



Summary of Benefits: High Option Plan

This is a summary only that lists the deductible amounts, the out-of-pocket limits, copayment amounts, and coinsurance percentages, and provides a brief description of NMPSIA High Option PPO Health Plan benefits.

NMPSIA High Option PPO Health Care Plan Benefits	Member's Share of Covered Charges	
	Preferred Provider ^{1,2}	Nonpreferred Provider ^{1,2}
Calendar Year Deductible¹		
Individual	\$300	
Family Limit (aggregate of three times the Individual amount)	\$900	
Calendar Year Out-of-Pocket Limit²		
Individual	\$2,800	\$3,200
Family Limit (aggregate of three times the Individual amount)	\$8,400	\$9,600
Office Visit/Exam Charge		
Office and Home Visits/Exams or Consultation (Other services received during the office visit and listed under "Other Services," below, such as therapy, are subject to deductible, copay, and/or coinsurance as listed in the rest of the summary.)	<i>(deductible waived)</i>	
Primary Preferred Provider (PPP) * Office/Home Visit	Office Visit Copay \$20	30%
Specialist Office/Home Visit	\$30	30%
Office Surgery (including casts, splints, and dressings) ⁴	20%	30%
Family Planning (including devices, insertion, etc.)	Office Visit Copay	30%
Allergy Injections (only), Extract Preparation	\$0 <i>(deductible waived)</i>	30%
Therapeutic Injections; Allergy Testing	Office Visit Copay	30%
Routine Services: <i>Deductible waived</i> for PPO and non-PPO routine adult physicals and gynecological exams, well-child care; routine vision/hearing screenings (only through age 17)	Plan Pays 100%	30%
Related Testing: <i>Deductible waived</i> for PPO and non-PPO tests, including routine Pap tests, mammograms, colonoscopies, cholesterol tests, urinalysis, etc., and immunizations	Plan Pays 100%	30%
OTHER SERVICES		
Ambulance: Nonemergency Transfer, Medically Necessary³	\$30 <i>(deductible waived)</i>	30%
Ambulance: Emergency Transport³	\$30 <i>(deductible waived)</i>	
Biofeedback (for specified medical conditions only)	\$30 <i>(deductible waived)</i>	30%
Cardiac and Pulmonary Rehabilitation, Outpatient	\$30 <i>(deductible waived)</i> Specialist/Outpatient	30%
Chiropractic Services, Acupuncture, Massage Therapy, and Rolfing (combined max. benefit of \$1500/calendar year) ⁷	\$30 <i>(deductible waived)</i>	30%
Dental/Facial Accident, Oral Surgery, TMJ/CMJ Services	Varies by service	30%
Emergency Room Treatment³	20% after deductible	
Physician and Other Professional Provider Charges ³	20% after deductible	
Hearing Aids and Related Services (Age 21 and older, hearing aids limited to \$500 per member in any 3-year period; routine exams/testing not covered. Under age 21, hearing aids paid at 100% of covered charges up to \$2200 per ear in any 3-year period; exams/testing subject to usual cost-sharing.)	20%	30%
Home Health Care/Home I.V. Services⁴	20%	30%
Limitations	Unlimited	120 visits/cal year
Hospice Services including respite care (limited to 10 days for each 6-month benefit period) and bereavement counseling (limited to 3 sessions during the hospice benefit period)	\$0 <i>(deductible waived)</i>	30%
Lab, X-Ray, and Other Diagnostic Tests (nonroutine)⁴ MRI, CT Scans, or PET Scans; Sleep Studies; Other Lab, X-Ray, Diagnostic Tests (Office/Outpatient)	20%	30%

* NOTE: A "PPP" or "Primary Preferred Provider" is a preferred provider in one of the following medical specialties only: Family Practice; General Practice; Internal Medicine; Obstetrics/Gynecology; Gynecology; or Pediatrics.

