

## 2010 Non-Medicare PPO Plans



Blue Cross and Blue Shield  
of New Mexico

**PRESBYTERIAN**

The following are the highlights of the New Mexico Retiree Health Care Authority Preferred Provider Organization (PPO) Plans administered by Blue Cross and Blue Shield of New Mexico (BCBSNM) or Presbyterian Health Plan (these companies are not affiliated with each other). All Plans are offered statewide; the BCBSNM Plans are available to members living out of state. This summary contains highlights only and is subject to change. Any services received must be medically necessary to be covered. **The specific terms of coverage, exclusions, and limitations are contained in the carrier's Member Benefit Booklet.**

PPO Benefits (These Plans have no lifetime maximum benefit, though certain services have maximum annual limits. See below).	What You Pay			
	Preferred Provider <sup>1</sup>		Nonpreferred Provider <sup>1</sup>	
<b>Annual Deductible</b> <sup>1</sup> (Deductible applies to all services unless indicated as "waived" below. There is no family deductible; preferred and nonpreferred amounts cross apply.)	Premier Plus: \$300/Individual			
	Premier: \$800/Individual			
<b>Annual Out-of-Pocket Limit</b> (Includes coinsurance only - NOT deductible, fixed-dollar copayments, penalty amounts, or noncovered charges. No family out of pocket amount; preferred and nonpreferred amounts cross apply.) <sup>2</sup>	Premier Plus: \$3,000			
	Premier: \$3,000			
	Preferred Provider <sup>1</sup>		Nonpreferred Provider <sup>1</sup>	
	Premier Plus	Premier	Premier Plus	Premier
<b>Office Services</b> (Deductible waived for Preferred Providers.) Office Visit (Includes mental health and chemical dependency services. 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	\$30	40%	50%
Office Surgery (including casts, splints, and dressings) <sup>4</sup>	20%	25%	40%	50%
Allergy Injections, Tests, Serum	20%	25%	40%	50%
<b>Preventive Services</b> Routine Adult Physicals and Gynecological Exams, Well-Child Care; Routine Vision or Hearing Screenings (only through age 18) (Deductible waived.)	Plan pays 100%	Plan pays 100%	40%	50%
Related Testing (includes routine Pap tests, mammograms, cholesterol tests, urinalysis, etc.), & Immunizations (Deductible waived.)	Plan pays 100%	Plan pays 100%	40%	50%
<b>Lab, X-Ray, and Pathology</b> (Deductible waived for Preferred Providers.) <sup>4</sup>	Plan pays 100%	Plan pays 100%	40%	50%
<b>EKG</b>	20%	25%	40%	50%
<b>High-Tech Radiology</b> (e.g., PET Scans) <sup>4</sup>	20%	25%	40%	50%
<b>Ambulance Services, Ground or Emergency Air Transport</b>	20%	25%	40%	50%
<b>Biofeedback</b> (for specified medical conditions only)	20%	25%	40%	50%
<b>Cardiac and Pulmonary Rehabilitation, Outpatient</b> <sup>4</sup>	20%	25%	40%	50%
<b>Colonoscopies</b> (initial routine or medical diagnostic)	Plan pays 100%	Plan pays 100%	40%	50%
<b>Emergency Room/Observation Room Treatment</b> (Emergency only. Deductible waived; copay waived if admitted inpatient.) <sup>3</sup>	\$100	\$125	\$100	\$125
Physician and Other Professional Provider Charges <sup>3</sup>	20%	25%	40%	50%
<b>Hearing Aids and Related Services:</b> Hearing aids for members under age 21 are paid at 100% of covered charges (deductible waived) up to a maximum of <b>\$2,200</b> per ear during any 3-year period. Exams/testing subject to usual cost-sharing provisions. (These services are not covered for members age 21 and older.) For members age 21 and older, benefits for hearing aids are limited to <b>\$500</b> per member during any 3-year period, subject to Plan deductible and coinsurance.				
<b>Home Health Care/Home I.V. Services</b> <sup>4</sup>	20%	25%	40%	50%
<b>Hospice Services</b> <sup>4</sup>	20%	25%	40%	50%

