New Mexico State University (NMSU)

Plan Highlights – PPO Plan **01/01/17**

Blue Cross and Blue Shield of New Mexico

Highlights the deductible, out-of-pocket limits, member coinsurance percentage amounts, and provides a brief description of NMSU's Health Care Plan benefits.

PPO Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges**	
	Preferred Provider[1]	**Nonpreferred Provider[1]**
Calendar Year Deductible (per individual) – Family deductible is aggregate of three times individual amount chosen.[1]	$750 ($2,250/family)	$2,000 ($4,000/family)
Annual Out-of-Pocket Limit – Includes coinsurance only; NOT deductible, copayments, penalty amounts, or noncovered charges.[2]	$3,750 ($9,000/family)	$6,500 ($14,750 family)
Office Services: If listed on this summary, other services received during the office visit to the Primary Preferred Provider (PPP*) or to the PPO Specialist, are subject to deductible and coinsurance as listed below.		
Primary Preferred Provider* Office Visit, Virtual Visit and initial office visit to diagnose pregnancy	$35 copay/visit (deductible waived for OV only)	50%
Mental Health/Virtual Visit/Chemical Dependency services (IOP/outpatient/office)	$35 copay/visit[4] (deductible waived for OV only)	50%[4]
Specialist Office Visit and initial office visit to diagnose pregnancy	$45 copay/visit (deductible waived for OV only)	50%
Office Surgery (including casts, splints, and dressings)	25%[4]	50%[4]
Allergy Injections, Tests, Serum	25%	50%
Preventive Services Routine Adult Physicals and Gynecological Exams; Well-Child Care; Mammograms; Routine Colonoscopies (office/outpatient); Preventive Testing (includes routine Pap tests, cholesterol tests, urinalysis, etc.); Immunizations; and Routine Vision or Hearing Screenings	No Charge	Not Covered
Acupuncture Treatment (benefit max. **$1,500**/year)	25%	Not Covered
Ambulance Services: Ground and Emergency Air Transport	25%[3]	
Ambulance Services: Nonemergency Air Transfer	25%[4]	50%[4]
Autism Spectrum Disorders (max $36,000 each calendar year; up to **$200,000** in a lifetime for applied behavioral analysis when part of a **preauthorized** treatment plan)	25%[4]	Not Covered
Cardiac and Pulmonary Rehabilitation	25%[4]	Not Covered
Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services	Member share based on place of treatment & type of service[4]	50%[4]
Emergency Room Treatment **Durable Medical Equipment and Supplies**	25%[4]	50%[4]
Hearing Aids and Related Services: Hearing aids for members under age 21 are paid at 100% of covered charges up to a maximum of $**2,200** per ear during any 3-year period; exams and testing are subject to usual cost-sharing provisions. These services are not covered for members age 21 and older.		
Home Health Care/Home I.V. Services (benefit max. **100 visits**/year)	25%[4]	50%[4]
Hospice Services	25%[4]	50%[4]
Lab, X-Ray, MRI, CT Scan, PET Scan and Basic Diagnostic Tests	25%[4]	50%[4]

* A Primary Preferred Provider is a 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. A "PPP" is a Primary Preferred Provider in the preferred provider network.

See footnotes on back.