NMPSIA High Option PPO Health Plan Benefits	Member's Share of Covered Charges	
	Preferred Provider ^{1,2}	Nonpreferred Provider ^{1,2}
Inpatient Hospital/Facility Services (High Option copays are waived if you are re-admitted for the same condition within 15 days of discharge or transferred to a rehab or skilled nursing facility within 15 days of discharge from acute care facility.)		
Medical/Surgical Acute Care and Maternity-Related Room and Board, Covered Ancillaries; Related Professional Charges ⁵ Skilled Nursing Facility (max. 60 days /calendar year) ⁵ Inpatient Physical Rehabilitation ⁵	\$500 facility copay/admission plus 20%	30%
Observation Stay including Related Professional Charges	\$100 facility copay plus 20%	30%
Maternity Services (see "Inpatient Hospital/Facility Services") Physician/Midwife Services (delivery, pre- and post-natal care) Hospital Admission (including routine newborn nursery charges) Extended Stay (Nonroutine) Charges for Covered Newborn ⁵	Office Visit Copay for initial visit \$500 copay per pregnancy plus 20% \$500 facility copay plus 20%	30%
Mental Health Services ^{4,5} Office, Outpatient Inpatient Partial Hospitalization ⁸ Facility-Based Intensive Outpatient Programs ⁸	\$30 (<i>deductible waived</i>) \$500 copay plus 20% \$250 copay plus 20% \$125 copay plus 20%	30%
Supplies, Durable Medical Equipment, Prosthetics, and Functional Orthotics ^{4,6} (Support hose limited to 6 pair/year . Mastectomy bras limited to three/year .)	20%	30%
Short-Term Rehabilitation, Outpatient and Office (Includes outpatient and office physical, occupational, and speech therapy services.) ⁴	\$30 (<i>deductible waived</i>)	30%
Smoking/Tobacco Use Cessation (lifetime max. benefit payment of \$500 includes medication)	50% (<i>deductible waived</i>)	
Substance Abuse Rehabilitation: Limited to 30 outpatient visits and 30 inpatient days/visits per year; lifetime maximum of two courses of treatment for all services combined. ^{4,5} Office, Outpatient Inpatient Partial Hospitalization ⁸ Facility-Based Intensive Outpatient Programs ⁸ Residential treatment center (For adults age 18 and older only. Max. 60 days /calendar year and 30 days per admission) ⁸	\$30 (<i>deductible waived</i>) \$500 copay plus 20% \$250 copay plus 20% \$125 copay plus 20% \$500 copay plus 20%	30%
Surgery, Outpatient Hospital, Ambulatory Surgery Facility ⁴ (including Related Professional Charges)	\$150 plus 20%	30%
Therapy: Chemotherapy and Radiation	No copay (<i>deductible waived</i>)	30%
Therapy: Dialysis ⁴	20%	30%
Transplant Services ^{4,5} Maximums apply to donor charges and travel, food, and lodging. Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network. See <i>Section 3</i> . ^{4,5}	Applicable copays based on place and type of service	No benefit
Urgent Care Facility	\$50 (<i>deductible waived</i>)	30%

Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Smoking/Tobacco Cessation Products: Administered by Catalyst Rx. Call Catalyst Rx Customer Service Center: 1-866-611-5948.

Footnotes are on page viii

FOOTNOTES:

- 1 All services are subject to deductible unless otherwise indicated in the *Summary of Benefits* (i.e., “deductible waived”). When applicable, the deductible must be met before benefit payments are made (excluding routine services, hearing aids for children under age 21, and drugs and items covered under the drug plan). Charges for preferred provider services cross-apply to the nonpreferred provider deductible, and vice versa.
- 2 After a member reaches the applicable out-of-pocket limit, the Plan pays 100 percent of his/her covered charges for the rest of the calendar year. Under the High Option plan, deductible, coinsurance, and copayments for preferred provider services do *not* cross-apply to the nonpreferred provider limit, nor vice versa. Under the Low Option Plan, however, deductible, copayment, and percentage coinsurance amounts paid for preferred provider services *do* cross-apply to the nonpreferred provider limit, and vice versa.
- 3 Initial treatment of a medical emergency is paid at the Preferred Provider benefit level. Follow-up treatment from a nonpreferred provider and treatment that is not for an emergency is paid at the Nonpreferred Provider level. Nonemergency air ambulance services are covered **only** when it is medically necessary to transfer the patient from one facility to another.
- 4 Certain services are not covered if prior approval is not obtained from BCBSNM (or Mesa Mental Health). A list of services requiring prior approval is in *Section 2*. Some services may require a written request for prior approval in order to be covered.
- 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, benefits for any related admissions will be denied. See *Section 2*.
- 6 Rental benefits for medical equipment and other items will not exceed 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.), doctor of oriental medicine (D.O.M.), doctor of chiropractic (D.C.), and licensed massage therapist (L.M.T.) are covered. Rolfing must be provided by a certified rolfer.
- 8 The partial hospitalization and facility-based intensive outpatient program (IOP) copayments are waived if the patient is admitted directly into either program from an inpatient facility or residential treatment center, or if the patient is admitted into a partial hospitalization program directly from an inpatient facility or residential treatment center.

Deductibles, copayments, 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.