Administered by
Blue Cross and Blue Shield of New Mexico

State of New Mexico

Plan Highlights – 2024 HMO Plan

The following are the highlights of the State of New Mexico HMO Plan administered by Blue Cross and Blue Shield of New Mexico (BCBSNM). Any services received must be medically necessary to be covered.

Benefit Highlights		HMO Provider[1,2]
Highlights of Cost-Sharing Features	**Annual Deductible[1]** (All services are subject to deductible unless noted otherwise.)	$425/Individual $850/Two-Person $1,275/Family*
	Annual Out-of-Pocket Limit[2] (Includes medical deductible, coinsurance, copayments, plus drug plan deductible, drug coinsurance, and drug copays. **Does not** include penalty amounts, or non-covered charges.)	$4,000/Individual $8,000/Two Person $12,000/Family*
	Lifetime Maximum	Unlimited (Certain services are subject to calendar year and/or lifetime maximums or are limited per condition.)
Type of Service	**Description of Service and Limitations**	**Your Share After Annual Deductible[1,2]** **HMO Provider**
Physician Services, Office	Primary Care Physician/Provider (PCP) Office Visit/Exam Copayment (non-preventive) • Office Surgery (including casts, splints, etc.) • Telehealth Services	$35 per visit (deductible waived) $35 per visit (deductible waived) No copay (deductible waived)
	Other non-Routine Office Services: Includes services of non-PCP providers (Specialists) • Office Surgery • Allergy Tests, Serum • Allergy Injections • Therapeutic Injections (with Physician) • Therapeutic Injections (with Nurse)	• 50 per visit (deductible waived) • $50 per visit (deductible waived)[4] • $50 per visit (deductible waived)[4] • No copay (deductible waived) • Included in Office Visit copay (PCP or Specialist) • No Charge (deductible waived)
	Preventive Services: including immunizations, lab, X-ray, colonoscopies, pap tests, mammograms, immunizations, and other wellness services; smoking/ tobacco cessation counseling, etc.	No Charge (deductible waived)
Diagnostic Testing, Outpatient	PET Scans, CT Scans, MRIs, (unless covered as part of a fixed-dollar copayment during ER visit, admission, etc.) Other Lab, X-Ray, EKGs, diagnostic services	25% (up to a max. member share of $250 per test)[4] 25%[4]
Inpatient Hospital Services, Acute Care	Hospitalization (includes semi-private room, board, drugs, medications, and ancillaries; inpatient physician visits, surgeon, assistant, and anesthesiologist)	$700 per admission[4,5]
	Related physician services (e.g., anesthetist, surgeon)	No Charge (deductible waived)[4]
Outpatient Hospital Services	Surgery – operating and recovery room Observation (nonemergency)	25%[4] $250 per visit[4]
	Other treatment room services not otherwise specified in this Summary	20%[4]
	Related physician services (e.g., anesthetist, surgeon)	No Charge (deductible waived)[4]
Emergency Services and Urgent Care	Emergency room or emergency observation room visit	$300 per visit[3]
	Urgent care center	$60 per visit
	Ambulance (ground and air transport)	Ground: $30 copay/trip Air: $100 copay/trip[3,4]
Transplants	Cornea, Kidney and Bone Marrow	Based on place of treatment and type of service[4,5,6]
	Bone marrow, heart, heart-lung, liver, lung, pancreas- kidney, and other medically necessary transplants (Case Management required; maximums apply to covered travel and lodging fees.)	Based on place of treatment and type of service[4,5,6]
Maternity Services	Initial visit to confirm pregnancy	$35 for initial visit if to a PCP (deductible waived)
	Physician/midwife services (delivery, prenatal/postnatal care)	Applicable copays based on place and type of service[4,5]
	Hospital admission	$500 per admission[4,5]
	Routine nursery care for covered newborn (Child covered from birth but must apply for coverage within 31 days.)	No copay[4,5]

