State of New Mexico

Blue Cross and Blue Shield of New Mexico

Plan Highlights – 2019 PPO Plan

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 Deductible[1]** (All services are subject to deductible unless noted otherwise.)	$500/Individual $1,000/Two-Person $1,500/Family*	$3,000/Individual $6,000/Two-Person $9,000/Family*
	Annual Out-of-Pocket Limit[2] (Includes medical deductible, coinsurance, copayments, plus drug plan deductible, drug coinsurance, and drug copays. **Does not** include penalty amounts, or noncovered charges.)	$4,000/Individual $8,000/Two Person $12,000/Family*	$9,000/Individual $16,000/Two Person $23,000/Family*
	Lifetime Maximum	Unlimited (Certain services are subject to calendar year and/or lifetime maximums or are limited per condition.)	
Type of Service	**Description of Service and Limitations**	**Your Share After Annual Deductible[1,2]** **Preferred Provider**	**Nonpreferred Provider**
Physician Services, Office	▪ PPO Primary Provider (PPP) Office Visit/Exam Copayment (non-preventive) ▪ Office Surgery (including casts, splints, etc.) ▪ Lab Tests, X-Rays EKGs, Other Diagnostics	▪ $40 per visit (deductible waived) ▪ $40 per visit (deductible waived)[4] ▪ 30%	50%[4]
	Other non-Routine Office Services: Includes services of non-PPP preferred providers (PPO Specialists) and Nonpreferred Providers. ▪ Office Surgery ▪ Allergy Tests, Serum ▪ Allergy Injections ▪ Therapeutic Injections (by Physician) ▪ Therapeutic Injections (by Nurse)	▪ $60 per visit (deductible waived)[4] ▪ $60 per visit (deductible waived)[4] ▪ No copay (deductible waived) ▪ Included in Office Visit copay ▪ No Charge (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	▪ 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	▪ 25% (up to a max. member share of $300 per test)[4] ▪ 30%[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)	$1,250 per admission (Related physician subject to deductible then no copay/coinsurance applies)[4,5]	50%[4,5]
Outpatient Hospital Services	Surgery – operating and recovery room Observation (nonemergency)	25%[4] $500 per visit[4]	50%[4]
	Other treatment room services not otherwise specified in this Summary	20%[4]	50%[4]
	Related physician services (e.g., anesthetist, surgeon)	20%	50%
Emergency Services and Urgent Care	Emergency room or emergency observation room visit	$325 per visit[3]	
	Urgent care center	$65 per visit	$75 per visit (after PPO ded.)
	Ambulance (nonemergency air transfer)	20%[4]	50%[4]
	Ambulance (emergency ground and air transport)	20%[3]	
Transplants	Bone marrow, heart, heart-lung, liver, lung, pancreas-kidney, and other medically necessary transplants (Case management required. maximums apply to covered travel and lodging fees.)	Applicable copays based on place and type of service[4,5,6]	Not covered

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Type of Service	Description of Service and Limitations	Your Share After Annual Deductible[1,2]	
		Preferred Provider	Nonpreferred Provider
Maternity Services	Initial visit to confirm pregnancy	$40 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/coinsurance.)[4,5]	50%[4,5]
Mental Health and Substance Abuse Rehabilitation Services	Outpatient/Office services	$30 per visit[4] (deductible waived)	50%[4,5]
	Inpatient services	$1,000 per admission[4,5]	
	Partial hospitalization	$500 per admission[5,7]	
	Intensive Outpatient Program	$55 per visit[5]	
	Residential Treatment Center (max. **60 days**/ calendar year)	$1,000 per admission (Related inpatient, RTC, partial hospital physician = No copay/coinsurance after deductible is met)[4,5,7]	
Other Office and Home Services	Acupuncture/Spinal Manipulation/Chiropractic Services (limited to **25 visits**/calendar year combined)	$60 per visit (deductible waived)	50%
	Biofeedback (for specified conditions only)	$60 per visit	50%
	Cardiac and Pulmonary rehabilitation	$60 per visit (deductible waived)[4]	50%[4]
	Chemotherapy, radiation therapy; dialysis	$55 per visit (deductible waived)[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)	28%[4] (unlimited benefit)	45%[4]
	Hearing exam/test - Adults & Children	$60 per visit	50%
	Hearing aids - Adults Only - Age 22 and Older	No copay (deductible waived) (max. benefit of $2,500 per ear, every 3 years starting with date of purchase.)	50% No copay (deductible waived)
	Hearing aids - Children Only - Age 21 and Younger	No charge (deductible waived)	50% No copay (deductible waived)
	Home health care and home I.V. services (up to **100 visits** per calendar year)	$55 per visit (deductible waived)[4]	50%[4]
	Hospice	No charge (deductible waived)[4,5]	50%[4,5]
	Naprapathy (limited to **$500**/calendar year)	$65 per visit (deductible waived)	50%
	Rehabilitation Facility and Skilled Nursing Facility	$1,250 per admission[4,5] (Related professional charges = No copay/coinsurance after deductible is met)	50%[4,5]
	Short-term rehabilitation: outpatient/office Physical, Occupational, and Speech therapies	$55 per visit (deductible waived)	50%
	TMJ/CMJ, oral surgery, and dental accident services	Applicable copayments, deductible, and/or coinsurance based on place and type of treatment	
Prescription Drugs, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods, Smoking/Tobacco Cessation		See your Express Scripts benefit summary for details.	

***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 calendar 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 an Individual deductible, that member's applicable deductible is satisfied for the calendar 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 calendar 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.
Note: A "PPP" is any Preferred Provider in one of the following categories of practice: 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 calendar 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 is 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 4 of your benefit booklet.

[5]Preauthorization (or admission review approval) is required for inpatient admissions. 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. See Section 4 in your benefit 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.

This is a summary only – please refer to the Summary of Benefits and Coverage (SBC) document and Benefit Booklet for more details.