

UNM Hospitals Extended Network Summary of Benefits

Administered by:



Blue Cross and Blue Shield
of New Mexico

This is a summary only that lists the deductible, out-of-pocket maximum, and copayment and coinsurance amounts, and provides a brief description of UNM Hospitals Extended Network benefits.

| UNM Hospitals Extended Network Benefits | Member's Share of Covered Charges | | |
|---|---|--|-------------------------------------|
| | In-Network Services | | Out-of-Network Services * |
| | Standard Network | Extended Network | |
| Calendar Year Deductible | None | | \$1,500 \$3,000 Family Aggregate |
| Calendar Year Out-of-Pocket Maximum (Includes copayments and coinsurance only. Does NOT include deductible; drug, mental health, or chemical dependency benefit payments; noncovered charges; or penalty amounts. In-Network and Out-of-Network amounts do not cross-apply.) | \$5,000 per individual | \$7,500 per individual | \$10,000 per individual |
| Annual and Lifetime Benefit Payment Limits | \$2,000,000 per member per calendar year and a lifetime benefit payment maximum of \$5,000,000 per member | | |
| Primary Care Physician (PCP) and OB/GYN Office Visits | \$25 per visit | \$40 per visit | 40%* |
| Specialist Physician Office Visit | \$35 per visit | \$55 per visit | 40%* |
| Office Surgery (including casts, splints, and dressings) | \$25 (or \$35 specialist) per visit | \$40 (or \$55 specialist) per visit | 40%* |
| Maternity Prenatal & Post-Partum Visits | \$25 (or \$35 specialist) initial visit only | \$40 (or \$55 specialist) initial visit only | 40%* |
| Lab Tests, X-Rays, EKGs, Other Diagnostic Tests | \$0 copay (included in office visit) | \$0 copay (included in office visit) | 40%* |
| Allergy Injections, Serum; Therapeutic Injections | \$0 copay (included in office visit) | \$0 copay (included in office visit) | Not Covered |
| Allergy Testing | \$35 per visit | \$55 per visit | Not Covered |
| Preventive Care Services | | | |
| Adult Wellness/Physical Exams | \$25 (or \$35 specialist)/visit | \$40 (or \$55 for specialist)/visit | Not Covered |
| Well Child Care, Immunizations, Mammography, Pap Tests | \$25 (or \$35 specialist)/visit | \$40 (or \$55 for specialist)/visit | |
| Vision & Hearing Screenings (only through age 17) | \$0 copay (included in office visit) | \$0 copay (included in office visit) | |
| Acupuncture (max. 20 visits/year) | \$35 per visit | \$55 per visit | Not Covered |
| Chiropractic Services ** | \$35 per visit | \$55 per visit | Not Covered |
| Ambulance: Ground & Emergency Air | Ground \$75 or Air \$125 | | |
| Emergency Room Treatment | \$200 per visit (waived if admitted) | \$300 per visit (waived if admitted) | 40%* |
| Urgent Care Facility | \$75 per visit | \$75 per visit | 40%* |
| Home Health Care/Home I.V. Care (max. 100 visits/year) ** | \$25 per visit | \$40 per visit | 40%* |
| Hospice Services (lifetime max. \$10,000; includes up to 7 days of respite care) ** | \$0 copay | \$0 copay | 40%* |
| Inpatient Hospital/Facility Services ** (See "Skilled Nursing Facility" for 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 and Board and Covered Ancillaries | \$200 per admission (no charge for inpatient physician services) | \$600 per admission (no charge for inpatient physician services) | 40%* |
| Skilled Nursing Facility (max. 60 days/lifetime) ** | \$0 copay | \$0 copay | 40%* |
| Surgery (Outpatient/Ambulatory Surgical Center) | \$100 copay | \$200 facility copay | 40%* |
| Observation Room (no emergency room) | \$0 copay | \$0 copay | 40%* |

BCBSNM is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, and Independent Licensee of the Blue Cross and Blue Shield Association.

