

# NMPSIA: High Option Plan (BCBS of NM network)

Coverage Period: 10/01/2012 – 09/30/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: PPO



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.bcbsnm.com](http://www.bcbsnm.com) or by calling toll-free at 1-888-966-7742.

Important Questions	Answers	Why this Matters:
<p><b>What is the overall <u>deductible</u>?</b></p>	<p>In-network Preferred Providers and Non-Preferred Providers combined: <b>\$300/person; \$900/family</b>. Does not apply to preventive care, outpatient prescription drugs, tobacco cessation benefits and these services from a preferred provider: office visits, allergy shots, acupuncture, spinal manipulation, ambulance transport, cardiac rehab, pulmonary rehab, urgent care facility, chemotherapy, radiation therapy and hospice. Copayments, a penalty for failure to obtain precertification, and non-eligible medical expenses do not count toward the <b><u>deductible</u></b>.</p>	<p>You must pay all the costs up to the <b><u>deductible</u></b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b><u>deductible</u></b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b><u>deductible</u></b>.</p>
<p><b>Are there other <u>deductibles</u> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet <b><u>deductibles</u></b> for specific services but see the chart starting on page 2 for other costs for services this plan covers.</p>
<p><b>Is there an <u>out-of-pocket limit</u> on my expenses?</b></p>	<p>Yes, In-network Preferred Provider: <b>\$2,800/person; \$8,400/family</b>. Non-Preferred Provider: <b>\$3,200/person; \$9,600/family</b></p>	<p>The <b><u>out-of-pocket limit</u></b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you pay for health care expenses.</p>
<p><b>What is not included in the <u>out-of-pocket limit</u>?</b></p>	<p>Premiums, balance-billed charges, health care this plan does not cover, charges in excess of annual maximum benefits, a penalty for failure to obtain precertification, outpatient retail/mail order prescription drug expenses do not count toward the <b><u>out-of-pocket limit</u></b>.</p>	<p>Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b>.</p>
<p><b>Is there an overall annual limit on what the plan pays?</b></p>	<p>No.</p>	<p>The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.</p>
<p><b>Does this plan use a <u>network of providers</u>?</b></p>	<p>Yes. For a list of <b>in-network Preferred providers within the state of New Mexico through New Mexico Blue Cross and Blue Shield</b>, see <a href="http://www.bcbsnm.com">www.bcbsnm.com</a> or call toll free at 1-888-966-7742. For a list of <b>BlueCard Access providers</b> outside of the state of New Mexico, call 1-800-810-2583.</p>	<p>If you use an in-network doctor or other health care <b><u>provider</u></b>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b><u>provider</u></b> for some services. Plans use the term in-network, <b><u>preferred</u></b> or participating for <b><u>providers</u></b> in their <b><u>network</u></b>. See the chart starting on page 2 for how this plan pays different kinds of <b><u>providers</u></b>.</p>

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Do I need a referral to see a <b>specialist</b> ?	No.	You can see the <b>specialist</b> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <b>excluded services</b> .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network Preferred **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care <b>provider's office</b> or clinic	Primary care visit to treat an injury or illness	\$20 copayment/visit, deductible waived.	30% coinsurance after deductible met.	---none---
	Specialist visit	\$30 copayment/visit, deductible waived.	30% coinsurance after deductible met.	---none---
	Other practitioner office visit	\$30 copayment/visit, deductible waived.	30% coinsurance after deductible met.	Acupuncture, spinal manipulation, massage therapy and rolfing combined maximum benefit is \$1,500/calendar year.
	Preventive care/screening/immunization	No charge.	30% coinsurance, deductible waived.	Plan covers preventive services & supplies required by the Health Reform law. Age and frequency guidelines apply to covered preventive care.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance, after deductible met.	30% coinsurance, after deductible met.	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance, after deductible met.	30% coinsurance, after deductible met.	PET scans require precertification.

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Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b><u>prescription drug coverage</u></b> is available from MEDCO at <a href="http://www.medco.com">www.medco.com</a> or call 1-800-498-4904.</p>	Generic drugs	Non-Walgreens Retail Pharmacy for 30-day supply: \$3 copay; At Walgreens: \$8 copay Mail Order for 90-day supply: \$7.50 copayment.	You pay 100%. Plan reimburses no more than it would have paid had you used an In-Network Retail pharmacy.	Certain Over the Counter (OTC) allergy medication and Prilosec OTC is covered. Prescription contraceptives: No charge for generic drugs. If the cost of the drug is less than the copay, you pay just the drug cost. Some prescriptions are subject to preapproval, quantity limits or step therapy requirements.
	Preferred brand drugs	Non-Walgreens Retail Pharmacy for 30-day supply: 30% coinsurance with minimum \$18 copay & maximum \$50 copay; At Walgreens: 30% coinsurance with minimum \$23 copay & maximum \$55 copay; Mail Order for 90-day supply: \$45 copayment.	You pay 100%. Plan reimburses no more than it would have paid had you used an In-Network Retail pharmacy.	Copay waiver for diabetes medication and supplies at Non-Walgreens locations: call Medco member services at 1-800-498-4904. Prescription contraceptives: No charge for brand drug if generic drug is medically inappropriate.  If you purchase a brand drug when generic drug is available you pay the brand drug cost-sharing plus the difference in cost between the brand drug and the generic drug. If the cost of the drug is less than the copayment, you pay just the drug cost. Some prescriptions are subject to preapproval, quantity limits or step therapy requirements.
	Non-preferred brand drugs	Retail Pharmacy for 30-day supply: 70% coinsurance; Mail Order for 90-day supply: 70% coinsurance.	You pay 100%. Plan reimburses no more than it would have paid had you used an In-Network Retail pharmacy.	If the cost of the drug is less than the copayment, you pay just the drug cost. Some prescriptions are subject to preapproval, quantity limits or step therapy requirements.
	Specialty drugs	Up to a 30-day supply you pay a \$75 copayment/fill until \$1,000 in copays paid. Then, copay reduces to \$7.50 copay (generic), \$45 copay (preferred) and 70% coinsurance for (non-preferred).	Not covered.	Specialty drugs require preapproval by calling MEDCO at 1-800-498-4904.

