to the process by which a health plan enrolls groups and individuals for membership or the number of enrollees who sign up in any one group.

Exception – A type of coverage determination that, if approved, allows a member to get a drug that is not on their plan sponsor's formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level. Members may also request an exception if their plan sponsor requires them to try another drug before receiving the drug they are requesting, or the Plan limits the quantity or dosage of the drug being are requesting (a formulary exception).

Exchange – The New Mexico Health Insurance Exchange.

Excluded Services –Health Care Services that are not Covered Services and that the Plan will not pay for.

Expedited Appeals – A request to do a more time sensitive medical necessity review of a denied urgent pre-service or urgent concurrent service when the standard appeal time periods could seriously jeopardize the member's life, health or the ability to attain, maintain or regain maximum function, or in the opinion of the treating provider member's condition cannot be adequately managed without the urgent care or services. An expedited appeal resolution is made within seventy two (72) hours, or sooner if the member's condition warrants.

Experimental, Investigational or **Unproven** – Any treatment, procedure, facility, equipment, drug, device, or supply that is not accepted as standard medical practice in the state where services are provided. In addition, if a federal or other governmental 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. To be considered standard medical practice and not Experimental or Investigational, treatment must meet all five of the following criteria:

1) A technology must have final approval from the appropriate regulatory government bodies;
2) The scientific evidence as published in evidence-based, peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes;
3) The technology must improve the net health outcome;
4) The technology must be as beneficial as any established alternatives; and
5) The improvement must be attainable outside the Investigational settings.

Explanation of Benefits (EOB) – A statement sent to covered individuals by a health plan explaining services provided, amount billed, and payments made to the provider and the amount the patient is responsible for.

Explanation of Payment (EOP) – A summary statement sent to the Provider which lists the services, amounts billed, denials, adjustments and payment for one or more claims.

Fee Schedule – A list of charges (or allowances) for specific procedures and services.

Fee-For-Service (FFS) – A method of paying provider and other health care providers in which each service (i.e. a doctor's office visit or procedure) carries a fee.

Follow-up Care – The contact with, or re-examination of a patient at prescribed intervals following diagnosis or during a course of treatment.

Formulary – A listing of covered drug products selected by the Plan in consultation with a team of health care Providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

Genetic Inborn Errors of Metabolism (IEM) – A rare, inherited disorder that is present at birth and results in death or mental retardation if untreated and requires consumption of special medical foods.

Grievance –A written complaint submitted by or on behalf of an enrollee regarding any aspect of the Member's Health Care Services, including but not limited to the:

1) Availability, delivery or quality of Health Care Services, including a complaint regarding an adverse determination made pursuant to utilization review;
2) Administrative practices of the health care plan that affect the availability, delivery or quality of Health Care Services;
3) Claims payment, handling or reimbursement for Health Care Services; or
4) Matters pertaining to the contractual relationship between an enrollee or Subscriber and a health care plan.

Grievant – Any of the following:

- a policyholder, subscriber, enrollee, or other individual, or that person's authorized representative or Provider, acting on behalf of that person with that person's consent, entitled to receive health care benefits provided by the health care plan;
- an individual, or that person's authorized representative, who may be entitled to receive health care benefits provided by the health care plan; or

Health Benefits Plan – A health plan or a policy, contract, certificate or agreement offered or issued by a health care plan or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of Health Care Services; this includes a traditional fee-for-service health benefits plan.

Health Care Facility – An institution providing Health Care Services, including a hospital or other licensed inpatient center; an ambulatory surgical or treatment center; a skilled nursing center; a residential treatment center; a home health agency; a diagnostic, laboratory or imaging center; and a rehabilitation or other therapeutic health setting.

Health Care Plan – A person that has a valid certificate of authority in good standing to act as a health maintenance organization, nonprofit health care plan or prepaid dental plan.

Health Care Professional – A physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide Health Care Services consistent with state law.

Health Care Services – Services, supplies, and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the health benefits plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay.

Health Employer Data and Information Set (HEDIS) – A set of HMO performance measures that are maintained by the National Committee for Quality Assurance. HEDIS data is collected annually and provides an informational resource for the public on issues of health plan quality.

Health Insurance Portability and Accountability Act (HIPAA) – The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was introduced to improve portability and continuity of health insurance coverage in the group and individual markets; to combat waste, fraud, and abuse in health insurance and health care delivery; to promote the use of medical savings accounts; to improve access to long-term care services and coverage; to simplify the administration of health insurance; and for other purposes. This act protects privacy and regulates the use of protected health information (PHI).

Health Maintenance Organization – Any person or entity who undertakes to provide or arrange for the delivery of basic Health Care Services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles.

Health Plan – An organized service to provide stipulated medical, hospital, and related services to individuals under a prepayment contract.

Healthcare Common Procedure Coding System (HCPCS) – A set of codes used by Medicare that describes services and procedures. HCPCS includes Current Procedural Terminology (CPT) codes for services not included in the normal CPT code list, such as durable medical equipment and ambulance service. While HCPCS is nationally defined, there is a provision for local use of certain codes.

HHS – The United States Department of Health and Human Services.

Hospitalist – A physician, usually an internist, who specializes in the care of hospitalized patients.

ICD-9; ICD-10 – The universal coding method used to document the incidence of disease, injury, mortality and illness. A diagnosis and procedure classification system designed to facilitate collection of uniform and comparable health information. This system is used to group patients into DRGs, prepare hospital and physician billings and prepare cost reports. Classification of disease by diagnosis codified into six-digit numbers.

Illness – A sickness or disease, including all related Conditions and occurrences, requiring Health Care Services.

In-Area – Services received in the member's health plan-designated service area.

Independent Review Organization (IRO) – An entity that is certified by the Commissioner to conduct reviews. By law, an IRO must not be affiliated with the HMO which has denied a request for authorization for proposed treatment. IROs perform an administrative review of the Medical Necessity and appropriated of Health Care Services being provided or proposed to be provided to a New Mexico resident which has been denied twice as not Medically Necessary or not appropriate.

Injury – Bodily injury due to an accident which results solely, directly and independently of disease, bodily infirmity, or any other causes.

In-network – Care received from a Participating Provider.

Inpatient – A patient who is admitted to a hospital that requires at least one overnight stay.
Insurance – A method of providing money to pay for specific types of losses which may occur. Insurance is a contract between one party and another. The policy states what types of losses are covered, what amounts will be paid for each loss and for all losses, and under what conditions.

Limits – Quantity or monetary thresholds associated with a particular benefit.
Living Will – A health care directive that tells others how a person would like to be treated if they lose their capacity to make decisions about health care; it contains instructions about the person's choices of medical treatment and it is prepared in advance, looking ahead to a time when they may no longer be able to make health care decisions for themselves.

Malpractice Liability Coverage – Insurance against the risk of suffering financial damage due to professional misconduct or lack of ordinary skill. Malpractice requires that the patient prove some injury and that the injury was the result of negligence on the part of the professional. A practitioner is liable for damages or injuries caused by malpractice.

Managed Care – A system or technique(s) generally used by third party payers or their agents to affect access to and control payment for Health Care Services. Managed care techniques most often include one or more of the following:

- Prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services;
- Contracts with selected health care providers;
- Financial incentives or disincentives for enrollees to use specific providers, services, or service sites;
- Controlled access to and coordination of services by a case manager; and
- Payer efforts to identify treatment alternatives and modify benefit restrictions for high cost patient care.

Medicaid – Title XIX and/or Title XXI of the Social Security Act and all amendments thereto.

Medical Management/Quality Improvement Committees– Committees composed of provider, the medical director, and other healthcare professionals that provide a mechanism for provider participation, communication and development and administration of CHRISTUS Health Plan

Medically Necessary means a treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of an Illness or Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided.

