Administered by:

Blue Cross and Blue Shield of New Mexico

NMRHCA Value Plan – 01/01/2024

The following highlights are for the New Mexico Retiree Health Care Authority's Value Plan that is administered by Blue Cross and Blue Shield of New Mexico (BCBSNM). **This plan is offered statewide and you MUST see a Value Plan contracted provider in NM or you will not be covered except for emergency or urgently needed care. You may not enroll in this plan if you are living outside of New Mexico.** 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.**

NMRHCA Value Plan Benefits – NM only provider network, no national provider network with Value HMO Plan. (This plan has no lifetime maximum benefit, though certain services have maximum annual limits. See below).	**NMRHCA Value Plan[1]** **What You Pay**
Annual Deductible[1] (Deductible applies to all services unless indicated as "waived" below. There is no family deductible.	$1,500
Annual Out-of-Pocket Limit (Includes copayments, deductible and coinsurance only - NOT prescription drug charges, penalty amounts, or non-covered charges. There is no family out of pocket amount.[2]	$5,500
Primary Preferred Provider (PPP)* Office Services 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.)	$35 copay (deductible waived)
Mental Health and Chemical Dependency (office visit only)	No Charge (deductible waived)
Specialist Provider Office Services Office Visit (Services received during the office visit, such as therapy, are subject to deductible and coinsurance as listed in the rest of the summary.)	$55 copay (deductible waived)
Office Surgery (including casts, splints, and dressings)	Office Visit copay (deductible waived)
Allergy Injections, Tests, Serum	30%
Preventive Services Routine Adult Physicals and Gynecological Exams, certain services for Family Planning, Well-Child Care; Routine Vision or Hearing Screenings (only through age 18) and Immunizations	Plan pays 100% (deductible waived)
Related Testing Includes routine Pap tests, mammograms, cholesterol tests, urinalysis, etc.	
Lab, X-Ray, and Pathology[4]	Plan pays 100% (deductible waived)
EKG	30%
High-Tech Radiology (e.g., MRI, MRA, CT Scan, PET Scans)[4] (Office /Free Standing Radiology)	$125 copay (deductible waived)
High-Tech Radiology (e.g., MRI, MRA, CT Scan, PET Scans)[4] (Outpatient Department of Hospital)	30%
Ambulance Services, Ground or Emergency Air Transport	30%
Biofeedback (for specified medical conditions only)	30%
Cardiac and Pulmonary Rehabilitation, Outpatient[4]	30%
Chiropractic Services, Acupuncture, Massage Therapy, and Rolfing (combined max. **1,500**/year)[7]	30%
Colonoscopies (initial routine or medical diagnostic)	Plan pays 100% (deductible waived)
Emergency Room/Observation Room Treatment[3] (Emergency Only; copay waived if admitted inpatient)	$350 copay (deductible waived)
Physician and other Professional Provider Charges[3]	30%
Hearing Aids and Related Services: Hearing aids for members under age 21 are paid at 100% of covered charges (deductible waived) up to a maximum of **$2,200** per hearing-impaired ear during any 3-year period. Exams/testing subject to usual cost-sharing provisions. For members age 21 and older, benefits for hearing aids are limited to **$500** per member during any 3-year period, subject to Plan deductible and coinsurance.[4]	
Home Health Care/Home I.V. Services[4]	30%
Hospice Services[4, 5]	30%

*A Primary Preferred Provider (PPP) is a preferred physician or other professional provider in one of the following categories of practice: Family or General Practice, Internal Medicine, Pediatrics, Obstetrics and Gynecology, and Gynecology Only.

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Inpatient Hospital/Facility Services (See "Short-Term Rehabilitation - Inpatient" for rehabilitation and skilled nursing facility admissions. See "Transplant Services," if applicable.)	
Medical/Surgical, and Maternity-Related Room and Board, Physician and Other Professional Provider charges, and Covered Ancillaries[5] Mental Health and Chemical Dependency (includes partial hospitalization)[5]	30% No Charge (deductible waived)
Maternity Services Including Routine Pediatrician Care for Covered Newborns (See "Inpatient Hospital/Facility)[5]	30%
Outpatient Facility and Physician Services (including surgery) Outpatient and intensive outpatient mental health and chemical dependency[4,5]	30% No Charge (deductible waived)
Prosthetics and Orthotics[4,6]	30%
Short-Term Rehabilitation - Inpatient[5] Rehabilitation Facility Skilled Nursing Facility (max of **60 days**/year)	30%
Short-Term Rehabilitation - Outpatient	
Physical Therapy Services	$35 copay per visit for first 4 visits; thereafter, no charge for the remainder of the calendar year
Occupational and Speech Therapy Services	$35 copay
Smoking/Tobacco Use Cessation	Plan Pays 100% (deductible waived)
Supplies and Durable Medical Equipment[4,6] (Incontinence supplies limited to **$200**/month; wigs, if covered, limited to **$200** every 3 years)	30%
Therapy: Chemotherapy, Dialysis, and Radiation[4]	30%
TMJ Services, Dental Accident, Oral Surgery[4]	30%
Transplant Services (Must be received at a facility that contracts with BCBSNM or the national BCBS transplant networks.)	
Cornea, Kidney, and Bone Marrow[4,5] Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney[4,5]	30%
Urgent Care Facility (Includes physician services)	$55 copay
Prescription Drugs – 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:

[1] The deductible must be met before benefit payments are made (excluding emergency room facility charges; 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).

[2] After a member reaches the applicable out-of-pocket limit, the Plan pays 100 percent of most of that member's covered charges for the remainder of the calendar year.

[3] Follow-up treatment from a Nonpreferred Provider requires prior authorization.

[4] 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.

[5] Admission review is required for inpatient admissions. 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.

[6] Rental benefits for medical equipment and other items will not exceed the purchase price of a new unit.

[7] Services administered by a licensed medical doctor (MD), doctor of osteopathy (DO), physical therapist (RPT or LPT), licensed massage therapist (LMT), doctor of oriental medicine (DOM.), and doctor of chiropractic (DC) are covered. Rolfing must be provided by a certified rolfer.

Claims Administrator 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 Agreement.

This is a summary only – please refer to the Benefit Booklet for more details.