NMRHCA Value Plan - 01/01/19

Blue Cross and Blue Shield of New Mexico

The following highlights are for the New Mexico Retiree Health Care Authority's Value Plan that is administered by Blue Cross and Blue Shield of New Mexico (BCBSNM). This plan is offered statewide, **not available to members living outside of New Mexico**. This summary contains highlights only and is subject to change. Any services received must be medically necessary to be covered. **The specific terms of coverage, exclusions, and limitations are contained in the carrier's Member Benefit Booklet.**

NMRHCA Value Plan Benefits (This plan has no lifetime maximum benefit, though certain services have maximum annual limits. See below).	**NMRHCA Value Plan[1]**
	What You Pay
Annual Deductible[1] (Deductible applies to all services unless indicated as "waived" below. There is no family deductible.	$1,500
Annual Out-of-Pocket Limit (Includes copayments, deductible and coinsurance only - NOT penalty amounts, or noncovered charges. There is no family out of pocket amount.[2]	$5,500
Primary Preferred Provider (PPP)*Office Services (Deductible waived) Office Visit (Includes mental health and chemical dependency services. Other services received during the office visit, such as therapy or surgery, are subject to deductible and coinsurance as listed in the rest of the summary.)	$35
Specialist Provider Office Services (Deductible waived) Office Visit (Services received during the office visit, such as therapy or surgery, are subject to deductible and coinsurance as listed in the rest of the summary.)	$55
Office Surgery (including casts, splints, and dressings)[4]	30%
Allergy Injections, Tests, Serum	30%
Preventive Services Routine Adult Physicals and Gynecological Exams, certain services for Family Planning, Well-Child Care; Routine Vision or Hearing Screenings (only through age 18) and Immunizations.	Plan pays 100% (deductible waived)
Related Testing (includes routine Pap tests, mammograms, cholesterol tests, urinalysis, etc.), and Immunizations.	
Lab, X-Ray, and Pathology (Deductible waived)[4]	Plan pays 100%
EKG	30%
High-Tech Radiology (e.g., MRI, MRA, CT Scan, PET Scans) [4] (Office /Free Standing Radiology)	$125 Copay (Deductible waived)
High-Tech Radiology (e.g., MRI, MRA, CT Scan, PET Scans)[4] (Outpatient Department of Hospital)	30%
Ambulance Services, Ground or Emergency Air Transport	30%
Biofeedback (for specified medical conditions only)	30%
Cardiac and Pulmonary Rehabilitation, Outpatient[4]	30%
Colonoscopies (initial routine or medical diagnostic)	Plan pays 100% (deductible waived)
Emergency Room/Observation Room Treatment (Emergency[3] Only; Deductible waived; copay waived if admitted inpatient.)	$175
Physician and other Professional Provider Charges[3]	30%
Hearing Aids and Related Services: Hearing aids for members under age 21 are paid at 100% of covered charges (deductible waived) up to a maximum of **$2,200** per ear during any 3 year period. Exams/testing subject to usual cost-sharing provisions. For members age 21 and older, benefits for hearing aids are limited to **$500** per member during any 3 year period, subject to Plan deductible and coinsurance.	
Home Health Care/Home I.V. Services[4]	30%
Hospice Services[4]	30%

*A Primary Preferred Provider (PPP) is a preferred physician or other professional provider in one of the following categories of practice: Family or General Practice, Internal Medicine, Pediatrics, Obstetrics and Gynecology, and Gynecology Only.

NMRHCA Value Plan Benefits (This plan has no lifetime maximum benefit, though certain services have maximum annual limits. See below).	**NMRHCA Value Plan[1]** **What You Pay**
Inpatient Hospital/Facility Services (See "Short-Term Rehabilitation - Inpatient" for rehabilitation and skilled nursing facility admissions. See "Transplant Services," if applicable.)	
Medical/Surgical, Mental Health and Chemical Dependency (includes partial hospitalization) and Maternity-Related Room and Board and Covered Ancillaries[5]	30%
Physician and Other Professional Provider Charges	30%
Maternity Services, including Routine Pediatrician Care for Covered Newborns (See "Inpatient Hospital/Facility)[5]	30%
Prosthetics and Orthotics[4,6]	30%
Short-Term Rehabilitation - Inpatient (Includes services in a rehabilitation facility or skilled nursing facility)	30%
Short-Term Rehabilitation - Outpatient	
Physical Therapy Services (copay on first 4 visits); obtained as alternative to Surgery.	$35 copay/per visit (deductible waived), thereafter No Charge for the remaining of the calendar year
Occupational and Speech Therapy Services	30%
Chiropractic Services, Acupuncture, Massage Therapy, and Rolfing (combined max. **$1,500**/year)[7]	30%
Smoking/Tobacco Use Cessation	Plan Pays 100% (deductible waived)
Supplies and Durable Medical Equipment[4,6] (Incontinence supplies limited to **$200**/month; wigs, if covered, limited to **$200** every 3 years.)	30%
Outpatient Facility and Physician Services (Including surgery, outpatient and intensive outpatient mental health and chemical dependency.)[4,5]	30%
Therapy: Chemotherapy, Dialysis, and Radiation[4]	30%
TMJ Services, Dental Accident, Oral Surgery[4]	30%
Transplant Services (Must be received at a facility that contracts with BCBSNM or the national BCBS transplant networks.)	
Cornea, Kidney, and Bone Marrow[4,5] Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney[4,5]	30%
Urgent Care Facility (Includes physician services)	$40
Prescription Drugs – Administered by the pharmacy benefit manager (PBM). Please refer to literature provided by the PBM for benefit and copay information or call NMRHCA at 1-800-233-2576.	

Footnotes:

[1] The deductible must be met before benefit payments are made (excluding emergency room facility charges; Preferred Provider routine/preventive services, office visits, urgent care facility visits, and lab, X-ray and diagnostic tests; and hearing aids for members under age 21).

[2] After a member reaches the applicable out-of-pocket limit, the Plan pays 100 percent of most of that member's covered charges for the remainder of the calendar year.

[3] Follow-up treatment from a Nonpreferred Provider requires prior authorization.

[4] Certain services are not covered if prior approval is not obtained from the Claims Administrator. See a Member's Benefit Booklet for a list of services requiring prior approval.

[5] Admission review is required for inpatient admissions. You pay a $300 penalty for covered medical/surgical facility services if approval is not obtained. Some services, such as transplants and physical rehabilitation, require additional approval. If you do not receive approval for these individually-identified procedures and services, benefits for any related admissions will be denied. See a Member's Benefit Booklet for details.

[6] Rental benefits for medical equipment and other items will not exceed the purchase price of a new unit.

[7] Services administered by a licensed medical doctor (M.D.), doctor of osteopathy (D.O.), physical therapist (R.P.T.or L.P.T.), licensed massage therapist (L.M.T.), doctor of oriental medicine (D.O.M.), and doctor of chiropractic (D.C.) are covered. Rolfing must be provided by a certified rolfer.

Claims Administrator 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 Agreement.

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