A treatment, drug, device, procedure, supply or service shall not be considered as Medically Necessary if it:

- Is Experimental, Investigational or Unproven or for research purposes;
- Is provided solely for educational purposes or the convenience of the patient, the patient's family, Physician, Hospital, or any other Provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- Could have been omitted without adversely affecting the patient's Condition or the quality of medical care;
- Does not apply to cancer chemotherapy or other types of therapy that are subjects of on-going phase IV clinical trials;
- Involves treatment of or the use of a medical device, drug, or substance not formally approved by the U.S. Food and Drug Administration (FDA); or
- Involves a service, supply, or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual.

We may require You or Your Provider to furnish peer-reviewed, evidence-based scientific literature that demonstrates that the service is required for the health of the Member.

Medicare – Title XVIII of the Social Security Act and all amendments thereto.

Member – An individual:

- who meets each of the enrollment and eligibility requirements described in this Policy;
- who has been properly enrolled in coverage with the Plan; and
- for whom the Plan has received any required Premium for the enrolled coverage.

Member ID card – Identification card issued to members upon enrollment in a health plan.

Member Services – A department within our plan responsible for answering Member's questions about their membership, benefits, grievances, and appeals.

Mental Illness/Disorder – Any Condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV, or current edition), and/or Mental Disorders Section of the International Classification of Disease.

National Accrediting Standards – The Joint Commission Accreditation standards and any and all accrediting standards that the CHRISTUS Health Plan is required to meet.

National Provider Identifier (NPI) – A unique ten digit number that is used nationally to identify a provider in standard electronic transactions. It is a requirement of the Health Insurance Portability and Accountability Act (HIPAA).

Network Pharmacy – A network pharmacy is a pharmacy where members of the Plan can get their prescription drug benefits. In most cases, their prescriptions are covered only if they are filled at one of the contracted network pharmacies.

Network Provider – "Provider" is the general term used for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. They are "**network providers**" when they have an agreement with the Plan to accept plan payment as

payment in full, and in some cases to coordinate as well as provide covered services to members of the Plan.

Non-Participating Provider – A Provider that is not a Participating Provider.

Obstetrician/Gynecologist (OB/GYN) – A Physician that is board eligible or certified by the American Board of Obstetricians and Gynecologists, or by the American College of Osteopathic Obstetricians and Gynecologists.

Out-of-Network Services – Health Care Services Obtained from a Non-Participating Provider.

Outpatient – Services that do not necessitate an overnight hospitalization, but visit to a hospital, clinic, or associated facility for diagnosis or treatment.

Outpatient Hospital – A place to receive Covered Services while not an Inpatient. Services considered Outpatient include, but are not limited to, services in an Emergency room regardless of whether the Member is subsequently admitted as an Inpatient in a hospital.

Participating Provider – A Physician, Provider, Hospital or Health Care Facility that has an agreement with the Plan to accept the Plan's rates and payments as payment in full when providing Health Care Services to Members.

Payer – The entity ultimately responsible for funding the payment for covered health services provided through the provider agreement. Sometimes used interchangeable with the word "payer".

Physician – One of the following:

- A doctor of medicine, surgery, or osteopathy;
- A doctor of podiatry or a doctor of chiropractic; or
- Any other licensed Provider who is required to be recognized as a Physician by state law and acts within the scope of his/her license to treat an Illness or Injury.

Physical Therapy – Therapy for the preservation, enhancement, or restoration of movement and physical function impaired or threatened by Illness or Injury that utilizes therapeutic exercise, physical modalities (as massage and electrotherapy), assistive devices, and patient education and training.

Physician Assistant – A person who has graduated from a nationally-recognized physician assistant or assistant surgeon program; or who is currently certified by the national commission of Physician Assistants. A Physician Assistant must be licensed to practice medicine under the supervision of a licensed Physician in the state in which they practice.

Plan – The health benefit plan established by CHRISTUS Health Plan and selected by the Member to provide Health Care Services to Members, as it exists on the Effective Date of this Policy or as subsequently amended as provided herein.

PPACA – The federal Patient Protection and Affordable Care Act.
Preadmission Review – A function performed by the CHRISTUS Health Plan to review and authorize hospitalizations to determine medical necessity.

Pre-authorization – A decision by a Health Care Plan that a Health Care Service requested by a Practitioner/Provider or Covered Person has been reviewed and, based upon the information available, meets the Health Care Plan's requirements for Coverage and Medical Necessity, and the requested Health Care Service is therefore approved.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prescription Drugs – Drugs for which sale or legal dispensing requires the order of a Provider with legal authority to prescribe drugs.

Preventive Health Guidelines – Guidelines, order sets and protocols related to maintaining good health, immunizations, or preventing illness or disease development.
Primary Care Provider or **PCP** – The Physician or other Provider Members see first for most health problems. The PCP makes sure Members get the care they need to keep them healthy. The PCP also may talk with other Physicians and Providers about the Member's care and refer them. PCPs include, but are not limited to family practice Physicians; general practitioners; internists; pediatricians; Obstetricians and/or Gynecologists (OB/GYNs). The PCP is responsible for providing Primary Care Services. These include annual examinations, routine immunizations, and treatment of non-emergency acute illnesses and injuries.

Primary Care Services – Services provided by a PCP or primary Provider of Health Care Services.

Prior Authorization – A formal process for obtaining approval from a health insurer before a specific treatment, procedure, service or supply has been provided.

Protected Health Information (PHI) – PHI is any individually identifiable health information that relates to a patient's past, present, or future physical or mental health and related health care services. PHI may include demographics, documentation of symptoms, examination and test results, diagnoses, and treatments. Personal information that is protected by the federal privacy policy.

Provider – An entity that performs or furnishes a medical, behavioral health, and/or dental service/treatment to members AND is recognized under Section 1866(e) of the Social Security Act.

Provider Agreement – A legal agreement between a payer and a subscribing group or individual which specifies rates, performance covenants, the relationship among the parties, schedule of benefits and other pertinent conditions. The contract usually is limited to a 12-month period and is subject to renewal thereafter.

Provider Directory – A comprehensive listing of all participating providers in a health plan.

Provider means a duly licensed Hospital, Physician, or other practitioner of the healing arts that is authorized to render Health Care Services within the scope of their license.

Provider Network – A list of the Providers that are Participating Providers.

Qualified Health Plan or **QHP** – Health care coverage that has been determined to meet the requirements in state and federal law for coverage to be offered through the Exchange.

Qualified Individual – With respect to the Exchange, an individual who has been determined eligible to enroll through the Exchange in a Qualified Health Plan in the individual or small group Exchange market.

Qualified Medical Child Support Order – An order from a State or Federal government agency or court. It requires a person to provide health care coverage for specific dependents.

Quality Improvement (QI) Program – A comprehensive system designed to assess and continually improve the processes and outcomes of care and services provided to health plan members.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that is covered per prescription or for a defined period of time.

Rescission of Coverage – A cancellation or discontinuance of coverage that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if the:

- cancellation or discontinuance of coverage has only a prospective effect; or
- cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Referral – An authorization granted by the Participating Physician/Primary Care Provider for use of another provider.

Request for Reconsideration – A request to reconsider the initial determination.

Second Opinions – Provide an opportunity or requirement to obtain a clinical evaluation by a Provider other than the one originally making a recommendation for a proposed health service to assess the Medical Necessity and appropriateness of the initial proposed health service.

Service Area – A geographic area approved by CMS and/or the New Mexico office of the Superintendent of Insurance, within which an eligible individual may enroll in a Health Insurance Exchange Plan.

Skilled Nursing Care – Services ordered by a Physician which require the clinical skills and professional personnel of a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Skilled Care is provided directly by or under the supervision of such personnel to a patient who needs those services twenty-four (24) hours a day, along with other treatment, for recovery from illness or injury. Skilled Care does not include Custodial Care.

