

# Non-Medicare PPO Gold, Silver, Bronze Plans

**This is a summary only** that lists the highlights and provides a brief description of NMRHCA PPO Health Plan benefits administered by Blue Cross and Blue Shield of New Mexico. The specific terms of coverage, exclusions and limitations are contained in the BCBSNM Member Benefit Booklet.

NMRHCA PPO Health Care Plan Benefits	Member's Share of Covered Charges					
	Preferred Provider <sup>1,2</sup>			Nonpreferred Provider <sup>1,2</sup>		
<b>Annual* Deductible</b> (There is no Family deductible.) <sup>1</sup>	Gold Plan: \$100/individual Silver Plan: \$400/individual Bronze Plan: \$800/individual					
<b>Annual* Out-of-Pocket Limit:</b> Includes coinsurance only - NOT deductible, fixed-dollar copayments, penalty amounts, or noncovered charges. (There is no Family limit.) <sup>2</sup>	Gold Plan: \$500/individual Silver Plan: \$2000/individual Bronze Plan: \$4000/individual					
<b>TYPE OF SERVICE</b>	Gold	Silver	Bronze	Gold	Silver	Bronze
<b>Office Services</b>						
Office Visit: Other services received during the office visit, such as therapy or surgery, are subject to deductible and coinsurance as listed in the rest of the summary.	\$20	\$25	\$30	30%	40%	50%
Office Surgery (including casts, splints, and dressings) <sup>4</sup>	10%	20%	25%	30%	40%	50%
Allergy Injections, Tests, Serum	10%	20%	25%	30%	40%	50%
<b>Preventive Services</b> (deductible waived)						
Routine Adult Physicals and Gynecological Exams, Well-Child Care; Routine Vision or Hearing Screenings (only through age 18)	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	30%	40%	50%
Related Testing (includes routine Pap tests, mammograms, colonoscopies, cholesterol tests, urinalysis, etc.), and Immunizations (deductible waived)	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	30%	40%	50%
<b>OTHER SERVICES</b>						
<b>Ambulance: Nonemergency Air Transfer, Medically Necessary</b> <sup>3</sup>	10%	20%	25%	30%	40%	50%
<b>Ambulance: Ground and Emergency Air Transport</b> <sup>3</sup>	10%	20%	25%	10%	20%	25%
<b>Biofeedback</b> (for specified medical conditions only)	10%	20%	25%	30%	40%	50%
<b>Cardiac and Pulmonary Rehabilitation, Outpatient</b> <sup>4</sup>	10%	20%	25%	30%	40%	50%
<b>Chiropractic Services, Acupuncture, Massage Therapy, and Roling</b> (combined max. benefit of \$1500/year) <sup>7</sup>	10%	20%	25%	30%	40%	50%
<b>Emergency Room/Observation Room Treatment</b> (emergency only; copayment waived if admitted to the hospital as an inpatient) <sup>3</sup>	\$75	\$100	\$125	\$75	\$100	\$125
Physician and Other Professional Provider Charges <sup>3</sup>	10%	20%	25%	10%	20%	25%
<b>Home Health Care/Home I.V. Services</b> <sup>4</sup>	10%	20%	25%	30%	40%	50%
<b>Hospice Services</b> including respite care (limited to 10 days for each 6-month benefit period) and bereavement counseling (limited to 3 sessions during the benefit period)	10%	20%	25%	30%	40%	50%
<b>Inpatient Hospital/Facility Services</b> (See "Short-Term Rehabilitation" for physical rehabilitation and skilled nursing facility admissions. See "Psychotherapeutic Services" for inpatient treatments related to mental health or chemical dependency. See "Transplant Services," if applicable.)						
Medical/Surgical and Maternity-Related Room, Board, Ancillaries <sup>5</sup>	10%	20%	25%	30%	40%	50%
Physician and Other Professional Provider Charges	10%	20%	25%	30%	40%	50%
Nursery Care for Covered Newborns (Extended Stay <sup>5</sup> or Routine)	10%	20%	25%	30%	40%	50%
<b>EKGs and High-Tech Radiology (MRIs, PET Scans, CT Scans)</b> <sup>4</sup>	10%	20%	25%	30%	40%	50%
<b>Other Lab, X-Ray, and Pathology</b> (Deductible waived) <sup>4</sup>	No charge	No charge	No charge	30%	40%	50%
<b>Maternity Services</b> , including Routine Pediatrician Care for Covered Newborns (also see "Inpatient Hospital/Facility Services")	10%	20%	25%	30%	40%	50%
<b>Prosthetics and Orthotics</b> <sup>4,6</sup>	10%	20%	25%	30%	40%	50%
Limitations: Annual max. includes up to \$200 during any 3-year period for wigs required due to specified medical conditions and up to four mastectomy bras/year.	Unlimited benefit			Maximum of \$1,000/year		
<b>Psychotherapeutic Services, Inpatient and Outpatient</b> (Includes mental health services and chemical dependency rehabilitation. Chemical dependency limited to 30 visits (inpatient and outpatient) per year; lifetime maximum of two courses of treatment for in- and outpatient services combined.) <sup>4,5</sup>	10%	20%	25%	30%	40%	50%

