Administered by:
Blue Cross and Blue Shield of New Mexico

Dona Ana County

PPO Plan Highlights – $750

Highlights copayments, deductible, out-of-pocket limits, member coinsurance percentage amounts, and provides a brief description of Dona Ana County health care plan benefits.

PPO Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.		Member's Share of Covered Charges	
		Preferred Provider[1]	**Nonpreferred Provider[1]**
Contract Year Deductible – (Only services subject to a percentage "coinsurance" amount apply toward deductible; except Lab and X-Ray.)[1] Prescription Drug benefit is not subject to the Deductible.		$750 ($2,250/family)	$2,000 ($6,000/family)
Contract Year Out-of-Pocket Limit (Includes deductible, coinsurance, and copayments; NOT prescription drugs, penalty amounts, or noncovered charges.[2]		$2,750 ($5,500/family)	$6,000 ($12,000/family)
Office Services: If listed on this summary, other services received during the office visit to the Primary Preferred Provider (PPP*) or to the PPO Specialist, such as physical therapy, etc., are subject to deductible and coinsurance as listed below.			
Primary Preferred Provider* Office Visit, Exam and initial office visit to diagnose pregnancy Virtual Visit (MDLIVE providers)		$30 copay/visit $30 copay/visit	50% coinsurance Not Covered
Mental Health and Chemical Dependency (outpatient/office) Virtual Visit (MDLIVE providers)		$0 copay/visit $0 copay/visit	50% coinsurance Not Covered
Specialist Office Visit and initial office visit to diagnose pregnancy		$45 copay/visit	50% coinsurance
Office Surgery (including casts, splints, and dressings)		OV copay/visit	50% coinsurance
Allergy Injections, Tests	Primary Provider	$30 copay/visit	50% coinsurance
	Specialist	$45 copay/visit	
Allergy Serum		50% coinsurance	50% coinsurance
Preventive Services 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), and Immunizations		No Charge (deductible waived)	50% coinsurance
Acupuncture / Spinal Manipulation (max. **25 visits**/year/combined)		OV copay/visit	50% coinsurance
Ambulance Services: Ground and Emergency Air Transport		$75 per trip/Ground $150 per trip/Air[3]	
Autism Spectrum Disorders Applied Behavioral Analysis[4], and Occupational, Physical, and Speech Therapy		Based on place of treatment and type of service	50% coinsurance
Cardiac and Pulmonary Rehabilitation (outpatient)		$45 copay/visit	50% coinsurance
Dental/Facial Accident, Oral Surgery, and TMJ/CMJ Services[4]		Based on place of treatment and type of service	50% coinsurance
Emergency Room Treatment		$240 copay/visit[3]	
Hearing Aids and Related Services for Adults and Children: Hearing aids are paid at 100% of covered charges up to a maximum of **1 hearing aid per hearing-impaired ear every 3 years**; exams and testing are subject to usual cost-sharing provisions.			
Home Health Care/Home I.V. Services (max. **100 visits**/year)		30% coinsurance	50% coinsurance
Hospice - Inpatient		30% coinsurance[5]	50% coinsurance[5]
Hospice - Home		No Charge after deductible[4]	50% coinsurance[4]
Lab, X-Ray, and Other Basic Diagnostic Tests		30% coinsurance (deductible waived)	50% coinsurance
MRI, CT Scans, PET Scans		30% coinsurance[4] (deductible waived)	50% coinsurance[4]

* 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. A "PPP" is a Primary Preferred Provider in the preferred provider network.

PPO Benefits – There is no lifetime maximum benefit. However, certain services have maximum annual limits. See below.	**Member's Share of Covered Charges**	
	Preferred Provider[1]	**Nonpreferred Provider[1]**
Inpatient Hospital/Facility Services		
Medical/Surgical, Maternity-Related Room and Board, and Covered Ancillaries	30% coinsurance[5]	50% coinsurance[5]
Mental Health/Chemical Dependency (including Partial Hospitalization), Residential Treatment Center	No Charge (deductible waived)[5]	
Maternity Services	Office copay for initial visit	
Routine Nursery/Pediatrician Care for Covered Newborns	30% coinsurance[5]	50% coinsurance[5]
Extended Newborn Stay	30% coinsurance[5]	50% coinsurance[5]
Outpatient Facility/Surgeon/Physician (including surgical procedures related to pregnancy and family planning; and nonroutine colonoscopies)	30% coinsurance	50% coinsurance
Short-Term Rehabilitation: Occupational, Physical, and Speech Therapy; including Physical Rehabilitation **Inpatient Rehabilitation / Skilled Nursing Facility** (max. **60 days**/year/combined)[5] **Outpatient Therapies** (max. **60 visits**/year/combined)	30% coinsurance[5]	50% coinsurance[5]
Supplies, Durable Medical Equipment, Prosthetics, Orthotics	30% coinsurance[6]	50% coinsurance[6]
Therapy: Chemotherapy, Dialysis, and Radiation	$100 copay/visit	50% 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	Based on place of treatment and type of service[4,5]	Based on place of treatment and type of service[4,5]
Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney (**$10,000** maximum for travel and lodging per diem)	30% coinsurance[4,5]	Not Covered
Urgent Care Facility	$80 copay/visit	50% coinsurance

Type of Prescription	**Copay Level**		**Your Copay**	
Retail Pharmacy (up to a 30-day supply)			**Minimum Copay**	**Maximum Copay**
Generic Drug*	**Tier 1**	20%	$5	$15
Brand-Name Drug on Drug List (No generic equivalent available)*	**Tier 2**	30%	$30	$80
Brand-Name Drug Not on Drug List (No generic equivalent available)*	**Tier 3**	40%	$55	$100
Nonprescription Enteral Nutritional Products and Special Medical Foods (brand-name or generic): Products must be preauthorized.	**50** percent of covered charges (Limited to a 30-day supply during any 30-day period)			
Specialty Drugs - not available through mail-order	**Tier 4**	$135 copay		
Mail-Order Pharmacy (lesser of a 90-day supply or 360 units)*	**Tier 1**	$12		
	Tier 2	$50		
Note: Specialty pharmacy drugs not available through mail-order.	**Tier 3**	$100		
Covered prescriptions from the following categories will be covered under the Preventive Rx benefit: Mental Health; Antipsychotics; Anticonvulsants; Substance Abuse Disorder. See contract documents for details.	No Charge			
Prescription Drug Out-of-Pocket Limit	**$1,500/Individual – $3,000/Family**			
* 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 deductible must be met before benefit payments are made for services with coinsurance. Deductible amounts do not cross-apply in the Preferred Provider and Nonpreferred Provider benefit levels.

[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.

[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. 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.

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.

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.

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