| UNM Hospitals Extended Network Benefits | Member's Share of Covered Charges | | |
|--|--|--|---|
| | In-Network Services | | Out-of-Network Services* |
| | Standard Network | Extended Network | |
| Colonoscopy | \$100 copay | \$200 copay | 40%* |
| Lab, X-Ray, Other Diagnostic Tests | \$0 | \$0 | |
| PET Scan, CT Scan** | \$100 copay | \$200 copay | 40%* |
| Magnetic Resonance Imaging (MRI) | \$150 copay | \$300 copay | |
| Psychotherapeutic Services – Inpatient ** Mental Health Chemical Dependency, Alcohol/Substance Abuse (up to 30 days/year; 60 days/lifetime for rehab) | \$200 per Mental Health admission (no charge for physician services) 30% Detox; 25% Rehab | \$600 per Mental Health admission (no charge for physician services) 30% Detox; 25% Rehab | 40% Mental Health * 50% Detox * Rehab - Not Covered |
| Psychotherapeutic Services – Outpatient ** Mental Health Chemical Dependency, Alcohol/Substance Abuse (up to 30 visits/year; 60 visits/lifetime for rehab) | \$35 per Mental Health visit 30% Detox; 25% Rehab | \$55 per Mental Health visit 30% Detox; 25% Rehab | 40% Mental Health * 50% Detox * Rehab – Not Covered |
| Infertility Services , including drugs and injections (lifetime max. of 12 attempts per employee/spouse) ** | 50% | Not Covered | Not Covered |
| Medical Supplies, Durable Medical Equipment, Prosthetics, Orthotics ** | 20% | 20% | 40%* |
| Smoking/Tobacco Cessation Counseling (90 minutes total or 2 group sessions per calendar year) | \$25 PCP visit \$35 Specialist visit | \$40 PCP visit \$55 Specialist visit | Not Covered |
| TMJ, Dental-Related Accident, Oral Surgery | Usual copays based on type of service and place of treatment | | 40%* |
| Physical, Speech, Occupational Therapy** | \$35 per visit | \$55 per visit | 40%* |
| Other Therapy, Outpatient Treatment Facility: Chemotherapy, Radiation, Inhalation Therapy Dialysis | No charge 20% | No charge 20% | 40%* |
| Transplant Services ** (Must be received at a facility that contracts with a Standard or Extended Network provider for the transplant being received, including a facility in the national transplant network.) | | | |
| Cornea, Kidney, and Bone Marrow, Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney (Max. two transplants per lifetime. Max. \$5,000 per transplant for lodging and meal expenses and \$5,000 per transplant for travel expenses.) | Usual copays based on place of treatment and type of service | | Not Covered |

Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods, & Smoking/Tobacco Cessation

| | | | |
|--|--|--------------------------------|-------------------|
| <p>Note: Deductible does not apply and copayments are not applied to the out-of-pocket limit nor waived once the limit is met. Certain drugs, nutritional products/special medical foods, and certain injectable medications require prior approval. Covered drugs and other items must be purchased at a pharmacy that participates in the Retail Pharmacy/Specialty or Mail Order Service programs. (BCBSNM has contracted with a separate program for administration of the prescription drug benefits.)</p> | Prescription Drug Plan | Retail 30-day | Mail-Order 90-day |
| | Generic Drug | \$10 | \$20 |
| | Brand (no generic available) – On Drug List | \$35 | \$70 |
| | Drug - On Drug List (Brand-Name with generic equivalent available) | \$60 | \$120 |
| | Specialty Medications (May require prior authorization; Mail-Order does not apply) | 20% or \$250 whichever is less | |
| | Nonprescription enteral nutritional products and special medical foods (prior authorization required) | 20% | |

* Member's share of out-of-network covered services after deductible is met. Member also pays difference between the covered charge, as determined by the Claims Administrator, and the provider's billed charge.

** These services require prior authorization from BCBSNM (or Mesa Mental Health) or benefits will be reduced or denied. See a benefit booklet for full limitations and requirements.

Note: Extended Network members have access to the entire HMO statewide network, subject to normal plan provisions (prior authorization requirements, etc.). However, by using providers affiliated with the Standard Network, you may have lower out-of-pocket expenses. You do not need a PCP referral in order to receive benefits at the Extended Network or Standard Network level of coverage. You may visit any Standard Network provider and receive Standard Network benefits for covered services. If you choose to visit a provider who is not a member of the Standard Network, but is a member of the BCBSNM Network (Extended Network), you will receive Extended Network benefits for covered services. If you choose a provider that belongs to neither network, you will receive Out-of-Network benefits for covered services. However, you will have to first meet a deductible and pay a percentage of covered charges (some exceptions, such as for emergency care are explained in the member's benefit booklet). Out-of-network providers may bill you for amounts that are over the covered charge. This amount can sometimes be significant, and is not applied to your out-of-pocket limit. Also, some benefits are available only if received from Network (either Extended or Standard) providers.

Note: BCBSNM provides 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 Administrative Services Agreement.