UNM Hospitals (UNMH)
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 **Effective January 1, 2015**	$250 ($500 Family Aggregate) Will begin with the 2015 Calendar Year		$1,500 $3,000 Family Aggregate
Calendar Year Out-of-Pocket Maximum*** (Includes copayments, deductible and coinsurance only. Does NOT include drug charges, noncovered charges, or penalty amounts. In and Out- of-Network amounts do not cross-apply.	$5,000 per individual $10,000 per family	$5,000 per individual $10,000 per family	$10,000 per individual
Primary Care Physician (PCP) and OB/GYN Office Visits	$30 per visit	$45 per visit	40%*
Specialist Physician Office Visit	$40 per visit	$60 per visit	40%*
Office Surgery (including casts, splints, and dressings)	$30 (or $40 specialist) per visit	$45 (or $60 specialist) per visit	40%*
Maternity Prenatal & Post-Partum Visits	$30 initial visit only	$45 initial visit only	40%*
Mental Health and Chemical Dependency Services	$30 per visit	$45 per visit	40%*
Allergy Injections, Serum; Therapeutic Injections	$0 copay (included in office visit)	$0 copay (included in office visit)	Not Covered
Allergy Testing	$40 per visit	$60 per visit	Not Covered
Preventive Care Services Adult Wellness/Physical Exams; Well Child Care; Immunizations; Preventive Lab Tests and X-Rays (mammogram, pap tests, urinalysis, etc.); Routine Colonoscopy (outpatient/office); Smoking/Tobacco Cessation Counseling; Vision & Hearing Screenings	No Charge	No Charge	Not Covered
Acupuncture (max. 20 visits/year)	$40 per visit after deductible	$60 per visit after deductible	Not Covered
**Spinal Manipulation ** **	$40 per visit after deductible	$60 per visit after deductible	Not Covered
Ambulance: Ground & Emergency Air	Ground $75 or Air $125 after deductible		
Emergency Room Treatment	$300 per visit after deductible (copay waived if admitted)	$300 per visit after deductible (copay waived if admitted)	
Urgent Care Facility – UNM Hospitals facility	$75 per visit after deductible	N/A	N/A
Urgent Care Facility – All other urgent care facilities	$100 per visit after deductible	$100 per visit after deductible	40%*
Home Health Care/Home I.V. Care (max. 100 visits/year) **	$30 per visit after deductible	$45 per visit after deductible	40%*
Hospice Services (up to 7 days of respite care) **	$0 copay after deductible	$0 copay after deductible	40%*
**Inpatient Hospital/Facility Services ** ** (See "Skilled Nursing Facility" for skilled nursing facility admissions. See "Transplant Services," if applicable.)			
Medical/Surgical, Mental Health/Chemical Dependency and Maternity-Related Room and Board and Covered Ancillaries; Physical Rehabilitation	$500 per admission after deductible (no charge for inpatient physician services)	$600 per admission after deductible (no charge for inpatient physician services)	40%*
Skilled Nursing Facility (max. 60 days/lifetime) **	$0 copay after deductible	$0 copay after deductible	40%*
Surgery (Outpatient/Ambulatory Surgical Center)**	$350 facility copay after deductible	$600 facility copay after deductible	40%*

UNM Hospitals Extended Network Benefits	Member's Share of Covered Charges		
	In-Network Services		Out-of-Network Services*
	Standard Network	Extended Network	
Observation Room (no emergency room)	$0 copay after deductible	$0 copay after deductible	40%*
Non-Routine Colonoscopy	$100 copay after deductible	$200 copay after deductible	40%*
Lab, X-Ray, Other Diagnostic Tests (office, outpatient, freestanding facilities)**	20% after deductible	20% after deductible	40%*
	$1,000 annual out-of-pocket limit		
PET Scan, CT Scan**	$200 copay after deductible	$200 copay after deductible	
Magnetic Resonance Imaging (MRI)	$250 copay after deductible	$300 copay after deductible	
Infertility Services, including drugs and injections (lifetime max. of 12 attempts per employee/spouse) **	50% after deductible	Not Covered	Not Covered
Medical Supplies, Durable Medical Equipment, Prosthetics, Orthotics **	20% after deductible	20% after deductible	40%*
Short-Term Rehabilitation (Physical, Speech, Occupational Therapy, Outpatient/Office)** (max. 35 visits/year)	$40 per visit after deductible	$60 per visit after deductible	40%*
Other Therapy, Outpatient Treatment Facility** Chemotherapy, Radiation, Inhalation Therapy	No charge	No charge	40%*
Dialysis	20% after deductible	20% after deductible	
TMJ, Dental-Related Accident, Oral Surgery**	Usual copays based on type of service and place of treatment		40%*
Transplant Services ** (Must be received at a facility that contracts as a Standard or Extended Network provider for the transplant being received, including a facility in the national BCBS transplant network.)			
Cornea, Kidney, and Bone Marrow, Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney (Max. $5,000 per transplant for lodging 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

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 preauthorization. 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.)

Prescription Drug Plan	Retail 30-day	Mail-Order 90-day
Generic Drug	$10	$20
Brand Name Drug On Drug List (no generic available)	$40	$80
Drug Not On Drug List (brand-name with generic equivalent available)	$70	$140
Specialty Medications (may require preauthorization; Mail-Order does **not** apply)	20% or $250 whichever is less	
Nonprescription enteral nutritional products and special medical foods (preauthorization 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 preauthorization from BCBSNM or benefits will be reduced or denied. See a benefit booklet for full limitations and requirements.**

***** In- and Out-of-Network out-of-pocket amounts do not cross apply.**

Note: Extended Network members have access to the entire HMO statewide network, subject to normal plan provisions (preauthorization 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 does not assume any financial risk or obligation with respect to claims, except as may be specified in the Administrative Services Agreement.