

Summary of Benefits

The following are the highlights of the NMSU PPO 250 Plan. 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	Calendar year deductible ¹ (Family deductibles are aggregate amounts. Does not include fixed-dollar copayments, drug plan copayments, or coinsurance amounts.)	\$250 Individual \$750 Family	\$500 Individual \$1,500 Family
	Calendar year out-of-pocket limit ² (Includes medical coinsurance amounts only, NOT deductible, copayments, prescription coinsurance, penalty amounts, or noncovered charges.)	\$2,000 Individual \$5,000 Family	\$4,000 Individual \$10,000 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 calendar year deductible ^{1,2}	
		Preferred Provider	Nonpreferred Provider
Physician Services, Office	PPO Primary Provider (PPP) Office Visit/Exam Copayment (nonpreventive): All other services received during the office visit to the PPP are subject to deductible and coinsurance as listed below.	\$25 per visit (deductible waived) ⁴ Copayment does not apply toward your calendar year deductibles or out-of-pocket limits.	Not Applicable
	Other Office Services: Includes all other services received during a PPP office visit and services of non-PPP providers (not including preventive services).	20%	40%
	- Office Surgery - Lab Tests, X-Rays, EKGs, Other Diagnostic Services - Therapeutic Injections, Allergy Injections, Tests, Serum	20%	40%
	Preventive Adult Services, including immunizations, lab, x-ray, colonoscopies, Pap tests, mammograms, immunizations, and other wellness services	Plan pays 100% of first \$400 per member each calendar year; thereafter, services subject to regular copay, deductible, and coinsurance provisions.	Not Covered
	Preventive Well-Child Care (through age 17), including lab, x-ray, immunizations, routine vision or hearing screenings, etc.	Plan pays 100% of first \$250 per member each calendar year; thereafter, services subject to regular copay, deductible, and coinsurance provisions.	Not Covered
Diagnostic Testing	Lab and x-ray; PET scans ⁴ , cardiac CT scans ⁴ , home sleep studies ⁴ , genetic testing & counseling ⁴ ; EKGs, MRIs	20% ⁴	40% ⁴
Inpatient Hospital Services, Acute Care	Hospitalization (includes semi-private room, board, drugs, medications, and ancillaries; inpatient physician visits, surgeon, assistant, and anesthesiologist)	20% ⁵	40% ⁵
Outpatient Hospital Services	Surgery – operating and recovery room; Observation	20% ⁴	40% ⁴
	Other treatment room services (e.g., radiation therapy)	20% ⁴	40% ⁴
	Related physician services	20%	40%
Emergency Services and Urgent Care	Emergency room visit	20%	40% ³
	Urgent care center	20%	40%
	Ambulance	20% ⁴	20% ⁴

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Type of Service	Description of Service and Limitations	Your share after calendar year deductible ¹	
		Preferred Provider	Nonpreferred Provider
Transplants	Cornea, kidney, bone marrow	20% ^{4,5,6}	Not Covered
	Heart, heart-lung, liver, lung, pancreas-kidney (Subject to a separate \$5,000 out-of-pocket limit per transplant type. Calendar year deductible does not apply. Additional maximums also apply to covered travel, food, & lodging.)	20% ^{4,5,6} (deductible waived)	Not Covered
Maternity Services	Initial visit to confirm pregnancy	\$25 for visit (deductible waived)	40%
	Physician/midwife services (delivery, prenatal/postnatal care)	20%	40%
	Hospital admission	20% ⁵	40% ⁵
	Routine nursery care for covered newborn (Child covered from birth, but must apply for coverage within 31 days.)	20% ⁵	40% ⁵
Mental Health Services and Chemical Dependency Rehabilitation*	Psychotherapeutic services, inpatient and outpatient (Maximum benefit of up to 60 days/visits per calendar year for all services combined. Chemical dependency also limited to services received within a maximum of two 12-month benefit periods.)	20% ⁴	Not Covered