Type of Service	Description of Service and Limitations	Your Share After Annual Deductible[1,2]
		HMO Provider
Mental Health and Substance Abuse Rehabilitation Services	Outpatient/Office services	No charge (deductible waived)[4]
	Telehealth services	No charge (deductible waived)
	Inpatient services	No charge (deductible waived)[4,5]
	Partial hospitalization	No charge (deductible waived)[5]
	Intensive outpatient program	No charge (deductible waived)[4]
	Residential treatment center (max. **60 days**/calendar year)	No charge (deductible waived)[4,5]
Other Services	Acupuncture & Spinal manipulation (ANY provider **except** Chiropractor) (limited to **25 visits / combined** / calendar year.)	$55 per visit (deductible waived)
	Chiropractic Services (Chiropractor Provider only) (Limited to **25 visits / combined** / calendar year with acupuncture.)	$35 Per Visit (deductible waived)
	Biofeedback (outpatient office visit) (for specified conditions only)	$55 per visit (deductible waived)
	Cardiac and Pulmonary Rehabilitation	$50 per visit[4] (deductible waived)
	Chemotherapy, Radiation therapy; Dialysis	No copay in Physician's Office
	Durable medical equipment, diabetic equipment, and supplies; orthopedic appliances, prosthetics and orthotics (Rental benefits may not exceed the purchase price of a new unit. Supplies limited to a **30-day supply** during a 30-day period)	25%[4]
	Hearing exam/test - Adults and Children	$50 per visit
	Hearing aids – Adults Only – Age 22 and Older	No copay (deductible waived) Hearing aids (max. benefit of **$2,500** per ear every **3 years** starting with date of purchase)
	Hearing aids – Children Only – Age 21 and Younger	No copay (deductible waived)
	Home health care and home I.V. services	$45 per Physician visit (deductible waived) or No Charge for Nurse visit[4]
	Hospice	No charge[4,5] (deductible waived)
	Naprapathy and Massage Therapy (limited to **25 visits / combined** / calendar year)	$60 per visit (deductible waived)
	Rehabilitation facility and Skilled Nursing facility	$700 per admission[4,5]
	Short-term rehabilitation: outpatient/office Physical, Occupational, and Speech therapies	$35 per visit (deductible waived)
	Applied Behavior Analysis for Autism Occupational, Physical and Speech Therapy for Autism	$25 per visit[4] (deductible waived) Based on place of treatment and type of service
	TMJ/CMJ, oral surgery, and dental accident services	Applicable copayments, deductible, and/or coinsurance based on place and type of treatment
Prescription Drugs, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods, Smoking/Tobacco Cessation		See your CVS benefit summary for details.

FOOTNOTES:

[1]All benefits are based on the covered charges as determined by BCBSNM. The deductible must be met before benefit payments are made for most covered services in a calendar year. ("Deductible waived" is indicated above for those services that are excluded from the deductible requirement.)

Note: A "PCP" is any HMO provider in one of the following categories of practice: Family Practice, Internal Medicine, General Practice, Gynecology, Pediatrics, or Obstetrics/Gynecology.

[2]After you reach the applicable out-of-pocket limit, BCBSNM pays 100 percent of most of your covered preferred Provider charges, whichever is applicable, for the rest of the calendar year. Amounts in excess of covered charges, penalty amounts, and non-covered charges do not count toward the out-of-pocket limit or deductible.

[3]Initial treatment of a medical emergency at an HMO or nonpreferred emergency room or trauma center is paid at the HMO Provider benefit level. If you must be admitted as an inpatient as a result of an emergency, the entire, related hospitalization is paid at the HMO Provider benefit level. Follow-up treatment and treatment that is not for an emergency is not covered. The emergency room or observation room copayment is waived if an inpatient admission results; then inpatient hospital benefits apply.

[4]Certain services are not covered if preauthorization is not obtained from BCBSNM. Nonemergency air ambulance transfer services are covered only when it is medically necessary to transfer the patient from one facility to another. A list of services requiring preauthorization is in Section 4 of your benefit booklet.

[5]Preauthorization (or admission review approval) is required for inpatient admissions. Some services, such as transplants, require additional approval. If you do not receive preauthorization for these individually-identified procedures or services, benefits for any related admissions will be denied. See Section 4 of your benefit booklet for additional details.

[6]Transplants must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.

***Note about Family deductibles and out-of-pocket limits:** If you have a Family contract, an entire family meets an applicable deductible or out-of- pocket limit for a calendar year when the total deductible amount or out-of-pocket limit for all family members reaches three times the Individual deductible or out-of-pocket limit amount (the deductible and out-of-pocket limit amounts for three or more family members are combined to satisfy the Family deductible and the Family out-of-pocket limit). However, once a member meets an Individual deductible, that member's applicable deductible is satisfied for the calendar year, and no more charges incurred by that member can be used to satisfy the Family deductible.

Note: For outpatient surgeries, you will pay a coinsurance percentage for the facility and the related physician charges.

This is a summary only – please refer to the Summary of Benefits and Coverage (SBC) document and Benefit Booklet for more details.