UNM Hospitals (UNMH)
PPO Plan
Summary of Benefits

Administered by:

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

UNM Hospitals PPO Plan Benefits	Member's Share of Covered Charges	
	Preferred Provider Network (In-Network Services)	**Out-of-Network Services ***
Calendar Year Deductible	$750 ($1,500 Family)	$2,250 ($4,500 Family)
Calendar Year Out-of-Pocket Maximum (Includes copayments, deductible and coinsurance only. Does NOT include drug charges, noncovered charges, or penalty amounts. In-Network and Out-of-Network amounts do not cross-apply.)	$5,000 per Individual $10,000 per Family	$10,000 per Individual
Office Services (nonroutine)		
Primary Preferred Provider* Office Visit/Exam and initial office visit to diagnose pregnancy	$35 per visit	40%*
Mental Health and Chemical Dependency Services	$35 per visit	40%*
Specialist Office Visit/Exam and initial office visit to diagnose pregnancy	$45 per visit	40%*
Office Surgery (including casts, splints and dressings)	$35 (or $45 specialist) per visit	40%*
Allergy Injections, Serum; Therapeutic Injections	$0 copay (included in office visit)	Not Covered
Allergy Testing	$45 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 and Hearing Screenings	No Charge	Not Covered
Acupuncture (max. **20 visits**/year)	$45 per visit after deductible	Not Covered
Ambulance Services: Ground and Emergency Air Transport	Ground $75 or Air $125 after PPO deductible	
Ambulance Services: Nonemergency Air Transfer	$125 after PPO deductible	
Autism Spectrum Disorders Applied Behavioral Analysis, and Occupational, Physical, and Speech Therapy	Usual copays or coinsurance based on place of treatment and type of service**	
Cardiac and Pulmonary Rehabilitiation, Outpatient	No charge after deductible	40%*
Dental/Facial Accident, Oral Surgery and TMJ/CMJ Services	Usual copays, deductible or coinsurance based on place of treatment and type of service	40%*
Emergency Room Facility (High-end diagnostic tests have a separate copay as indicated in this document)	$300 per visit after PPO deductible (copay waived if admitted)	
Gender Reassignment Surgery and Related Services**	Covered Based on Place of Treatment and Type of Service	
Home Health/Home I.V. Care (max. **100 visits**/year)**	$35 per visit after deductible	40%*
Hospice Services** (up to **7 days** of respite care)	No charge after deductible	40%*
Infertility Services, including drugs and injections (lifetime max. **12 attempts** per employee/spouse)**	50% after PPO deductible*	
Inpatient Hospital/Facility Services** (See "Transplant Services," if applicable)		
Medical/Surgical, Mental Health/Chemical Dependency, and Maternity-Related Room and Board, Covered Ancillaries; Inpatient Physical Rehabilitation	$500 per day for up to 2 days after deductible (no charge for inpatient physician services)	40%*
Routine Nursery Care for Covered Newborns (covered as part of mother's claim)	$500 per day for up to 2 days after deductible (no charge for inpatient physician services)	40%*

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UNM Hospitals PPO Plan Benefits	Member's Share of Covered Charges	
	Preferred Provider Network (In-Network Services)	**Out-of-Network Services ***
Lab, X-Ray, Diagnostic Tests (office, outpatient, freestanding facilities) **PET Scans, CT Scan**** **Magnetic Resonance Imaging (MRI)**** ($1,000 annual out-of-pocket max for all lab and diagnostic services – for PPO Network only)	20% after deductible $200 copay after deductible $250 copay after deductible	40%*
Non-Routine Colonoscopy	$100 copay after deductible	40%*
Outpatient Facility/Surgeon/Physician (surgical procedures and pregnancy-related services)	$350 facility copay after deductible	40%*
Short-Term Rehabilitation (Physical, Occupational, and Speech Therapy, Outpatient/Office)** (max. **35 visits**/year/combined) **Skilled Nursing Facility** (max. **60 days**/lifetime)	$35 (or $45 specialist) per visit after deductible No charge after deductible	40%* 40%*
Spinal Manipulation	$45 per visit after deductible	Not Covered
Supplies, Durable Medical Equipment, Prosthetics, Orthotics	20% after deductible	40%*
Therapies Chemotherapy, Radiation, Inhalation Therapy Dialysis	No charge after deductible 20% after deductible	40%*
Transplant Services** (Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network)		
Cornea, Kidney, and Bone Marrow	Based on place of treatment and type of service	40%*
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney (Max. **$10,000** per transplant for lodging and travel expenses.)	Based on place of treatment and type of service	Not Covered
Urgent Care Facility – UNM Hospitals facility	$75 per visit after deductible	Not Covered
Urgent Care Facility – All other urgent care facilities	$100 per visit after deductible	40%*

Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods, and Smoking/Tobacco Cessation			
Note: 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 Out of Pocket maximum: once the out of pocket maximum is met, prescription drugs are paid 100%.	**Prescription Plan Copayments:**	**Retail 30-day**	**Mail-Order 90-day**
	Preferred Generic Drug	$8	$16
	Non-Preferred Generic Drug	$20	$40
	Preferred Brand Name Drug	$60	$90
	Non-Preferred Brand Name Drug	$100	$150
	Preferred Specialty Medications ***	$150	N/A
	Non-Preferred Specialty Medications ***	$300	N/A
	Nonprescription enteral nutritional products and special medical foods	50%	
Prescription Drug Plan Out-of-Pocket Limit	$2,500/Individual $5,000/Family		

* 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 may require preauthorization from BCBSNM or benefits will be reduced or denied. See a benefit booklet for full limitations and requirements.

*** Specialty Medications may require preauthorization; Mail Order is not available for Specialty Medications.

Note: You do not need a PCP referral in order to receive benefits at the Preferred Provider Network level of coverage. You may visit any Preferred Provider Network provider and receive Preferred Provider (In-Network) benefits for covered services. 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 Preferred Provider Network 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.

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