PPO Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges**	
	Preferred Provider[1]	**Nonpreferred Provider[1]**
Inpatient Hospital/Facility Services (See "Short-Term Rehabilitation" for physical rehabilitation and skilled nursing facility admissions and "Transplant Services," if applicable.)		
Medical/Surgical, Mental Health/Chemical Dependency, Maternity-Related Room and Board, and Covered Ancillaries	25%[5]	50%[5]
Maternity Services (also see "Inpatient Hospital/Facility Services")	25%[5]	50%[5]
Routine Nursery/Pediatrician Care for Covered Newborns	25%[5]	50%[5]
Outpatient Facility/Physician (including surgical procedures related to pregnancy and family planning; and nonroutine colonoscopies)	25%[4,5]	50%[4,5]
Prosthetics and Orthotics	25%[4]	50%[4]
Short-Term Rehabilitation: Inpatient and Outpatient - Occupational, Physical, and Speech Therapy (max. **60 visits** per condition, per year for all services combined)	25%	Not Covered
Skilled Nursing Facility and Inpatient Rehabilitation (max. **60 days** per condition per year combined)	25%[4,5]	Not Covered
Spinal Manipulation Services (max. **$1,500**/year)	25%	Not Covered
Therapy: Chemotherapy, Dialysis, Radiation Therapy, Electroshock Therapy, Narcosynthesis	25%[4]	50%[4]
Transplant Services (Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.)		
Cornea, Kidney, and Bone Marrow **Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney** (Subject to a separate **$5,000** out-of-pocket limit per transplant type. Additional benefit maximums also apply. Calendar year deductible does not apply.)	25%[4,5]	Not Covered
Urgent Care Facility	25%	50%

FOOTNOTES:

1 All benefit payments are based on the covered charge as determined by BCBSNM. The deductible must be met before benefit payments are made for most services, except services with a copayment, hearing aids, and certain preventive services. Deductible amounts do not cross-apply in the Preferred Provider and Nonpreferred Provider benefit levels.

2 After a member reaches the applicable out-of-pocket limit, BCBSNM pays 100 percent of most of that member's covered Preferred or Nonpreferred Provider charges, whichever is applicable. Out-of-pocket amounts do not cross-apply in the Preferred Provider and Nonpreferred Provider benefit levels. (Specified transplant services are subject to a separate out-of-pocket limit.)

3 Initial treatment of a medical emergency is paid at Preferred Provider level. Follow-up treatment and treatment that is not for an emergency is paid at Nonpreferred Provider level.

4 Certain services are not covered if preauthorization is not obtained from BCBSNM. A list of services requiring preauthorization is in Section 2.

5 Preauthorization is required for inpatient admissions. You pay a $300 penalty for covered medical/surgical and/or mental health/chemical dependency facility services if preauthorization is not obtained. Some services, such as transplants and physical rehabilitation, require additional preauthorization. If you do not receive preauthorization 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.

IMPORTANT: Deductible amounts and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than the provider's billed charges. Preferred providers will not charge you the difference between the covered charge and the billed charge for covered services; nonpreferred providers may.

See NMSU Prescription Drug Benefit Summary on next page.

NMSU Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods Summary

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 preauthorization or benefits will be denied.[4,7] The Generics Plus Drug List is a list of preferred drugs that are available to members at lower copayment levels. Drugs not on the list are still covered, but at a higher copayment. The BCBSNM Pharmacy and Therapeutics Committee (made up of physicians & pharmacists) evaluate drugs for their therapeutic uniqueness, safety, and cost to select drugs to be included on the Generics Plus Drug List. The Generics Plus Drug List is available on the BCBSNM web site at www.bcbsnm.com. Your copayment for prescription drugs is based on whether the drug you receive is a generic or a brand-name drug **AND** whether the drug is on the Generics Plus Drug List.	**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	$15 [7]	$15 [7]	$15 [7]
	Brand-Name Drug on Drug List	30% [7]	$30 [7]	$50 [7]
	Not on Drug List	40% [7]	$50 [7]	$85 [7]
	Specialty Pharmacy	25% [7]	$130 [7]	$275 [7]
Mail-Order Plan (up to a 90-day supply or 360 units, whichever is less)	Generic Drug on Drug	$20 [7]	$25 [7]	$25 [7]
	Brand-Name Drug On Drug List	30% [7]	$55 [7]	$95 [7]
	Not on Drug List	40% [7]	$95 [7]	$165 [7]
Nonprescription enteral nutritional products and special medical foods (up to a 30-day supply per 30-day period; requires preauthorization)		50% [4,7]		

7 Prescription drugs must be purchased at a pharmacy that participates in the Retail Pharmacy, Specialty Pharmacy, or Mail Order Services 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 is available, you will pay the difference in cost between the generic and brand-name drug, in addition to the generic drug copayment.