



Summary of Benefits and Copayments

This summary provides a very brief description of Blue Cross and Blue Shield of New Mexico (BCBSNM) Approved Alliance HMO Health Plan benefits and copayments. Copayments are per member and maximums are per member, per calendar year, unless stated otherwise. Some services require prior authorization from BCBSNM. The plan provides the benefits listed below only when medically necessary. Copayments are due at the time of service. Your maximum out-of-pocket limit for covered services, excluding drug plan copayments, is **\$3,500 individual** or **\$7,000 family**, subject to the provisions of this benefit booklet. *This is a summary of benefits only; please read the Benefit Booklet for details.*

Type of Service	Member Copayment
PRIMARY CARE PHYSICIAN (PCP) SERVICES	
Office Visits: Well-child care visits; annual physical examinations; pediatric and adult immunizations; vision and hearing screening (under age 18); health education and counseling; nonroutine office visits, including for maternity care; therapeutic injections; medication checks; limited smoking cessation counseling services	\$35 per visit (if received during office visit, there will be no additional copayment for immunizations; otherwise, office visit copayment may apply)
Inpatient Professional Services and Outpatient Surgery (e.g., physician visits, maternity deliveries)	No copayment for professional services (see "Hospital/Facility Services" on next page)
SPECIALIST PHYSICIAN SERVICES (no referral required)	
Routine/Preventive Office Visits: including immunizations; vision and hearing screening (under age 18); health education and counseling	\$35 per visit (if during office visit, there will be no additional copayment for immunizations; otherwise, office visit copayment may apply)
Nonroutine Office Visits (including for covered mental health services of a professional provider), therapeutic injections, exams, consultations, allergy care, office surgery, limited smoking cessation counseling services	\$50 per visit (if received during office visit, there will be no additional copayment for injections; otherwise, office visit copayment may apply)
Inpatient Professional Services and Outpatient Surgery (e.g., physician visits, maternity deliveries, anesthesiologist, surgeon, physical therapist)	No copayment for professional services (see "Hospital/Facility Services" on next page)
Family Planning: Contraceptive counseling and prescription contraceptive devices provided in a physician's office, if provided by a specialist, and in-office sterilization procedures	\$50 per visit (\$35 per visit if provided by your PCP; see "Primary Care Physician (PCP) Services," above)
Initial studies, diagnostic procedures, and services for infertility as determined medically necessary by an HMO-participating physician	50% of covered charges after applicable copayment (based on place of treatment)
Cardiac and Pulmonary Rehabilitation (limit of two months of care/year)	\$50 per visit
Chemotherapy, Radiation Therapy	No copay
Dialysis/ Plasmapheresis and Photopheresis (limit of two months of care/year)	\$35 per visit
EMERGENCY/URGENT CARE SERVICES	
Emergency Room Center or Observation Room	\$150 per visit
Urgent Care Facility	\$45 per visit
Ambulance, Ground Transportation	\$50 per trip
Ambulance, Air Transportation	\$100 per trip

HOSPITAL/FACILITY SERVICES	
Inpatient Hospital Acute Care Admission , including mental health services and short-term medical detoxification from the effects of alcoholism or drug abuse, surgery, maternity deliveries and C-sections, and specified transplant services performed at transplant centers contracted with BCBSNM or the national BCBS transplant network for the transplant being provided.	\$500 per day*
Inpatient Physical Rehabilitation	
Skilled Nursing Facility Admissions (limited to 30 days/calendar year)	
Blood and Blood Derivatives	Plan pays cost of administration
Outpatient/Treatment Room (not including emergency room or observation room services; see "Emergency Room Care or Observation")	\$350 per visit
OTHER PROVIDER SERVICES	
Acupuncture (limited to 20 visits per calendar year)	\$50 per visit
Chiropractic Services (limited to 10 visits per calendar year)	\$50 per visit
Durable Medical Equipment and Supplies (not including contraceptive devices payable under the family planning benefit)	50% of covered charges
Hearing Aids/Related Services: 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 Health Care	No copayment
Hospice Care (limited to six months of care for home and inpatient services combined; see "Hospital/Facility Services" for inpatient copayments)	No copayment for home services \$500 per day for inpatient services*
Laboratory, Pathology, Radiology, and Other Diagnostic Tests (including routine mammograms and Pap tests)	No copayment (if received during a visit that requires a copayment, such tests will be included in the calculation of the member's total applicable copayment)
Physical, Occupational, and Speech Therapy (Benefits limited to two months of care per condition, which may be extended upon recommendation by the PCP in consultation with BCBSNM.)	\$50 per visit
Prosthetic Devices (excluding breast prosthetics, limited to an annual maximum benefit payment of \$1500)	50% of covered charges
PRESCRIPTION DRUGS, INSULIN, DIABETIC SUPPLIES, SPECIAL MEDICAL FOODS	
Not subject to out-of-pocket limit. Covered items must be obtained from a pharmacy that participates in the BCBSNM Retail Pharmacy/Specialty Pharmacy Programs or through the BCBSNM Mail-Order Program. Maximum benefit of \$5,000 per calendar year ; then no more benefits available except for diabetic supplies. Certain drugs, injectables, and special medical foods require prior authorization or benefits will be denied. If you or your provider order a brand-name drug when a generic equivalent is available, you will also pay the difference in cost between the generic and the brand-name, in addition to the generic drug copayment.	
Retail Pharmacy Program (up to a 30-day supply or 120 units, whichever is less)	Member Copayments
Generic Drug on Drug List	Tier-One copay: \$20
Brand-Name Drug on Drug List (no generic equivalent)	Tier-Two copay: \$40
Drug Not on Drug List	Tier-Three copay: \$60
Specialty Pharmacy Drug Program (up to a 30-day supply or 120 units, whichever is less)	Tier-Four copay: 15% up to a maximum copayment of \$250 per prescription
Mail-Order Program (up to a 90-day supply or 360 units, whichever is less)	2 ½ times the applicable copay listed for Retail Pharmacy (Specialty pharmacy drugs are not covered through Mail-Order program.)

* Inpatient hospital copayments are limited to a maximum out-of-pocket per year of \$2,500. All fixed-dollar copayments and percentage copayment amounts (excluding those paid under the drug plan, but including daily inpatient hospital fixed-dollar copayments) are applied to the general annual out-of-pocket limit of \$3,500 per member. Once a member reaches his/her \$3,500 out-of-pocket limit, this plan pays 100 percent of that member's covered charges for the rest of the calendar year.