Skilled Nursing Facility – A place that:

1) Is legally operated as a Skilled Nursing Facility;
2) Primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Care under the supervision of a Physician;
3) Provides continuous 24 hour a day nursing service by or under the supervision of a Licensed Practical Nurse;
4) Maintains a daily medical record on each patient; and
5) Provides Rehabilitation services, such as Physical, Occupational and Speech therapy, and may provide other multidisciplinary services, such as Respiratory Therapy, dietician/nutrition services, and medical social work.

Specialist – A Physician who provides Covered Services for a specific disease or part of the body. Examples include internists who care for diseases of internal organs in adults; oncologists who care for patients with cancer; cardiologists who care for patients with heart Conditions; and orthopedists who care for patients with certain bone, joint, or muscle Conditions and psychiatrists care for Members with Behavioral Disorders or Mental Illness/Disorders.

Speech Therapy – The treatment and exercises for treating voice and speech and swallowing disorders due to diagnosed Illness or Injury provided by a qualified Provider.

Step Therapy – A utilization tool that requires members to first try another drug to treat the medical condition before the Plan will cover the drug the physician may have initially prescribed.

Subluxation – Misalignment, demonstrable by x-rays or Chiropractic examination, which produces pain and is correctible by manual manipulation

Subscriber – An individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the managed health care plan, or in the case of an individual contract, the person in whose name the contract is issued.

Summary of Benefits – The written materials required by NMSA 1978 Section 59A-57-4 to be given to the Grievant by the health care plan or group contract holder.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Tax Identification Number (TIN) – A number assigned by the Federal Government in which a business or entity is identified for filing and paying taxes related to the business or entity.

Termination Date – 11:59 pm on the last day of the month for which premiums were paid and the date that the Member's coverage ends.

Termination of Coverage – The cancellation or non-renewal of coverage provided by a health care plan to a Grievant but does not include a voluntary termination by a Grievant or termination of a health benefits plan that does not contain a renewal provision;

Third Party Liability – Recovery of the reasonable value of care and treatment furnished or to be furnished by or for the government to persons entitled to such care and treatment when such persons suffer injury or disease under circumstances which create tort or contractual liability on third parties, including insurance companies, to pay damages.

Treatment Plan – A treatment plan is a multidisciplinary care plan for each beneficiary in active case management. It includes specific services to be delivered, the frequency of services, expected duration, community resources, military resources, all funding options, treatment goals, and assessment of the beneficiary environment. The Plan is updated monthly and modified when appropriate. These plans are developed in collaboration with the attending provider and beneficiary or guardian.

Urgent Care –Medically Necessary Health Care Services provided in emergencies or after a Primary Care Provider's normal business hours for unforeseen Conditions due to Illness or Injury that are not life-threatening but require prompt medical attention.

Urgent Illness – A non-life-threatening illness that requires prompt medical attention. Some examples of urgent situations are sprains; a rising fever despite having taken medication; new ear pain; an asthma attack where medications are not helping; an animal bite; an object in the eye or eye infection; a cut that may need stitches; a child with severe vomiting or diarrhea; a possible broken bone; shortness of breath; a sore throat; flu symptoms; a urinary tract infection; or a migraine headache where medicines are not relieving the pain.

Utilization Management – Set of techniques used by or on behalf of purchasers of health care benefits to manage the cost of health care before its provision by influencing patient-care decision making through case-by-case assessments of the appropriateness of care based on accepted dental practices.

NEW MEXICO HEALTH INSURANCE EXCHANGE PLANS

CHRISTUS Health Plan New Mexico: Gold

Overall deductible	$2,600 person / $5,200 family Doesn't apply to preventive care, primary care, specialty care, Outpatient Mental Health/Substance Abuse, Laboratory, or X-Ray/Diagnostic Services	Members must pay all the costs up to the deductible amount before this plan begins to pay for covered services. The chart below shows for how much Members pay for covered services after they meet the deductible. Copays do not count towards the deductible.
Out–of–pocket limit on expenses	**$4,150** person **/ $8,300** family	The out-of-pocket limit is the most a Member could pay during a coverage period (usually one year) for their share of the cost of covered services.
Services Type	**Member Cost For Use Of Participating Provider**	**Limitations & Exceptions**
Primary care visit to treat an injury or illness	$5 copay/visit	Not subject to deductible
Specialist visit	$20 copay/visit	Not subject to deductible
Preventive care/screening/immunization	No charge	Not subject to deductible
Diagnostic test (x-ray, blood work)	$20 copay/test for x-rays and diagnostic imaging and No charge for blood work	Not subject to deductible
Imaging (CT/PET scans, MRIs)	$100 copay/test	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied.
Generic drugs	$ 4 copay/prescription (retail and mail order)	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
Preferred brand drugs	$ 35 copay/prescription (retail and mail order)	
Non-preferred brand drugs	$ 75 copay/ prescription (retail and mail order)	
Specialty drugs	15% coinsurance	
Facility fee (e.g., ambulatory surgery center)	15% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied.
Physician/surgeon fees	15% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied .
Emergency room services	$150 copay (in/out network)	——————none——————
Emergency medical transportation	15% coinsurance (in/out network)	
Urgent care	$20 copay/visit (in/out network)	——————none——————
Facility fee (e.g., hospital room)	$150 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fee	$150 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied

Mental/Behavioral health outpatient services	**$15 copay/visit**	**Not subject to deductible**
Mental/Behavioral health inpatient services	$150 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Substance use disorder outpatient services	$15 copay/visit	Not subject to deductible
Substance use disorder inpatient services	$150 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Prenatal and postnatal care	$20 copay/visit	Not subject to deductible
Delivery and all inpatient services	$150 copay/admit	See www.christushealthplan.com for more details
Home health care	15% coinsurance	——————none——————
Rehabilitation services	$20 copay/visit	——————none——————
Habilitation services	$20 copay/visit	——————none——————
Skilled nursing care	15% coinsurance	——————none——————
Durable medical equipment	15% coinsurance	——————none——————
Hospice service	15% coinsurance	——————none——————
Eye exam	No Charge	
Glasses	No Charge	
Children's Dental check-up	No Charge	Limited services covered. Refer to www.christushealthplan.com or the member handbook for more details

CHRISTUS Health Plan New Mexico: Gold S

Overall deductible	**$2,600 person / $5,200 family Doesn't apply to preventive care, primary care, specialty care, Outpatient Mental Health/Substance Abuse, Laboratory, or X-Ray/Diagnostic Services**	**Members must pay all the costs up to the deductible amount before this plan begins to pay for covered services. The chart below shows for how much Members pay for covered services after they meet the deductible. Copays do not count towards the deductible.**
Out–of–pocket limit on expenses	**$4,150** person **/ $8,300** family	The **out-of-pocket limit** is the most a Member could pay during a coverage period (usually one year) for their share of the cost of covered services.
Services Type	**Member Cost For Use Of Participating Provider**	**Limitations & Exceptions**
Primary care visit to treat an injury or illness	$5 copay/visit	Not subject to deductible
Specialist visit	$20 copay/visit	Not subject to deductible
Preventive care/screening/immunization	No charge	Not subject to deductible
Diagnostic test (x-ray, blood work)	$20 copay/test for x-rays and diagnostic imaging and No charge for blood work	Not subject to deductible
Imaging (CT/PET scans, MRIs)	$100 copay/test	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied.
Generic drugs	$ 4 copay/prescription (retail and mail order)	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
Preferred brand drugs	$ 35 copay/prescription (retail and mail order)	
Non-preferred brand drugs	$ 75 copay/ prescription (retail and mail order)	
Specialty drugs	15% coinsurance	
Facility fee (e.g., ambulatory surgery center)	15% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied.
Physician/surgeon fees	15% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied .
Emergency room services	$150 copay (in/out network)	——————none——————
Emergency medical transportation	15% coinsurance	
Urgent care	$20 copay/visit (in/out network)	——————none——————
Facility fee (e.g., hospital room)	$150 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fee	$150 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied

