



Bernalillo County

Summary of Benefits – EPO Plan

Summary only – lists copayments, deductible and out-of-pocket limit amounts; member coinsurance percentage amounts; and provides a brief description of Bernalillo County's health care plan benefits.

Benefit Summary – This plan does not cover services received from nonpreferred providers, except in an emergency.		Member's Share of Covered Charges From a Preferred Provider
Annual Deductible (Except for diagnostic lab and x-ray – which are not subject to a deductible – only covered charges for services subject to percentage "coinsurance" amounts apply toward deductible.) ¹		\$100 (\$300/family)
Annual Out-of-Pocket Limit (Deductible, Coinsurance and Copayments apply; prescription drugs, penalty amounts, and non-covered charges do not.)		\$2,500 (\$5,000/family)
Primary Preferred Provider (PPP) Office Services *		
Office Visit**, Medication Management **; Initial visit to diagnose pregnancy		\$25 copay/Adult
Office Surgery (including casts, splints, and dressings)		\$10 copay/Child
Mental Health/Chemical Dependency Services (outpatient/office)		
Specialty Physician Office Services		
Office Visit**, Medication Management**, Office Evaluations; Initial visit to diagnose pregnancy		\$50 copay/Adult \$40 copay/Child
Office Surgery (including casts, splints, and dressings)		
Preventive Care (Outpatient/office adult medical care/routine exams; well child care; vision and hearing screening; Immunizations, routine labs (pap smear, cholesterol, etc.), routine mammogram, routine colonoscopy)		No Charge (Deductible waived)
Acupuncture/Spinal Manipulation (max. 18 visits/year)		\$50 copay/Adult \$40 copay/Child
Allergy Services (testing, serum extracts and injections) (Injections included in office visit copay; \$0 copay if nurse visit only)	Primary Provider	20% copayment
	Specialist	20% copayment
Allergy Serum		20% copayment
Ambulance Services		Emergency/high Risk: \$50 copay ground/trip \$100 copay air/trip Inter-Facility Transfer: \$0 copay ground/trip \$100 copay air/trip
Cardiac and Pulmonary Rehabilitation (outpatient)		\$25 copay/Adult \$10 copay/Child
Administration of Blood/Blood Components		\$0 copay
Cardiac Cath		\$200 copay/Adult \$150 copay/Child
Chemotherapy and Radiation Therapy		\$0 copay
Contraceptive Methods (IUD, Hormone Injections, Inserted Devices) Breastfeeding support, supplies and counseling for one year after delivery		Plan pays 100%
Dialysis		20% copayment
Dental/Facial Accidents, Oral Surgery, TMJ/CMJ Services		Included in office visit copay
Durable Medical Equipment, Supplies, Prosthetics, and Orthotics		20% copayment ⁴
Emergency and Urgent Care Services		
Emergency Room (includes all related ER services)		\$150
Observation Room (including pregnancy)		\$150
Urgent Care Facility		\$40/Adult or \$10/Child

See footnotes on back.

Hearing Aids and Related Services: Hearing aids for members under age 21 are paid at 100% of covered charges up to a maximum of **2 hearing aids** every 3-years; exams and testing are subject to usual cost-sharing provisions. These services are not covered for members age 21 and older.

Home Health Care (prescribed home nursing care, physician, and therapy care – 100 visits/year)		\$0 copay
Hospice (*waived if transferred directly from an Inpatient Hospital, rehabilitation, or Skilled Nursing Facility)	Inpatient	*\$500 copay; \$350 (child)
	In Home	\$0 copay
Infertility Services (including drugs and injections)		50% copay
Autism Spectrum Disorder (Diagnosis and Treatment for all children up to age 19 or up to age 22 if still attending high school) Up to \$36,000 per member per Contract Year	PCP	\$10 copay/visit Child
	Specialist	\$40 copay/visit Child
	Outpatient Physical Therapy	\$40 copay/visit Child
	Outpatient Occupational Therapy	\$40 copay/visit Child
	Outpatient Speech Therapy	\$40 copay/visit Child
	Applied Behavioral Analysis (ABA)	\$10 copay/visit Child

* 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.

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.