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

Other Services	Acupuncture treatment (max. benefit of \$1,500/ calendar year)	20%	Not Covered
	Spinal manipulation (max. benefit of \$1,500/ calendar year)	20%	Not Covered
	Cardiac or pulmonary rehabilitation ⁴	20% ⁴	Not Covered
	Chemotherapy ⁴ or radiation therapy; electroshock ⁴ therapy; narcosis ⁴	20% ⁴	40% ⁴
	TMJ/CMJ, oral surgery, & dental accident services	20% ^{4,5}	40% ^{4,5}
	Diabetic self-management; health education	20% ⁴	40% ⁴
	Hearing aids: For members age 21 and older, hearing aids, routine exams, and testing are not covered. Hearing aids for members under age 21 are paid at 100% of covered charges up to a maximum of \$2200 per ear during any 3-year period; exams and testing are subject to usual cost-sharing provisions.		
	Home dialysis ⁴ ; other dialysis	20% ⁴	40% ⁴
	Durable medical equipment, diabetic equipment and supplies; orthopedic appliances (Rental benefits not to exceed the purchase price of a new unit. Supplies limited to a 30-day supply during a 30-day period.)	20% ⁴ (unlimited benefit)	40% ⁴ (Max. benefit of \$1,000/year)
	Family planning services (e.g., sterilization, infertility testing, birth control injections, device insertion and removal, genetic testing and counseling) ⁴	20% ⁴	40% ⁴
	Home health care and home I.V. services (up to 100 visits/calendar year)	20% ⁴	40% ⁴
	Hormone replacement therapy ⁴	20% ⁴	40% ⁴
	Hospice (not including bereavement counseling; lifetime max. benefit of \$10,000)	20% ⁴	40% ⁴
	Insulin supply purchased at a physician's office	20% ⁴	40% ⁴
	Prosthetics and orthotics (Limitations: Benefits for covered support hose are limited to six pair of hose per year. Benefits for mastectomy bras are limited to three per year.)	20% ⁴ (unlimited benefit)	40% ⁴ (Max. benefit of \$1,000/year)
	Smoking/tobacco use cessation counseling (Choice of two group sessions or 90 minutes of counseling/ calendar year.)	20%	Not Covered
	Short-term rehabilitation: inpatient and outpatient physical, occupational, and speech therapies, rehabilitation facility, skilled nursing facility (Benefits are limited to a lifetime maximum of up to 60 days/ visits per condition for all services combined.)	20% ^{4,5}	Not Covered

See footnotes on next page

Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods				
Note: Deductible does not apply and copayments and coinsurance are not applied to out-of-pocket. Certain drugs, special medical foods, and enteral nutritional products require prior approval or benefits will be denied. ^{4,7}	Type of Prescription	Percentage of covered charge you pay (coinsurance), if the percentage is between the minimum and maximum copayments:	Minimum Copayment	Maximum Copayment
Retail/Specialty Pharmacy Program (up to a 30-day supply or 120 units, whichever is less)	Generic Drug on Drug List	20% ⁷	\$10 ⁷	\$20 ⁷
	Brand-Name Drug on Drug List	30% ⁷	\$25 ⁷	\$45 ⁷
	Not on Drug List	40% ⁷	\$45 ⁷	\$80 ⁷
	Specialty Pharmacy Drugs	25% ⁷	\$125 ⁷	\$250 ⁷
Mail-Order Plan (up to a 90-day supply or 360 units, whichever is less)	Generic Drug on Drug List	20% ⁷	\$20 ⁷	\$40 ⁷
	Brand-Name Drug On Drug List	30% ⁷	\$50 ⁷	\$90 ⁷
	Not on Drug List	40% ⁷	\$90 ⁷	\$160 ⁷
Nonprescription enteral nutritional products and special medical foods (up to a 30-day supply per 30-day period; requires prior approval)		50% ^{4,7}		

Footnotes:

- 1 All benefits are based on the covered charge as determined by BCBSNM. The deductible must be met before benefit payments are made (excluding the PPP office visit, for which you pay a \$25 copayment, hearing aids for children under age 21, and certain preventive services and transplants). All other services billed during an office visit will apply to deductible and coinsurance. **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. Deductible and out-of-pocket amounts do not cross-apply in the Preferred Provider and Nonpreferred Provider benefit levels. Amounts in excess of covered charges do not count toward the out-of-pocket limit or deductible.
- 3 Initial treatment of a medical emergency 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.
- 4 Certain services are not covered if prior approval is not obtained from BCBSNM. A list of services requiring prior approval is in *Section 2*.
- 5 Admission review is required for inpatient admissions. You pay a \$300 penalty for covered medical/surgical facility services if admission review approval is not obtained. Some services, such as transplants and physical rehabilitation, require additional approval. If you do not receive approval for such individually identified procedures and services, benefits for any related admissions will be denied. The \$300 penalty will not apply in such cases.
- 6 Transplants must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.
- 7 Prescription drugs must be purchased at a pharmacy that participates in the Retail Pharmacy, Specialty Pharmacy, or Mail Order Service programs. (BCBSNM has contracted with a separate program for administration of your prescription drug benefits.) **Note:** Under this prescription program, if you prefer a brand-name drug that has a generic equivalent or if you or your provider orders a brand-name drug when a generic equivalent is available, **you will pay the difference in cost** between the generic and brand-name drug, in addition to the generic copayment.