\* Effective January 1, 2006, and unless stated otherwise, deductibles, out-of-pockets, and benefit limitations are based on a "calendar year," which begins on 01/01 each year and ends on 12/31 of the same year. Some services are limited according to a "3-year" or "one-year" period. In such cases, the start of the "year" begins on the date you first receive the service in question and ends an applicable number of years later.

NMRHCA PPO Health Plan Benefits (continued)	Member's Share of Covered Charges					
	Preferred Provider <sup>1,2</sup>			Nonpreferred Provider <sup>1,2</sup>		
<b>Short-Term Rehabilitation, Inpatient and Outpatient</b> (Includes services in a rehabilitation facility or skilled nursing facility, and outpatient physical, occupational, and speech therapy services. Skilled nursing facility benefits limited to <b>60 days</b> per year. Outpatient therapies are limited to <b>60 visits</b> per condition per year.)	10%	20%	25%	30%	40%	50%
<b>Smoking/Tobacco Use Cessation</b> (Lifetime max. benefit payment of <b>\$500</b> includes medication.)	50%	50%	50%	50%	50%	50%
<b>Supplies and Durable Medical Equipment</b> <sup>4,6</sup> (Limitations: Benefits for hearing aids are limited to <b>\$500</b> per member during any 3-year period. Benefits for adult incontinence supplies are limited to <b>\$200</b> per month. Benefits for covered support hose are limited to <b>six pair</b> of hose per year.)	10%	20%	25%	30%	40%	50%
<b>Colonoscopies</b> (initial routine or medical procedure) <b>Other Surgery</b> (including additional colonoscopies), <b>Inpatient or Outpatient</b> (For transplants, see "Transplant Services," below.) <sup>4</sup>	No charge 10%	No charge 20%	No charge 25%	No charge 30%	No charge 40%	No charge 50%
<b>Therapy: Chemotherapy, Dialysis, and Radiation</b> <sup>4</sup>	10%	20%	25%	30%	40%	50%
<b>TMJ Services, Dental Accident, Oral Surgery</b>	10%	20%	25%	30%	40%	50%
<b>Transplant Services</b> \$500,000 lifetime limit, which includes a maximum of \$10,000 in donor expenses and \$10,000 in travel, food, and lodging. The travel, food, and lodging maximum includes a maximum per diem of \$125 for food and lodging. Transplants must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network. <sup>4,5</sup>	10%	20%	25%	No benefit		
<b>Urgent Care Facility</b>	\$25	\$30	\$35	30%	40%	50%

**Prescription Drugs, Insulin, Nutritional Products:** Administered by Express Scripts. Call Express Scripts at 1-800-811-0297.

- 1 The member's initial covered charges (for services that are subject to percent coinsurance) that are incurred in a calendar year are applied to the annual calendar year deductible; the deductible must be met before benefit payments are made (excluding routine/preventive services, lab and pathology, drugs and items covered under the prescription drug plan, and services that are subject to a fixed-dollar copayment).
- 2 After a member reaches the applicable out-of-pocket limit in a calendar year, the Plan pays 100 percent of his/her covered charges. Amounts in excess of covered charges and fixed-dollar copayments are not applied to the out-of-pocket limit and copayments will not be waived once the out-of-pocket limit is met.
- 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. Emergency/observation room copayments are waived if you are directly admitted as an inpatient; the copayment also does **not** include related physician charges (which will be subject to deductible and coinsurance).
- 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.
- 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.), licensed massage therapist (L.M.T.), doctor of oriental medicine (D.O.M.), and doctor of chiropractic (D.C.) are covered. Rolfing must be provided by a certified rolfer.

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.