Mental/Behavioral health outpatient services	$15 copay/visit	Not subject to deductible
Mental/Behavioral health inpatient services	$150 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Substance use disorder outpatient services	$15 copay/visit	Not subject to deductible
Substance use disorder inpatient services	$150 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Prenatal and postnatal care	$20 copay/visit	Not subject to deductible
Delivery and all inpatient services	$150 copay/admit	See www.christushealthplan.com for more details
Home health care	15% coinsurance	——————none——————
Rehabilitation services	$20 copay/visit	——————none——————
Habilitation services	$20 copay/visit	——————none——————
Skilled nursing care	15% coinsurance	——————none——————
Durable medical equipment	15% coinsurance	——————none——————
Hospice service	15% coinsurance	——————none——————
Eye exam	No Charge	
Glasses	No Charge	
Children's Dental check-up	No Charge	Limited services covered. Refer to www.christushealthplan.com or the member handbook for more details

CHRISTUS Health Plan New Mexico: Silver HD

Overall deductible	**$5,000 person / $10,000 family Doesn't apply to preventive care, primary care, specialty care, Outpatient Mental Health/Substance Abuse, Laboratory, or X-Ray/Diagnostic Services/**	**Members must pay all the costs up to the deductible amount before this plan begins to pay for covered services. The chart below shows for how much Members pay for covered services after they meet the deductible. Copays do not count towards the deductible.**
Out–of–pocket limit on expenses	**$6,000**person / **$12,000** family	The **out-of-pocket limit** is the most a Member could pay during a coverage period (usually one year) for their share of the cost of covered services.
Services Type	**Member Cost For Use Of Participating Provider**	**Limitations & Exceptions**
Primary care visit to treat an injury or illness	$10 copay/visit	Not subject to deductible
Specialist visit	$35 copay/visit	Not subject to deductible
Preventive care/screening/immunization	No charge	Not subject to deductible
Diagnostic test (x-ray, blood work)	$30 copayment/test for x-rays and diagnostic imaging and No charge for blood work; deductible does not apply	
Imaging (CT/PET scans, MRIs)	$250 copay/test	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Generic drugs	$12 copay/prescription (retail and mail order)	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
Preferred brand drugs	$60 copay/prescription (retail and mail order)	
Non-preferred brand drugs	$95 copay/ prescription (retail and mail order)	
Specialty drugs	25% coinsurance	
Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fees	20% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Emergency room services	$250 copay (in/out network)	——————none——————
Emergency medical transportation	20% coinsurance (in/out network)	——————none——————
Urgent care	$35 copay/visit (in/out network)	——————none——————
Facility fee (e.g., hospital room)	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fee	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied

Mental/Behavioral health outpatient services	$20 copay/visit	Not subject to deductible
Mental/Behavioral health inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Substance use disorder outpatient services	$20 copay/visit	Not subject to deductible
Substance use disorder inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Prenatal and postnatal care	$35 copay/visit	Not subject to deductible
Delivery and all inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied See www.christushealthplan.com for more details
Home health care	20% coinsurance	——————none——————
Rehabilitation services	$30 copay/visit	——————none——————
Habilitation services	$30 copay/visit	——————none——————
Skilled nursing care	20% coinsurance	——————none——————
Durable medical equipment	20% coinsurance	——————none——————
Hospice service	20% coinsurance	——————none——————
Eye exam	No Charge	Limited to one exam per year for children, one every 24 months for adults
Glasses	No Charge	Limited to one pair of glasses per year for children, one every 24 months for adults. $100 allowance for frames or $150 for contacts
Children's Dental check-up	No Charge	Limited services covered. Refer to www.christushealthplan.com or the member handbook for more details.

CHRISTUS Health Plan New Mexico: Silver HD 73%

Overall deductible	$3,000 person / $6,000 family **Doesn't apply to preventive care, primary care, specialty care, Outpatient Mental Health/Substance Abuse, Laboratory, or X-Ray/Diagnostic Services/**	**Members must pay all the costs up to the deductible amount before this plan begins to pay for covered services. The chart below shows for how much Members pay for covered services after they meet the deductible. Copays do not count towards the deductible.**
Out–of–pocket limit on expenses	**$4,500** person **/ $9,000** family	The **out-of-pocket limit** is the most a Member could pay during a coverage period (usually one year) for their share of the cost of covered services.
Services Type	**Member Cost For Use Of Participating Provider**	**Limitations & Exceptions**
Primary care visit to treat an injury or illness	$10 copay/visit	Not subject to deductible
Specialist visit	$35 copay/visit	Not subject to deductible
Preventive care/screening/immunization	No charge	Not subject to deductible
Diagnostic test (x-ray, blood work)	$30 copayment/test for x-rays and diagnostic imaging and No charge for blood work	Not subject to deductible
Imaging (CT/PET scans, MRIs)	$250 copay/test	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied .
Generic drugs	$12 copay/prescription (retail and mail order)	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
Preferred brand drugs	$60 copay/prescription (retail and mail order)	
Non-preferred brand drugs	$95 copay/ prescription (retail and mail order)	
Specialty drugs	25% coinsurance	
Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied .
Physician/surgeon fees	20% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied .
Emergency room services	$250 copay (in/out network)	——————none——————
Emergency medical transportation	20% coinsurance (in/out network)	——————none——————
Urgent care	$35 copay/visit (in/out network)	——————none——————
Facility fee (e.g., hospital room)	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied .
Physician/surgeon fee	$1,000copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied

Mental/Behavioral health outpatient services	$20 copay/visit	Not subject to deductible
Mental/Behavioral health inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied .
Substance use disorder outpatient services	$20 copay/visit	Not subject to deductible
Substance use disorder inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied .
Prenatal and postnatal care	$35 copay/visit	Not subject to deductible
Delivery and all inpatient services	$1,000 copay/admit	See www.christushealthplan.com for more details Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Home health care	20% coinsurance	——————none——————
Rehabilitation services	$30 copay/visit	——————none——————
Habilitation services	$30 copay/visit	——————none——————
Skilled nursing care	20% coinsurance	——————none——————
Durable medical equipment	20% coinsurance	——————none——————
Hospice service	20% coinsurance	——————none——————
Eye exam	No Charge	Limited to one exam per year for children, one every 24 months for adults
Glasses	No Charge	Limited to one pair of glasses per year for children, one every 24 months for adults. $100 allowance for frames or $150 for contacts
Children's Dental check-up	No Charge	Limited services covered. Refer to www.christushealthplan.com or the member handbook for more details

CHRISTUS Health Plan New Mexico: Silver HD 87%

Overall deductible	**$550 person / $1,100 family** **Doesn't apply to preventive care, primary care, specialty care, Outpatient Mental Health/Substance Abuse, Laboratory, or X-Ray/Diagnostic Services/**	**Members must pay all the costs up to the deductible amount before this plan begins to pay for covered services. The chart below shows for how much Members pay for covered services after they meet the deductible. Copays do not count towards the deductible.**
Out–of–pocket limit on expenses	**$1,500** person **/ $3,000** family	The **out-of-pocket limit** is the most a Member could pay during a coverage period (usually one year) for their share of the cost of covered services.
Services Type	Member Cost For Use Of Participating Provider	Limitations & Exceptions
Primary care visit to treat an injury or illness	$10 copay/visit	Not subject to deductible
Specialist visit	$35 copay/visit	Not subject to deductible
Preventive care/screening/immunization	No charge	Not subject to deductible
Diagnostic test (x-ray, blood work)	$30 copayment/test for x-rays and diagnostic imaging and No charge for blood work	Not subject to deductible
Imaging (CT/PET scans, MRIs)	$250 copay/test	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied.
Generic drugs	$12 copay/prescription (retail and mail order)	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
Preferred brand drugs	$60 copay/prescription (retail and mail order)	
Non-preferred brand drugs	$95 copay/ prescription (retail and mail order)	
Specialty drugs	25% coinsurance	
Facility fee (e.g., ambulatory surgery center)	20% coinsurance	——————none——————
Physician/surgeon fees	20% coinsurance	——————none——————
Emergency room services	$250 copay (in/out network)	——————none——————
Emergency medical transportation	20% coinsurance (in/out network)	——————none——————
Urgent care	$35 copay/visit (in/out network)	——————none——————
Facility fee (e.g., hospital room)	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fee	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Mental/Behavioral health outpatient services	$20 copay/visit	Not subject to deductible
Mental/Behavioral health inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Substance use disorder outpatient services	$20 copay/visit	Not subject to deductible
Substance use disorder inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Prenatal and postnatal care	$35 copay/visit	Not subject to deductible
Delivery and all inpatient services	$1,000 copay/admit	See www.christushealthplan.com for more details Preauthorization is required. If you don't get preauthorization, benefits MAY be denied