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If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 copay plus 20% coinsurance, after deductible met.	30% coinsurance, after deductible met.	---none---
	Physician/surgeon fees	20% coinsurance, after deductible met.	30% coinsurance, after deductible met.	---none---
If you need immediate medical attention	Emergency room services	20% coinsurance, after deductible met.	20% coinsurance, after deductible met.	---none---
	Emergency medical transportation	\$30 copay/trip, deductible waived.	\$30 copay, deductible waived.	---none---
	Urgent care	\$50 copay/visit, deductible waived.	30% coinsurance, after deductible met.	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 copay/admission plus 20% coinsurance, after deductible met.	30% coinsurance, after deductible met.	Elective hospital admission requires precertification. Copay waived if re-admitted for same condition within 15 days of discharge.
	Physician/surgeon fee	20% coinsurance, after deductible met.	30% coinsurance, after deductible met.	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$30 copayment/visit, deductible waived.	30% coinsurance, after deductible met.	---none---
	Mental/Behavioral health inpatient services	\$500 copay/admission plus 20% coinsurance, after deductible met.	30% coinsurance, after deductible met.	Elective hospital admission, partial hospitalization and day treatment requires precertification. Partial hospitalization: \$250 copay plus the coinsurance; Intensive Outpatient: \$125 copay plus coinsurance.
	Substance use disorder outpatient services	\$30 copayment/visit, deductible waived.	30% coinsurance, after deductible met.	This Plan opted out of compliance with Mental Health Parity Addictions Equity Act. Maximum 30 outpatient visits/year for substance abuse treatment. Maximum 30 inpatient days/year for substance abuse treatment. Maximum 2 courses of treatment for inpatient and outpatient services combined. Elective hospital admission, partial hospitalization and day treatment requires precertification. Partial hospitalization: \$250 copay plus the coinsurance; Intensive Outpatient: \$125 copay plus coinsurance.
	Substance use disorder inpatient services	\$500 copay/admission plus 20% coinsurance, after deductible met.	30% coinsurance, after deductible met.	

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Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	For initial office visit, copay applies, deductible waived; thereafter, no charge.	30% coinsurance, after deductible met.	Ultrasound payable as a diagnostic test.
	Delivery and all inpatient services	\$500 copay/admission plus 20% coinsurance, after deductible met.	30% coinsurance, after deductible met.	Precertification required only if hospital stay is more than 48 hours for vaginal delivery or 96 hours for C-section.
If you need help recovering or have other special health needs	Home health care	20% coinsurance, after deductible met.	30% coinsurance, after deductible met.	Non-preferred provider max benefit 120 visits/calendar year. Precertification required.
	Rehabilitation services	Outpatient visits: \$30 copay, deductible waived. Inpatient rehab. admit: \$500 copay per admission plus 20% coinsurance, after deductible.	30% coinsurance, after deductible met.	Outpatient physical, occupational & speech therapy maximum benefit is 60 visits/condition calendar year.
	Habilitation services	Not covered.	Not covered.	You pay 100% of these expenses.
	Skilled nursing care	\$500 copay/admission plus 20% coinsurance, after deductible met.	30% coinsurance, after deductible met.	Precertify admission. Maximum benefit is 60 days per calendar year.
	Durable medical equipment	20% coinsurance, after deductible met.	30% coinsurance, after deductible met.	Insulin pump supplies: no charge from Preferred provider. DME over \$500 requires precertification.
	Hospice service	No charge.	30% coinsurance, after deductible met.	Max benefit 10 days for each 6 month benefit period. Precertification required.
If your child needs dental or eye care	Eye exam	No charge if obtained during a preventive care office visit.	Not covered.	Covered for children up to 17 yrs.
	Glasses	Not covered.	Not covered.	You pay 100% of these expenses.
	Dental check-up	Not covered.	Not covered.	You pay 100% of these expenses.

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## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- |                               |  |                            |
|-------------------------------|--|----------------------------|
| • Cosmetic surgery            | • Habilitation services                              | • Private duty nursing     |
| • Dental care (Adult) (Child) | • Long-term care                                     | • Routine eye care (Adult) |
| • Eyeglasses                  | • Non-emergency care when traveling outside the U.S. | • Routine foot care        |

### Other Covered Services

(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- |   |   |  |
|---|---|--|
| • Acupuncture, spinal manipulation, massage therapy & rolfing maximum benefit is \$1,500/calendar yr; no coverage for maintenance chiropractic therapy. | • Bariatric Surgery (when precertified)   | • Infertility treatment (limited treatment covered plus testing to determine the cause of infertility and certain surgical treatment procedures) |
|   | • Hearing aids: Under 21 years, \$2,200/ear in any 3-year period; age 21 and older \$500/member in any 3-year period. | • Weight loss programs (when provided by a Physician, licensed nutritionist or registered dietitian).  |

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact ERISA at 1-800-233-3164. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Medical Plan Claims Administrator (New Mexico BCBS) at 1-888-966-7742.

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-966-7742.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-888-966-7742.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,720
- Patient pays \$1,820

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$300
Copays	\$510
Coinsurance	\$860
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,820</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,420
- Patient pays \$980

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$300
Copays	\$380
Coinsurance	\$220
Limits or exclusions	\$80
<b>Total</b>	<b>\$980</b>

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

**\*No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

**\*No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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