UNM Hospitals (UNMH)
Consumer-Driven HSA Plan

Administered by:
Blue Cross and Blue Shield of New Mexico

Highlights the deductible, out-of-pocket limits, member coinsurance percentage amounts and provides a brief description of UNM Hospitals Consumer-Driven Plan benefits.

UNM Hospitals Consumer-Driven Plan Benefits	Member's Share of Covered Charges	
	Standard Network (In-Network Services)[1]	**Out-of-Network Services[1]**
Individual Annual Deductible	$1,600	$3,200
Family Annual Deductible: Aggregate – All family members' services apply to the Family Deductible. Once the entire Family Deductible is met; then all family members' services apply coinsurance benefits.	$3,200	$7,200
Annual Out-of-Pocket Limit: Embedded - (Includes deductible, coinsurance, and prescription drugs only - NOT penalty amounts or noncovered charges.)[2]	$5,000/Individual Coverage $10,000/Family Coverage	$10,000/Individual (Medical only)
Office Services (non-routine)		
Office Visit/Exams/Consultations	20% coinsurance	40% coinsurance
Allergy Injections, Tests, Serum	20% coinsurance	40% coinsurance
Office Surgery (including casts, splints, and dressings)	20% coinsurance	40% coinsurance
Mental Health and Chemical Dependency (outpatient/office)	20% coinsurance	40% coinsurance
Preventive Services Routine Adult Physicals and Gynecological Exams, Related Testing (includes routine Pap tests, mammograms, cholesterol tests, urinalysis, etc.), Routine colonoscopies (outpatient/office), Immunizations, Well-Child Care; and Routine Vision or Hearing Screenings	No Charge (Deductible waived)	40% coinsurance
Acupuncture Treatment (max. **20 visits**/year)	20% coinsurance	40% coinsurance
Ambulance Services: Ground and Emergency Air Transport	20% coinsurance[3]	
Ambulance Services: Nonemergency Air Transfer	20% coinsurance[4]	40% coinsurance[4]
Autism Spectrum Disorders Applied Behavioral Analysis,[4] and Occupational, Physical, and Speech Therapy	20% coinsurance	40% coinsurance
Cardiac and Pulmonary Rehabilitation, Outpatient	20% coinsurance	40% coinsurance
Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services	20% coinsurance[4]	40% coinsurance[4]
Emergency Room Treatment	20% coinsurance[3]	
Gender Reassignment Surgery and Related Services[4]	Covered Based on Place of Treatment and Type of Service[4]	
Home Health Care/Home I.V. Services (max. **100 visits**/year)	20% coinsurance	40% coinsurance
Hospice Services (up to **7 days** of respite care)	20% coinsurance[4,5]	40% coinsurance[4,5]
Infertility Services including drugs and injections (lifetime max. of **12 attempts** per employee/spouse)	20% coinsurance[4,5]	40% coinsurance[4,5]
Inpatient Hospital/Facility and Physician Services		
Medical/Surgical, Mental Health/Chemical Dependency (including partial hospitalization), Residential Treatment Center, Maternity-Related Room and Board and Covered Ancillaries	20% coinsurance[5]	40% coinsurance[5]
Routine Nursery Care for Covered Newborns	20% coinsurance	40% coinsurance
Lab, X-Ray, and Other Diagnostic Tests	20% coinsurance	40% coinsurance
MRIs, CT Scans, PET Scans	20% coinsurance[4]	40% coinsurance[4]
Maternity Services (pre- and post-natal, delivery, and newborn charges)	20% coinsurance[5]	40% coinsurance[5]
Short-Term Rehabilitation: Occupational, Physical, and Speech Therapy; including Physical Rehabilitation **Inpatient Rehabilitation** **Outpatient and Office Rehabilitation** (max. **35 visits**/year)/combined) **Skilled Nursing** (max. **60 days**/lifetime)	20% coinsurance[5]	40% coinsurance[5]
Spinal Manipulation Services	20% coinsurance	40% coinsurance
Supplies, Durable Medical Equipment, Prosthetics, Orthotics	20% coinsurance[6]	40% coinsurance[6]
Outpatient Facility/Surgeon/Physician (surgical procedures, pregnancy-related services, and non-routine colonoscopies)	20% coinsurance	40% coinsurance

UNM Hospitals Consumer-Driven Plan Benefits	Member's Share of Covered Charges	
	Standard Network (In-Network Services)[1]	Out-of-Network Services[1]
Therapy: Chemotherapy, Dialysis, and Radiation	20% coinsurance	40% coinsurance
Transplant Services (Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.)		
Cornea, Kidney, and Bone Marrow	20% coinsurance[4,5]	40% coinsurance[4,5]
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney (**$10,000** maximum for travel and lodging per diem)		No Benefit
Urgent Care Facility	20% coinsurance	40% coinsurance

Copay Level	Type of Prescription (must be on Drug List)	Your Copay		
Retail Pharmacy (up to a 30-day supply) **Mail-Order Pharmacy** (up to a 90-day supply)		**Preventive Rx**	**Non-Preventive Rx**	**Mail-Order Pharmacy**
Tier 1	**Preferred Generic Drug**	$8	20% coinsurance	2x Retail
Tier 2	**Non-Preferred Generic Drug**	$20	20% coinsurance	2x Retail
Tier 3	**Preferred Brand-Name Drug**	$45	20% coinsurance	2x Retail
Tier 4	**Non-Preferred Brand-Name Drug**	$75	20% coinsurance	2x Retail
Tier 5	**Preferred Specialty Drug** (not available through mail-order)	$150	20% coinsurance	Not Covered
Tier 6	**Non-Preferred Specialty Drug** (not available through mail-order)	$300	20% coinsurance	Not Covered
All Tiers	**Nonprescription Enteral Nutritional Products and Special Medical Foods** (brand-name or generic): Products must be **prior-approved**.	20% coinsurance (Limited to a 30-day supply during any 30-day period)		
All Tiers	**Prescription Drug Out-of-Pocket Limit**	Combined with Medical OOP Limit (refer to Summary of Benefits and Coverage for details)		
For all brand-name drugs with a generic equivalent, if you or your provider orders the brand-name, you will pay the applicable copay PLUS the **difference in cost** between the brand-name drug and its generic equivalent.				

FOOTNOTES:

[1] The Individual or Family Coverage deductible (as applicable) must be met before benefit payments are made, including for services covered under the drug plan.

[2] After a member or family reaches the applicable out-of-pocket limit, BCBSNM pays 100 percent of that member's or family's Preferred Provider or Nonpreferred Provider covered charges, whichever is applicable. Amounts paid under the drug plan are subject to the Preferred Provider limit. Preferred Provider/prescription drug coinsurance and copayment amounts do not cross-apply to the Nonpreferred Provider out-of-pocket limit amount, or vice versa.

[3] Initial treatment of a medical emergency is paid at Preferred Provider level. Follow-up treatment and treatment that is not for an emergency is paid at Nonpreferred Provider level.

[4] Certain services are not covered if preauthorization is not obtained from BCBSNM. See a Benefit Booklet for a list of services requiring preauthorization.

[5] Preauthorization is required for inpatient admissions. Some services, such as transplants, require additional preauthorization. If you do not receive preauthorization for these individually-identified procedures and services, benefits for any related admissions will be denied. See a Benefit Booklet for details

[6] Rental benefits will not exceed the purchase price of a new unit.

IMPORTANT: Deductible amounts and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than the provider's billed charges. Preferred Providers will not charge you the difference between the covered charge and the billed charge for covered services; Nonpreferred Providers may.

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.

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