

**Bernalillo County**

## Plan Highlights – PPO Plan


**Blue Cross and Blue Shield  
of New Mexico**

**Summary only** – lists the deductible, out-of-pocket limits, member coinsurance percentage amounts, and provides a brief description of Bernalillo County's Health Care Plan benefits.

<b>PPO Benefits</b> – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	<b>Member's Share of Covered Charges</b>	
	<b>Preferred Provider<sup>1</sup></b>	<b>Nonpreferred Provider<sup>1</sup></b>
<b>Annual Deductible</b> – Family deductible is aggregate of three times individual amount chosen. <sup>1</sup>	\$750 (\$1,500/family)	\$1,500 (\$3,000/family)
<b>Annual Out-of-Pocket Limit</b> – Includes deductible, coinsurance, and copayments; NOT prescription drugs, penalty amounts, or noncovered charges. <sup>2</sup>	\$5,000 (\$10,000 family)	\$10,000 (\$20,000 family)
<b>Primary Preferred Provider*</b> Office Visit and Initial office visit to diagnose pregnancy	\$30 copay/visit	50% coinsurance
<b>Mental Health and Chemical Dependency (outpatient/office)</b>		50% coinsurance
<b>Specialist</b> Office Visit and initial office visit to diagnose pregnancy	\$60 copay/visit	50% coinsurance
<b>Office Surgery</b> (including casts, splints, and dressings)	20% coinsurance	50% coinsurance
<b>Allergy Services</b> (testing, serum extracts and injections) (Injections included in office visit copay; \$0 copay if nurse visit only)	20% coinsurance	50% coinsurance
<b>Preventive Services</b> Routine Adult Physicals and Gynecological Exams, Well-Child Care; Routine Vision or Hearing Screenings, Related Testing (includes routine Pap tests, cholesterol tests, urinalysis, etc.), Routine Colonoscopies (outpatient/office), Smoking/Tobacco Cessation Counseling, and Immunizations	No Charge (Deductible waived)	50% coinsurance
<b>Acupuncture Treatment</b> (max. 18 visits/year)	\$50 copay per visit	50% coinsurance
<b>Ambulance Services: Ground and Emergency Air Transport</b>	\$50 copay ground; \$100 copay air	
<b>Ambulance Services: Nonemergency Air Transfer</b>	\$100 copay air	50% coinsurance <sup>4</sup>
<b>Cardiac and Pulmonary Rehabilitation</b> (outpatient)	20% coinsurance	50% coinsurance
<b>Cardiac Cath</b>	\$300 copay/Adult	50% coinsurance
<b>Chemotherapy and Radiation</b>	20% coinsurance	50% coinsurance
<b>Dialysis</b>	20% coinsurance	50% coinsurance
<b>Contraceptive Methods</b> (IUD, Hormone Injections, Inserted Devices) Breastfeeding support, supplies and counseling for one year after delivery	20% coinsurance	50% coinsurance
<b>Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services</b>	20% coinsurance	50% coinsurance
<b>Durable Medical Equipment, Supplies, Prosthetics, Orthotics</b>	20% with prior authorization <sup>6</sup>	50% coinsurance <sup>6</sup>
<b>Emergency Room Treatment</b>	\$250 copay/visit <sup>3</sup>	
<b>Urgent Care Facility</b>	\$75 copay/visit	
<b>Hearing Aids and Related Services:</b> Hearing aids for members under age 21 are paid at 100% of covered charges up to a maximum of <b>2 hearing aids every 3-years</b> ; exams and testing are subject to usual cost-sharing provisions. These services are not covered for members age 21 and older.		
<b>Home Health Care/Home I.V. Services</b> (max. 100 visits/year)	20% coinsurance	50% coinsurance
<b>Hospice Services</b> (*waived if transferred directly from an Inpatient Hospital, rehabilitation, or Skilled Nursing Facility)	20% coinsurance	50% coinsurance

See footnotes on back.