Home health care	20% coinsurance	——————none——————
Rehabilitation services	$30 copay/visit	——————none——————
Habilitation services	$30 copay/visit	——————none——————
Skilled nursing care	20% coinsurance	——————none——————
Durable medical equipment	20% coinsurance	——————none——————
Hospice service	20% coinsurance	——————none——————
Eye exam	No Charge	
Glasses	No Charge	
Children's Dental check-up	No Charge	Limited services covered. Refer to www.christushealthplan.com or the member handbook for more details

CHRISTUS Health Plan New Mexico: Silver HD 94%

Overall deductible	**$125 person / $250 family Doesn't apply to preventive care, primary care, specialty care, Outpatient Mental Health/Substance Abuse, Laboratory, or X-Ray/Diagnostic Services/**	**Members must pay all the costs up to the deductible amount before this plan begins to pay for covered services. The chart below shows for how much Members pay for covered services after they meet the deductible. Copays do not count towards the deductible.**
Out–of–pocket limit on expenses	**$500** person **/ $1,000** family	The **out-of-pocket limit** is the most a Member could pay during a coverage period (usually one year) for their share of the cost of covered services.
Services Type	**Member Cost For Use Of Participating Provider**	**Limitations & Exceptions**
Primary care visit to treat an injury or illness	$10 copay/visit	Not subject to deductible
Specialist visit	$35 copay/visit	Not subject to deductible
Preventive care/screening/immunization	No charge	Not subject to deductible
Diagnostic test (x-ray, blood work)	$30 copayment/test for x-rays and diagnostic imaging and No charge for blood work	Not subject to deductible
Imaging (CT/PET scans, MRIs)	$250 copay/test	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied.
Generic drugs	$12 copay/prescription (retail and mail order)	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
Preferred brand drugs	$60 copay/prescription (retail and mail order)	
Non-preferred brand drugs	$95 copay/ prescription (retail and mail order)	
Specialty drugs	25% coinsurance	
Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fees	20% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Emergency room services	$250 copay (in/out network)	——————none——————
Emergency medical transportation	20% coinsurance (in/out network)	——————none——————
Urgent care	$35 copay/visit (in/out network)	——————none——————
Facility fee (e.g., hospital room)	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fee	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Mental/Behavioral health outpatient services	$20 copay/visit	Not subject to deductible
Mental/Behavioral health inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Substance use disorder outpatient services	$20 copay/visit	Not subject to deductible
Substance use disorder inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Prenatal and postnatal care	$35 copay/visit	Not subject to deductible

Delivery and all inpatient services	$1,000 copay/admit	See www.christushealthplan.com for more details Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Home health care	20% coinsurance	——————none——————
Rehabilitation services	$30 copay/visit	——————none——————
Habilitation services	$30 copay/visit	——————none——————
Skilled nursing care	20% coinsurance	——————none——————
Durable medical equipment	20% coinsurance	——————none——————
Hospice service	20% coinsurance	——————none——————
Eye exam	No Charge	
Glasses	No Charge	
Children's Dental check-up	No Charge	Limited services covered. Refer to www.christushealthplan.com or the member handbook for more details

CHRISTUS Health Plan New Mexico: Silver LD

Overall deductible	$3,000 **person** / $6,000 **family Doesn't apply to preventive care, primary care, specialty care, Outpatient Mental Health Substance Abuse, Laboratory, or X-Ray Diagnostic Services/**	**Members must pay all the costs up to the** deductible **amount before this plan begins to pay for covered services. The chart below shows for how much Members pay for covered services after they meet the** deductible**. Copays do not count towards the deductible.**
Out–of–pocket limit on expenses	**$5,000** person **/ $10,000** family	The **out-of-pocket limit** is the most a Member could pay during a coverage period (usually one year) for their share of the cost of covered services.
Services Type	**Member Cost For Use Of Participating Provider**	**Limitations & Exceptions**
Primary care visit to treat an injury or illness	$10 copay/visit	Not subject to deductible
Specialist visit	$35 copay/visit	Not subject to deductible
Preventive care/screening/immunization	No charge	Not subject to deductible
Diagnostic test (x-ray, blood work)	$30 copayment/test for x-rays and diagnostic imaging and No charge for blood work	Not subject to deductible
Imaging (CT/PET scans, MRIs)	$250 copay/test	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied.
Generic drugs	$12 copay/prescription (retail and mail order)	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
Preferred brand drugs	$60 copay/prescription (retail and mail order)	
Non-preferred brand drugs	$95 copay/ prescription (retail and mail order)	
Specialty drugs	35% coinsurance	
Facility fee (e.g., ambulatory surgery center)	35% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied.
Physician/surgeon fees	35% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied.
Emergency room services	$250 copay (in/out network)	——————none——————
Emergency medical transportation	35% coinsurance (in/out network)	——————none——————
Urgent care	$35 copay/visit (in/out network)	——————none——————
Facility fee (e.g., hospital room)	$1,000copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fee	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Mental/Behavioral health outpatient services	$30 copay/visit	Not subject to deductible
Mental/Behavioral health inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Substance use disorder outpatient services	$30 copay/visit	Not subject to deductible
Substance use disorder inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Prenatal and postnatal care	$35 copay/visit	Not subject to deductible
Delivery and all inpatient services	$1,000 copay/admit	See www.christushealthplan.com for more details

		Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Home health care	35%coinsurance	——————none——————
Rehabilitation services	$30 copay/visit	——————none——————
Habilitation services	$30 copay/visit	——————none——————
Skilled nursing care	35% coinsurance	——————none——————
Durable medical equipment	35% coinsurance	——————none——————
Hospice service	35% coinsurance	——————none——————
Eye exam	No Charge	Limited to one exam per year for children, one every 24 months for adults
Glasses	No Charge	Limited to one pair of glasses per year for children, one every 24 months for adults. $100 allowance for frames or $150 for contacts
Children'sDental check-up	No Charge	Limited services covered. Refer to www.christushealthplan.com or the member handbook for more details

