



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 ^{1,2}	Nonpreferred Provider ^{1,2}
Calendar Year Deductible ¹		
Individual		\$1,500
Family Limit (aggregate of three times the Individual amount)		\$4,500
Calendar Year Out-of-Pocket Limit ²		
Individual	\$3,500	\$4,500
Family Limit	\$8,750	\$10,500
Office Visit/Exam Charge (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.)	<i>(deductible waived)</i>	
Primary Preferred Provider (PPP) * Office/Home Visit	Office Visit	
Specialist Office/Home Visit	Copayment:	
Office Surgery (including casts, splints, and dressings) ⁴	\$25	50%
Family Planning (including devices, insertion, etc.)	\$35	50%
Allergy Injections (only), Extract Preparation	25%	50%
Therapeutic Injections; Allergy Testing	25%	50%
Routine Services: routine adult physicals and gynecological exams, well-child care; routine vision or hearing screenings (only through age 17)	<i>(deductible waived)</i> Plan Pays 100%	<i>(deductible waived)</i> 50%
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%	50%
OTHER SERVICES		
Ambulance: Nonemergency Transfer, Medically Necessary ³	25%	25%
Ambulance: Emergency Transport ³	25%	25%
Biofeedback (for specified medical conditions only)	25%	50%
Cardiac and Pulmonary Rehabilitation, Outpatient	25%	50%
Chiropractic Services, Acupuncture, Massage Therapy, and Rolfing (combined max. benefit of \$1500/calendar year) ⁷	25%	50%
Dental/Facial Accident, Oral Surgery, TMJ/CMJ Services	25%	50%
Emergency Room Treatment ³	25% after deductible	
Physician and Other Professional Provider Charges ³	25% 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.)	25%	50%
Home Health Care/Home I.V. Services ⁴	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 Low Option PPO Health Plan Benefits	Member's Share of Covered Charges	
	Preferred Provider ^{1,2}	Nonpreferred Provider ^{1,2}
Hospice Services including respite care (limited to 10 days for each 6-month benefit period) and bereavement counseling (limited to three sessions during the hospice benefit period)	25%	50%
Inpatient Hospital/Facility Services		
Medical/Surgical Acute Care , including Maternity-Related, Room and Board, Covered Ancillaries; Related Professional Charges ⁵	25%	50%
Skilled Nursing Facility (max. 60 days /calendar year) ⁵	25%	50%
Inpatient Physical Rehabilitation ⁵	25%	50%
Observation Room (nonemergency)	25%	50%
Lab, X-Ray, and Other Diagnostic Tests (nonroutine) ⁴ 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%
Maternity Services (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 ⁵	25%	50%
Mental Health Services ^{4,5} Office, Outpatient; Inpatient; Partial Hospitalization ⁸ Facility-Based Intensive Outpatient Programs ⁸	25%	50%
Short-Term Rehabilitation, Outpatient (Includes outpatient physical, occupational, and speech therapy services.) ⁴	25%	50%
Smoking/Tobacco Use Cessation (lifetime max. benefit payment of \$500 includes medication)	50%	50%
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	25%	50%
Supplies, Durable Medical Equipment, Prosthetics, Functional Orthotics ^{4,6} (Support hose limited to six pair/year. Mastectomy bras limited to three /year.)	25%	50%
Surgery, Outpatient Hospital or Ambulatory Surgery Facility ⁴	25%	50%
Therapy: Chemotherapy, Dialysis, and Radiation	25%	50%
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 3.4.5</i>)	25%	No benefit
Urgent Care Facility	\$50 (<i>deductible waived</i>)	25%
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 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 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.