

State of New Mexico

Summary of Benefits – July 1, 2013



**BlueCross BlueShield
of New Mexico**

The following are the highlights of the State of New Mexico PPO Plan administered by Blue Cross and Blue Shield of New Mexico (BCBSNM). Any services received must be medically necessary to be covered.

Benefit Highlights		Preferred Provider ^{1,2}	NonPreferred Provider ^{1,2}
Highlights of Cost-Sharing Features	Annual Plan Year Deductible¹ (All services are subject to deductible unless noted otherwise.)	\$700/Individual \$1,400/Two-Person \$2,100/Family*	\$2,800/Individual \$5,600/Two-Person \$8,400/Family*
	Annual Plan Year Out-of-Pocket Limit² (Includes medical deductible, coinsurance, and copayments only; not drug plan payments.)	\$3,500/Individual \$7,000/Two Person \$10,500/ Family*	\$7,000/Individual \$14,000/Two Person \$21,000/Family*
	Lifetime Maximum	Unlimited (Certain services are subject to Plan year and/or lifetime maximums or are limited per condition.)	
Type of Service	Description of Service and Limitations	Your Share After Plan Year Deductible ^{1,2}	
		Preferred Provider	NonPreferred Provider
Physician Services, Office	PPO Primary Provider (PPP) Office Visit/Exam Copayment (non-preventive) <ul style="list-style-type: none"> Office Surgery (including casts, splints, etc.) Lab Tests, X-Rays EKGs, Other Diagnostics 	\$30 per visit (deductible waived) \$30 per visit (deductible waived) ⁴ 20%	50% ⁴
	Other non-Routine Office Services: Includes services of non-PPP preferred providers (PPO Specialists) and nonpreferred providers. <ul style="list-style-type: none"> Office Surgery Therapeutic Injections, Allergy Tests, Serum Allergy Injections 	\$50 per visit ⁴ \$50 per visit ⁴ No copay (deductible waived)	50% ⁴
	Preventive Services: including immunizations, lab, x-ray, colonoscopies, pap tests, mammograms, immunizations, and other wellness services; smoking/tobacco cessation counseling, etc.	No charge (deductible waived)	50% (deductible waived)
Diagnostic Testing, Outpatient	<ul style="list-style-type: none"> PET scans, CT scans, MRIs, (unless covered as part of a fixed-dollar copayment during ER visit, admission, etc.) Other lab, x-ray, EKGs, diagnostic services 	20% (up to a max. member share of \$200 per test) ⁴ 20% ⁴	50% ⁴
Inpatient Hospital Services, Acute Care	Hospitalization (includes semi-private room, board, drugs, medications, and ancillaries; inpatient physician visits, surgeon, assistant, and anesthesiologist)	\$1,000 per admission (Related physician subject to deductible then 20%; no copay applies) ^{4,5}	50% ^{4,5}
Outpatient Hospital Services	Surgery – operating and recovery room	20% ⁴	50% ⁴
	Observation (nonemergency)	\$500 per visit ⁴	50% ⁴
	Other treatment room services not otherwise specified in this Summary	20% ⁴	50% ⁴
Emergency Services and Urgent Care	Related physician services (e.g., anesthesiologist, surgeon)	20%	50%
	Emergency room or emergency observation room visit	\$175 per visit	\$175 per visit ³
	Urgent care center	\$50 per visit	\$50 per visit
	Ambulance (nonemergency air transfer)	20% ⁴	50% ⁴
Transplants	Ambulance (emergency ground and air transport)	20% ³	20% ³
	Bone marrow, heart, heart-lung, liver, lung, pancreas-kidney, and other medically necessary transplants (Case management required. Maximums apply to covered travel & lodging fees.)	Applicable copays based on place and type of service ^{4,5,6}	Not covered