Blue Cross and Blue Shield of New Mexico (BCBSNM) is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Benefit Summary – This plan does not cover services received from nonpreferred providers, except in an emergency.	Member's Share of Covered Charges From a Preferred Provider
---	--

Inpatient Hospital/Facility Services (See "Short-Term Rehabilitation" for physical rehabilitation and skilled nursing facility admissions and "Transplant Services," if applicable.)	
Room and Board and Physician Care such as Physician Visits, Surgeon, Anesthesiologist, Lab, X-Ray, Other Diagnostic Tests, Medical/Surgical, and Mental Health/Chemical Dependency (including partial hospitalization); and Maternity	\$500 copay/admission (adult) \$350 copy/admission (child)
Lab Tests, X-Rays, EKGs, & Other Diagnostic Services (including tests done in office, outpatient facility, freestanding facility, ambulatory surgery facility)	No Charge
CT Scans	\$125 copay/Adult ³ \$75 copay/Child ³
GI Lab	\$175 copay/Adult ³ \$150 copay/Child ³
Home/Sleep Studies	\$50 copay per study ³
MRI and PET Scans	\$150 copay/Adult ³ \$100 copay/Child ³
Outpatient Facility (including surgical procedures related to pregnancy and family planning; and nonroutine colonoscopies)	\$500 copay/visit (adult) \$200 copay/visit (child)
Outpatient Physician/Surgeon (including surgical procedures related to pregnancy and family planning, nonroutine colonoscopies)	20% copayment
Short-Term Rehabilitation: Occupational, Physical, and Speech Therapy – outpatient or office (max. 35 visits/year)	\$50 per visit
Skilled Nursing Facility and Inpatient Rehabilitation (max. 60 days/year) (waived if transferred directly from an Inpatient Hospital, rehabilitation, or Hospice facility)	\$500 per admit/Adult; \$350 per admit/Child
Transplant Services (Must use facilities that contract with BCBSNM or through the national BCBS transplant network.)	
Cornea, Kidney, Bone Marrow	\$500 copay; \$350 (child)
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney: \$10,000 maximum for travel and per diem	

Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods				
Copayments are not applied to out-of-pocket. Certain drugs, special medical foods, and enteral nutritional products require preauthorization or benefits will be denied.	Generic Drug	Brand-Name Drug		
		If a generic equivalent is available and you or your doctor order the brand-name drug, you pay:	If there is no generic equivalent available:	
			On Drug List	Not on Drug List
Retail Pharmacy Program (up to a 30-day supply or 120 units, whichever is less)	\$10	\$10 plus difference in covered charge between the brand-name and the generic equivalent	\$30	\$50
Specialty Pharmacy Drug	20% of covered charge up to a maximum copayment of \$400 per prescription			
Mail-Order Service (up to a 90-day supply or 360 units, whichever is less)	\$20	\$20 plus difference in covered charge between the brand-name and the generic equivalent	\$75	\$150
	(Specialty pharmacy drugs are not available through Mail-Order Service)			
Nonprescription enteral nutritional products and special medical foods	50% of covered charges ³			

See footnotes on back.

FOOTNOTES:

- 1 Each member's initial covered charges (for most services that are subject to a percentage "coinsurance" amount) are applied to the deductible. The deductible must be met before benefit payments are made for such services. **Note:** A deductible is not required for covered services that are subject to a fixed-dollar copayment, hearing aids, or outpatient diagnostic testing.
- 2 After a member (or family) reaches the out-of-pocket limit during a single calendar year, BCBSNM pays 100 percent of that member's (or family's) covered charges for the remainder of the calendar year.
- 3 Certain services are not covered if preauthorization is not obtained from BCBSNM. See a benefit booklet for details.
- 4 Preauthorization is required for inpatient admissions. You pay a \$400 penalty for covered facility services if preauthorization is not obtained. 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.
- 5 Rental benefits for medical equipment and other items will not exceed the purchase price of a new unit.

Important Note: You must use a BCBSNM preferred provider, unless in an emergency. Deductibles, copayments, and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than billed charges. Covered services received from preferred providers that contract with their local BCBS Plan are also eligible for coverage under this plan.