CHRISTUS Health Plan New Mexico: Silver LD 73%

Overall deductible	$2,500 person / $5,000 family **Doesn't apply to preventive care, primary care, specialty care, Outpatient Mental Health/Substance Abuse, Laboratory, or X-Ray/Diagnostic Services/**	**Members must pay all the costs up to the deductible amount before this plan begins to pay for covered services. The chart below shows for how much Members pay for covered services after they meet the deductible. Copays do not count towards the deductible.**
Out–of–pocket limit on expenses	**$4,000**person **/ $8,000** family	The **out-of-pocket limit** is the most a Member could pay during a coverage period (usually one year) for their share of the cost of covered services.
Services Type	**Member Cost For Use Of Participating Provider**	**Limitations & Exceptions**
Primary care visit to treat an injury or illness	$10 copay/visit	Not subject to deductible
Specialist visit	$35copay/visit	Not subject to deductible
Preventive care/screening/immunization	No charge	Not subject to deductible
Diagnostic test (x-ray, blood work)	$30 copayment/test for x-rays and diagnostic imaging and No charge for blood work	Not subject to deductible
Imaging (CT/PET scans, MRIs)	$250 copay/test	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied.
Generic drugs	$12 copay/prescription (retail and mail order)	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
Preferred brand drugs	$60 copay/prescription (retail and mail order)	
Non-preferred brand drugs	$95 copay/ prescription (retail and mail order)	
Specialty drugs	35% coinsurance	
Facility fee (e.g., ambulatory surgery center)	35% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fees	35% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Emergency room services	$250 copay (in/out network)	——————none——————
Emergency medical transportation	35% coinsurance (in/out network)	——————none——————
Urgent care	$35 copay/visit (in/out network)	——————none——————
Facility fee (e.g., hospital room)	$1,000copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fee	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Mental/Behavioral health outpatient services	$30 copay/visit	Not subject to deductible
Mental/Behavioral health inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Substance use disorder outpatient services	$30 copay/visit	Not subject to deductible
Substance use disorder inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Prenatal and postnatal care	$35 copay/visit	Not subject to deductible
Delivery and all inpatient services	$1,000 copay/admit	See www.christushealthplan.com for more details

Home health care	35%coinsurance	——————none——————
Rehabilitation services	$30 copay/visit	——————none——————
Habilitation services	$30 copay/visit	——————none——————
Skilled nursing care	35% coinsurance	——————none——————
Durable medical equipment	35% coinsurance	——————none——————
Hospice service	35% coinsurance	——————none——————
Eye exam	No Charge	
Glasses	No Charge	
Children's Dental check-up	No Charge	Limited services covered. Refer to www.christushealthplan.com or the member handbook for more details

CHRISTUS Health Plan New Mexico: Silver LD 87%

Overall deductible	$550person / $1,100 family **Doesn't apply to preventive care, primary care, specialty care, Outpatient Mental Health/Substance Abuse, Laboratory, or X-Ray/Diagnostic Services/**	**Members must pay all the costs up to the deductible amount before this plan begins to pay for covered services. The chart below shows for how much Members pay for covered services after they meet the deductible. Copays do not count towards the deductible.**
Out–of–pocket limit on expenses	**$1,500** person **/ $3,000** family	The **out-of-pocket limit** is the most a Member could pay during a coverage period (usually one year) for their share of the cost of covered services.
Services Type	**Member Cost For Use Of Participating Provider**	**Limitations & Exceptions**
Primary care visit to treat an injury or illness	$10 copay/visit	Not subject to deductible
Specialist visit	$35 copay/visit	Not subject to deductible
Preventive care/screening/immunization	No charge	Not subject to deductible
Diagnostic test (x-ray, blood work)	$30 copayment/test for x-rays and diagnostic imaging and No charge for blood work	Not subject to deductible
Imaging (CT/PET scans, MRIs)	$250 copay/test	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied.
Generic drugs	$12 copay/prescription (retail and mail order)	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Not subject to deductible.
Preferred brand drugs	$60 copay/prescription (retail and mail order)	Not subject to deductible.
Non-preferred brand drugs	$95 copay/ prescription (retail and mail order)	Not subject to deductible.
Specialty drugs	35% coinsurance	Not subject to deductible
Facility fee (e.g., ambulatory surgery center)	35% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fees	35% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Emergency room services	$250 copay (in/out network)	——————none——————
Emergency medical transportation	35% coinsurance (in/out network)	——————none——————
Urgent care	$35 copay/visit (in/out network)	——————none——————
Facility fee (e.g., hospital room)	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fee	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Mental/Behavioral health outpatient services	$30 copay/visit	Not subject to deductible
Mental/Behavioral health inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Substance use disorder outpatient services	$30 copay/visit	Not subject to deductible
Substance use disorder inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Prenatal and postnatal care	$35 copay/visit	Not subject to deductible
Delivery and all inpatient services	$1,000 copay/admit	See www.christushealthplan.com for more details Preauthorization is required. If you don't get preauthorization, benefits MAY be denied

Home health care	35% coinsurance	——————none——————
Rehabilitation services	$30 copay/visit	——————none——————
Habilitation services	$30 copay/visit	——————none——————
Skilled nursing care	35% coinsurance	——————none——————
Durable medical equipment	35% coinsurance	——————none——————
Hospice service	35% coinsurance	——————none——————
Eye exam	No Charge	
Glasses	No Charge	
Children's Dental check-up	No Charge	Limited services covered. Refer to www.christushealthplan.com or the member handbook for more details

CHRISTUS Health Plan New Mexico: Silver LD 94%

Overall deductible	**$125 person / $250 family Doesn't apply to preventive care, primary care, specialty care, Outpatient Mental Health/Substance Abuse, Laboratory, or X-Ray/Diagnostic Services/**	**Members must pay all the costs up to the deductible amount before this plan begins to pay for covered services. The chart below shows for how much Members pay for covered services after they meet the deductible. Copays do not count towards the deductible.**
Out–of–pocket limit on expenses	$500 person / $1,000 family	The **out-of-pocket limit** is the most a Member could pay during a coverage period (usually one year) for their share of the cost of covered services.
Services Type	**Member Cost For Use Of Participating Provider**	**Limitations & Exceptions**
Primary care visit to treat an injury or illness	$10 copay/visit	Not subject to deductible
Specialist visit	$35 copay/visit	Not subject to deductible
Preventive care/screening/immunization	No charge	Not subject to deductible
Diagnostic test (x-ray, blood work)	$30 copayment/test for x-rays and diagnostic imaging and No charge for blood work	Not subject to deductible
Imaging (CT/PET scans, MRIs)	$250 copay/test	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied.
Generic drugs	$12 copay/prescription (retail and mail order)	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
Preferred brand drugs	$60 copay/prescription (retail and mail order)	
Non-preferred brand drugs	$95 copay/ prescription (retail and mail order)	
Specialty drugs	35% coinsurance	
Facility fee (e.g., ambulatory surgery center)	35% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fees	35% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Emergency room services	$150 copay (in/out network)	——————none——————
Emergency medical transportation	10% coinsurance (in/out network)	——————none——————
Urgent care	$20 copay/visit	——————none——————
Facility fee (e.g., hospital room)	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fee	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Mental/Behavioral health outpatient services	$30 copay/visit	Not subject to deductible
Mental/Behavioral health inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Substance use disorder outpatient services	$30 copay/visit	Not subject to deductible
Substance use disorder inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Prenatal and postnatal care	$35 copay/visit	Not subject to deductible
Delivery and all inpatient services	$1,000 copay/admit	See www.christushealthplan.com for more details Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Home health care	35% coinsurance	——————none——————
Rehabilitation services	$30 copay/visit	——————none——————
Habilitation services	$30 copay/visit	——————none——————
Skilled nursing care	35% coinsurance	——————none——————

Durable medical equipment	35% coinsurance	—————none—————
Hospice service	35% coinsurance	—————none—————
Eye exam	No Charge	
Glasses	No Charge	
Children's Dental check-up	No Charge	Limited services covered. Refer to www.christushealthplan.com or the member handbook for more details

