



# Summary of Benefits: July 1, 2009

The following are the highlights of the State of New Mexico PPO Plan administered by Blue Cross and Blue Shield of New Mexico. Any services received must be medically necessary to be covered. The specific terms of coverage, limitations, and exclusions are detailed in a separate document.

Benefit Highlights		Preferred Provider <sup>1,2</sup>	Nonpreferred Provider <sup>1,2</sup>
<b>Highlights of Cost-Sharing Features</b>	Annual Plan Year Deductible <sup>1</sup> (Family deductible is an aggregate amount that may be met by three or more family members combined.) <b>NOTE:</b> All services are subject to deductible except preventive care, certain diagnostic tests, and PPP office services.	\$300 Individual \$600 Two-Person \$900 Family	\$1,500 Individual \$3,000 Two-Person \$4,500 Family
	Annual Plan Year Out-of-Pocket Limit <sup>2</sup> (Includes medical plan deductible, coinsurance, and copayments only; NOT drug plan payments, penalty amounts, or noncovered charges.)	\$3,000 Individual \$6,000 Two-Party \$9,000 Family	\$6,000 Individual \$12,000 Two-Party \$18,000 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 <sup>1,2</sup>	
		Preferred Provider	Nonpreferred Provider
<b>Physician Services, Office</b>	PPO Primary Provider (PPP) Office Visit/Exam Copayment (nonpreventive) - Office Surgery (including casts, splints, etc.) - Lab Tests, X-Rays, EKGs, Other Diagnostics	\$20 per visit (deductible waived) \$20 per visit (deductible waived) <sup>4</sup> 10% <sup>4</sup>	Not Applicable
	Other Non-Routine Office Services: Includes services of non-PPP preferred providers (PPO Specialists) and nonpreferred providers. - Office Surgery - Therapeutic Injections, Allergy Injections, Tests, Serum	\$30 per visit <sup>4</sup>	40% <sup>4</sup>
	Preventive Adult Services, including immunizations, lab, x-ray, colonoscopies, Pap tests, mammograms, immunizations, and other wellness services	No copay (deductible waived)	40% (deductible waived)
	Preventive Well-Child Care (through age 17), including lab, x-ray, immunizations, routine vision screening, etc. Hearing screenings (up to age 25)	No copay (deductible waived)	40% (deductible waived)
<b>Diagnostic Testing</b>	- PET scans <sup>4</sup> , CT scans <sup>4</sup> , MRIs, (unless covered as part of a fixed-dollar copayment during ER visit, admission, etc.) - Other lab, x-ray, sleep studies <sup>4</sup> , genetic testing & counseling <sup>4</sup> , EKGs	10% <sup>4</sup> (up to a max. member share of \$200 per test)  10% <sup>4</sup>	40% <sup>4</sup>
<b>Inpatient Hospital Services, Acute Care</b>	Hospitalization (includes semi-private room, board, drugs, medications, and ancillaries; inpatient physician visits, surgeon, assistant, and anesthesiologist)	\$400 per admission <sup>5</sup> No copay for related physician	40% <sup>3,5</sup>
<b>Outpatient Hospital Services</b>	Surgery – operating and recovery room; Observation (nonemergency)	10% <sup>4</sup> \$200 per visit	40% <sup>4</sup>
	Other treatment room services (e.g., radiation therapy)	\$200 per visit <sup>4</sup>	40% <sup>4</sup>
	Related physician services	10%	40%
<b>Emergency Services and Urgent Care</b>	Emergency room visit (deductible applies)	\$175 per visit	\$175 per visit <sup>3</sup>
	Urgent care center	\$50 per visit	\$50 per visit
	Ambulance (nonemergency air transfer)	20% <sup>4</sup>	40% <sup>3,4</sup>
	Ambulance (ground and emergency air transport)	20%	20% <sup>3</sup>