<b>PPO Benefits</b> (These Plans have no lifetime maximum benefit, though certain services have maximum annual limits. See below).	<b>Preferred Provider <sup>1</sup></b>		<b>Nonpreferred Provider <sup>1</sup></b>	
	<b>Premier Plus</b>	<b>Premier</b>	<b>Premier Plus</b>	<b>Premier</b>
<b>Inpatient Hospital/Facility Services</b> (See "Short-Term Rehabilitation - Inpatient" for rehabilitation and skilled nursing facility admissions. See "Transplant Services," if applicable.)				
Medical/Surgical, Mental Health & Chemical Dependency (includes partial hospitalization) and Maternity-Related Room and Board and Covered Ancillaries <sup>5</sup>	20%	25%	40%	50%
Physician and Other Professional Provider Charges	20%	25%	40%	50%
<b>Maternity Services</b> , including Routine Pediatric Care for Covered Newborns (See "Inpatient Hospital/Facility Services.") <sup>5</sup>	20%	25%	40%	50%
<b>Prosthetics and Orthotics</b> <sup>4,6</sup>	20%	25%	40%	50%
Limitations	Unlimited benefit		Maximum of <b>\$1,000/year</b>	
<b>Short-Term Rehabilitation - Inpatient</b> (Includes services in a rehabilitation facility or skilled nursing facility. Skilled nursing facility benefits are limited to <b>60 days</b> /calendar year.) <sup>5</sup>	20%	25%	40%	50%
<b>Short-Term Rehabilitation - Outpatient</b> (Includes physical, occupational, and speech therapy services. Outpatient therapies are limited to <b>60 days</b> /condition per calendar year.) <sup>4</sup>	20%	25%	40%	50%
<b>Chiropractic Services, Acupuncture, Massage Therapy, and Rolfing</b> (combined max. <b>\$1,500/year</b> ) <sup>7</sup>	20%	25%	40%	50%
<b>Smoking/Tobacco Use Cessation</b> (Lifetime benefit payment of <b>\$500</b> includes medication.)	50%	50%	50%	50%
<b>Supplies and Durable Medical Equipment</b> <sup>4,6</sup> (Incontinence supplies limited to <b>\$200/month</b> ; wigs, if covered, limited to <b>\$200</b> every 3 years.)	20%	25%	40%	50%
<b>Outpatient Facility &amp; Physician Services</b> (Including surgery, outpatient and intensive outpatient mental health and chemical dependency.) <sup>4,5</sup>	20%	25%	40%	50%
<b>Therapy: Chemotherapy, Dialysis, and Radiation</b> <sup>4</sup>	20%	25%	40%	50%
<b>TMJ Services, Dental Accident, Oral Surgery</b> <sup>4</sup>	20%	25%	40%	50%
<b>Transplant Services</b> (Must be received at a facility that contracts with BCBSNM/Presbyterian or their national transplant networks.)				
<b>Cornea, Kidney, and Bone Marrow</b> <sup>4,5</sup>	20%	25%	<b>No benefit</b>	
<b>Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney</b> (Lifetime max. <b>\$500,000</b> . Additional maximums also apply.) <sup>4,5</sup>	20%	25%		
<b>Urgent Care Facility</b> (Includes physician services. <i>Deductible waived for Preferred Provider services.</i> )	\$30	\$35	40%	50%
<b>Prescription Drugs</b> – Administered by the pharmacy benefit manager (PBM). Please refer to literature provided by the PBM for benefit and copay information or call NMRHCA at 1-800-233-2576.				

**Footnotes:**

<sup>1</sup> The deductible must be met before benefit payments are made (excluding emergency room facility charges; drugs and items covered under the prescription drug plan; preferred provider routine/preventive services, office visits, urgent care facility visits, and lab, x-ray and diagnostic tests; and hearing aids for members under age 21).

<sup>2</sup> After a member reaches the applicable out-of-pocket limit, the Plan pays 100 percent of most of that member's covered charges. (Copayments are not waived after the out-of-pocket limit is met.)

<sup>3</sup> Initial treatment of a medical emergency is paid at Preferred Provider level. Follow-up treatment from a nonpreferred provider and treatment that is not for an emergency is paid at Nonpreferred Provider level. Emergency/observation room copayment waived if admitted.

<sup>4</sup> Certain services are not covered if prior approval is not obtained from the Claims Administrator. See a Member's Benefit Booklet for a list of services requiring prior approval.

<sup>5</sup> 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 and services, benefits for any related admissions will be denied. See a Member's Benefit Booklet for details.

<sup>6</sup> Rental benefits for medical equipment and other items will not exceed the purchase price of a new unit.

<sup>7</sup> 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 covered charges, which may be less than billed charges. Claim Administrators provide administrative claims payment services only and do not assume any financial risk or obligation with respect to claims, except as may be specified in the Professional Services Agreement.**