



# Summary of Benefits: Low 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 Low Option PPO Health Plan benefits.

NMPSIA Low Option PPO Health Care Plan Benefits	Member's Share of Covered Charges	
	Preferred Provider <sup>1,2</sup>	Nonpreferred Provider <sup>1,2</sup>
<b>Calendar Year Deductible<sup>1</sup></b> Individual Family Limit (aggregate of three times the Individual amount)		\$1,500 \$4,500
<b>Calendar Year Out-of-Pocket Limit<sup>2</sup></b> Individual Family Limit	\$3,500 \$8,750	\$4,500 \$10,500
<b>Office Visit/Exam Charge</b> (Other services received during the office visit, such as therapy or surgery, are subject to deductible, copayment, and coinsurance as listed in the rest of the summary.) <b>Primary Preferred Provider (PPP) * Office/Home Visit</b> <b>Specialist Office/Home Visit</b>	(deductible waived) <b>Office Visit Copayment:</b> \$25 \$35	50% 50%
Office Surgery (including casts, splints, and dressings) <sup>4</sup>	25%	50%
Family Planning (including devices, insertion, etc.)	25%	50%
Allergy Injections (only), Extract Preparation	25%	50%
Therapeutic Injections; Allergy Testing	25%	50%
<b>Routine Services:</b> Routine adult physicals and gynecological exams, well-child care; routine vision/hearing screenings; related testing (routine pap tests, mammograms, cholesterol tests, urinalysis, etc.); routine colonoscopy; health education counseling, including smoking/tobacco cessation counseling, and immunizations	\$0 (deductible waived)	50% (deductible waived for routine testing only)
<b>OTHER SERVICES</b>		
<b>Acupuncture, Spinal Manipulation, Massage Therapy, and Rolfing</b> (combined max. benefit of \$1,500/calendar year) <sup>7</sup>	25%	50%
<b>Ambulance: Nonemergency Transfer, Medically Necessary<sup>3</sup></b>	25%	25%
<b>Ambulance: Emergency Transport<sup>3</sup></b>	25%	25%
<b>Biofeedback</b> (for specified medical conditions only)	25%	50%
<b>Cardiac and Pulmonary Rehabilitation, Outpatient</b>	25%	50%
<b>Dental/Facial Accident, Oral Surgery, TMJ/CMJ Services</b>	25%	50%
<b>Emergency Room Treatment<sup>3</sup></b>	25% after deductible	
Physician and Other Professional Provider Charges <sup>3</sup>	25% after deductible	
<b>Hearing Aids and Related Services</b> (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 \$2,200 per ear in any 3-year period; exams/testing subject to usual cost-sharing.)	25%	50%
<b>Home Health Care/Home I.V. Services<sup>4</sup></b>	25%	50%
Limitations	Unlimited	120 visits/cal year

\* 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 PPO Health Plan**

**Low Option Plan Summary of Benefits**

NMPSIA Low Option PPO Health Plan Benefits	Member's Share of Covered Charges	
	Preferred Provider <sup>1,2</sup>	Nonpreferred Provider <sup>1,2</sup>
<b>Hospice Services</b> including respite care (limited to <b>10 days</b> for each 6-month benefit period) and bereavement counseling (limited to <b>three sessions</b> during the hospice benefit period)	25%	50%
<b>Inpatient Hospital/Facility Services</b>		
<b>Medical/Surgical Acute Care</b> , including Maternity-Related, Room and Board, Covered Ancillaries; Related Professional Charges <sup>5</sup>	25%	50%
<b>Skilled Nursing Facility</b> (max. <b>60 days</b> /calendar year) <sup>5</sup>	25%	50%
<b>Inpatient Physical Rehabilitation</b> <sup>5</sup>	25%	50%
<b>Observation Room</b> (nonemergency)	25%	50%
<b>Lab, X-Ray, and Other Diagnostic Tests (nonroutine)</b> <sup>4</sup> MRI or PET Scans in X-Ray Facility/Office/Outpatient Facility Sleep Studies, CT Scans in X-Ray Facility/Office/Outpatient Other Laboratory, X-Ray, and Diagnostic Tests	25%	50%
<b>Maternity Services</b> (also 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 <sup>5</sup>	25%	50%
<b>Mental Health Services</b> <sup>4,5</sup> Office, Home, Outpatient; Inpatient; Partial Hospitalization <sup>8</sup> Facility-Based Intensive Outpatient Programs (IOP) <sup>8</sup>	25%	50%
<b>Short-Term Rehabilitation, Outpatient</b> (Includes outpatient physical, occupational, and speech therapy services.) <sup>4</sup>	25%	50%
<b>Smoking/Tobacco Use Cessation</b> (lifetime max. benefit payment of <b>\$500</b> includes medication, hypnotherapy, acupuncture, related tests, and any counseling programs not eligible under Preventive)	50%	50%
<b>Substance Abuse Rehabilitation</b> <sup>4,5</sup> Office, Home, Outpatient, Inpatient, Partial Hospitalization <sup>8</sup> Facility-Based Intensive Outpatient Programs (IOP) <sup>8</sup> Residential Treatment Center (For adults age 18 and older only. Max. <b>60 days</b> /calendar year and <b>30 days</b> per admission) <sup>8</sup>	25%	50%
<b>Supplies, Durable Medical Equipment, Prosthetics, and Functional Orthotics</b> <sup>4,6</sup> (Support hose limited to <b>6 pair</b> (or <b>12 hose</b> ) per calendar year. Mastectomy bras limited to <b>three</b> /calendar year.)	25%	50%
<b>Insulin Pump Supplies</b> (insertion sets, reservoirs)	\$0 (deductible waived)	50%
<b>Surgery, Outpatient Hospital or Ambulatory Surgery Facility</b> <sup>4</sup>	25%	50%
<b>Therapy: Chemotherapy, Dialysis, and Radiation</b>	25%	50%
<b>Transplant Services</b> <sup>4,5</sup> (Maximums apply to donor charges and travel and lodging. Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network. See <i>Section 3</i> . <sup>4,5</sup> )	25%	No benefit
<b>Urgent Care Facility</b>	\$50 (deductible waived)	25%
<b>Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Smoking/Tobacco Cessation Products:</b> Administered Medco Health Solutions. Call Medco Health Solutions Customer Service Center: 1-800-498-4904.		

Footnotes are on next page

**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 preauthorization is not obtained from BCBSNM. A list of services requiring preauthorization is in *Section 2*. Some services may require a written request for preauthorization in order to be covered.
- 5 Preauthorization is required for inpatient admissions. You pay a \$300 penalty for covered medical/surgical facility services if authorization is not obtained. Some services, such as transplants and physical rehabilitation, require additional authorization. If you do not receive authorization 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.**



## Blue Cross and Blue Shield of New Mexico

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