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

Type of Service	Description of Service and Limitations	Your Share After Plan Year Deductible ^{1,2}	
		Preferred Provider	NonPreferred Provider
Maternity Services	Initial visit to confirm pregnancy	\$30 for initial visit if to a PPP (deductible waived)	50%
	Physician/midwife services (delivery, prenatal/postnatal care)	Applicable copays based on place and type of service ^{4,5}	50% ^{4,5}
	Hospital admission	\$1,000 per admission ^{4,5}	50% ^{4,5}
	Routine nursery care for covered newborn (Child covered from birth, but must apply for coverage within 31 days.)	No copay (Related physician subject to deductible then no copay)	50% ^{4,5}
Mental Health and Substance Abuse Rehabilitation Services	Outpatient /Office services	\$30 per visit ⁴	50% ^{4,5}
	Inpatient services	\$1,000 per admission ^{4,5}	
	Partial hospitalization	\$500 per admission ^{5,7}	
	Intensive outpatient program	\$50 per visit ^{5,7}	
	Residential treatment center (max. 60 days/plan year)	\$1,000 per admission (Related inpatient, RTC, partial hospital physician = No copay after deductible is met) ^{4,5,7}	
Other Office and Home Services	Acupuncture/Chiropractic Services (limited to \$1,500/plan year combined)	\$50 per visit	50%
	Biofeedback (for specified conditions only)	\$50 per visit	50%
	Cardiac and Pulmonary rehabilitation	\$50 per visit ⁴	50% ⁴
	Chemotherapy, radiation therapy; dialysis	\$50 per visit ⁴	50% ⁴
	Durable medical equipment, diabetic equipment, and supplies; orthopedic appliances, prosthetics and orthotics (Rental benefits may not exceed the purchase price of a new unit. Supplies limited to a 30-day supply during a 30-day period)	25% ⁴ (unlimited benefit)	50% ⁴
	Hearing exam/test	\$50 per visit	50%
	Hearing aids (max. benefit of \$2,500 per ear every 36 months starting with date of purchase)	No copay (deductible waived) ⁴	No copay (deductible waived) ⁴
	Home health care and home I.V. services (up to 100 visits per Plan year)	\$50 per visit ⁴	50% ⁴
	Hospice	No charge ⁴ (deductible waived)	50% ⁴
	Naprapathy (limited to \$500/plan year)	\$50 per visit	50%
	Rehabilitation facility and Skilled nursing facility	\$1,000 per admission ^{4,5} (Related professional charges = No copay after deductible is met)	50% ^{4,5}
	Short-term rehabilitation: outpatient/office Physical, Occupational, and Speech therapies	\$50 per visit ⁴	50% ⁴
TMJ/CMJ, oral surgery, & dental accident services	Applicable copayments, deductible, and/or coinsurance based on place and type of treatment		

***Note about Family deductibles and out-of-pocket limits:** If you have a Family contract, an entire family meets an applicable deductible or out-of-pocket limit for a plan year when the total deductible amount or out-of-pocket limit for all family members reaches three times the Individual deductible or out-of-pocket limit amount (the deductible and out-of-pocket limit amounts for three or more family members are combined to satisfy the Family deductible and the Family out-of-pocket limit). However, once a member meets and Individual deductible, that member's applicable deductible is satisfied for the Plan year, and no more charges incurred by that member can be used to satisfy the Family deductible.

Note: For outpatient surgeries, you will pay a coinsurance percentage for the facility *and* the related physician charges.

Blue Cross and Blue Shield of New Mexico (BCBSNM) provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims, except as may be specified in the Professional Services Agreement.

FOOTNOTES:

1 All benefits are based on the covered charges as determined by BCBSNM. The deductible must be met before benefit payments are made for most covered services in a Plan year. ("Deductible waived" is indicated above for those services that are excluded from the deductible requirement.) Preferred provider amounts do not cross apply to the nonpreferred provider deductible nor vice versa. A Plan year begins July 1 each year and ends on June 30 of the following year.

Note: A "PPP" is any preferred provider with a specialty of Family Practice, Internal Medicine, General Practice, Gynecology, Pediatrics, or Obstetrics/Gynecology.

2 After you reach the applicable out-of-pocket limit, BCBSNM pays 100 percent of most of your covered preferred or nonpreferred provider charges, whichever is applicable, for the rest of the Plan year. Preferred provider amounts do not cross-apply to the nonpreferred provider limit nor vice versa. Amounts in excess of covered charges, penalty amounts, and noncovered charges do not count toward the out-of-pocket limit or deductible.

3 Initial treatment of a medical emergency at a preferred or nonpreferred emergency room or trauma center is paid at the Preferred Provider benefit level. If you must be admitted as an inpatient as a result of an emergency, the entire, related hospitalization is paid at the Preferred Provider benefit level. Follow-up treatment and treatment that is not for an emergency are paid at the Nonpreferred Provider level. The emergency room or observation room copayment is waived if an inpatient admission results; then inpatient hospital benefits apply.

4 Certain services are not covered if preauthorization is not obtained from BCBSNM. Nonemergency air ambulance transfer services are covered only when it is medically necessary to transfer the patient from one facility to another. A list of services requiring preauthorization is in *Section 2* of your booklet.

5 Preauthorization (or admission review approval) is required for inpatient admissions. You pay a **\$300** penalty for covered nonemergency medical/surgical facility services if admission review approval is not obtained before being admitted to a nonpreferred facility. Some services, such as transplants, require additional approval. If you do not receive preauthorization for these individually identified procedures or services, benefits for any related admissions will be denied. The \$300 penalty will not apply in such cases. See *Section 2* in your booklet for additional details.

6 Transplants must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.

7 The partial hospitalization copayment is waived if the patient is directly admitted into the program from an inpatient facility.