CHRISTUS Health Plan New Mexico: Silver SLD

Overall deductible	$3,000 person / $6,000 family Doesn't apply to preventive care, primary care, specialty care, Outpatient Mental Health/Substance Abuse, Laboratory, or X-Ray/Diagnostic Services/	Members must pay all the costs up to the deductible amount before this plan begins to pay for covered services. The chart below shows for how much Members pay for covered services after they meet the deductible. Copays do not count towards the deductible.
Out–of–pocket limit on expenses	**$5,000** person **/ $10,000** family	The **out-of-pocket limit** is the most a Member could pay during a coverage period (usually one year) for their share of the cost of covered services.
Services Type	**Member Cost For Use Of Participating Provider**	**Limitations & Exceptions**
Primary care visit to treat an injury or illness	$10 copay/visit	Not subject to deductible
Specialist visit	$35 copay/visit	Not subject to deductible
Preventive care/screening/immunization	No charge	Not subject to deductible
Diagnostic test (x-ray, blood work)	$30 copayment/test for x-rays and diagnostic imaging and No charge for blood work	Not subject to deductible
Imaging (CT/PET scans, MRIs)	$250 copay/test	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied.
Generic drugs	$12 copay/prescription (retail and mail order)	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)..
Preferred brand drugs	$60 copay/prescription (retail and mail order)	
Non-preferred brand drugs	$95 copay/ prescription (retail and mail order)	
Specialty drugs	35% coinsurance	
Facility fee (e.g., ambulatory surgery center)	35% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fees	35% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Emergency room services	$250 copay (in/out network)	——————none——————
Emergency medical transportation	35% coinsurance (in/out network)	——————none——————
Urgent care	$35 copay/visit (in/out network)	——————none——————
Facility fee (e.g., hospital room)	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fee	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied

Mental/Behavioral health outpatient services	$30 copay/visit	Not subject to deductible
Mental/Behavioral health inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Substance use disorder outpatient services	$30 copay/visit	Not subject to deductible
Substance use disorder inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Prenatal and postnatal care	$35 copay/visit	Not subject to deductible
Delivery and all inpatient services	$1,000 copay/admit	See www.christushealthplan.com for more details Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Home health care	35% coinsurance	——————none——————
Rehabilitation services	$30 copay/visit	——————none——————
Habilitation services	$30 copay/visit	——————none——————
Skilled nursing care	35% coinsurance	——————none——————
Durable medical equipment	35% coinsurance	——————none——————
Hospice service	35% coinsurance	——————none——————
Eye exam	No Charge	
Glasses	No Charge	
Children's Dental check-up	No Charge	Limited services covered. Refer to www.christushealthplan.com or the member handbook for more details

CHRISTUS Health Plan New Mexico: Silver SLD 73%

Overall deductible	$2,500 person / $5,000 family Doesn't apply to preventive care, primary care, specialty care, Outpatient Mental Health/Substance Abuse, Laboratory, or X-Ray/Diagnostic Services/	Members must pay all the costs up to the deductible amount before this plan begins to pay for covered services. The chart below shows for how much Members pay for covered services after they meet the deductible. Copays do not count towards the deductible.
Out–of–pocket limit on expenses	**$4,000** person **/ $8,000** family	The **out-of-pocket limit** is the most a Member could pay during a coverage period (usually one year) for their share of the cost of covered services.
Services Type	**Member Cost For Use Of Participating Provider**	**Limitations & Exceptions**
Primary care visit to treat an injury or illness	$10 copay/visit	Not subject to deductible
Specialist visit	$35 copay/visit	Not subject to deductible
Preventive care/screening/immunization	No charge	Not subject to deductible
Diagnostic test (x-ray, blood work)	$30 copayment/test for x-rays and diagnostic imaging and No charge for blood work	Not subject to deductible
Imaging (CT/PET scans, MRIs)	$250 copay/test	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Generic drugs	$12 copay/prescription (retail and mail order)	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
Preferred brand drugs	$60 copay/prescription (retail and mail order)	
Non-preferred brand drugs	$95 copay/ prescription (retail and mail order)	
Specialty drugs	35% coinsurance	
Facility fee (e.g., ambulatory surgery center)	35% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fees	35% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Emergency room services	$250 copay (in/out network)	——————none——————
Emergency medical transportation	35% coinsurance (in/out network)	——————none——————
Urgent care	$35 copay/visit (in/out network)	——————none——————
Facility fee (e.g., hospital room)	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fee	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Mental/Behavioral health outpatient services	$30 copay/visit	Not subject to deductible
Mental/Behavioral health inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Substance use disorder outpatient services	$30 copay/visit	Not subject to deductible
Substance use disorder inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Prenatal and postnatal care	$35 copay/visit	Not subject to deductible
Delivery and all inpatient services	$1,000 copay/admit	See www.christushealthplan.com for more details Preauthorization is required. If you don't get preauthorization, benefits MAY be denied

Home health care	35% coinsurance	——————none——————
Rehabilitation services	$30 copay/visit	——————none——————
Habilitation services	$30 copay/visit	——————none——————
Skilled nursing care	35% coinsurance	——————none——————
Durable medical equipment	35% coinsurance	——————none——————
Hospice service	35% coinsurance	——————none——————
Eye exam	No Charge	
Glasses	No Charge	
Children's Dental check-up	No Charge	Limited services covered. Refer to www.christushealthplan.com or the member handbook for more details

CHRISTUS Health Plan New Mexico: Silver SLD 87%

Overall deductible	$550 person / $1,100 family Doesn't apply to preventive care, primary care, specialty care, Outpatient Mental Health/Substance Abuse, Laboratory, or X-Ray/Diagnostic Services/	Members must pay all the costs up to the deductible amount before this plan begins to pay for covered services. The chart below shows for how much Members pay for covered services after they meet the deductible. Copays do not count towards the deductible.
Out–of–pocket limit on expenses	$1,500 person / $3,000 family	The out-of-pocket limit is the most a Member could pay during a coverage period (usually one year) for their share of the cost of covered services.
Services Type	**Member Cost For Use Of Participating Provider**	**Limitations & Exceptions**
Primary care visit to treat an injury or illness	$10 copay/visit	Not subject to deductible
Specialist visit	$35 copay/visit	Not subject to deductible
Preventive care/screening/immunization	No charge	Not subject to deductible
Diagnostic test (x-ray, blood work)	$30 copayment/test for x-rays and diagnostic imaging and No charge for blood work	Not subject to deductible
Imaging (CT/PET scans, MRIs)	$250 copay/test	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Generic drugs	$12 copay/prescription (retail and mail order)	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
Preferred brand drugs	$60 copay/prescription (retail and mail order)	
Non-preferred brand drugs	$95 copay/ prescription (retail and mail order)	
Specialty drugs	35% coinsurance	
Facility fee (e.g., ambulatory surgery center)	35% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fees	35% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Emergency room services	$250 copay (in/out network)	——————none——————
Emergency medical transportation	35% coinsurance (in/out network)	——————none——————
Urgent care	$35 copay/visit (in/out network)	——————none——————
Facility fee (e.g., hospital room)	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fee	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Mental/Behavioral health outpatient services	$30 copay/visit	Not subject to deductible
Mental/Behavioral health inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Substance use disorder outpatient services	$30 copay/visit	Not subject to deductible
Substance use disorder inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Prenatal and postnatal care	$35 copay/visit	Not subject to deductible
Delivery and all inpatient services	$1,000 copay/admit	See www.christushealthplan.com for more details Preauthorization is required. If you don't get preauthorization, benefits MAY be denied

Home health care	**35% coinsurance**	**——————none——————**
Rehabilitation services	$30 copay/visit	——————none——————
Habilitation services	$30 copay/visit	——————none——————
Skilled nursing care	35% coinsurance	——————none——————
Durable medical equipment	35% coinsurance	——————none——————
Hospice service	35% coinsurance	——————none——————
Eye exam	No Charge	
Glasses	No Charge	
Children's Dental check-up	No Charge	Limited services covered. Refer to www.christushealthplan.com or the member handbook for more details