Type of Service	Description of Service and Limitations	Your Share After Plan Year Deductible <sup>1,2</sup>	
		Preferred Provider	Nonpreferred Provider
<b>Transplants</b>	Bone marrow, heart, heart-lung, liver, lung, pancreas-kidney, and other medically necessary transplants (Case management required. Maximums apply to covered travel, food, & lodging.)	Applicable copays based on place and type of service <sup>4,5,6</sup>	Not Covered
<b>Maternity Services</b>	Initial visit to confirm pregnancy	\$20 for initial visit if to a PPP (deductible waived)	40%
	Physician/midwife services (delivery, prenatal/postnatal care)	Applicable copays based on place and type of service <sup>4,5,6</sup>	40%
	Hospital admission	\$400 per admission <sup>5</sup>	40% <sup>5</sup>
	Routine nursery care for covered newborn (Child covered from birth, but must apply for coverage within 31 days.)	No copay <sup>5</sup>	40% <sup>5</sup>
<b>Mental Health Services</b>	<ul style="list-style-type: none"> <li>- Outpatient/office services</li> <li>- Inpatient services</li> <li>- Partial hospitalization</li> <li>- Intensive outpatient program</li> <li>- Residential treatment center (max. <b>60 days</b>/Plan year in combination with substance abuse services)</li> </ul>	\$30 per visit <sup>4</sup> \$400 per admission <sup>5</sup> \$200 per admission <sup>5,7</sup> \$35 per visit <sup>4,7</sup> \$400 per admission <sup>5</sup> Related inpatient, RTC, and partial hospital physician charges = 10% <sup>4</sup>	40% <sup>4,5</sup>
<b>Substance Abuse (Alcoholism and Drug Abuse) Rehabilitation*</b>	<ul style="list-style-type: none"> <li>- Outpatient/office services (max <b>30 visits</b>/Plan year)</li> <li>- Intensive outpatient program (applied to outpatient benefit maximum of <b>30 visits</b>/Plan year)</li> <li>- Inpatient services; Partial hospitalization (max. <b>30 days</b>/Plan year for both combined)</li> <li>- Residential treatment center (max. <b>60 days</b>/Plan year in combination with nonsubstance abuse)</li> </ul> Note: Substance abuse limited to services received within a maximum of <b>two 12-month</b> benefit periods.	\$30 per visit <sup>4</sup> \$35 per visit <sup>4,7</sup> \$400 per inpatient admission <sup>5</sup> \$200 per partial admission <sup>5,7</sup> \$400 per admission <sup>5</sup> Related inpatient, RTC, and partial hospital physician charges = 10% <sup>4</sup>	40% <sup>4,5</sup>

\* To obtain mental health or substance abuse services, you must call Mesa Mental Health at 1-800-583-6372.

<b>Other Office and Home Services</b>	Acupuncture, rolfing, massage therapy, chiropractic services (max. benefit of <b>\$1,500</b> /Plan year)	\$30 per visit <sup>8</sup>	40% <sup>8</sup>
	Biofeedback (for specified conditions only)	\$30 per visit	40%
	Cardiac or pulmonary rehabilitation	\$30 per visit <sup>4</sup>	40% <sup>4</sup>
	Chemotherapy; radiation therapy; dialysis	\$30 per visit <sup>4</sup>	40% <sup>4</sup>
	Chronic pain treatment	Applicable copayments, deductible, and/or coinsurance based on place and type of treatment <sup>4</sup>	
	TMJ/CMJ, oral surgery, & dental accident services	Applicable copayments, deductible, and/or coinsurance based on place and type of treatment <sup>4,5</sup>	
	Durable medical equipment, diabetic equipment and supplies; orthopedic appliances, prosthetics and orthotics (Rental benefits not to exceed the purchase price of a new unit. Supplies limited to a <b>30-day supply</b> during a 30-day period.)	25% <sup>4</sup> (unlimited benefit)	40% <sup>4</sup> (Max. benefit of <b>\$1,000</b> /Plan year)
	Hearing exam/test	\$30 per visit <sup>4</sup>	40% <sup>4</sup>
	Hearing aids	15% <sup>4</sup>	15% <sup>4</sup>
	Home health care and home I.V. services (up to <b>100 visits</b> /Plan year)	\$30 per visit <sup>4</sup>	40% <sup>4</sup>
	Hospice (lifetime max. benefit of <b>\$7,500</b> )	No copay <sup>4</sup>	40% <sup>4</sup>
	Insulin supply purchased at a physician's office	30% <sup>4</sup>	40% <sup>4</sup>
	Naprapathy treatment (max. benefit of <b>\$1,500</b> /Plan year)	\$30 per visit <sup>8</sup>	40% <sup>8</sup>
	Smoking/tobacco use cessation	50%	50%
	Short-term rehabilitation: inpatient and outpatient physical, occupational, and speech therapies, rehabilitation facility, skilled nursing facility	\$30 per office/outpatient <sup>4,8</sup> \$400 per admission <sup>5</sup> (related professional charges = no copay)	40% <sup>4,5</sup>

## Footnotes:

- 1 All benefits are based on the covered charge as determined by BCBSNM. The deductible must be met before benefit payments are made for most covered services in a Plan year (excluding PPP office visits and preventive services). Preferred provider amounts cross-apply to the nonpreferred provider deductible and vice versa. A Plan year begins July 1 each year and ends on June 30 of the following year. Any amounts applied to the Plan year deductible during the last quarter of the Plan year (i.e., April 1 through June 30) will be used to help satisfy the next Plan year deductible. 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 cross-apply to the nonpreferred provider limit and vice versa. Amounts in excess of covered 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 prior approval 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 prior approval is in *Section 2*.
- 5 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 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. The \$300 penalty will not apply in such cases. See *Section 2* for 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.
- 8 Covered massage therapy received as part of a chiropractic or physical therapy session are covered under either the chiropractic service benefit (when rendered by a chiropractor), or as part of the short-term rehabilitation benefit (when rendered by a licensed medical doctor, doctor of osteopathy, registered physical therapist, licensed physical therapist, or doctor of oriental medicine). Massage therapy under the "Alternative Therapy" benefit must be provided by a licensed massage therapist. Rolfing must be provided by a licensed rolfer.

Administered by:



## 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.**