<b>Autism Spectrum Disorder</b> (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	\$30 copay/visit Child	50% coinsurance
	Specialist	\$60 copay/visit Child	
	Outpatient PT	\$60 copay/visit Child	
	Outpatient OT	\$60 copay/visit Child	
	Outpatient ST	\$60 copay/visit Child	
	Applied Behavioral Analysis (ABA)	\$30 copay/visit Child	
<b>Infertility Services</b> (including drugs and injections)		50% copay	Not Covered
<b>Lab, X-Ray, and Other Basic Diagnostic Tests</b>		No Charge	50% coinsurance
<b>CT Scans</b>		\$125 copay/test <sup>4</sup>	50% coinsurance <sup>4</sup>
<b>GI Lab</b>		\$200 copay/Adult <sup>3</sup>	50% coinsurance <sup>3</sup>
<b>Home/Sleep Studies</b>		\$50 copay per study <sup>3</sup>	50% coinsurance <sup>3</sup>
<b>MRI and PET Scans</b>		\$200 copay/test <sup>4</sup>	50% coinsurance <sup>4</sup>

\* A Primary Preferred Provider is a 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.

<b>PPO Benefits</b> – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.		<b>Member's Share of Covered Charges</b>		
		<b>Preferred Provider<sup>1</sup></b>		<b>Nonpreferred Provider<sup>1</sup></b>
<b>Inpatient Hospital/Facility Services</b>				
Medical/Surgical, Mental Health/Chemical Dependency (including Partial Hospitalization), Maternity-Related Room and Board, and Covered Ancillaries; (Well-baby Newborn charges pay 20% coinsurance; Extended Stay Newborn charges subject to deductible and 20% coinsurance)		20% coinsurance <sup>5</sup>		50% coinsurance <sup>5</sup>
<b>Outpatient Facility/Physician</b> (including surgical procedures related to pregnancy and family planning; and nonroutine colonoscopies)		20% coinsurance		50% coinsurance
<b>Short-Term Rehabilitation:</b> Occupational, Physical, and Speech Therapy – outpatient or office (max. 35 visits/year)		\$75 per visit		50% coinsurance
<b>Skilled Nursing Facility and Inpatient Rehabilitation</b> (max. 30 days/year) (waived if transferred directly from an Inpatient Hospital, rehabilitation, or Hospice facility)		20% coinsurance		50% coinsurance <sup>5</sup>
<b>Spinal Manipulation Services</b> (max. 18 visits/year)		\$60 copay		50% coinsurance
<b>Transplant Services</b> (Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.)				
<b>Cornea, Kidney, and Bone Marrow</b>		20% coinsurance		Not Covered
<b>Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney</b> (\$10,000 maximum for travel and lodging per diem)				
<b>Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods</b>				
Copayments are not applied to out-of-pocket. Certain drugs, special medical foods, and enteral nutritional products require preauthorization or benefits will be denied.	<b>Generic Drug</b>	<b>Brand-Name Drug</b>		
		<b>If a generic equivalent is available and you or your doctor order the brand-name drug, you pay:</b>	<b>If there is no generic equivalent available:</b>	
			<b>On Drug List</b>	<b>Not on Drug List</b>
<b>Retail Pharmacy Program</b> (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
<b>Specialty Pharmacy Drug</b>	<b>20% of covered charge up to a maximum copayment of \$500 per prescription</b>			
<b>Mail-Order Service</b> (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)			
<b>Nonprescription enteral nutritional products and special medical foods</b>	<b>50% of covered charges<sup>3</sup></b>			

**FOOTNOTES:**

1 The deductible must be met before benefit payments are made for most services. Deductible amounts do not cross-apply in the Preferred Provider and Nonpreferred Provider benefit levels. Deductible applies to all Nonpreferred benefits.

2 After a member reaches the applicable out-of-pocket limit, BCBSNM pays 100 percent of most of that member's covered Preferred or Nonpreferred Provider charges, whichever is applicable. Out-of-pocket amounts do not cross-apply in the Preferred Provider and Nonpreferred Provider benefit levels. (Specified transplant services are subject to a separate out-of-pocket limit.)

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 Member's Benefit Booklet for a list of services requiring preauthorization.

5 Preauthorization is required for inpatient admissions. You pay a \$300 penalty for covered medical/surgical facility services if preauthorization is not obtained. Some services, such as transplants and inpatient physical rehabilitation, 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 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.

**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.**

See footnotes on back.