CHRISTUS Health Plan New Mexico: Silver SLD 94%

Overall deductible	$125 person / $250 family Doesn't apply to preventive care, primary care, specialty care, Outpatient Mental Health/Substance Abuse, Laboratory, or X-Ray/Diagnostic Services/	Members must pay all the costs up to the deductible amount before this plan begins to pay for covered services. The chart below shows for how much Members pay for covered services after they meet the deductible. Copays do not count towards the deductible.
Out–of–pocket limit on expenses	$500 person / $1,000family	The out-of-pocket limit is the most a Member could pay during a coverage period (usually one year) for their share of the cost of covered services.
Services Type	**Member Cost For Use Of Participating Provider**	**Limitations & Exceptions**
Primary care visit to treat an injury or illness	$10 copay/visit	Not subject to deductible
Specialist visit	$35 copay/visit	Not subject to deductible
Preventive care/screening/immunization	No charge	Not subject to deductible
Diagnostic test (x-ray, blood work)	$30 copayment/test for x-rays and diagnostic imaging and No charge for blood work	Not subject to deductible
Imaging (CT/PET scans, MRIs)	$250 copay/test	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Generic drugs	$12 copay/prescription (retail and mail order)	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
Preferred brand drugs	$60 copay/prescription (retail and mail order)	
Non-preferred brand drugs	$95 copay/ prescription (retail and mail order)	
Specialty drugs	35% coinsurance	
Facility fee (e.g., ambulatory surgery center)	35% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fees	35% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Emergency room services	$250 copay (in/out network)	——————none——————
Emergency medical transportation	35% coinsurance (in/out network)	——————none——————
Urgent care	$35 copay/visit (in/out network)	——————none——————
Facility fee (e.g., hospital room)	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Physician/surgeon fee	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Mental/Behavioral health outpatient services	$30 copay/visit	Not subject to deductible
Mental/Behavioral health inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Substance use disorder outpatient services	$30 copay/visit	Not subject to deductible
Substance use disorder inpatient services	$1,000 copay/admit	Preauthorization is required. If you don't get preauthorization, benefits MAY be denied
Prenatal and postnatal care	$35 copay/visit	Not subject to deductible
Delivery and all inpatient services	$1,000 copay/admit	See www.christushealthplan.com for more details Preauthorization is required. If you don't get preauthorization, benefits MAY be denied

Home health care	35% coinsurance	——————none——————
Rehabilitation services	$30 copay/visit	——————none——————
Habilitation services	$30 copay/visit	——————none——————
Skilled nursing care	35% coinsurance	——————none——————
Durable medical equipment	35% coinsurance	——————none——————
Hospice service	35% coinsurance	——————none——————
Eye exam	No Charge	
Glasses	No Charge	
Children's Dental check-up	No Charge	Limited services covered. Refer to www.christushealthplan.com or the member handbook for more details

CHRISTUS Health Plan New Mexico: Catastrophic

Overall deductible	$7,350 person / $14,700	Members must pay all the costs up to the deductible amount before this plan begins to pay for covered services. The chart below shows for how much Members pay for covered services after they meet the deductible. Copays do not count towards the deductible.
Out–of–pocket limit on expenses	$7,350 person / $14,700	The out-of-pocket limit is the most a Member could pay during a coverage period (usually one year) for their share of the cost of covered services.
Services Type	**Member Cost For Use Of Participating Provider**	**Limitations & Exceptions**
Primary care visit to treat an injury or illness	No Charge After Deductible	————none————
Specialist visit	No Charge After Deductible	————none————
Other practitioner office visit	No Charge After Deductible	————none————
Preventive care/screening/immunization	No charge	————none————
Diagnostic test (x-ray, blood work)	No Charge After Deductible	————none————
Imaging (CT/PET scans, MRIs)	No Charge After Deductible	————none————
Generic drugs	No Charge After Deductible	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). ————none————
Preferred brand drugs	No Charge After Deductible	————none————
Non-preferred brand drugs	No Charge After Deductible	————none————
Specialty drugs	No Charge After Deductible	————none————
Facility fee (e.g., ambulatory surgery center)	No Charge After Deductible	————none————
Physician/surgeon fees	No Charge After Deductible	————none————
Emergency room services	No Charge After Deductible	————none————
Emergency medical transportation	No Charge After Deductible	————none————
Urgent care	No Charge After Deductible	————none————
Facility fee (e.g., hospital room)	No Charge After Deductible	————none————
Physician/surgeon fee	No Charge After Deductible	————none————
Mental/Behavioral health outpatient services	No Charge After Deductible	————none————
Mental/Behavioral health inpatient services	No Charge After Deductible	————none————
Substance use disorder outpatient services	No Charge After Deductible	————none————
Substance use disorder inpatient services	No Charge After Deductible	————none————
Prenatal and postnatal care	No Charge After Deductible	————none————
Delivery and all inpatient services	No Charge After Deductible	See www.christushealthplan.com for more details
Home health care	No Charge After Deductible	————none————
Rehabilitation services	No Charge After Deductible	————none————
Habilitation services	No Charge After Deductible	————none————
Skilled nursing care	No Charge After Deductible	————none————
Durable medical equipment	No Charge After Deductible	————none————
Hospice service	No Charge After Deductible	————none————
Eye exam	No Charge After Deductible	
Glasses	No Charge After Deductible	
Dental check-up	No Charge After Deductible	Limited services covered. Refer to www.christushealthplan.com or the member handbook for more details

CHRISTUS Health Plan New Mexico: Catastrophic S

Overall deductible	$7,350 person / $14,700 family	Members must pay all the costs up to the deductible amount before this plan begins to pay for covered services. The chart below shows for how much Members pay for covered services after they meet the deductible. Copays do not count towards the deductible.
Out–of–pocket limit on expenses	$7,350 person / $14,700 family	The out-of-pocket limit is the most a Member could pay during a coverage period (usually one year) for their share of the cost of covered services.
Services Type	**Member Cost For Use Of Participating Provider**	**Limitations & Exceptions**
Primary care visit to treat an injury or illness	No Charge After Deductible	————none————
Specialist visit	No Charge After Deductible	————none————
Other practitioner office visit	No Charge After Deductible	————none————
Preventive care/screening/immunization	No charge	Not subject to deductible
Diagnostic test (x-ray, blood work)	No Charge After Deductible	————none————
Imaging (CT/PET scans, MRIs)	No Charge After Deductible	————none————
Generic drugs	No Charge After Deductible	————none————
Preferred brand drugs	No Charge After Deductible	————none————
Non-preferred brand drugs	No Charge After Deductible	————none————
Specialty drugs	No Charge After Deductible	————none————
Facility fee (e.g., ambulatory surgery center)	No Charge After Deductible	————none————
Physician/surgeon fees	No Charge After Deductible	————none————
Emergency room services	No Charge After Deductible	————none————
Emergency medical transportation	No Charge After Deductible	————none————
Urgent care	No Charge After Deductible	————none————
Facility fee (e.g., hospital room)	No Charge After Deductible	————none————
Physician/surgeon fee	No Charge After Deductible	————none————
Mental/Behavioral health outpatient services	No Charge After Deductible	————none————
Mental/Behavioral health inpatient services	No Charge After Deductible	————none————
Substance use disorder outpatient services	No Charge After Deductible	————none————
Substance use disorder inpatient services	No Charge After Deductible	————none————
Prenatal and postnatal care	No Charge After Deductible	————none————
Delivery and all inpatient services	No Charge After Deductible	See www.christushealthplan.com for more details
Home health care	No Charge After Deductible	————none————
Rehabilitation services	No Charge After Deductible	————none————
Habilitation services	No Charge After Deductible	————none————
Skilled nursing care	No Charge After Deductible	————none————
Durable medical equipment	No Charge After Deductible	————none————
Hospice service	No Charge After Deductible	————none————
Eye exam	No Charge After Deductible	
Glasses	No Charge After Deductible	
Dental check-up	No Charge After Deductible	Limited services covered. Refer to www.christushealthplan.com or the member handbook for more details